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PCC Behavioral Health Integration Meeting

Thursday, January 30, 2025 | 2:00 – 4:00 PM ET

agenda

I.	Welcome & Announcements	Larry McNeely, Primary Care Collaborative
II.	Co-Chair Remarks	Mary Giliberti, Mental Health America & Alin Severance, UPMC Health Plan
III.	Assessing CMMI's Innovation in Behavioral Health Model	Kiera Peoples, National Partnership for Women and Families
IV.	Dec 12 Member Meeting and the Path Ahead	Susan McDaniel, University of Rochester Medical Center & Larry McNeely, Primary Care Collaborative
V.	Behavioral Health Prevalence, Utilization, and Spending Among Older Adult Medicare Beneficiaries	Matthew Toth & Brent Gibbons, RTI
VI.	Wrap-Up and What's Ahead	Larry McNeely, Primary Care Collaborative

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Welcome & Announcements

Larry McNeely | Primary Care Collaborative

Senate Finance Priorities for 119th

"As we work with the Trump Administration **to address America's epidemic of chronic disease**, the Committee must also streamline clinician payment systems and incentivize alternative payment models …We **must improve primary care**, support chronic-care benefits in Medicare and provide Medicare doctors with long-term payment stability."

-Chairman Mike Crapo, Press Release, 1/7/25

Save the Date



SCALING

What Works for Better Health

PCC Conference 2025

CALENDAR HOLD

June 4-5, 2025
Washington, DC

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Co-Chair's Remarks

Mary Giliberti | Mental Health America
Alin Severance | UPMC Health Plan

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Assessing CMMI's Innovation in Behavioral Health Model

Kiera Peoples | National Partnership for Women and Families

national partnership for women & families

Enhancing Women's Health Through the Innovation in Behavioral Health Model

An Analysis on the Community-Based Model from CMMI

Kiera Peoples
1/29/2025

Overview of the IBH Model

Goal: Develop and enhance infrastructure of specialty BH organizations to provide person-centered care to beneficiaries with moderate to severe BH conditions

Timeline: January 2025 – December 2032

- Pre-implementation Period: Jan. 2025 - Dec 2027
- Implementation Period: Jan. 2028 - Dec. 2032

Participating States:

- Oklahoma
- Michigan
- New York
- South Carolina

Overview of the IBH Model

- **Transformation Areas**
  - **Care Integration:** Address both BH and physical health care in community-based BH setting.
  - **Care Management:** Provide self-management support and person-centered care planning.
  - **Health Equity:** Conduct HRSN screenings, population needs assessment, and a health equity plan.
  - **Health IT:** Support data sharing between providers and patients. Help to track referrals and follow ups for health-related social needs

- **Metrics of Success**
  - Improved health outcomes for **diabetes**, **hypertension**, and **tobacco use**
  - Improved **health IT capabilities** to support care coordination
  - Reduction in **hospitalizations**
  - Increased use of **referred services** (e.g., HRSNs, primary care)
  - Patient-reported outcome measures (**PROM**)

Payment Approach

- **Medicaid:** States must develop and implement their own Medicaid payment arrangement complementing existing payment approaches.
- **Medicare:** Optional participation.
  - Will receive upfront funding for Health IT investments and practice transformation
  - Also, will receive risk-adjusted, per-member-per-month payments for screening and care coordination.
- **NOTE:** Both approaches will incorporate **performance-based payments** using specified quality measures and must be directionally aligned.
- This is the **first CMMI model** to focus on **multi-payer alignment** for beneficiaries with mental health and SUD conditions under both Medicaid and Medicare.

How the Model Addresses Patient and Consumer Priorities

- **Access to Care**
  - Reduces the need for patients to navigate separate systems to address concerns that are likely associated with their BH conditions.
  - Care integration could minimize common barriers, such as transportation and child care.
- **Patient and Family Engagement**
  - SMAs must implement a convening structure to enhance the model by aligning efforts of interested or impacted groups
  - Encouraged to recruit a variety of stakeholders, including beneficiaries with **lived experience** and **caregivers**, promoting the incorporation of patient experiences in the model's development and implementation.

Women's Behavioral Health

- In 2021, compared to male counterparts, women aged 18–25 were significantly more likely to:
  - Have any mental illness across various U.S. regions, social statuses, employment situations, and racial and ethnic groups.
  - Suffer from serious mental illness across all racial and ethnic groups.
  - Experience a major depressive episode across all racial and ethnic groups.
  - Have thoughts of suicide.
  - Have an unmet need for mental health support.
- Barriers to Seeking Services
  - Economic Constraints
  - Pervasive Stigma

Recommendations to Maximize Impact on Women's Health

- Prioritize a physical health consultant with experience in women's health
- Co-locate primary care, BH, and OB-GYN providers
- Improve evaluation measures by requiring women's health screening and BH outcome measures
- Prioritize patient outcome and experience measures
- Emphasize patient/community engagement
- Promote secure data sharing and privacy

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Dec 12 Member Meeting and the Path Ahead

Susan McDaniel | University of Rochester Medical Center
Larry McNeely | Primary Care Collaborative

Eric Hargan, JD

Former Deputy Secretary, Department of Health and Human Services;
Founder and CEO, Hargan Group



Incoming Administration:

- Is Committed to Making America Healthy Again and addressing chronic disease
- Wants to disrupt the status quo

His Advice:

- Show how Primary Care is central to this Administration's priorities

Member-Led Breakout Groups

The Ask of Participants:

Identify 2 Policy Opportunities and 1 Policy to Preserve

Breakout Groups:

- **Behavioral Health Integration** (Susan McDaniel – APA)
- **Comms** (Katherine Gergen-Barnett, HMS Ctr for PC)
- **Equity/Patient-Centeredness** (Sarah Coombs – NPWF)
- **Medicaid/CHIP** (Stephanie Glier – AAP)
- **Medicare** (Dorothy Siemon – AARP)

Member-Led Breakout Groups

SELECTED TAKEAWAYS

Equity/Patient-Centeredness

- Maintain our Principles, but Reframe the Message
  - Inequities→ Rural/Underserved
  - Equity→ Quality;
  - SDoH→ Non-medical drivers

Member-Led Breakout Groups

SELECTED TAKEAWAYS

Behavioral Health Integration

- Integrated PC key to chronic disease, behavior change

Communications

- Move toward shared messaging w New Congress, Admin
- To Make Amer. Healthy Again, stronger PC is central

Member-Led Breakout Groups

SELECTED TAKEAWAYS

Medicaid/CHIP –

- Highlight red state PC initiatives aimed at chronic disease

Medicare

- Across TM & MA, support shift to hybrid pay, address pricing/valuation and offer cost-sharing relief
- Build on progress (PC Flex, APCM, G2211, GPDC/REACH)

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

Matt Toth & Brent Gibbons | RTI

Behavioral Health Diagnosis, Service Utilization, and Spending Among Older Adult Medicare Beneficiaries

Matt Toth, MSW, PhD
Brent Gibbons, PhD

Adapted from: Toth, M., Gibbons, B., Levinson, A., Kar, N., Keyes, V., Nye., E., Jacobus-Kantor, L., and Creedon, T. Behavioral Health Diagnosis, Service Utilization, and Spending Among Older Adult Medicare Beneficiaries: A Chartbook. Washington, DC: The Office of the Assistant Secretary for Planning and Evaluation. U.S. Department of Health and Human Services. January 15, 2025.

RTI INTERNATIONAL

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Background

- **Behavioral health (BH) disorders are common among older adults.**
  - Surveys found 12 percent of older adults reported any mental illness, and less than 3 percent reported any SUD (SAMHSA, 2019).

- **Older adults with BH 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

(Boockvar, K., 2014; CDC., 2008; Figueroa et al., 2017).

Background

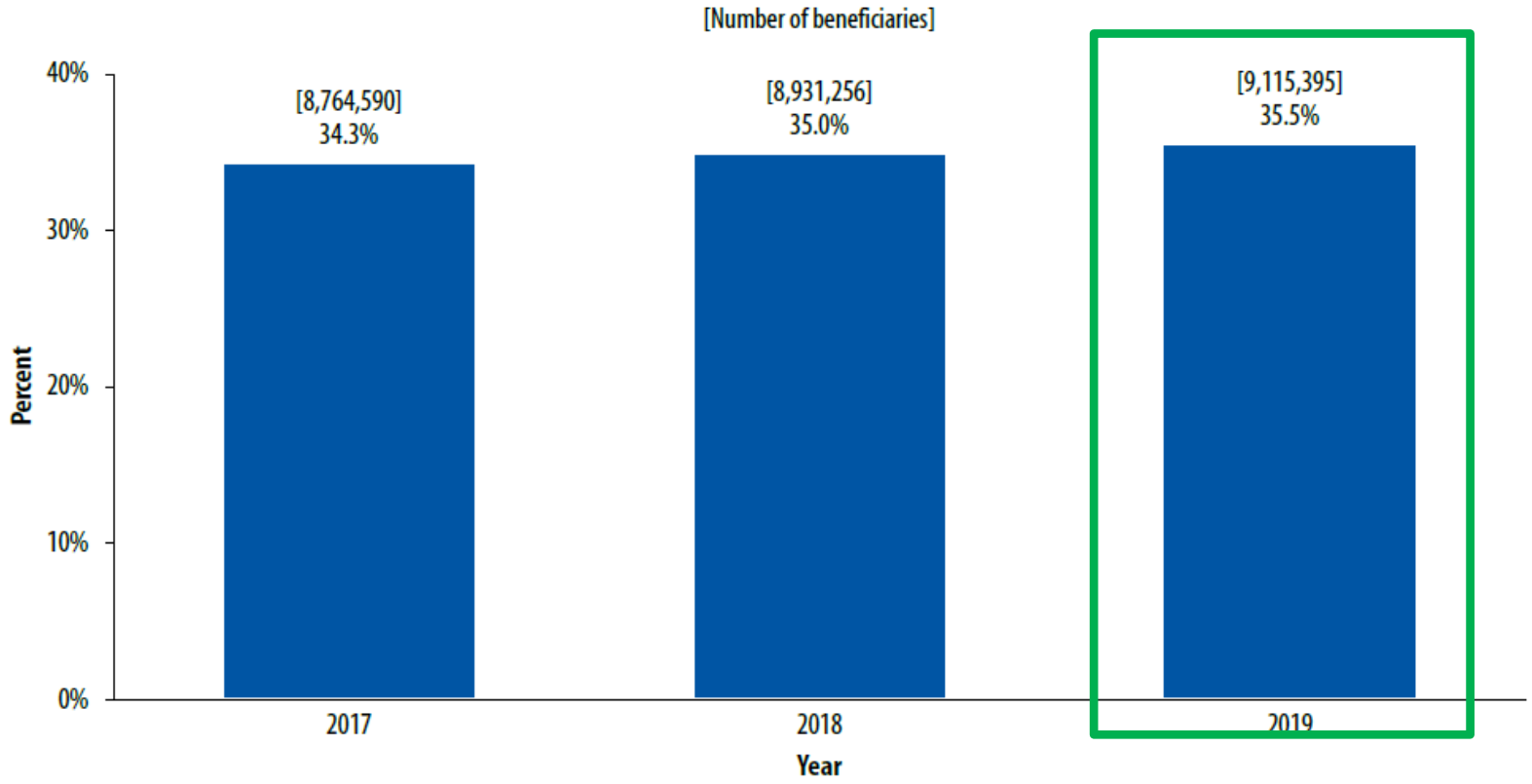
- **We performed an annual cross-sectional analysis of the national population of FFS Medicare beneficiaries 65 years and older, using 100% of FFS claims and administrative data from 2017 to 2019 to:**
  - Estimate the annual rate of Medicare FFS beneficiaries with any BH diagnosis or BH-related service.
  - Determine what services are used, how often, and at what cost to Medicare and beneficiaries.

Methods

- **Sample construction:** Medicare beneficiaries ages 65+ with 12 months of enrollment in Part A and B FFS, alive all year, and in one of the 50 states or DC.
- **Identification of the behavioral health population:** beneficiaries with at least 1 claim in the previous 12 months with a diagnosis code, prescription drug, or procedure code for behavioral health disorders.
  - Separately examined mental health and substance use disorder prevalence, service use, and spending.
- **Specification of the outcomes:** all-cause and BH-specific annual Medicare spending and service utilization.
  - **Spending and OOP payments outcomes:** inpatient spending, outpatient spending, physician spending, Part D drug spending, total FFS spending.
  - **Utilization outcomes:** inpatient stays, ED visits, E&M visits, outpatient BH visits.

What is the Rate of BH diagnosis and BH-Related Services use among Medicare FFS beneficiaries aged 65 and older?

EXHIBIT 3-1 Rates of Behavioral Health Diagnosis and Behavioral Health-Related Service Use Among Medicare Beneficiaries 65 Years and Older, 2017–2019

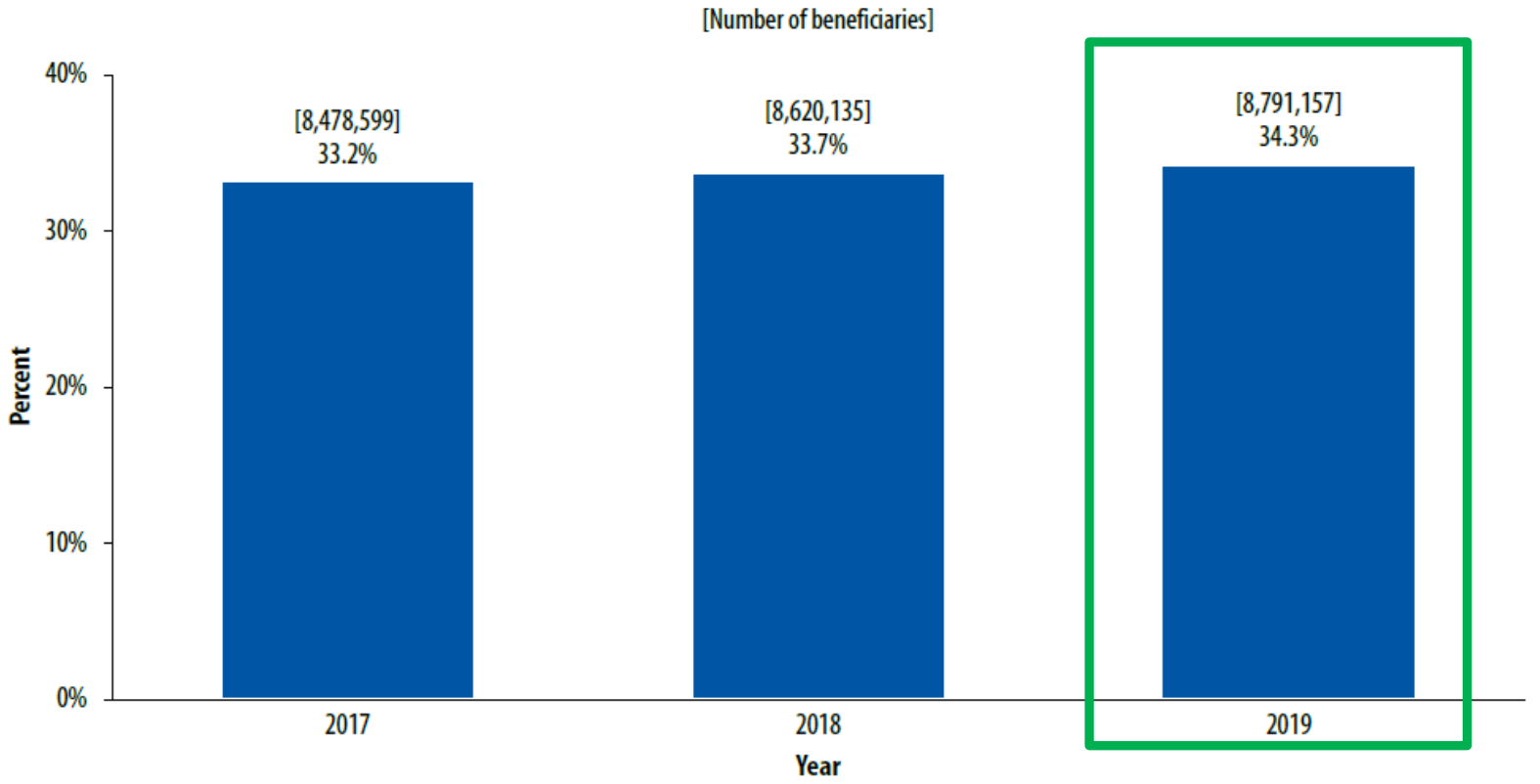


NOTE: Beneficiaries were defined as having a BH diagnosis or BH-related service use if they had any MH- or SUD-related diagnosis, procedure, or NDCs during the year. Beneficiaries with any BH diagnosis or BH-related service use were matched 1:1 among those without based on age and sex. Beneficiaries needed a full 12 months of eligibility (Part A/B, no HMO, alive, 65 and older, and residing in the 50 states) to be included in the analysis.

SOURCE: Medicare FFS claims and the Medicare Summary Beneficiary Files.

What is the Number and Percent of Medicare Beneficiaries with a MH diagnosis or MH-Related Service Use?

EXHIBIT 3-3 **Number and Percent of Medicare Beneficiaries 65 Years and Older with a Mental Health Diagnosis or Mental Health-Related Service Use, 2017–2019**

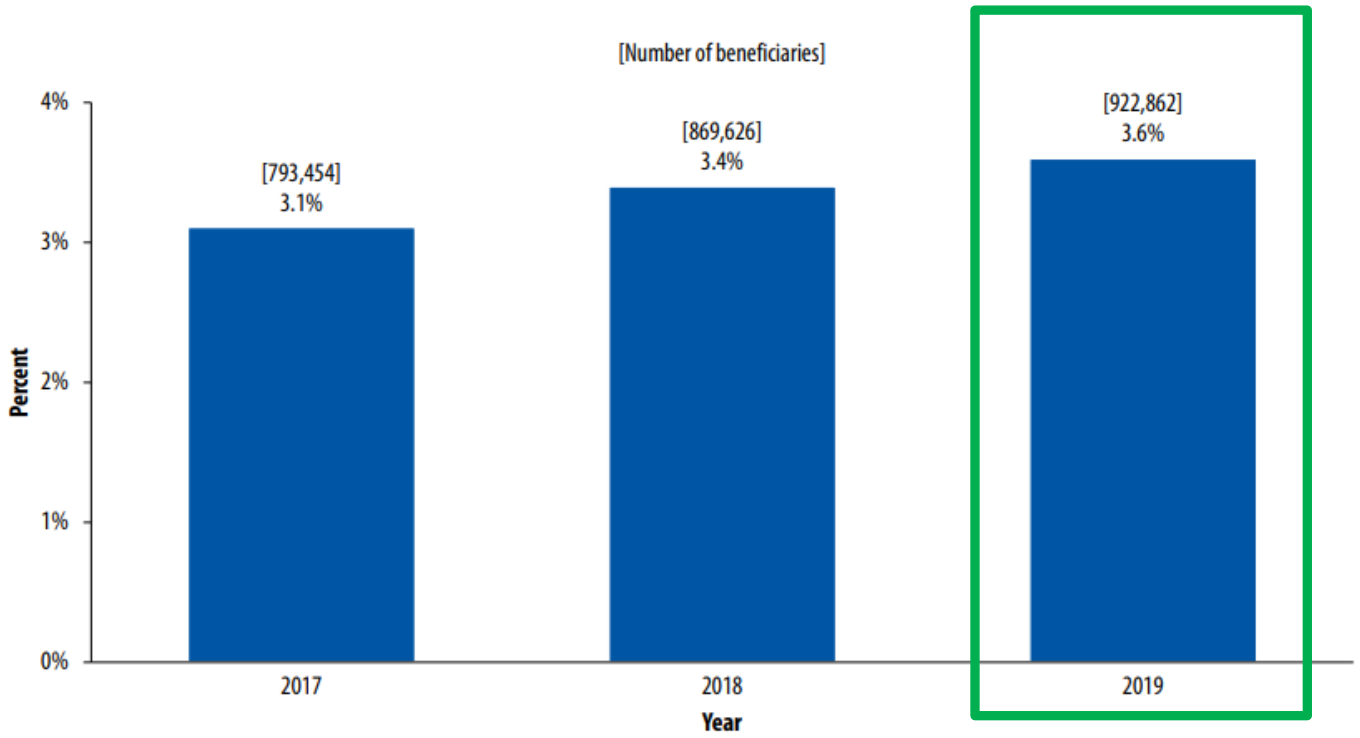


NOTE: Beneficiaries were included if they had any MH related diagnosis, procedure, or NDCs during the year. Beneficiaries needed a full 12 months of eligibility (Part A/B, no HMO, alive, 65 and older, and residing in the 50 states) to be included in the analysis.

SOURCE: Medicare FFS claims and the Medicare Summary Beneficiary Files.

What is the Number and Percent of Medicare Beneficiaries with a SUD diagnosis or SUD-Related Service Use?

EXHIBIT 3-6 Substance Use Disorder Prevalence Among Medicare Beneficiaries 65 Years and Older, 2017–2019



NOTE: Beneficiaries were defined as having a SUD if they had any substance use related diagnosis, procedure, or NDC codes during the year. Beneficiaries needed a full 12 months of eligibility (Part A/B, no HMO, alive, 65 and older, and residing in the 50 states) to be included in the analysis.

SOURCE: Medicare FFS claims and the Medicare Summary Beneficiary Files.

What are the service utilization patterns among older Medicare FFS beneficiaries with a mental health diagnosis or any MH-related service use?

EXHIBIT 4-2 **Number and Percent of Beneficiaries with a Mental Health Diagnosis or any Mental Health-Related Service Use Who Had Any Mental Health-Related Service Utilization, by Service Type, 2017–2019**

Service Type	Frequency			Percentage		
	2017	2018	2019	2017	2018	2019
MH-Related Outpatient Services	2,326,867	2,399,759	2,478,667	27.4%	27.8%	28.2%
MH-Related Physician E&M Visits	1,706,233	1,766,438	1,837,616	20.1%	20.5%	20.9%
MH-Related Inpatient Stays	60,537	58,358	56,967	0.7%	0.7%	0.6%
MH-Related ED Visits	67,320	66,116	63,560	0.8%	0.8%	0.7%
MH-Related Prescription Drug Fills	5,982,330	6,014,872	6,085,415	70.6%	69.8%	69.2%

NOTE: Beneficiaries were included if they had any MH related diagnosis, procedure, or NDCs during the year. MH-related outpatient services are defined as any non-ED claim in the outpatient or carrier files with a principal diagnosis of a MH condition. MH-related physician E&M services are defined as having any E&M code or visit to FQHC or RHC with a principal diagnosis of any MH condition. MH-related inpatient services include any admission to a short-term or psychiatric hospital with a principal diagnosis of a MH condition. MH-related outpatient ED visits are any ED visit that does not end in a hospitalization with a principal diagnosis of a MH condition. MH-related prescription drug use was defined based on having any MH-related psychotherapeutic Part D drug event. Beneficiaries needed a full 12 months of eligibility (Part A/B, no HMO, alive, 65 and older, and residing in the 50 states) to be included in the analysis.

SOURCE: Medicare Summary Beneficiary Files and Medicare FFS claims.

What are the service utilization patterns among older Medicare FFS beneficiaries with a SUD diagnosis or any SUD-related service use?

EXHIBIT 4-11 Number and Percent of Beneficiaries with a Substance Use Disorder Diagnosis or any Substance Use Disorder-Related Service Use Who Had Any Substance Use-Related Service Utilization, by Service Type, 2017–2019

Service Type	Frequency			Percentage		
	2017	2018	2019	2017	2018	2019
Any Substance Use-Related Outpatient Services	193,547	204,153	207,561	24.4%	23.5%	22.5%
Substance Use-Related Physician E&M Visits	68,332	77,588	84,617	8.6%	8.9%	9.2%
Substance Use-Related Inpatient Stays	23,502	23,297	22,970	3.0%	2.7%	2.5%
Substance Use-Related ED Visits	27,382	27,358	27,326	3.5%	3.1%	3.0%
Substance-Use Related Prescription Drug Fills	21,463	26,984	33,777	2.7%	3.1%	3.7%

NOTE: Beneficiaries were included if they had any SUD-related diagnosis, procedure, or NDCs during the year. Physician E&M services are defined as having any E&M code or visit to FQHC or RHC. Acute inpatient admissions include any admission to a short-term acute or psychiatric hospital. Outpatient ED visits are any ED visit that does not end in a hospitalization. Prescription drug fills includes include any Part D event with a service date during the year. SUD-related utilization was defined as having any service with a principal diagnosis of any SUD. SUD-related prescription drug use was defined based on NDCs. Beneficiaries needed a full 12 months of eligibility (Part A/B, no HMO, alive, 65 and older, and residing in the 50 states) to be included in the analysis. Any service utilization includes both BH and non-BH service utilization.

SOURCE: Medicare Summary Beneficiary Files and Medicare FFS claims.

What are the service utilization differences between beneficiaries with and without a BH diagnosis or any BH-related service use?

EXHIBIT 4-19 Comparison of All-Cause Any Service Utilization by Medicare Beneficiaries With and Without a Behavioral Health Diagnosis or any Behavioral Health-Related Service Use, 2017–2019

Service Type	BH Disorder											
	No BH						Any BH					
	2017		2018		2019		2017		2018		2019	
	N	%	N	%	N	%	N	%	N	%	N	%
Any Physician E&M Visits	7,824,149	89.3	7,959,535	89.1	8,140,868	89.3	8,626,022	98.4	8,788,713	98.4	8,971,463	98.4
Any Acute Inpatient Stays	892,235	10.2	876,871	9.8	876,354	9.6	2,231,377	25.5	2,194,588	24.6	2,188,151	24.0
Any Outpatient ED Visits	1,605,410	18.3	1,616,021	18.1	1,655,173	18.2	3,021,329	34.5	3,035,287	34.0	3,079,180	33.8
Any Prescription Drug Fills	5,114,576	58.4	5,262,832	58.9	5,459,848	59.9	7,088,012	80.9	7,207,256	80.7	7,360,317	80.7

NOTE: Total BH N = 8,764,590 in 2017, 8,931,256 in 2018, and 9,115,395 in 2019. Beneficiaries were defined as having a BH-diagnosis or BH-related service use if they had any MH- or SUD-related diagnosis, procedure, or NDCs during the year. These beneficiaries were matched 1:1 based on age and sex with beneficiaries without any BH diagnosis or BH-related service use. Beneficiaries needed a full 12 months of eligibility (Parts A/B, no HMO, alive, 65 and older, and residing in the 50 states) to be included in the analysis. Any service utilization includes both BH and non-BH service utilization. The sample was not required to have a full 12 months of Part D enrollment, thus differences in prescription drug use between the BH and non-BH samples may reflect underlying differences in Part D enrollment.

SOURCE: Medicare Summary Beneficiary Files and Medicare FFS claims.

What are the patterns of Medicare expenditures among older adults with a MH diagnosis or any MH-related service use?

EXHIBIT 5-1 Average Annual Medicare Spending Per Beneficiary with a Mental Health Diagnosis or Mental Health-Related Service Use, by Service Type, 2017–2019

Service Type	Medicare Spending, $											
	All-cause						MH-related					
	2017		2018		2019		2017		2018		2019	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Total FFS Spending	15,717	27,719	16,090	28,391	16,590	29,480	282	2,370	283	2,352	291	2,418
Inpatient Services	5,377	16,063	5,391	16,337	5,485	16,831	105	1,870	101	1,857	101	1,914
Outpatient Services	2,831	7,871	3,045	8,352	3,235	9,140	34	474	36	486	38	517
Physician Services	4,175	7,053	4,339	7,546	4,557	8,199	121	503	127	524	134	552
Prescription Drugs	2,226	9,628	2,375	10,624	2,527	11,947	110	806	114	946	120	1,100

NOTE: Total FFS spending is defined as the sum of all service lines, including inpatient, outpatient, carrier, home health, hospice, skilled nursing facility, and DME. Beneficiaries were included if they had any MH related diagnosis, procedure, or NDCs during the year. MH-related Medicare spending was defined as having summing payment amounts for claims with a principal diagnosis of any MH condition. MH-related prescription drug use was defined based having any Part D psychotherapeutic drug events. Beneficiaries needed a full 12 months of eligibility (Part A/B, no HMO, alive, 65 and older, and residing in the 50 states) to be included in the analysis. This analysis of PBPY spending includes all MH beneficiaries, regardless of whether they used services within these categories.

SOURCE: Medicare Summary Beneficiary Files and Medicare FFS claims.

What are the patterns of Medicare expenditures among older adults with an SUD diagnosis or any SUD related service use?

EXHIBIT 5-5 **Average Annual Medicare Spending Per Beneficiary with a Substance Use Disorder Diagnosis or Substance Use Disorder-Related Service Use, by Service Type, 2017–2019**

Service Type	Medicare Spending, $											
	All-cause						SUD-related					
	2017		2018		2019		2017		2018		2019	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Total FFS Spending	25,262	37,213	25,123	37,522	25,617	38,787	467	3,168	459	3,529	462	3,301
Inpatient Services	11,109	23,776	10,818	23,710	10,898	24,265	299	2,668	295	3,093	288	2,772
Outpatient Services	3,740	8,794	3,937	9,258	4,144	10,195	52	465	52	454	53	477
Physician Services	5,747	8,135	5,841	8,835	6,069	9,446	76	322	75	332	77	375
Prescription Drugs	2,669	11,567	2,819	11,843	2,981	12,498	18	224	22	260	26	281

NOTE: Total FFS spending is defined as the sum of all service lines, including inpatient, outpatient, carrier, home health, hospice, skilled nursing facility, and DME. Beneficiaries were included if they had any SUD-related diagnosis, procedure, or NDCs during the year. SUD-related utilization was defined as having any service with a principal diagnosis of any SUD. SUD-related prescription drug use was defined based on NDCs. Beneficiaries needed a full 12 months of eligibility (Part A/B, no HMO, alive, 65 and older, and residing in the 50 states) to be included in the analysis. This analysis of PBPY spending includes all SUD beneficiaries, regardless of whether they used services within these categories.

SOURCE: Medicare Summary Beneficiary Files and Medicare FFS claims.

What are the differences in Medicare spending between beneficiaries with and without a BH diagnosis or BH-related service use?

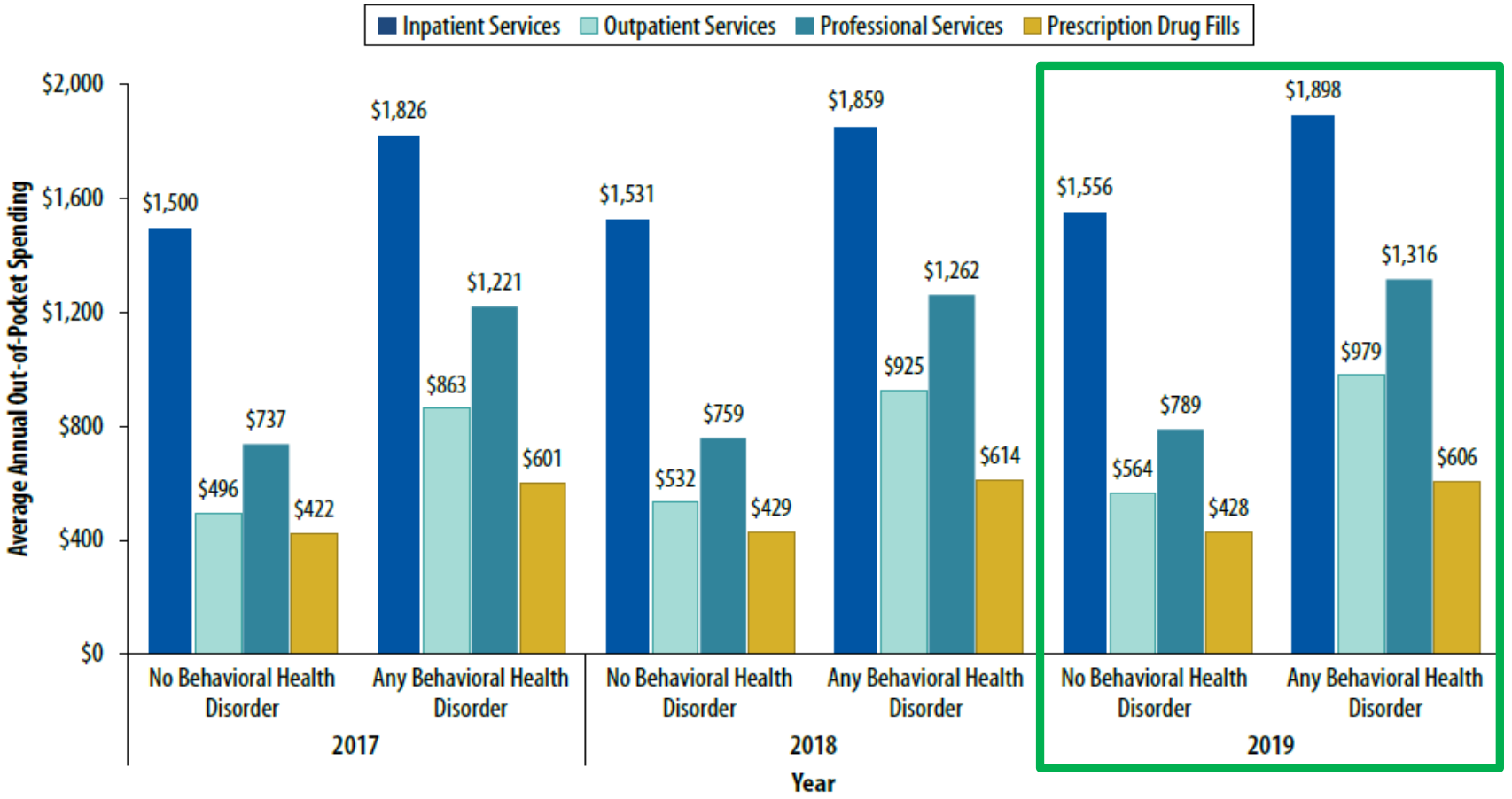
EXHIBIT 5-9 Comparison of Medicare Spending Per Age/Gender Matched Medicare Beneficiary With and Without a Behavioral Health Diagnosis or Behavioral Health-Related Service Use, 2017–2019

Service Type	BH Disorder, $											
	No BH						Any BH					
	2017		2018		2019		2017		2018		2019	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Total FFS Spending	5,976	13,662	6,177	14,180	6,419	14,745	15,740	27,686	16,104	28,351	16,601	29,445
Inpatient Services	1,572	7,168	1,578	7,367	1,615	7,534	5,430	16,090	5,442	16,362	5,538	16,865
Outpatient Services	1,317	4,960	1,420	5,247	1,511	5,752	2,830	7,858	3,043	8,337	3,232	9,131
Physician Services	2,172	4,603	2,254	4,995	2,370	5,402	4,174	7,048	4,335	7,544	4,551	8,191
Prescription Drugs	878	5,979	946	6,638	1,022	7,383	2,205	9,589	2,353	10,581	2,502	11,897

NOTE: Total BH N = 8,764,590 in 2017, 8,931,256 in 2018, and 9,115,395 in 2019. Total FFS spending is defined as the sum of all service lines, including inpatient, outpatient, carrier, home health, hospice, skilled nursing facility, and DME. Beneficiaries were defined as having a BH-diagnosis or BH-related service use if they had any MH- or SUD-related diagnosis, procedure, or NDCs during the year. These beneficiaries were matched 1:1 based on age and sex with beneficiaries without any BH diagnosis or BH-related service use. Beneficiaries needed a full 12 months of eligibility (Part A/B, no HMO, alive, 65 and older, and residing in the 50 states) to be included in the analysis. The sample was not required to have a full 12 months of Part D enrollment, thus differences in prescription drug spending between the BH and non-BH samples may reflect underlying differences in Part D enrollment. This analysis of PBPY spending includes all BH beneficiaries and matched non-BH beneficiaries, regardless of whether they used services within these categories.

SOURCE: Medicare Summary Beneficiary Files and Medicare FFS claims.

EXHIBIT 5-11 Average Annual Out-of-Pocket Spending Per Beneficiary With and Without a Behavioral Health Diagnosis or Behavioral Health-Related Service Use Who Had Any Spending within the Service Category, by Service Type, 2017–2019



NOTE: Professional OOP payments include beneficiary cost-sharing from both carrier and DME files to account for OOP Part B covered drug treatments. Prescription Drug OOP was calculated on beneficiaries with any drug fills during the year due to the large number of beneficiaries without any drug costs. Beneficiaries were defined as having a BH-diagnosis or BH-related service use if they had any MH- or SUD-related diagnosis, procedure, or NDCs during the year. These beneficiaries were matched 1:1 based on age and sex with beneficiaries without any BH diagnosis or BH-related service use. Beneficiaries needed a full 12 months of eligibility (Part A/B, no HMO, alive, 65 and older, and residing in the 50 states) to be included in the analysis. The sample was not required to have a full 12 months of Part D enrollment, thus differences in prescription drug OOP payments between the BH and non-BH samples may reflect underlying differences in Part D enrollment.

SOURCE: Medicare Summary Beneficiary Files and Medicare FFS claims.

Discussion

- **The rate of FFS Medicare beneficiaries aged 65 and older with any BH diagnoses or BH-related service use increased slightly from 34.3 percent in 2017 to 35.5% in 2019.**

- **Approximately a quarter of beneficiaries with a MH/SUD diagnosis or any MH or SUD related service use had a BH outpatient visit.**

- **Inpatient and ED use was common among beneficiaries with a BH diagnosis, MH and SUD inpatient and ED visits were less common.**
  - Approximately 25 and 34 percent of beneficiaries with a BH disorder had an acute inpatient admission or ED visit, respectively from 2017 to 2019

Discussion (Continued)

- **Medicare beneficiaries with a BH diagnosis or BH-related service use had greater Medicare spending and OOP than non-BH beneficiaries.**

- **Approximately half of beneficiaries with BH diagnosis or BH-service us had Full-Dual Eligibility States (*Exhibit 3-2*).**
  - Highlights the importance of efforts to expand integrated care for the dual eligible population through DSNPs.

Limitations

- **These estimates are based on utilization of services; thus, we miss the proportion of the BH population not receiving services.**
- **This approach may over-estimate those with BH disorders in that some psychotherapeutics may be used for non-BH conditions.**
- **We used broad measures of utilization; thus, we were not able to observe rates of use among specific types of BH providers or services.**

Conclusion

- **The rate of BH diagnoses or BH-related service use is greater than survey-based estimates and about one third of the Medicare FFS population 65 years and older.**
- **Among these beneficiaries, all-cause inpatient and ED use was common. MH and SUD-related acute services was not common.**
- **Almost all beneficiaries had at least 1 EM visit, and approximately a quarter had a BH outpatient visit during the year.**
- **Across all service categories, Medicare beneficiaries with a BH diagnosis or BH-related services use had greater Medicare spending, service utilization, and OOP than non-BH beneficiaries.**

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Thank you

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Supplemental BH Chartbook slides and figures



The majority of beneficiaries with a BH disorder were identified by diagnosis or prescription drug use.

EXHIBIT 2-1 Percent of Fee-For-Service Medicare Beneficiaries With Any Mental Health or Substance Use Related Diagnoses, Procedures, or Prescription Fills, 2017–2019

Characteristic	Frequency			Percentage		
	2017	2018	2019	2017	2018	2019
Total Medicare FFS Sample	25,546,400	25,554,668	25,650,564	100.0%	100.0%	100.0%
Diagnosis						
MH	6,253,033	6,498,045	6,563,671	24.5%	25.4%	25.6%
SUD	782,670	856,553	907,007	3.1%	3.4%	3.5%
Procedure						
MH	816,313	850,333	884,361	3.2%	3.3%	3.4%
SUD	12,877	13,254	13,474	0.1%	0.1%	0.1%
Prescription Drug						
MH	5,982,329	6,014,891	6,085,414	23.4%	23.5%	23.7%
SUD	21,460	26,983	33,781	0.1%	0.1%	0.1%

NOTE: Diagnosis, procedure, and prescription drug categories are not mutually exclusive.

EXHIBIT 3-2 **Rates of Behavioral Health Diagnosis and Behavioral Health-Related Service Use Among Medicare Beneficiaries 65 Years and Older, by Demographic Characteristics, 2017–2019**

Characteristic	Frequency			Percentage		
	2017	2018	2019	2017	2018	2019
Age						
65–74	4,428,061	4,545,960	4,669,242	33.0%	33.8%	34.4%
75–84	2,872,068	2,960,655	3,035,042	34.5%	35.2%	35.9%
85+	1,464,461	1,424,641	1,411,111	38.4%	38.7%	39.1%
Sex						
Female	5,915,295	5,996,442	6,093,350	41.1%	41.8%	42.4%
Male	2,849,295	2,934,814	3,022,045	25.5%	26.2%	26.8%
Race/ethnicity						
Non-Hispanic White	7,503,412	7,646,615	7,806,473	35.7%	36.4%	37.1%
Black/African American	510,822	505,921	503,351	27.8%	28.2%	28.5%
Hispanic	403,669	402,663	403,835	31.4%	31.6%	31.7%
Asian/Pacific Islander	151,566	158,071	163,182	21.9%	22.3%	22.6%
American Indian/Alaska Native	37,569	38,916	39,844	31.5%	32.1%	33.1%
Other	50,731	52,541	54,546	25.1%	25.4%	25.9%
Unknown	106,821	126,529	144,164	27.4%	28.4%	29.1%
Dual Status						
Non-Dual Eligible	7,424,665	7,626,726	7,841,146	32.0%	32.8%	33.5%
Dual Eligible	1,339,925	1,304,530	1,274,249	56.3%	56.3%	56.6%
Rurality						
Urban	6,832,952	6,975,261	7,129,162	34.4%	35.1%	35.7%
Large rural city/town	1,005,459	1,017,559	1,033,312	34.8%	35.3%	35.8%
Small rural town	544,002	551,174	557,687	34.3%	34.9%	35.3%
Isolated town	381,352	386,553	394,628	32.0%	32.4%	32.9%

NOTE: Beneficiaries were defined as having a BH diagnosis or BH-related service use if they had any MH- or SUD-related diagnosis, procedure, or NDCs during the year. Beneficiaries needed a full 12 months of eligibility (Part A/B, no HMO, alive, 65 and older, and residing in the 50 states) to be included in the analysis.

SOURCE: Medicare FFS claims and the Medicare Summary Beneficiary Files.

Anxiety and Depressive disorders were the most prevalent MH disorders among Medicare beneficiaries from 2017 to 2019

EXHIBIT 3-5 Mental Health Disorder Prevalence Among Medicare Beneficiaries 65 and Older: 2017–2019

Characteristic	Frequency			Percentage		
	2017	2018	2019	2017	2018	2019
Disorder						
ADHD	62,202	70,355	79,102	0.2%	0.3%	0.3%
Anxiety Disorders	3,802,906	4,006,671	4,192,954	14.9%	15.7%	16.3%
Bipolar	416,824	442,112	467,499	1.6%	1.7%	1.8%
Depressive Disorders	3,815,049	3,988,050	4,195,101	14.9%	15.6%	16.4%
Eating Disorders	323,145	319,704	321,152	1.3%	1.3%	1.3%
Personality Disorders	303,301	307,346	303,514	1.2%	1.2%	1.2%
PTSD	118,128	133,551	150,903	0.5%	0.5%	0.6%
Schizophrenia and Other Psychotic Disorders	406,027	392,297	382,475	1.6%	1.5%	1.5%

NOTE: Beneficiaries were defined as having a specific MH condition if they had any MH related diagnosis only. Beneficiaries needed a full 12 months of eligibility (Part A/B, no HMO, alive, 65 and older, and residing in the 50 states) to be included in the analysis.

SOURCE: Medicare FFS claims and the Medicare Summary Beneficiary Files.

Drug and opioid use disorders were the most common disorders among Medicare beneficiaries with an SUD diagnosis or SUD-related service use, 2017 to 2019.

EXHIBIT 3-8 Condition-Specific Substance Use Prevalence Among Medicare Beneficiaries 65 Years and Older, 2017–2019

Characteristic	Frequency			Percentage		
	2017	2018	2019	2017	2018	2019
Disorder						
Alcohol Use Disorder	248,639	267,585	277,275	1.0%	1.0%	1.1%
Drug Use Disorder	509,284	578,789	627,498	2.0%	2.3%	2.4%
Opioid Use Disorder	302,455	323,246	336,932	1.2%	1.3%	1.3%

NOTE: Beneficiaries were defined as having a SUD if they had any substance use related diagnosis, procedure, or NDC codes during the year. Prevalence estimates for drug use disorders included beneficiaries with OUD. Beneficiaries needed a full 12 months of eligibility (Part A/B, no HMO, alive, 65 and older, and residing in the 50 states) to be included in the analysis.

SOURCE: Medicare FFS claims and the Medicare Summary Beneficiary Files.

What are the service utilization patterns among older Medicare FFS beneficiaries with a mental health (MH) disorder?

- Nearly all had an E&M visit during the year.
- A substantial proportion had an acute hospitalization or ED visit during the year.

EXHIBIT 4-1 Number and Percent of Beneficiaries with a Mental Health Disorder Who Had Any Service Utilization, by Service Type, 2017–2019

Service Category	Frequency			Percentage		
	2017	2018	2019	2017	2018	2019
Any Physician E&M Visits	8,354,218	8,492,557	8,662,367	98.5%	98.5%	98.5%
Any Acute Inpatient Stay	2,133,470	2,094,434	2,086,405	25.2%	24.3%	23.7%
Any Outpatient ED Visits	2,914,518	2,923,864	2,964,730	34.4%	33.9%	33.7%
Any Prescription Drug Fills	6,911,330	7,012,911	7,154,595	81.5%	81.4%	81.4%

NOTE: Beneficiaries were defined as having a MH disorder if they had any MH related diagnosis, procedure, or NDC codes during the year. Physician E&M services are defined as having any E&M code or visit to FQHC or RHC. Acute inpatient admissions include any admission to a short-term acute hospital. Outpatient ED visits are any ED visit that does not end in a hospitalization. Prescription drug fills includes include any Part D event with a service date during the year. Beneficiaries needed a full 12 months of eligibility (Part A/B, no HMO, alive, 65 and older, and residing in the 50 states) to be included in the analysis. Any service utilization includes both BH and non-BH service utilization.

SOURCE: Medicare Summary Beneficiary Files and Medicare FFS claims.

What are the service utilization patterns among older Medicare FFS beneficiaries with a substance use disorder (SUD)?

- Close to half of all Medicare beneficiaries with an SUD had an acute hospitalization or an ED visit from 2017 to 2019.
- Approximately all beneficiaries with an SUD had at least 1 EM visit.

EXHIBIT 4-10 Number and Percent of Beneficiaries with a Substance Use Disorder Who Had Any Service Utilization, by Service Type, 2017–2019

Service Category	Frequency			Percentage		
	2017	2018	2019	2017	2018	2019
Physician E&M Visits	771,372	846,042	898,886	97.2%	97.3%	97.4%
Acute Inpatient Stays	344,653	357,703	368,342	43.4%	41.1%	39.9%
ED Visits	369,250	390,279	406,622	46.5%	44.9%	44.1%
Prescription Drug Fills	586,926	646,054	690,522	74.0%	74.3%	74.8%

NOTE: Beneficiaries were defined as having a SUD if they had any SUD related diagnosis, procedure, or NDC codes during the year. Physician E&M services are defined as having any E&M code or visit to FQHC or RHC. Acute inpatient admissions include any admission to a short-term acute or psychiatric hospital. Outpatient ED visits are any ED visit that does not end in a hospitalization. Prescription drug fills includes include any Part D event with a service date during the year. SUD related utilization was defined as having any service with a principal diagnosis of any SUD. SUD related prescription drug use was defined based on NDC codes. Beneficiaries needed a full 12 months of eligibility (Part A/B, no HMO, alive, 65 and older, and residing in the 50 states) to be included in the analysis. Any service utilization includes both BH and non-BH service utilization.

SOURCE: Medicare Summary Beneficiary Files and Medicare FFS claims.

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Convening + Uniting + Transforming

Wrap-up and What's Ahead

Larry McNeely | Primary Care Collaborative

Upcoming BHI Meetings

- Meeting dates for the remainder of 2025:
  - **April 24, 2025 – *Hybrid Option***
  - **July 24, 2025 – *Virtual ONLY***
  - **October 23, 2025 – *Hybrid Option***
- Join us in-person in April and October at PCC Headquarters!
  - 1101 Connecticut Ave NW