

Top Issues in Behavioral Health 2026 Newsletter

ANNUAL NEWSLETTER
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Behavioral Health Investment in 2026: Navigating Legal Risk and Closing The Deal



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Investment in the behavioral health sector remains a significant focus for PE firms and a broad range of strategic and nontraditional financial acquirors. 2025 saw a notable uptick in reported behavioral M&A deals with over 100 reported transactions, led by mental health and followed by substance abuse treatment and autism/IDD transactions. We continue to see buyers carefully assessing business and clinical models, as well as reimbursement and compliance.

Early indications for 2026 suggest accelerating behavioral health investment activity driven by an ongoing need for access to care, investor confidence in the space, moderating interest rates and technology-enabled innovation. We anticipate continued interest in turnaround opportunities involving providers that

have experienced financial or operational challenges, particularly for strategic acquirors with capacity for growth investment. We continue to see investor focus centering on "proof of value," due diligence and mitigating increasingly complex regulatory risks.

These emerging investment themes, along with continued regulatory and reimbursement change impacting behavioral health, raise a range of potential legal risk areas on the path to closing the deal. Below, we provide an overview of key issues — some new, others familiar — for the year ahead and takeaways for arriving at successful closings notwithstanding certain risks and challenges.

Foundational Issues – CPOM, CHOW and Pre-Closing Approvals

Regulatory structure continues to be a foundational element and focus point in transaction due diligence and execution. In states with corporate practice of medicine (CPOM) restrictions, underlying entity legal structure becomes an even more important focus area, particularly in states,

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like California and Illinois,¹ that have adopted new or enhanced requirements that licensed professionals own certain health care providers. Adapting to these requirements remains a focus in transactional and operational contexts and can require implementing PC-MSO or “friendly PC” arrangements. We have seen increased attention to this topic in outpatient mental health and autism/ ABA treatment transactions, where providers are often operating under individual clinician license credentials as opposed to state agency licensure at the program level. A clear understanding of how these evolving requirements apply — which can be nuanced based on state of operation, clinical services provided and a provider’s business model — remains a key foundational element to transaction success.

For providers holding program and/or facility-level licensure, transaction structure and state agency rules can often require pre-

closing change of ownership (CHOW) approvals, which can trigger long lead-time processes as a gating item to closing. As CHOW process requirements and timing will often vary based on state agency rules, transaction structure and other factors, we continue to see value in mapping them out early in a transaction and aligning them with corporate structure and tax considerations for a timely and efficient transaction process. Where possible, we recommend considering potential CHOW implications well ahead of a transaction process.

Additionally and related to the above, an increasing number of states have adopted² or are considering³ state-level pre-closing notice or approval processes for transactions involving health care providers. These processes can apply equally to programs that are operated under licensed professional ownership, or program and/or facility level licensure, and are intended to mitigate perceived impacts

on access to and cost of care and interference in clinical operations. Some states, notably California and Oregon, have exempted certain behavioral health transactions from these processes depending on the services involved, licensure and structure of the provider. These processes can be costly and time-consuming gating issues to transaction completion. We see this delineation as positive, given ongoing need for investment in and access to behavioral treatment and observe that payor behavior — as opposed to M&A investment — remains a predominant factor in access to and cost of treatment. Nonetheless, as an increasing share of behavioral transactions may be subject to pre-closing reporting and approval requirements going forward, we recommend vigilance in assessment and transaction planning, as well as regularly monitoring applicable legislative and regulatory developments.

1. California Senate Bill 351 regarding California corporate practice of medicine restrictions (effective January 1, 2026) and Illinois Behavior Analyst Licensing Act 225 ILCS 6/150 regarding Illinois (effective January 2027).

2. See Governor Newsom Embraces Tighter Requirements on Private Equity and Hedge Fund Investments in California Health Care By Signing AB 1415 and SB 351 (October 2025) available at <https://www.polsinelli.com/paul-a-gomez/publications/newsom-signs-ab1415-sb351-california-health-care-investment-requirements> (explaining expanded OHCA notice and review requirements for health care and certain behavioral health care transactions as well as further codified corporate practice of medicine restrictions and heightened enforcement scrutiny related to same).

3. “Four More States Weigh Bans on Private-Equity Interference in Medical Care” Wall Street Journal (January 30, 2026).



Due Diligence and Valuation Support – Licensing and Credentialing


Adherence to applicable licensing requirements at both the facility and professional levels is a fundamental building block for a compliant treatment program and a primary potential legal risk and due diligence area. A provider's clinical and business model should align with the facility types, programs and services licensed in the jurisdiction. Any gaps or mismatches between services provided and services licensed come at the risk of not only adverse action by the licensing agency, but also audit, recoupment and/or overpayment liability under commercial insurance and government-pay reimbursement

arrangements. Payor arrangements typically require compliance with all legal requirements applicable to patient services reimbursed by the payor. Provider practices that promote compliance with licensing, credentialing and CPOM requirements can help avoid due diligence, valuation and transaction execution challenges.

Credentialing issues are particularly relevant for providers that have embraced specialized treatment modalities, such as interventional psychiatry modalities like TMS and Spravato, as well as technology-enabled

treatment that leverages artificial intelligence (AI) capabilities.⁴ We see scope of licensure and billable services, adherence to clinical engagement and “incident to” billing requirements, and patient safety guardrails among the areas drawing attention — particularly as treatment models are increasingly outpacing licensing and reimbursement frameworks. Defining and assessing compliance with regulatory and payor requirements for these and other evolving treatment modalities will continue to be a focus area in both operational and transaction contexts.

4. For a more in-depth analysis of the layers of regulatory requirements and potential threats of liability that can flow from providers use of AI mental health and other behavioral health tools please refer to “Empathy Is Not Enough: Compliant AI Mental Health and Companion Chatbots,” Laila Paszti, Iliana L. Peters, Joelle M. Wilson on p. 8.



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Reimbursement and Risk Allocation

We continue to see payors targeting behavioral health providers for audits and recoupments for alleged noncompliance with these requirements. Payor recoupment claims are typically not covered by a provider's insurance policies and may be excluded from or subjected to heightened underwriting review in transaction representation and warranty coverage.

A behavioral health provider's contracted commercial and governmental payors have overlapping, but not always identical, requirements. Across behavioral health, we see reimbursement sources varying considerably based on provider type and service line, as well as commercial payor policies and evolving reimbursement guidelines at the federal and state level.⁵ As noted above, we continue to see reimbursement, credentialing and compliance as primary focus areas for due diligence. Similarly, chart review and revenue cycle assessment are also standard components of transaction due diligence. Where issues are identified, we see a significant focus on ensuring that provider practices and documentation align with payor requirements,

and potential gap areas giving rise to valuation, risk allocation and potentially closing implications.

In light of this, we recommend sellers consider engaging in a sell-side coding review as part of transaction preparation work. This is particularly important as acquirors will regularly conduct their own reviews as part of confirmatory diligence. Early identification and remediation, if warranted, can help keep a transaction on track.

Fraud and Abuse Compliance

A range of health care fraud and abuse statutes can apply to behavioral health day-to-day operations and transactions. These include the federal Anti-Kickback Statute (AKS), the federal False Claims Act, the federal Civil Monetary Penalties Law, the federal Eliminating Kickbacks in Recovery Act (EKRA) and various state law corollaries. Many of these laws depend on the involvement of government payor programs but many may apply regardless of the payor types involved. As a result, it is important to be proactive in engaging appropriate counsel to assess applicable regulations and ensure ongoing compliance

with same. Common professional services agreements, management agreements, leases of space, marketing arrangements and other vendor arrangements can conflict with these — triggering fines and penalties and actions by payors to recoup part or all of payment made for services rendered — and create impediments to competing transactions should they arise in the course of due diligence.

Providing free or below fair market value housing or travel assistance to patients receiving behavioral health care, including in particular addiction treatment, can expose providers to liability under these regulations. We are seeing increasing regulatory focus on the offering of financial incentives or nonmonetary benefits, such as housing or travel assistance, as potentially unlawful inducements to patients in exchange for referrals to treatment services. These considerations are often balanced against challenges that patients — particularly those seeking treatment from opioid addiction — have in securing stable housing at early stages of treatment. We similarly see compliance risk arising in remuneration arrangements between a treatment

5. The Big Beautiful Bill and the Future of Medicaid, Polsinelli D.C. Download Podcast, Harry Sporidis, Marisa Campbell and Jennifer L. Evans (July 17, 2025). <https://www.polsinelli.com/d-c-download/s1-e2-the-big-beautiful-bill-and-the-future-of-medicaid>.



provider and referral sources — which in some cases, can include workforce members — tied to the volume or value of referrals.

Earnouts are not uncommon as a means of helping buyers and sellers bridge a valuation gap to reach a mutually agreeable transaction price. Nevertheless, they warrant careful consideration in behavioral health transactions in light of enhanced governmental scrutiny and potential violation of some of the laws noted above if not structured appropriately. For example, transactions in which a seller will remain with the target business and will be in a position to generate patient referrals can raise more elevated compliance risks and require careful vetting and consideration. Qualified legal counsel should be engaged to help define and align permissible metrics that are consistent with applicable legal requirements and economic expectations, ideally at an early stage of the transaction.

Assessing compliance requires a deep understanding of the relevant facts and circumstances and applying evolving legal standards. For example, in

a case involving marketing personnel and percentage-based compensation structures this past year, the *Ninth Circuit Court of Appeals in U.S. v. Schena* determined that EKRA applies to standard sales conduct only if the sales conduct “unduly influences” a referral source or involves a “wrongful effort to unduly influence the decisions of” referral sources or patients.⁶ In other words, percentage-based compensation arrangements may not necessarily violate EKRA. We recommend continued monitoring and vigilance in this developing area, particularly in light of heightened regulatory scrutiny of fraud and abuse by health care providers.⁷

AI and Privacy

AI tools are being used with increased frequency to provide emotional support, mental health guidance, and simulated companionship. These tools, including chatbots and systems, created to sustain ongoing responsive relationships are addressing gaps created by cost, access barriers and shortages of licensed behavioral health professionals.

In practice, once a company defines what services AI tools will provide, it must then carefully assess whether it crosses into the medical device threshold (pulling in FDA regulation) and how it will comply with other key regulatory requirements including those in the privacy, consumer protection and health care regulatory realms.

Additionally, privacy risk has evolved from passive data protection to active governance of emerging technologies. In 2026, “shadow AI” — the unauthorized use of AI tools by clinical or administrative staff — has become a major liability. This joins ongoing federal enforcement against the use of tracking pixels on patient portals, which regulators continue to view as an impermissible sharing of patient data with social media companies.

As a result, due diligence should include a thorough review and assessment of a target’s AI use of varying types to ensure compliance and mitigate risk, which can now flow from multiple federal and state laws as well as case law — all of which are developing rapidly.⁸

6. For more detail, please refer to “Fraud and Enforcement Uptick Suggests Heightened Scrutiny in 2026,” T. Jeffrey Fitzgerald on p. 18.

7. Polsinelli Issue Brief: State-Level Medicaid Fraud in Focus (January 7, 2026). <https://www.polsinelli.com/publications/issue-brief-state-level-medicaid-fraud-in-focus>.

8. For a more in-depth analysis of the layers of regulatory requirements and potential threats of liability that can flow from providers use of AI mental health and other behavioral health tools please refer to “Empathy Is Not Enough: Compliant AI Mental Health and Companion Chatbots,” Laila Paszti, Iliana L. Peters, Joelle M. Wilson on p. 8.



Getting to the Closing: Early Preparation and Thoughtful Navigation

The behavioral health sector continues to draw investment interest and at the same time, is becoming more complex. As a result, it also continues to become more of a focus for regulatory and payor enforcement activity. Early preparation and engagement with knowledgeable legal and other advisors can be a significant force multiplier towards transaction success, and the elimination or mitigation of surprise or delay on the path to closing.

As investors, providers and other stakeholders consider transaction preparation in the year ahead, we recommend:

- Getting started early on legal and regulatory assessments, including planning for any transaction approvals. As provider profile and transaction structure can significantly impact necessary approvals and related processes, involve experienced counsel during early stages of transaction planning.
- The novelty and complexity of transactional and operational issues, as well as the “one size fits few” nature of behavioral health, puts a premium on thoughtful and focused due diligence to help expedite closing. Legal due diligence should include marketing activities, fraud and abuse compliance, reimbursement billing/coding, AI and privacy, licensing and credentialing, corporate practice and PC/MSO structures and payor disputes.
- Parties to a transaction should align early, including with legal counsel, to address antitrust-related enforcement concerns and work to minimize or mitigate the potential for lengthy regulatory review, including by addressing required filings, market concentration and cost and access-to-care concerns that may be implicated.
- Monitor evolving legal and regulatory standards applicable to behavioral health providers, including ongoing changes to federal and state antitrust and mini-HSR requirements as more becomes known on how heightened scrutiny, review processes and/or legal challenges take hold.⁹
- Related to the above, scrutiny may be heightened when private equity firms engage in a given transaction, but the waters remain navigable, and private equity investment and activity in behavioral health remains strong. Thoughtful, early legal and business strategy and a clear commitment to maintaining and increasing quality and access to care is key.
- The maxim “time kills all deals” derives from learned experience. Adhering to a shared timeline as closely as possible with trusted deal partners who are aligned on business culture and mission can significantly aid in maintaining momentum, helping all parties navigate obstacles and arrive at a successful and timely closing.

9. Polsinelli’s national Behavioral Health Law Group continues to monitor and assess legal and regulatory trends, along with federal and state antitrust review of health care and behavioral health care transactions.



Empathy is not Enough: Compliant AI Mental Health and Companion Chatbots



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I. Introduction

Artificial intelligence (AI) tools are increasingly being used to provide emotional support, mental health guidance and simulated companionship, filling gaps created by cost and access barriers and shortages of licensed mental health professionals.

Many of these tools are intentionally designed to avoid diagnosis or treatment functions that would trigger medical device classification and the attendant Food and Drug Administration (FDA) regulatory requirements, including the need for premarket clearance and regulatory approval before launch. However, in addition to potential FDA regulatory implications, companies

developing, offering or marketing AI mental health or companion tools are encountering a more complex and increasingly enforced regulatory reality.

II. Regulatory Overview

In practice, once a company defines what services an AI chatbot will provide and determines whether it crosses into the medical device threshold (which is beyond the scope of this article), the compliance inquiry primarily involves reconciling a regulatory trifecta: privacy, consumer protection and health care regulation:

- Data privacy, security and breach regulations form a complex mix of both federal and state laws (including HIPAA) that significantly limit the use of personally identifiable information and protected health information for training AI. These laws also require clear notice to users or patients and, in many cases, their consent for how their information is used, including for features like “wiretapping,” chat functionality, text messaging and advertising and marketing. Aggressive and frequent class action lawsuits result in significant legal

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risk for these activities, apart from active state and federal regulators and their investigations.

- Consumer protection regulation is driven by the Federal Trade Commission (FTC) and state consumer protection laws. The FTC has used its enforcement authority to regulate deceptive or unfair practices involving AI tools, including misleading health claims, improper data use and exploitative or manipulative AI tool design. At the state level, attorneys general have likewise brought enforcement actions under state consumer protection and unfair competition statutes.
- Health care regulation applicable to AI chatbots includes state statutes governing therapy and mental health services, as well as emerging AI-specific legislation, with California leading the charge in directly addressing therapeutic and companion chatbot applications. Regulators are also increasingly evaluating whether and how AI tools intersect with the practice of learned professions, an area where no comprehensive legal framework yet exists but which remains a key focus from a regulatory-

risk perspective. Some states, including Utah, have begun to create limited pathways for AI-enabled tools to provide services traditionally reserved for licensed professionals, signaling potential future regulatory models that balance innovation, oversight and patient protection.

While other regulation may also come into play (e.g. insurance), this article considers those three key regulatory regimes not just as an abstract legal framework but as a practical roadmap for product, legal and compliance teams rolling these tools out.

III. Step One: Understanding Your AI Chatbot's Function

Every compliance analysis ought to begin with this deceptively simple question: what is this AI chatbot actually doing for users?

Regulators increasingly look past how the AI chatbot is branded or marketed to functional reality (i.e., how it is being used). An AI chatbot marketed as “wellness support” may still be treated as therapy-adjacent in certain contexts — e.g., if it sustains emotionally intimate dialogue, guides users through treatment-like exercises, responds

empathetically to distress or trauma or encourages reliance over time. Recent legislative efforts, particularly in California, make clear that “therapy” is being defined by behavior and user perception, not by disclaimers alone. If a tool independently conducts therapy-like interactions, even if not overtly diagnosing or prescribing, it may cross into regulated territory and trigger FTC scrutiny and state consumer protection and health data obligations, as well as potential licensing requirements under emerging state laws. For example:

- **FTC “Net Impression” Standard:** The FTC evaluates claims based on the overall impression conveyed to consumers, not just explicit disclaimers. If a chatbot functionally behaves like therapy, the FTC may treat it as making therapeutic claims regardless of labels.
- **State Professional Licensing Laws:** Most states define “therapy” or “psychotherapy” based on the nature of services provided, not just titles. The AI chatbot activities described (e.g., emotionally intimate dialogue, treatment-like exercises, responding to distress) often match statutory definitions of counseling or therapy practice.



- **California SB 903 (Proposed):** This recently introduced bill explicitly prohibits AI from “offering or advertising therapy” based on functional behavior, not just marketing language. It looks at what the system actually does.

Even if an AI chatbot is not marketed as wellness support but instead offers just “companionship,” regulators are increasingly concerned about the long-term effects on users, particularly teens and children:

- **FTC:** In September 2025, the FTC launched a Section 6(b) market study specifically examining companion chatbots. The inquiry signals heightened scrutiny of design choices around persona anthropomorphism, memory and relational continuity, monetization tied to emotional engagement and youth safeguards.
- **California SB 243:** This bill, which took effect at the beginning of this year, triggers oversight of AI chatbots with “human-

like social interaction” rather than medical intent. This establishes that functional behavior, not marketing labels, determines regulatory treatment. This represents a significant shift in the regulatory landscape: chatbots designed to simulate friendship, romance or ongoing emotional connection now face compliance obligations regardless of whether they make any health or therapeutic claims. The regulatory trigger is the nature of the interaction itself — sustained, personalized, emotionally responsive dialogue that mimics human relationships. Under SB 243, companion chatbots must implement mandatory AI identity disclosures, recurring reminders for minors, suicide and self-harm safety protocols, public transparency around safeguards and annual reporting to the Office of Suicide Prevention. The law also creates a private right of action with statutory damages, exposing companies

to direct liability from users harmed by inadequate safeguards.

This foundational determination of the chatbot’s actual use or function is crucial because it triggers specific elements of the regulatory trifecta — and potentially additional obligations beyond those three frameworks.

PRACTICAL TAKEAWAY:

Before launch, teams should document in plain language what the chatbot is designed not to do and ensure that product behavior actually reflects those limits.

Importantly, regardless of how an AI chatbot is classified or what disclaimers it provides, any system engaging in emotionally responsive dialogue with users must implement robust suicide and self-harm safeguards. This baseline expectation cuts across all three elements of the regulatory trifecta and is increasingly treated as non-negotiable. (See *Section V for additional information*).



IV. The Regulatory Trifecta Explained

Once the use/function boundary is set, companies face overlapping obligations across three regulatory regimes. These regimes are converging and each reinforces the others.

1. Regime One: Data Privacy, Security and Breach Requirements

A. Data Ownership

Generally, pursuant to state and federal law, the data owner (including the HIPAA “covered entity”) owns the personally identifiable information (or HIPAA “protected health information”) collected by these tools. As such, the tool’s vendor or data processor (or HIPAA “business associate”) and the data owner must coordinate closely on how the personal information is collected and used to ensure compliance with applicable state and federal laws protecting the privacy and security of the personal information, and that the data owner is not left holding the bag if something goes wrong, as with a breach.

Additionally, privacy and security protections must be embedded into system design from the outset — including data minimization in model architecture, encryption at

rest and in transit, access controls that limit the collection, use and disclosure of personal information to the minimum necessary (and only as provided for by terms and conditions, website privacy policies and individual consumer consents), audit logging and other technical safeguards. Retroactive policies and privacy notices cannot substitute for systems built to handle personal information securely by design.

Even when HIPAA does not apply, its privacy, security and breach notification requirements increasingly function as a baseline expectation for handling mental health data, including with regard to de-identification (or anonymization) of personal information. State consumer health data laws and FTC enforcement borrow heavily from HIPAA concepts such as de-identification, purpose limitation, data minimization and confidentiality.

Finally, depending on the proposed use of the AI chatbot data, owners should evaluate whether 42 C.F.R. Part 2 obligations, which have significant criminal and civil penalties attached, are triggered (e.g., by potential disclosure of substance use disorder treatment information or when the chatbot’s use or function

may bring it within the scope of federally assisted substance use disorder treatment programs).

B. Consumer Consent

State consumer health data laws, HIPAA and federal wiretapping requirements typically require affirmative, informed and written consent from the individual consumer before engaging in chat discussions (which are recorded) and collecting, using or disclosing personal information for a variety of activities, particularly marketing and advertising, including through website tracking technologies. The Department of Health and Human Services (HHS), the States’ Attorneys General, the FTC and many courts around the country have taken the position that mental health and addiction-related information warrant the highest level of privacy and security protection — for example, making undisclosed use for model training or third-party sharing a significant deceptive practice risk, imposing significant penalties after regulatory investigations involving such information and creating significant class action litigation risk associated with recording conversations involving such information and with marketing using such information.



2. Element Two: FTC Oversight and Consumer Protection

The Federal Trade Commission has become the most active federal regulator of AI chatbots.

A. Health Claims — Explicit and Implicit

The FTC evaluates claims based on net impression, not labels. An AI chatbot that conducts daily emotional check-ins, responds empathetically to anxiety or depression and frames itself as emotionally supportive may be treated as making mental health claims even if it avoids diagnostic language.

PRACTICAL TAKEAWAY:

Claims relating to mental health generally require competent and reliable scientific evidence. Overstating effectiveness or minimizing limitations creates enforcement risk.

B. Data Use and Secondary Exploitation

The FTC has repeatedly emphasized that mental health data is among the most sensitive categories of personal information. Enforcement actions have focused on undisclosed use of chat data for model training, sharing sensitive data with third parties and indefinitely retaining emotional disclosures.

PRACTICAL TAKEAWAY:

Privacy disclosures must be plain-language, specific and aligned with actual data practices.

C. Emotional Manipulation and Engagement Design

The FTC is increasingly attentive to exploitative engagement patterns, particularly where systems encourage dependency or prolonged use among vulnerable users. Design choices that optimize for session length or emotional reliance may be reframed as unfair practices, not neutral user experience (UX) decisions.



D. Litigation and Market Studies

Recent lawsuits and FTC market studies (as discussed above) reflect growing concern about synthetic relationships: AI systems designed to simulate friendship, romance or emotional intimacy.

A wave of wrongful death lawsuits has emerged following tragic teen suicides linked to companion chatbots. Most prominently, *Garcia v. Character Technologies* was filed in October 2024 after 14-year-old Sewell Setzer III's death following prolonged interactions with Character.AI — a platform where users can engage in conversations with customizable AI characters.

In May 2025, Judge Anne Conway of the U.S. District Court for the Middle District of Florida issued a landmark ruling allowing most claims to proceed. The court rejected First Amendment defenses, holding that chatbot output is not protected speech, and ruled that AI chatbots can be considered “products” subject to traditional product liability — including strict liability for defective design, failure to warn and negligence. This marked the first time a U.S. court applied conventional tort principles to generative AI.

Character.AI settled multiple lawsuits in January 2026 after implementing reactive safety measures, including banning minors from open-ended conversations in November 2025.

PRACTICAL TAKEAWAY: The FTC's Section 6(b) companion chatbot study signals that companies should be prepared to justify their design, governance and safety decisions in detail. This includes:

- Documenting the rationale behind persona design, memory systems and engagement mechanics;
- Assessing whether monetization models tie revenue to emotional dependency;
- Implementing robust youth protections including age-appropriate content filters and usage safeguards;
- Documenting design and testing of models and use of user data; and
- Conducting internal audits to identify gaps before regulatory scrutiny intensifies.



E. State Consumer Protection

State attorneys general have similarly increasingly scrutinized AI chatbots marketed or deployed in the behavioral health space, using state consumer protection and deceptive practices laws to address concerns about misleading claims, user harm and inadequate safeguards. Notably, the Texas Attorney General has opened investigations into specific AI chatbots for allegedly marketing chatbot tools

as therapeutic or mental health support without appropriate disclosures, oversight or professional involvement, raising concerns about deception and the unauthorized provision of mental health services. These actions reflect a broader enforcement trend in which state AGs are examining whether AI chatbots improperly present themselves as substitutes for licensed behavioral health

professionals, fail to warn users about limitations and risks or exploit vulnerable populations. Even in the absence of AI-specific behavioral health statutes, state AGs have signaled that existing unfair and deceptive acts and practices laws apply fully to AI chatbot tools that make mental health-related claims or engage users in emotionally sensitive contexts.

3. Element Three: Health Care/Therapy Regulation

It is important to evaluate existing state health care laws governing therapy and other licensed professional activities, which may apply based on how an AI chatbot functions or is marketed. States are also beginning to adopt AI-specific laws that regulate companion and emotionally engaging chatbots through disclosure, safety and user-protection requirements. For example:

A. New York AI Companion Model Law

New York requires operators of “AI companions” (systems that simulate human interaction and sustain personal dialogues) to implement reasonable protocols to detect and address self-harm or suicidal ideation and to provide clear disclosures that users are not interacting with a human.

B. California’s Companion Chatbot Act (SB 243)

California’s SB 243 imposes mandatory AI identity disclosures, recurring reminders for minors, suicide and self-harm safety protocols, public transparency around safeguards, annual reporting to the Office of Suicide Prevention and a private right of action with statutory damages. The trigger is human-like social interaction, not medical intent.

C. California’s Proposed SB 903: No AI “Therapy” Without a License

California’s proposed SB 903 prohibits AI systems from offering or advertising therapy unless a licensed professional is responsible for care. The bill would bar AI from independently conducting therapy, restrict AI use by clinicians to administrative or supervised support and require disclosure and consent for AI use in therapy contexts, while imposing civil penalties for violations.

PRACTICAL TAKEAWAY: Marketing language, conversational framing and functional autonomy now carry statutory risk.



VI. Practical Rollout Checklist

Before deployment, teams should be able to answer “yes” to several critical questions:

- Have we clearly defined what services the chatbot does not provide?
- Does conversational behavior match our disclaimers and marketing?
- Are data practices transparent and limited?
- Are engagement mechanics defensible under FTC scrutiny?
- Do we comply with state consumer health data laws?
- Are therapy-like features constrained or supervised?
- Are suicide and self-harm protocols implemented and tested?

If any answer is unclear, risk is likely higher than expected.

VII. Conclusion: Compliance is about Behavior, Not Labels

AI mental health and companion tools now operate in a complicated regulatory paradigm. Companies must comply simultaneously with HIPAA norms, FTC consumer protection standards and state privacy and therapy regulation, among other frameworks.

The unifying principle across all three is simple. If an AI system simulates empathy or a relationship, regulators will expect transparency, restraint and human accountability.

For companies, the path forward is not avoidance, but compliance by design — building AI systems that support users without substituting for licensed care or exploiting vulnerability.

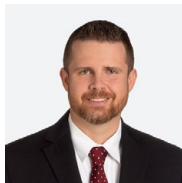
Payor Audit Spotlight Squarely Focused on ABA Services



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Key Takeaways

- Payor audit activity targeting Applied Behavior Analysis (ABA) providers has increased significantly for commercial insurance at both the state and federal agency levels.
- Budget pressures and heightened federal oversight have intensified state Medicaid program integrity efforts.
- Growth in autism diagnoses and expanded access to ABA services in commercial plans and Medicaid has led to increased utilization and spending, drawing audit scrutiny.
- ABA providers face unique compliance risks due to complex coverage, supervision and documentation requirements.

- Prompt, strategic responses to payment audits and investigations are critical to mitigating recoupment risk.
- Failure to adequately respond to Medicaid audits risks not only financial losses but continued Medicaid participation.

ABA providers are facing material commercial and governmental audits and payment reviews nationwide. This heightened scrutiny reflects increased ABA spending and broader fiscal and regulatory pressures on Medicaid programs. The scrutiny presents compliance and financial risks for providers serving children with autism spectrum disorder. Understanding the drivers of this trend is essential for providers seeking to manage exposure and protect revenue.

State Medicaid programs are operating under growing financial strain. Federal financial limits and new administrative requirements of H.R. 1 combined with rising health care costs have placed sustained pressure on state budgets. At the same time, federal oversight of Medicaid and ABA has intensified, from the Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Health

and Human Services Office of Inspector General (OIG). Audit activity has become a key tool for states seeking to control costs and monitor compliance with program requirements.

At the same time, utilization of ABA services has increased substantially, drawing scrutiny from all payors. More children are receiving services due to higher diagnosis rates and greater recognition of autism-related needs. States have also taken steps to address historical gaps in access to ABA services under Medicaid. Under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, ABA services are generally recognized as a mandatory covered service when medically necessary for eligible children. As states have expanded access and provider capacity, Medicaid spending on ABA services has risen accordingly.

ABA services present challenges from a program integrity and operations perspective. These services are highly individualized, subject to detailed supervision and credentialing requirements and reliant on robust clinical documentation. Even providers acting in good faith may face allegations of noncompliance related to medical necessity

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determinations, supervision ratios, documentation deficiencies, or technical billing rules. ABA providers have become frequent targets for audits and overpayment reviews.

Recent state audit activity illustrates this trend. Medicaid agencies in several states have expanded reviews of ABA services, often focusing on utilization patterns, documentation and compliance with state-specific coverage standards. Adverse findings can lead to extrapolated recoupment demands and, in some cases, broader enforcement implications.

Federal attention, including allegations of widespread fraud in some states, has further put ABA providers in the spotlight. Administratively, an OIG series audit in the field is investigating how ABA is delivered and reimbursed. To date, Medicaid programs in seven states have endured the OIG audit of autism services which is likely to result in increased state audit activity. Responding to OIG findings will push state Medicaid programs into audits or investigations of ABA providers and eventually lead to overpayment demands.

In this environment, audit notices should be treated as serious business events that may suggest underlying or potential investigations. Early assessment, careful issue framing and strategic engagement and appeals can significantly affect outcomes. Qualified health care counsel with deep experience assisting ABA providers with Medicaid audits, investigations and compliance is essential to helping clients navigate regulatory complexity, respond effectively to audit findings and mitigate financial and operational risk.



Fraud and Enforcement Uptick Suggests Heightened Scrutiny in 2026



**T. Jeffrey
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Across the entire health care industry, the federal government resolved fraud and abuse allegations for a record-setting amount in 2025. Caught in this wave, behavioral health providers also experienced a notable uptick in fraud and regulatory-related settlements.

At the same time, the industry also received some helpful guidance about the application of the Eliminating Kickbacks in Recovery Act (EKRA) in the form of the first appellate court opinion interpreting the statute.

Background

Providers are well-aware that they operate in a highly regulated industry and that significant financial penalties may be imposed for alleged noncompliance. States can take action against the licenses of both individuals and facilities. At the federal level, enforcement tools include the False Claims Act (FCA), the Civil Monetary Penalties Law and the federal exclusion statute.

The FCA is the government's primary civil enforcement tool as it allows the government to impose significant civil penalties, including treble damages for the alleged submission of false or fraudulent claims to the government. While the FCA is most commonly applied in the context of Medicare and Medicaid, it also applies to other federal programs that fund behavioral health care, including the Veterans Administration and TRICARE.

In 2018, Congress added another statute to the panoply of fraud abuse laws by enacting EKRA, which prohibits kickbacks for patient referrals related to recovery homes, clinical laboratories and clinical treatment facilities. EKRA is a criminal statute, and there are no implementing regulations or guidance from the federal government to assist providers in interpreting its scope. Given its breadth, EKRA has created a fair amount of uncertainty regarding permissible sales and marketing activities within the behavioral health and clinical laboratory industries.

Record-Setting Fraud & Abuse Recoveries

The U.S. Department of Justice (DOJ) annually reports on amounts recovered through its enforcement efforts. For 2025, the DOJ reported record recoveries of more than \$6.8 billion across all government programs and more than \$5.7 billion from resolutions involving federal health care programs.¹ These are the largest annual recoveries since the DOJ began publishing data in the 1980s.

Notably, the DOJ recovered more in federal health care matters in 2025 than it did from 2022 to 2024 combined. That said, the lion's share of the aggregate recovery stemmed from a small number of matters involving large pharmaceutical manufacturers and enforcement related to prescription opioid medications.

The DOJ also reported that new health care investigations increased by approximately 40% in 2025 compared to 2024, signaling that elevated enforcement levels are likely to continue for the foreseeable future.

1. <https://www.justice.gov/opa/media/1424121/dl>

Behavior Health Settlements

Behavioral health providers were not immune to the rising tide of fraud and abuse enforcement. To the contrary, there was a significant volume of resolutions across the industry. Drawing from DOJ press releases, the following are noteworthy behavioral health-related settlements from 2025:

SEABROOK, a rehabilitation facility in New Jersey, paid \$19.75 million to resolve allegations that it billed Medicaid and the Veterans Administration for short-term residential treatment and partial hospitalization services for which it was not properly licensed and staff were not properly credentialed. (04/30/25)

STEVEN OSBEY, a co-owner of Reign & Inspirations, LLC, a behavioral health company in North Carolina, agreed to a consent judgment of \$4,711,159 to resolve allegations of billing noncompliance, including allegedly improper billing for in-home physician visits. In a separate criminal action, the company's co-owner was sentenced to 52 months in prison. (05/05/25)

DR. MOHD AZFAR MALIK, owner of Psych Care Consultants in Missouri, paid \$501,556 to resolve allegations of billing and coding noncompliance, including claims that face-to-face psychotherapy services were billed on days when he was out of town and that services furnished by other practitioners were billed using his credentials. (07/22/25)

ARMAND NTCHANA, an Advanced Practice Registered Nurse and owner of Integrated Procure Service in Connecticut, paid \$600,000 to resolve allegations of billing and coding noncompliance, including billing for the services rendered by an unlicensed provider and improper billing evaluation and management services during the same visit as a psychotherapy service. (08/06/25)

DANIEL JACOBSEN, a Virginia Licensed Clinical Social Worker, paid \$449,014.93 to resolve allegations of billing and coding noncompliance, including alleged upcoding of Medicaid claims and creation of false psychotherapy progress notes. In a separate criminal action, Mr. Jacobsen was sentenced to three months in prison after he pled guilty to health care fraud. (08/11/25)

DR. RICHARD ZIELINSKI, an Oklahoma psychiatrist, paid \$173,143 to resolve allegations of billing and coding noncompliance, including alleged upcoding of evaluation and managing services billed to Medicaid and allegations that he directed employees to fabricate medical records. (08/12/25)

AMERICAN PSYCHIATRIC CENTERS, d/b/a Comprehensive Psychiatric Services, paid \$2.75 million to resolve allegations of billing and coding noncompliance, including the alleged improper use of psychotherapy service add-on codes 90833 and 90836. (08/19/25)

MINDPATH CARE CENTERS, a North Carolina provider, paid \$1.9 million to resolve allegations of billing and coding noncompliance, including alleged improper billing for psychotherapy treatments and insufficient documentation of separate time and treatments furnished. (12/02/25)

BEHAVIORAL HEALTH RESOURCES in Olympia, Washington, paid \$1.1 million to resolve a class action lawsuit stemming from a data incident and potential data breach identified in November 2024. (12/04/25)

RECOVERY CENTERS OF AMERICA, based in Pennsylvania, paid \$2 million to resolve allegations of noncompliance with the Controlled Substances Act including alleged noncompliance related to dispensing and record-keeping requirements. (12/11/25)

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Several trends emerge from these settlements. First, the government continues to investigate providers across the spectrum, from independent practitioners to large facilities. While modest size providers may think that they are “too small” for DOJ scrutiny, the settlements suggest otherwise.

Second, many of the settlements involve coding and billing deficiencies. As such, providers should consider investing in processes and controls to ensure that claims are accurate, properly documented and compliant with program requirements, especially for government program patients.

Finally, several cases appear to turn on state licensure issues, underscoring the importance of compliance with licensure requirements at both the facility and individual level.

Court of Appeals Provides Some Clarity about EKRA

In July 2025, the U.S. Court of Appeals for the Ninth Circuit issued an opinion in *U.S. v. Schena*.² To date, this is the only appellate court decision interpreting EKRA.

While the court upheld the conviction of a laboratory owner who was found to have directed his sales force to pay kickbacks to doctors, the decision provides meaningful guidance regarding how courts are likely to apply EKRA's prohibitions in the sales and marketing context.

The Ninth Circuit concluded that standard sales and business development activities are not prohibited by EKRA; rather, the law only prohibits sales conduct if there is “unduly influence” of a referral source or a “wrongful effort to unduly influence the decisions of [persons] making referrals.” The Ninth Circuit explained:

- “We conclude that a percentage-based compensation structure for marketing agents, without more, does not violate [EKRA]. But the evidence is sufficient to show wrongful inducement when, as here, the defendant pays remuneration to a marketing agent to have him unduly influence doctors' referrals through false or fraudulent representations about the covered medical services.”
- “And at oral argument, the government itself agreed that a percentage-based payment to a marketer is not per se unlawful under EKRA. All marketing efforts are intended to influence the recipient. In the absence of a clearer

2. <https://cdn.ca9.uscourts.gov/datastore/opinions/2025/07/11/23-2989.pdf>

indication in the statute, we are hard-pressed to read EKRA to criminalize (with major federal penalties) a standard payment structure for marketing personnel, even when the marketing personnel are persuasive in driving business.”

- “Future cases will be needed to give content to the specific circumstances in which payments to a marketing agent reflect a wrongful effort to unduly influence the decisions of doctors and medical professionals making referrals.”

The key take-home message from *Schena* is that EKRA applies to standard sales conduct only if the sales conduct “unduly influences” a referral source or involves a “wrongful effort to unduly influence the decisions of” referral sources or patients. Further, *Schena* clearly states that “percentage-based” or similar compensation structures for sales representatives are not prohibited standing alone.

Conclusion

Behavioral health providers will continue to operate in an environment with a heightened level of governmental scrutiny. As federal funding for behavioral health increases, so too will the risk of potential noncompliance under fraud and abuse laws. Accordingly, robust corporate compliance programs focused on traditional risk areas, such as coding, financial relationships and licensure, remain essential components of prudent regulatory risk management.



Thoughts from *The 10 Minute HealthBizCast* on Behavioral Health



Bobby Guy
Shareholder
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When we launched *The 10 Minute HealthBizCast* in early 2020, our goal was to interview leaders at health care companies about how they're changing health care — hence our moniker, “Exploring Ways to Make Healthcare Better.” We'd been planning the *HealthBizCast* and lining up guests since 2019, and it just happened that the COVID pandemic hit right as we launched, making health care the top issue on everyone's mind (and leaving a lot of people isolated at home with time to listen to podcasts. . . who knew?).

Over the course of nine albums, we've learned a lot, and one of our central themes on the *HealthBizCast* has been this: *behavioral health is central to coordinated, efficient health care delivery.* The field has received insufficient attention in health care since time immemorial, and this only results in more pain for the suffering and more cost to the system. It's time for behavioral health to get integrated into mainstream health care delivery.

Behavioral health has been evolving and innovating so quickly that we continue to interview more leaders in the space. In fact, on Album 9, five of our 10 interviews were with behavioral health leaders:

ON TRACK 2, we talked with Dr. Mark Dente, the chief growth officer of Curio Digital Therapeutics, about Curio's quest to solve the gap in care surrounding post-partum depression. Curio brands itself as a “specialized women's digital behavioral health company,” and Mark's stories of the problems and inefficiencies surrounding post-partum depression are compelling for anyone passionate about effective health care.

ON TRACK 4, we interviewed Steve Biljan, co-founder and chief commercial officer of EvolvedMD. Steve talked to us about the company's program to provide “comprehensive behavioral primary care,” moving behavioral care into the mainstream of health care delivery so that intervention can happen early and often, dramatically changing the experience for both patients and their doctors.

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ON TRACK 5, we took a roller coaster ride with J.R. Greene, the founder and past CEO of Psychiatric Medical Care, about the evolution of behavioral care from the 1970s to now and the challenges facing behavioral care companies even as the stigma of mental health falls away. He also tells us about awards season, the Tom Cruise movie *Minority Report*, and several other hot topics that all string together to explain behavioral health for those who love roller coasters and movies. (He also has an amazing story about being “The Big Orange Tux” guy at the University of Tennessee national championship game, but sadly, we ran out of time and had to cut that part).

ON TRACK 6, we talked with Bruce Brandeis, CEO of Mindyra, about the company’s drive to bring predictive analytics and AI to behavioral health. Bruce comes to behavioral health after being a successful founder of companies like Lavongo and Care AI, and he goes deep into the problems (and solutions) of how to measure success in behavioral health.

ON TRACK 9, we interviewed Chris Perkins, the co-founder and CEO of Velocity Behavioral Health, about the human capital problem in behavioral health. Chris goes on to discuss Velocity’s ultimate goal to develop the first behavioral health teaching hospital in the U.S.

We’re currently working hard at the *HealthBizCast* to plan Album 10 for launch in late spring/early summer 2026. On Album 10, we’ll also surpass 100 tracks (we call them albums and tracks because, well, we are in Nashville), and we anticipate continuing to explore the great opportunities that behavioral health presents for improving patient outcomes and experience.

The **10 Minute HealthBizCast** is available on all streaming platforms.

To sign up for the mailing list and to receive information about when we’re launching new albums, [click here](#).



The ABCs of Business and Payor-Related Compliance Pain Points for ABA/Autism Providers



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If you know the acronyms ABA, ASD, BT, RBT, FBA, DSM-5, 2-tier model, 3-tier model and most importantly, you can say BACB and BCBA three times very fast without tripping over your words, then most assuredly you are in the autism business and I congratulate you!¹

If you do not know the meaning of these words or their application within the ABA business well, then you are either relatively new to this business or, just perhaps, you are a third-party payor who reimburses ABA providers. Yes, although payors understand that you may provide home- or clinic-based ABA services or a combination of modalities, how many times have you sat across the virtual payor table to engage in a discussion regarding your current and future rates, talking about your BCBA-to-BT ratios and how you are “different” from other providers — only to find that you are left with a blank stare?

As a lawyer that advises private equity-backed sponsors and ABA providers in the context of government audits and investigations, commercial payor disputes and transactional acquisition strategies, I am sad to report that many payors do not understand this industry — although most assuredly they are unhappy with their increasing spend treating children, adolescents and adults with autism. However, there are also many ABA providers that do not understand the payors or the payor guidelines with whom they routinely work.

Now, you ask, how is that possible? I hear the same story: “we routinely document the BT/RBT services and the BCBA direct and indirect supervision we perform down to the nearest 15-minute increments and we do so in the latest electronic medical record system that we have developed or licensed from one of the leading vendors in the ABA space.” That is often followed closely by: “we provide industry-leading training and education for our staff and closely track and monitor the functional goals

of our clients and constantly work to communicate with our clients’ respective parents or other caregivers.”

Yes, I have heard it all before in the context of due diligence while representing buyers or sellers of ABA businesses and in responding to very shrewd buyers in the burgeoning space. Should I represent you or be on the other side of the table, I begin to ask the tough questions:

- Can you please provide me with the coverage guidelines for all of your payors?
- For ABC payor, are they a 2-tier or 3-tier model and, if they are 3-tier, can you show me where the payor’s policies confirm the approach?
- What are the ratio requirements for each payor?
- Does the payor have minimum requirements for direct and indirect supervision?
- I understand you deploy telehealth — do you have confirmation from the payor that this type of care can be provided for BCBA direct or indirect supervision?

1. Although the “sophisticated reader” will most assuredly know: Applied Behavior Analysis (ABA), Autism Spectrum Disorder (ASD), Behavioral Technicians (BT), Registered Behavior Technician (RBT), Board Certified Behavioral Analyst (BCBA), Behavior Analyst Certification Board® (BACB®), Functional Behavioral Assessment (FBA), DSM or DSM-5TR: Diagnostic and Statistical Manual of Mental Disorders, 5th ed. If the terms 2-tier and 3-tier model do not ring a bell, then we are at the least favorite part of the great game of my own childhood Monopoly: “Do not pass Go and do not collect \$200.”

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- Fantastic, you are allowed to provide care by telehealth. But I noticed that you are providing that service with an individual from a location outside the state where the client is located. Have you evaluated whether your BCBA staff can provide that service across state lines without licensure in both states?
- For your cash posting, how do you know if their payments to your organization are consistent with your rates and then know when to write off the billed AR to the actual payment rates?
- Do your contracts prohibit you from waiving client copayments or deductibles? I noticed that you never charge patients above their insurance payments. What is your collection policy?
- You recently underwent a change in ownership (even if just a proportionate increase or decrease in certain owners' percentage interest beyond maybe 5%) or had a change in the management of your company. Do you know whether your contracts or

the payors' credentialing guidelines require you to report that change and if so, when are you required to report?

And then the glazed eyes sometimes appear to be blinded by high beam headlights that someone just won't shut off on a late night going down a two-lane dark road. Related to this, I often am asked by providers whether they really need to keep track of all of this — pleading that they just deliver the best quality care to children that have been ignored or misdiagnosed for years and years.

I have some news which many providers and private equity-backed sponsors have come to understand. The world of ABA has radically changed in the last 10 years. The industry has moved from a largely paper-based record system (with perhaps the exception of time-record tracking). ABA coverage has spread through the nation like wildfire, spurred by the Affordable Care Act with expanded state Medicaid coverage and increased numbers of individuals qualifying for Medicaid. And

the payor industry (including Medicaid managed care organizations) have awoken to the fact that they are now covering a therapy they had very little knowledge of the inception of the mandate to add ABA coverage into their portfolio of covered services — but they are learning fast.

The ABA's industry challenge is now well-beyond the creation of the BACB and convincing states to accept BACB certification for deemed BCBA licensure status (see, there I said, go ahead and say it three times real fast). ABA is now big business in the United States. According to the CDC, about 1 in 31 (3.2%) children aged eight years or younger has been identified with ASD according to estimates from CDC's ADDM Network.² As a result, approximately 1.3 million children eight years or younger have or should be diagnosed with ASD. And so, as all of those skimming this article know, the ABA industry has emerged at breakneck speed and without a shadow of a doubt, is an incredibly important service to the kids that have fallen through the cracks for years.

2. Centers for Disease Control, "Prevalence and Early Identification of Autism Spectrum Disorder Among Children Aged 4 and 8 Years — Autism and Developmental Disabilities Monitoring Network, 16 Sites, United States 2022". Based on recent Census Bureau and related data, there are approximately 38 to 40 million children under the age of eight in the United States.



How Do I get Prepared For the Future?

The future is now, and as a lawyer who represents providers and investors, the time is also now to put a rigorous set of systems in place to prepare your organization for the emerging world of working with payors and government enforcement agencies.

While no system or systems will perfectly help prepare your organization for payor relationships, audits or that planned “exit” in the future, critical policies, procedures and practices will guide the growth of your organization and the defense of your organization in payment disputes and governmental investigations at the state and federal levels increasingly emerging in the ABA space. While list below is not dispositive, I would encourage you to score your organization (and I promise not to call and ask how you did):

THE PAYOR “BIBLE.”

Maintain a comprehensive compendium of all of your payor agreements, sometimes known as your contracting “bible,” and ensure that you have established electronic record retention (i.e., folders) of all of your payor agreements.

CONTRACTING MAINTENANCE SYSTEM.

Establish a spreadsheet or documentation system that includes (1) the payor agreement rates and (2) payor agreement policies and procedures at the time you enter into each contract. And please don’t enter into a contract if you do not understand those policies at the time of contracting execution, no matter how excited you are to “finally” be in-network.

ROUTINE POLICY REVIEW.

Routinely (at least annually) review payor policies relating to ABA therapy. If the policies don’t make sense (what a surprise), it is imperative to seek clarification from the payor.³

COMMUNICATION RECORD SYSTEM.

Maintain a vigorous communication tracking system with all payor communications. I wish I had a recording of every time I have heard “well, so-and-so told us that the plan accommodated a three-tier model!” Oh, another phrase *du jour* — telehealth — which I routinely hear that ABC payor fully accommodates XYZ telehealth BCBA supervision services. And as a lawyer representing providers, buyers and sellers, I ask who told you that and when, since I can’t find that in the policy or

your contract? Best practice is to document whom you spoke to (full name), phone number, date of conversation and preferably, an e-mail address. Best practice is to send an email back to the person with whom you spoke, thanking the individual and confirming the explanation, i.e., yes, we accept three-tier models. Do not assume that she will be there when you have a dispute and time fades memories, regardless.

ADVOCATE FOR CLARITY.

When new policies are proposed, do not assume that they are fixed in stone. If they are ambiguous (or nonsensical), there is time to seek clarification and possibly educate the payors on aspects of their policies that do not align with the manner in which care is actually delivered or documented.

3. At least one (very large) national payor maintains that its ‘physician incident to’ policy also applies with respect to supervision and documentation of ABA therapy. Physician incident to policies emanate from the 1965 Social Security Act Amendments (Public Law 89-67), as codified in Section 1871(s)(2)A of the Act, with regulations and sub-regulatory manual guidance issued by the Centers for Medicare and Medicaid Services (CMS) (f/k/a the Health Care Financing Administration or HCFA) dating back nearly 50 years ago. The statute and CMS’ implementation enable physicians to bill for the services and procedures performed by physician staff, incident to his or her professional services and meeting applicable, typically in-office, supervision standards for that type of clinical service. Now, if you ask what do these ‘incident to’ guidelines have to do with ABA rendered in the home care setting, I cannot answer your outstanding question. If you finally figure it out, please call me directly.



Also, payor policies appear electronically on payor websites and when a policy is changed and one goes back to look for the prior draft — it doesn't exist. You CANNOT assume that the policies that applied when you contracted with the plan remain available after a change. We encourage printing to paper and scanning to .pdf or printing straight to a .pdf that is scanned and retained in each payor's electronic file.

MEDICAID FEE-FOR-SERVICE GUIDELINES. Many states have no Medicaid fee-for-service guidelines because the state had already adopted a Medicaid managed care system, leaving Medicaid managed care organizations (MCO) to develop their own policies and procedures in the absence of state requirements for coverage and payment. But that is not consistently the case and since Medicaid MCOs build their guidelines on state guidance (which can and certainly does change), you must know whether the state has any Medicaid guidelines in the autism space and maintain copies of all of these requirements (as well as hopefully understand these requirements).

CREDENTIALING REQUIREMENTS.

Credentialing requirements are often buried in the deep recesses of payor guidelines, and I have had at least one payor insist that BTs should be credentialed with the plan over the years. Other questions to clearly understand: how long does it take to credential a BCBA, and does the payor have a policy of accommodating retroactive reimbursement to the date that he or she started working for you as long as their credentialing application is submitted at least a certain number of days before or after he or she joins your organization? Or could you face a gap in reimbursement? Print the credentialing forms when filed, even if they are electronically submitted solely through an online system.

CONTRACTING DISPUTE RIGHTS. Know your dispute rights for each contract and ensure that your contracting payor compendia or “bible” tracks your contractual provisions. There is no standard for payor disputes across payor agreements, even if the same state and even if each payor is a Medicaid managed care

organization. Some require that the dispute be filed within X of days of a denial of payment or any other dispute. The dispute process at each payor can vary from an internal review as a first step sometimes called a “meet-and-greet” requirement, then mediation before arbitration or any combination. You must know the payor dispute requirements or, if even one step is missed within the time period set by your contract, you may be out of luck. The house wins.

STATE LICENSURE AND CORPORATE PRACTICE REQUIREMENTS. We remain in an emerging industry, and many states are trying to figure it all out. One of the issues is whether the entity providing the ABA services must be owned by a licensed professional. This may also depend upon whether you are providing psychiatry services in some form or fashion. The nature of state corporate practice of medicine (or similar laws) may dictate a different structure to your organization through a management service organization (MSO) framework.



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Ok, now breathe. Score yourself. Be honest. I will never know.

If you are a buyer in the space, these are relatively basic, fundamental questions that will drive the diligence review of your target as well as your engagement with the owners of the business to “test” their systems, experience in the business and whether the company might be a solid strategic or platform acquisition. If you are an operating ABA provider, including a future, hopeful seller looking for your own exit, then do not wait for the day when a potential suitor, their consultant or lawyer asks a tough question or when you must search for your lawyer’s phone number — although I am most assuredly happy to hop on a video call to just say hello.

The future is strong. ABA is a growing industry yet young in the grand scheme of the provider-care world. One can look back at many emerging industries in health care that jumped on the screen, then faced the challenges of growth and changing reimbursement system(s), new payor standards and payment requirements and emerging state laws playing catch-up to the new industry. The road to success is paved with building blocks laid in a tight herringbone pattern. Beautiful to look at when completed, but getting to that finished look will undoubtedly have a few bumps along the way.



Striking the Right Balance: Addressing the Tension Between Worker Classification Laws and Behavioral Health Care Regulatory Requirements



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Behavioral health organizations increasingly operate at the intersection of workforce classification frameworks and health care regulatory requirements that were developed independently and often point in different directions. Many licensed professionals — including psychiatrists, psychologists, therapists and counselors — favor independent contractor arrangements for the autonomy, flexibility and professional independence they offer, while organizations value these models for their scalability, efficiency and access to specialized talent.

However, contractor-based models also create a recurring challenge: reconciling worker classification standards with health care regulatory expectations. The oversight, quality controls and compliance measures required to support patient safety and applicable compliance requirements can, if not carefully structured, impact the analysis of independent contractor classification. This tension underscores the need for thoughtful structuring and periodic reassessment of contractor-based models in the behavioral health context.

Overview of Independent Contractor Classification Standards

Independent contractor classification is governed by laws that vary by jurisdiction and regulatory framework. As a result, there is no single, universal test, and behavioral health organizations frequently must assess classification under both federal and state standards.

Federal Framework

At the federal level, the Internal Revenue Service (IRS) applies a multi-factor test focused on the degree of control a company exercises over a worker. While the IRS historically described this as a 20-factor test, it now groups the factors into three primary categories:

1. **BEHAVIORAL CONTROL**, including whether the company directs how the worker performs the work, provides training or requires adherence to detailed instructions.
2. **FINANCIAL CONTROL**, such as how the worker is paid, whether expenses are reimbursed and whether the worker has the opportunity for profit or loss.
3. **THE RELATIONSHIP OF THE PARTIES**, including whether there is a written agreement, whether benefits are provided and whether the relationship is expected to be ongoing.

Under the IRS test, greater organizational control over the manner and means of the work generally weighs in favor of employee classification.

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Variations in State Worker Classification Standards

States apply their own standards for worker classification, and these standards can vary significantly by jurisdiction and regulatory context.

For example, California generally applies the “ABC” test for purposes of wage-and-hour and unemployment insurance laws, subject to statutory exceptions. Under this framework, a worker is presumed to be an employee unless the company establishes all three of the following elements:

- a. The worker is free from the control and direction of the company in connection with the performance of the work, both under the contract and in fact;
- b. The worker performs work that is outside the usual course of the company’s business; and

- c. The worker is customarily engaged in an independently established trade, occupation or business of the same nature as the work performed.

In the behavioral health context, application of the ABC test can raise nuanced questions, particularly with respect to how an organization defines its business activities and structures its relationships with licensed professionals. It may also involve a more difficult analysis given that certain health professionals may be exempt from the ABC test (and instead use a multi-factor standard) while others may not, potentially making it more challenging to structure the desired employment or contractor arrangement in a consistent manner within a given organization.

Other states take a more flexible approach. Texas, for example, applies a 20-factor test that considers a wide range of facts, with no single factor controlling. Relevant considerations include whether the worker receives instructions or training, the degree of integration into the company’s operations, control over work hours and location, the method of compensation and whether the worker supplies their own tools and equipment.

Across jurisdictions, the common thread is the degree of independence exercised by the worker. Greater financial, operational and professional independence generally weighs in favor of independent contractor classification, while the specific analysis depends on the applicable legal standard and factual context.



Workforce Classification in a Regulated Healthcare Environment

Behavioral health companies do not operate in a vacuum. In addition to labor and tax laws, they are subject to a complex web of health care regulations designed to protect patients, ensure quality of care and prevent fraud and abuse. These requirements often necessitate a level of oversight and standardization that can appear inconsistent with independent contractor status.

Policies, Standards, and Clinical Oversight

Behavioral health organizations are often required — by payors, accrediting bodies and professional standards — to implement clinical protocols, quality assurance processes, privacy policies and other oversight mechanisms. While these measures are essential to patient safety and regulatory compliance, they must be thoughtfully structured within independent contractor models to avoid inadvertently signaling a level of control inconsistent with independent contractor status.

Clinical Supervision and Documentation Requirements

Supervision requirements present another area of tension. Certain providers, such as advanced practice practitioners, associate-level clinicians or trainees may require clinical supervision to provide services within their scope of practice or to meet payor requirements. Structured supervision arrangements, if not carefully designed, may resemble employer-employee relationships.

Documentation requirements also warrant careful calibration. Behavioral health providers are subject to detailed documentation standards imposed by payors, accrediting bodies and regulators. While organizations often standardize electronic health record use, chart completion timing expectations and documentation best practices, these expectations should be structured to support regulatory and contract requirements without unduly dictating the way independent contractors perform their services.

Health Care Fraud, Waste and Abuse and Privacy Obligations

Independent contractor arrangements must also be evaluated through a health care regulatory lens. For example, compensation arrangements and methodologies should be structured to comply with the federal Anti-Kickback Statute and related laws that prohibit or restrict payments in exchange for referrals. The parties must also ensure that there is clarity regarding their roles and responsibilities with respect to HIPAA and other data privacy and security laws.



Practical Considerations for Contractor-Based Models

Despite the inherent tension between worker classification and health care regulatory requirements, behavioral health organizations that engage professionals as independent contractors can take steps to better align these competing considerations:

USE CAREFULLY DRAFTED INDEPENDENT CONTRACTOR AGREEMENTS. Agreements should accurately reflect the intended relationship, clearly defining the economic arrangement and the respective roles and responsibilities of the parties.

CLEARLY ARTICULATE CONTRACTOR INDEPENDENCE. Agreements should emphasize the contractor's ability to control scheduling, maintain other professional relationships and exercise independent clinical judgment, subject to applicable licensure, payor and regulatory requirements. Compliance, confidentiality and documentation obligations should be framed around regulatory outcomes rather than day-to-day operational control.

STRUCTURE COMPENSATION ARRANGEMENTS THOUGHTFULLY. Compensation should reflect fair market value for services actually provided, be consistent with industry norms and avoid any linkage to patient referrals. Where feasible, compensation should be tied to services rendered rather than hours worked.

REASSESS CONTRACTOR MODELS PERIODICALLY.

Workforce structures should be reviewed regularly as laws, payor requirements and business operations evolve, recognizing that models that were defensible at one point may require adjustment over time.

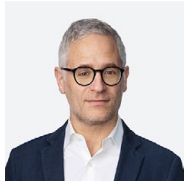
Conclusion

Addressing these issues effectively often requires collaboration with and between employment and health care regulatory counsel. Workforce classification decisions should not be evaluated in isolation from payor contracting structures, clinical oversight requirements or health care compliance obligations. Organizations that take a coordinated, cross-disciplinary approach are often better positioned to evaluate, adapt and scale their models in light of scrutiny across regulatory regimes.¹

1. Reconciling worker classification requirements with behavioral health care regulatory requirements often involves a nuanced, fact-specific analysis tailored to the particular provider and arrangement. Engaging employment counsel and health care regulatory counsel to work collaboratively early in the process can help organizations evaluate competing considerations, identify areas of tension, and make informed decisions based on their particular circumstances.



NIMBYism is Alive and Well in the Golden State



**Zachary
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NIMBYism — the “Not In My Backyard” sentiment that drives localities to exclude disfavored populations from their communities — has always been a pain point for the drug and alcohol treatment industry. While most communities readily acknowledge that treatment is a “good thing” in the abstract, many will quickly change their tune at the prospect of an actual residential treatment center or sober living home moving into their neighborhood. Unfortunately, this all too frequently creates a battle line between well-meaning treatment providers and the communities they desire to serve. Despite the treatment industry’s deep roots in Southern California, that region is not immune from NIMBYism, as recent events continue to highlight. As discussed below, two recent clashes in Southern California do not bode well for the treatment community as a whole.

“Integral” RTCs Face Tightening Restriction in Los Angeles

One of the landmark victories in the NIMBYism battle was the promulgation of Section 11834.23 of the California Health & Safety Code, which established a “safe harbor” for small residential treatment facilities by requiring state and local governments to treat those facilities as a residential single family use for all zoning/land use-related purposes. Specifically, Section 11834.23 provides that “[w]hether or not unrelated persons are living together, an alcohol or other drug recovery or treatment facility that serves six or fewer persons **shall be considered a residential use of property** for the purposes of this article. In addition, the residents and operators of the facility **shall be considered a family** for the purposes of any law or zoning ordinance that relates to the residential use of property pursuant to this article.” The statute elaborates on the rights it affords with a variety of circumstances in which “six-pack” treatment centers are protected from NIMBYism. For example:

- “Any local ordinance that deals with health and safety [or] building standards . . . **shall not distinguish alcohol or other drug recovery or treatment facilities that serve six or fewer persons from other single-family dwellings.**” H&S Code § 11834.23(d);
- “A conditional use permit, zoning variance, or other zoning clearance **shall not be required of an alcohol or other drug recovery or treatment facility that serves six or fewer persons that is not required of a single-family residence in the same zone.**” H&S Code § 11834.23(e);
- “Use of a single-family dwelling for purposes of an alcohol or other drug recovery facility serving six or fewer persons **shall not constitute a change of occupancy.**” H&S Code § 11834.23(f); and
- “A fire inspection clearance or other permit, license, clearance, or similar authorization **shall not be denied to an alcohol or other drug recovery or treatment facility because of a failure to comply with local ordinances from which the facility is exempt under Section 11834.23.**” H&S Code § 11834.24.

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The treatment community has long relied on this “six-and-under rule” to preserve its right to exist within the broader community. At the same time however, operational and financial realities have increasingly challenged the viability of operating a single six-bed facility. To address this reality, Southern California operators have turned to what is known as an “integral license” — a type of license specifically designed to allow for the coordination of operations of multiple residential treatment centers — to allow not only for economies of scale and associated operational efficiencies but also the clinical benefit of a larger client milieu. The Department of Healthcare Services (DHCS), the licensing body for residential treatment centers in California, is expressly authorized by Cal. Code Regs. Tit. 22, § 81008 (Licensing of Integral Facilities) to “issue a single license for separate buildings which might otherwise require separate licenses.”

There is an obvious tension between the “six-and-under rule” in H&S Code § 11834.23 and the notion of an integral license that allows for the coordination of multiple six-bed treatment centers. Some may question whether three separate buildings on contiguous plots, holding an

integral license for 18 total clients, with no more than six clients per property, be afforded the protections of Section 11834.23. On one hand, the integral license limits each building to no more than six clients, such that by outward appearances it would be difficult to distinguish between one of three buildings under an integral license and a building being used as a standalone residential treatment center on its own license. On the other hand, from the perspective of communities concerned with the potential overconcentration of treatment centers, 18 clients being treated across three contiguous lots — or, in some instances, on three separate addresses on a single parcel — is in many ways the functional equivalent of a single 18-client treatment center that would be outside the scope of the “six-and-under rule.”

For years, the City of Los Angeles consistently addressed this issue in a manner favorable to the treatment industry, focusing on the number of clients in any particular building for purposes of applying the “six-and-under rule” under Section 11834.23, regardless of whether each building held its own license or if multiple buildings operated under a single integral license.

Recent events, however, have indicated that a change may be coming, as operators applying for integral licenses began to experience resistance in late 2025. The Los Angeles Fire Department, which is tasked with issuing fire clearance as a precondition to licensure, refused to issue Form STD 850s confirming fire clearance to applicants of integral licenses, even where no fire safety-related issues exist. Contributing to the confusion, Los Angeles Department of City Planning has retained its long-standing position that even in the context of an application for an integral license, the “six-and-under rule” applies to each individual building, not the total number of beds across multiple integral buildings.

By all accounts, the Los Angeles City Attorney’s office is actively working to reconcile the stated positions of LAFD and City Planning to issue citywide guidance on the application of Section 11834.23 to residential treatment centers operating under integral licenses. In the meantime, applicants for integral licenses are stuck in administrative limbo, unable to complete their license applications with DHCS without fire clearance from LAFD, and operators already operating under integral licenses worry that they may



soon be facing the prospect of code enforcement if the “six-and-under rule” is abruptly deemed inapplicable.

As tensions mount, litigation unsurprisingly is taking center stage. Multiple operators awaiting licensure have filed petitions for writ of mandate under Section 1085 of the Code of Civil Procedure, asking the Los Angeles County Superior Court to instruct LAFD to issue the 850s. Only time will tell whether these lawsuits are successful, and whether the fate of integral licenses more generally will continue to enjoy the protections of the Health & Safety Code’s “six-and-under rule.”

Increasing Restriction for Orange County Sober Living

The drug and alcohol treatment community has a long history of conflict with Orange County and its wealthier coastal cities in particular. Ever tightening restrictions have made their way into local zoning ordinances, frequently targeting sober living homes. Because sober living homes are not licensed by the state, they are typically understood to fall outside the protections of H&S Code § 11834.23 even when they have six or fewer residents, rendering them susceptible to restrictive local regulation.

The most recent entrant into the race to restrict the operation of sober living homes is none other than “Surf City U.S.A.” — Huntington Beach — which recently adopted Ordinance Nos. 4340 and 4341. Effective Nov. 6, 2025, these new ordinances build on existing local law:

1. To require permits for all sober living homes city-wide;
2. To establish rigorous operational requirements and best practices; and
3. To impose stiff penalties on any sober living homes that continue to operate without a permit.

Sober living homes have 120 days from the effective date of the new ordinances to submit their permit applications. While the application process is just barely underway, two notable (and related) issues have emerged causing consternation within the treatment community.

First, it appears Huntington Beach is seeking to largely eliminate a long-established exception to sober living regulation for homes that operate as a “single housekeeping unit.” For years, sober living homes have looked to longstanding law under the Americans with Disabilities Act and Fair Housing Act to argue that sober living homes must

be treated like any other single-family residence so long as they operate as a “single housekeeping unit,” as defined based on a variety of factors generally focused on the ways in which the residents interact. While Huntington Beach’s zoning ordinances still carve out an exception to the sober living restrictions for homes that operate as a “single housekeeping unit,” the ordinances at the same time make clear that this exception is available only to standalone sober living homes that are not affiliated with either a licensed treatment center or any other sober living home. For example, it would seem that an operator of an outpatient treatment center is prohibited from also operating a sober living home for its clients, regardless of whether that home operated as a single housekeeping unit. While no actual data is available, this new restriction will surely impact many, and possibly most, of the sober living homes in Huntington Beach.

Second and relatedly, the city’s new permit application requires that applicants identify any other sober living home or licensed facility “managed, owned or operated” by the applicant or anyone within the applicant’s organization. While the application is not entirely



clear, it appears the request extends to homes or facilities not only in Huntington Beach but also anywhere in Orange County or any other jurisdiction in the entire state of California. Meanwhile, the ordinance further buttresses this obligation to disclose “affiliated” sober living homes by imposing a stiff penalty against any operator that attempts to “fly under the radar” without a permit. Specifically, if a sober living home operator fails to apply for a permit — or, in fact, if an operator does apply, but its application is denied — the operator (including any individual affiliated with that operator) is banned from

operating any sober living home in Huntington Beach for a period of five years.

The legality of these more aggressive aspects of these new ordinances will surely be scrutinized. For now, however, they present a dilemma for those operating more than a single standalone sober living home. Presumably, some operators will keep their heads down and hope to avoid detection rather than having to identify their other homes or facilities as part of the application process. Others may go forward with the permit application, hoping to obtain an exception or accommodation, or to

challenge the validity of the ordinances in court if their applications are denied.

NIMBYism is nothing new, particularly for the drug and alcohol addiction treatment community. The battle lines are ever-changing, however, and it is incumbent upon operators and investors in the industry to stay current, not only on a federal and state level, but perhaps most of all on a local level. Surely, these examples in Southern California present just two of many instances that will be of great interest in 2026 and beyond.



Long-Term Implications of Medicare Coverage for Digital Mental Health Therapies



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In the 2025 and 2026 Medicare Physician Fee Schedule (MPFS) rules, the Centers for Medicare and Medicaid Services (CMS) finalized policies that significantly increase payment for technology-enabled behavioral health care.¹ For the first time, Medicare will pay for certain digital mental health therapies (DMHT) that allow patients to self-manage behavioral health conditions as part of an overall treatment plan. As a result of its combined 2025 and 2026 policies, Medicare now covers tools used to manage insomnia, substance abuse disorder, anxiety, depression and (as of 2026) attention deficit and hyperactivity disorder (ADHD), and leaves the door open for increased behavioral health technology coverage in the future.

The devices, most of which are app-based therapies qualifying as software as a medical device (SaMD), are covered as part of a professional service under a

behavioral health plan of care. CMS will only pay for devices for which the Food and Drug Administration (FDA) has granted pre-market approval, authorized on a De Novo basis or cleared through a premarket submission under Section 510(k) of the Food, Drug and Cosmetics Act, and classified under regulations 21 C.F.R. §§ 882.5801 (computerized behavioral health therapy (CBT) devices for psychiatric disorders) or 5803 (digital therapy device for ADHD). In general, these tools facilitate a patient's self-management of behavioral health conditions but are only available upon prescription by a qualified professional.

Medicare will pay for DMHT as a professional service, reflecting clinicians' time supporting patients' use of an approved device using HCPCS codes G0552 (supply and initial education of the DMHT device), G0553 (initial 20 minutes of monthly treatment management services related to the DMHT device, requiring at least one interactive communication with the patient per calendar month), and G0554 (each additional 20 minutes of

monthly management time).² In order to be covered, the device must be billed on an "incident to" basis, such that the billing practitioner must incur a cost for the device as a supply; the device must be furnished to a beneficiary in association with the billing practitioner's ongoing delivery of behavioral health care treatment under a plan of care; and the device must be used in a manner consistent with its FDA classification. While CMS initially required that the item must be billed by the *diagnosing* practitioner, it loosened this rule in 2026 so that any practitioner responsible for the plan of care may bill for the relevant codes.

Medicare coverage for DMHT has important longer-term implications. First, this underscores CMS's ongoing effort to expand coverage for services that go beyond traditional medical intervention, such as Chronic Care Management, Advanced Primary Care Management and Psychiatric Collaborative Care Model services. These care management and coordination services go beyond traditional face-to-

1. 89 Fed Reg. 97923-28, 90 Fed. Reg. 49473-76.

2. The information here is only a summary of the actual HCPCS code descriptors. Please consult the MPFS and appropriate coding guidance for more information.

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face clinical services to cover services delivered by a care team, which may include both licensed medical practitioners and support personnel.

A growing industry of technology-enabled vendors has emerged to provide infrastructure to help practices furnish and bill for these services, including personnel, information technology and administrative capabilities around documentation and billing. Practices bill for the services (usually on an incident to basis), then pay a fair market value fee to the service provider. Given the enormous influence of Medicare coverage decisions, the program's payment of DMHT is likely to facilitate new relationships between technology vendors and behavioral health providers.

Second, CMS expressed interest in further reimbursement for technologically enhanced patient care. In the MPFS, CMS solicited comments on coverage for CBT or other devices falling under

FDA regulations 21 C.F.R. §§ 876.5960 (gastrointestinal conditions); 882.5050 (biofeedback devices); 882.5705 (sleep disturbance for psychiatric conditions); and 882.5804 (fibromyalgia symptoms). CMS also considered comments advocating coverage of digital tools that were not FDA approved, cleared or authorized for purposes of lifestyle management as part of a mental health treatment plan of care. Finally, CMS considered covering the administration of an eye-tracking test to evaluate the presence of Autism Spectrum Disorder (ASD). While CMS did not finalize these proposals, the agency said it would continue to consider opportunities to expand coverage. Notably, any additional devices authorized, approved or cleared by the FDA under 21 §§ 882.5801 and 5803 will automatically be covered.

Third, CMS is still actively developing its policy. Commenters identified practical problems in implementing DMHT. Some

commenters identified inconsistencies in rate-setting and medical necessity standards between MACs and asked the agency to set a single national rate. Others expressed concern that the codes potentially could cover a broad range of different devices, requiring distinct work values and practice expenses. CMS rejected both suggestions on the grounds that it did not have sufficient data to change its methodology but left open the door to further refinement along these lines.

Medicare's coverage of DMHT is likely to encourage other payors to consider similar coverage. Behavioral health providers should be aware of this additional opportunity to support patient care and earn additional reimbursement. It also creates new revenue opportunities for developers and vendors of behavioral health technology, which may stimulate the development of additional DMHT products. Finally, this coverage decision may lead to further coverage for technologically-enabled, patient-centered care.



About Polsinelli's Behavioral Health Law Group

Behavioral health providers have unique business model, care delivery and regulatory issues that require focused legal expertise informed by real-world experience in the behavioral health space. Polsinelli's Behavioral Health Group, one of the largest in the country, is a cross-functional team with significant experience completing major transactions and resolving complex regulatory matters involving behavioral health providers.

Upcoming Events

The Polsinelli team is excited to connect with you at the upcoming Behavioral Health VALUE Conference in Orlando, March 4-6.

2026 Reimbursement Summit – Nashville
Thursday, April 16
Register [here](#).

Health Care Dealmakers Conference – Dallas
May 13 -14
Register [here](#).

Autism Investor Summit (West) – Scottsdale
May 13-15
Register [here](#).

Contact Sinead McGuire, smcguire@polsinelli.com, for more information about any upcoming Polsinelli Behavioral Health Law Group events.

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