Behavioral Health Integration Meeting

JANUARY 30ST, 2025 | 2:00 – 4:00 PM ET

PARTICIPATING ORGANIZATIONS

American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American College of Clinical Pharmacy, American College of Physicians, American Psychiatric Association, American Psychological Association, HealthTeamWorks, Johns Hopkins Health System, Mathematica, Meadows Mental Health Policy Institute, Mental Health America, NAACOS, National Partnership for Women & Families, NCQA, Oak Street Health, Primary Care Collaborative, Primary Care Development Corporation, Society of General Internal Medicine, UPMC Health Plan

THANK YOU TO OUR SPEAKERS:

- Co-chairs: Alin Severance MD, UPMC Health Plan & Mary Giliberti, Mental Health America
- Kiera Peoples, National Partnership for Women and Families
- Susan McDaniel Ph.D., University of Rochester Medical Center
- Trip Stanford, American Psychiatric Association
- Matt Toth, Ph.D. & Brent Gibbons, Ph.D., RTI

MEETING SUMMARY

Welcome and Announcements

Larry McNeely opened the meeting with a brief overview of the agenda and some key announcements.

- Senator Crapo identified primary care and chronic disease as a Senate Finance Committee priority for the 119th Congress
- **Save the Date: June 4 – June 5, 2025,** the PCC will be hosting its biennial conference, *Scaling What Works for Primary Care*. **Click here to mark your calendar!**

Co-Chair Remarks

Alin Severance of UPMC Health Plan, addressed the looming uncertainty of health policy with the new administration and Congress but reminded attendees that the priority of strengthening primary care and behavioral health integration is still critical. Alin shared that we have a compelling narrative and strong evidence to support our fight to strengthen the primary care system and support behavioral health integration.

Mary Giliberti of Mental Health America acknowledged the opportunity to be proactive in our advocacy. Given the recent press release from Chairman Crapo and recent comments

for HHS nominee RFK Jr. on chronic conditions, we need to be proactive in the ways in which we discuss behavioral health integration. Mary highlighted that our conversations need to show that mental health conditions are chronic conditions and how they often co-occur as comorbidities. Mary shared that we need to focus on educating and keeping this narrative at the front of mind for policymakers.

Assessing CMMI's Innovation in Behavioral Health Model

Kiera Peoples of the National Partnership for Women and Families gave an overview of the Innovation in Behavioral Health (IBH) model and how it can be used to support women's health care. The goal of the IBH Model is to develop and enhance behavioral health access in order to provide person-centered care for beneficiaries. The model began in January 2025 and will go through December 2032. Currently there are four participating states: Oklahoma, Michigan, New York, and South Carolina.

The IBH model is looking to transform:

- Care Integration
- Care Management
- Health Equity
- Health IT

Keira provided an overview of the various metrics of success that the model will be evaluated on, and the payment approaches that Medicare and Medicaid will be utilizing. Kiera noted that both Medicare and Medicaid will incorporate elements of performance-based payments, and that this model is the first CMMI model that focuses on multi-payer alignment for behavioral health providers.

Keria explained how the model addresses patient and consumer priorities through

- Access to Care
- Patient and Family Engagement
- Early Detection

Kiera then went on to explain the risk and prevalence of mental illness among women and reviewed the National Partnership's recommendations to help maximize the impact on women's health. Some of their key recommendations include:

- Co-locating primary care, behavioral health and OB-GYN clinicians
- Prioritize a physical health consultant who has experience in women's health
- Prioritizing patient outcomes and experiences
- Emphasizing patient and community engagement

- Promoting data security and privacy

Dec 12 Member Meeting and the Path Forward

Larry handed it over to Ann and Susan McDaniel to reflect on the December 12 Member meeting. Ann briefly reflected on Mary Giliberti's comments, reinforcing the current opportunity to advocate for behavioral health with this new administration. Ann then introduced Susan McDaniel, Vice Chair of the PCC Board of Directors.

Susan briefly discussed the key takeaways from conversations with Eric Hargan, Former Deputy Secretary of HHS and Patrick Dumas, Staff Director of Ways and Means Committee. Susan highlighted that primary care is key to Making America Health Again and behavioral health is an integral part of that.

Susan then transitioned to discussing the key takeaways from the small group discussion dedicated to behavioral health integration. Her points included:

- How to expand Medicare beyond the collaborative care model
- Celebrating BHI wins in states
- Shifting the focus to children given the potential cuts to Medicaid
- Increasing funding for workforce development
- The importance of value-based care

Trip Stanford of American Psychiatric Association then provided a quick update on the COMPLETE Care Act. Trip reviewed the COMPLETE Care Act and its progress in the previous Congress. Trip shared that the bipartisan bill had moved quickly through Congress and with little opposition but had not made it out of session due to timing and more education needed – particularly on the House side.

Trip then shared that in this new Congress, key Congressman and Senators remain supportive of the bill and are eager to reintroduce the legislation. Trip closed out by thanking attendees for all the support shown to this legislation in the last Congress.

Larry opened the floor for reflections from attendees.

Julio Abreu with American Psychological Association reiterated the need for bipartisan sponsors on the COMPLETE Care Act and asked for PCC's help in securing a Republican sponsor in the House.

Larry asked the group where they think the PCC should be focusing their efforts.

Ann added that she believes Abe Sutton, reported to be the next director of CMMI. She identified him as an opportunity to make progress on PCC priorities.

Scott Barstow shared Medicaid is a top priority for the American Psychological Association.

Larry agreed, adding that Medicaid is vital for Medicare beneficiaries, and that we must try to connect the dots for this administration - pointing out how a strong Medicare depends on strong Medicaid.

Larry asked about the state of the SUPPORT Act and the broader healthcare extender package. Scott shared he hasn't heard much but has heard about the possibility of a Medicare conversion factor update bill being reintroduced. This is something APA would support.

Katherine Suberlak with Oak Street Health added Oak has a large dual eligible population and the impact of Medicaid and behavioral health access will be monitored.

Behavioral Health Prevalence, Utilization, and Spending Among Older Adult Medicare Beneficiaries

Larry introduced Matt Toth and Brent Gibbons with RTI to present a report, developed for ASPE published on January 17th about behavioral health care and Medicare beneficiaries. Larry stressed that this research can be a valuable tool when advocating for Medicare on the Hill.

Matt began the presentation with an overview of their findings, including the following: 1/3 of the Medicare fee-for-service population (65 and older) had some form of behavioral health diagnosis, service use or prescription drug fill. They also found that behavioral health beneficiaries are getting treatment in primary care as opposed to behavioral health specific care. Some other key findings were that older adults with behavioral health disorders have:

- Worse health and functional outcomes
- Higher rates of emergency department (ED) visits
- More medications used
- Higher costs compared to those without BH disorders

Matt then gave a background for what inspired this research. He explained that behavioral health disorders are common among older adults, and this population has worse health outcomes. The goal of this research is to estimate the number and percent of fee-for-

service Medicare beneficiaries with a behavioral health diagnosis or who have had a behavioral health related service and determine what kind of services they use, how often and at what cost to the beneficiary and to Medicare.

Matt reviewed the methodology used and how the population and outcome metrics were selected. He then gave a detailed overview of the results, including diagnosis numbers, service use, utilization patterns, and spending. Larry highlighted a slide regarding Medicare expenditures for mental health services and service type, which demonstrates an opportunity for primary care, integrated primary care to do the work of driving down those avoidable utilizations.

The conclusion Matt presented was that across all service categories, Medicare beneficiaries with a BH diagnosis or BH-related services use had greater Medicare spending, service utilization, and out-of-pocket costs than non-BH beneficiaries.

Larry responded that because Medicare beneficiaries in fee for service Medicare with behavioral health diagnosis are simply not accessing behavioral health outpatient services, there is an opportunity to improve outcomes and reduce costs by leveraging primary care.

Matt highlighted the opportunity to continue to integrate behavioral health services in primary care settings as well as provide behavioral health specific services that have been difficult to access.

Brent added that physical health care is also not being addressed and is another place where integrated care can help reduce the adverse outcomes found in this study.

Dominque Quincy with the PCC asked about why patients weren't accessing primary care and what the barriers were.

Matt explained that this was secondary data, so they don’t have that information.

Alin suggested that Medicare beneficiaries with a behavioral diagnosis are also physically sicker than those without, so it is difficult to compare these populations.

Matt agreed and explained that there was an effort to adjust for demographic conditions but didn’t feel like it would be helpful to adjust for comorbidities. He noted this comparison wasn’t something that we can infer causality from.

Brent added that the data suggests these patients are getting treatment with prescription drugs but no other impactful services for behavioral health. However, SUD services have a low percentage of prescription drug treatment.

Alin agreed and added that there is a large opportunity to incorporate prescription drugs into AUD and SUD treatment for this population.

Scott thanked Matt and Brent for their presentation and spoke to the low rate of outpatient services for behavioral patients. He also noted the discrepancy between SUD services and SUD spend.

Ann Greiner highlighted the cost comparison in the presentation and suggested that centering behavioral health integration could help address efficacy and cost concerns.

Matt shared his next takeaway is understanding the relationship between dual eligible beneficiaries and access to behavioral health services. This includes addressing integrated payments between Medicare and Medicaid, as well as care coordination.

Angie Berg with HealthTeamWorks highlighted the power of single session therapy in primary care settings. She noted that in rural settings, this can be even more impactful because of stigma. Embedding the single session in rural settings can help address barriers caused by the rural clinician shortage, as well as using telehealth.

Ann highlighted the need to uplift stories like this on the Hill because a lot of members of Congress care about rural health.

Closing Remarks and What's Ahead

Larry thanked the speakers and shared the dates for upcoming BHI meetings:

- April 24, 2025 – In-Person Meeting with a Virtual Option
- July 24, 2025 – *Virtual ONLY*
- October 23, 2025 – In-Person Meeting with a Virtual Option

Alin shared his closing thoughts, including thanking Larry for the hopeful and proactive tone of the meeting. One idea he shared is how to reach down and work with the front lines to get clinicians involved. He shared he has had exciting conversations with medical directors about how to better support patients and implement integrated models.

Scott emphasized the need to uplift PCPs in this process and support development of resources directly to the provider community.

Larry highlighted AAFP's work in this area.

Dominque shared about physician improvement projects as well as the need organization processes when new treatments come out to support implementation. This helps support quality as well.

Karen Ferguson with AACAP shared that AACAP has just launched a 6-part, member- only series for child and adolescent psychiatrists highlighting collaborative care and its value. It covers getting started, how to get paid for this work, and building collaborations with PCPs, among other topics.

Mark Borer with AACAP added that when implementing cross framework models, it is important that people understand the details of the models to adapt them to their own practices.

Larry added that there is now a safety planning intervention in Medicare's payment rule. This and similar policies are an opportunity to help reimburse clinicians for work they do anyway.

He wrapped the meeting and invited attendees to join in person for April's BHI Workgroup meeting.