Behavioral Health Integration Meeting

JULY 24TH, 2025 | 2:00 – 4:00 PM ET

PARTICIPATING ORGANIZATIONS

American Academy of Child and Adolescent Physiatry, American Academy of Family Physicians, American College of Physicians, American Psychiatric Association, American Psychological Association, Blue Shield of California, Centivo, EvolvedMD, Families USA, Humana, Meadows Mental Health Policy Institute, Mental Health America, NAACOS, Primary Care Development Corporation, Rhode Island Primary Care Physician Corporation, Society of General Internal Medicine

Thank you to our Speakers

- Scott Barstow*, American Psychological Association*
- Naomi Fener, *Families USA*
- Andrew Riley*, Oregon Health & Science University*

MEETING SUMMARY

Welcome & Announcements

Larry McNeely, Policy Director of the PCC, began the meeting by reviewing the agenda and sharing some PCC updates. The PCC has updated its Shared Principles to emphasize prevention and lifestyle change as part of its vision to address the chronic disease epidemic. Larry also shared that the PCC is having a webinar on July 29 at 1 p.m., featuring employer innovators showcasing scalable models for integrated, whole-person primary care, and encouraged everyone to attend and amplify.

Ann Greiner, President and CEO of the PCC, spoke about the larger political environment and how the PCC is responding. She acknowledged that this is an unpredictable time, particularly with the transition to a new administration and Congress. Ann shared that PCC will continue to assess the implications of these developments, balancing proactive engagement in Medicare and behavioral health policy with strategic resistance to Medicaid cuts. She expressed appreciation for all of PCC's members and their feedback and support.

Updates on HR 1

Larry began by setting the context of PCC's broader policy platform, Better Health – NOW, Today's conversation focused on Medicaid following the passage of HR 1, with a focus on behavioral health implications. He shared some overview slides of Medicaid provisions in HR 1 from NASHP for review.

Larry first offered an overview of how HR 1 will impact Medicaid coverage and what that means for state policymakers.

- Larry emphasized that, despite reports of delayed implementation, many state policymakers are already preparing for potential reductions in federal Medicaid support, prompting immediate policy considerations at the state level.
- Several provisions of the legislation are already in effect, including the prohibition of enforcement on eligibility streamlining (as of July 4), parts of the nursing home staffing rule, and certain provider tax and state-directed payment measures. While redeterminations are scheduled for January 2027, semi-annual reporting and community engagement processes will begin sooner and are expected to impact coverage and access to primary care.
- Additional concerns include the suspension of the Medicaid expansion FMAP starting in early 2026 and funding restrictions for immigrant populations (including access to community health centers)
- A few provisions offer opportunities for primary care including the new $50 billion Rural Health Transformation Fund set to begin distribution in January 2026. Provisions affecting HSA and High-Deductible Health Plans will also expand flexibility for telehealth and direct primary care.

Larry reminded the group that the PCC has been actively engaged since March, including sending a coalition letter urging Congress to reject Medicaid cuts that would reduce access to primary care, and it plans to continue convening members for further advocacy and strategic response. He then invited Scott Barstow with the American Psychological Assocation to offer a perspective.

Scott gave a high-level overview of APA's priorities on HR 1 and what actions they are taking to support their members and clinicians.

- Right now, a lot of effort is going into helping psychologists and state psychological associations prepare for the expected cuts to Medicaid behavioral health services.
- The main points APA will be emphasizing include how critical behavioral health services are, not just broadly, but especially within Medicaid, which funds about a quarter of all mental health and substance use treatment. Since these services are considered "optional" under Medicaid, there's a real risk they'll be among the first things cut, even though research shows that cutting them could drive up other healthcare costs.

- APA will be encouraging advocates to stress the importance of maintaining access to both community mental health centers and outpatient care, especially in rural and underserved areas.

Larry then turned the conversation over to Naomi Fener with Families USA. Naomi shared Families USA's top Medicaid and public health priorities. She encouraged folks to reach out as Families is newer in this space. Her email is nfener@familiesusa.org.

- Her team is currently focused on vaccine work but expressed shock at how quickly HR 1 was passed and is shifting to a harm reduction approach.
- Efforts are now centered on supporting states in implementing new requirements, such as work mandates, in ways that minimize harm and engaging in active discussions about legal and strategic workarounds.
- Additional priorities include exploring alternative state revenue sources to offset losses from provider tax changes and seeking opportunities in the potential September health care package.

Larry opened the floor up to other questions or comments.

Tim Clement with Mental Health America shared their top priorities.

- MHA has just begun a new project with *Inseparable* to develop a "playbook" for state Medicaid agencies on implementing exemptions to work requirements, particularly for individuals with substance use disorders and disabling mental disorders.
- Language included in the final bill requires states to attempt *ex parte* verification for these individuals, though this process is complex and relies on accessing and coordinating data from multiple sources such as opioid treatment programs, managed care organizations, and pharmacy benefit managers.
- The project aims to identify and address barriers to data sharing and verification in order to reduce the number of vulnerable individuals who fall through the cracks and lose coverage. A convening is planned for November to bring together stakeholders and further advance this work.

Larry shared that he saw a post from the American Psychiatric Association highlighting progress toward coverage for collaborative care in Colorado and other states, bringing the total to around 36 states taking steps in that direction.

Julio Abreu with American Psychological Association highlighted the urgent need to build a broad coalition and begin meeting with state Medicaid directors as soon as possible, since

states must start developing complex implementation plans well before official effective dates. Early engagement is especially important to promote whole-person health approaches, with states like Colorado and New Mexico already calling special sessions and making them key targets for advocacy efforts.

Larry transitioned the group to a conversation about the 2026 CMS Physican Fee Schedule Proposed Rule.

Medicare PFS NPRM: Informing the PCC Response

Larry began the conversation by reminding folks of PCC's standing commitment to improving behavioral health integration in Medicare, with a strong focus on aligning payment reform with NASEM's 2021 recommendations for high-quality primary care. A key goal has been advocating for better and more appropriate payment for both primary care and BHI, which are historically undervalued and under-reimbursed.

This year's proposed rule includes significant steps forward, though still incremental, that could strengthen support for integrated, whole-person care. PCC is encouraging members to engage in the comment process to support these changes. Comments are due to CMS on September 12th.

Larry then turned to Chiyedza Mvundura, Policy Associate at the PCC, to highlight wins for primary care and behavioral health within Medicare in recent years. She noted that

- In 2023, licensed clinical social workers and counseling professionals were authorized to bill for general behavioral health services, broadening access to care.
- In 2024, valuation for behavioral health management codes was increased, and billing privileges were extended to include clinical social workers, mental health counselors, and marriage and family therapists for behavioral health assessment and integration services.

Larry also noted that there were important add-on codes for valuation and management to support better therapy from psychiatric practices

Chiyedza continued to policies from last year's fee schedule.

- In the past year, several key behavioral health-related billing codes were added, including two for safety planning interventions and post-crisis care follow-up, six for interprofessional consultation services, and new codes for digital mental health treatment devices.

- Beyond behavioral health, broader primary care gains were also seen. CMS re-evaluated and increased valuations for office and outpatient E/M codes in 2021, introduced the G20211 code in 2024 to support relationship-building and continuity of care, and most notably, introduced new APCM (Advanced Primary Care Management) codes, marking a major milestone in response to longstanding PCC and BHI community advocacy.

Chiyedza handed it back to Larry to discuss opportunities in this year's proposed rule.

- While recent advocacy has led to important wins in securing reimbursement for previously uncovered services in Medicare, systemic issues persist, particularly the ongoing bias in the fee schedule against cognitive services and the heavy administrative burden associated with them. PCC has emphasized that reforming the fee schedule is important but not sufficient; the ultimate goal remains broader payment reform, including workable hybrid models.
- The new proposed rule includes several promising provisions, such as a proposed efficiency adjustment, proposed updates to indirect practice expense, and new add-on codes for BHI within APCM.
- CMS is also exploring how to integrate preventive services into the new APCM codes to reduce cost sharing and improve access.

PCC will be coordinating feedback on our comment letter through the Better Health – Now process. Larry encouraged all stakeholders to engage, as this rule presents significant opportunities to strengthen primary care if implemented thoughtfully.

Larry opened the discussion up for comments.

Scott emphasized that the devaluation of cognitive services is not the only challenge facing psychologists and other behavioral health providers under the current fee schedule. He pointed to the Indirect Practice Cost Index, which has consistently undervalued behavioral services. Scott added that while CMS has acknowledged this issue, they have not taken steps to address it. This will be a key point raised in their forthcoming comments.

Ann shared that some stakeholders will be opposed of CMS's proposed direction and may raise their concerns to both the administration and Capitol Hill. Ann emphasized the importance of a unified response from the primary care community. In the coming weeks, PCC will be working to engage additional stakeholder groups to support a coordinated response.

Behavioral Health Integration in Pediatric Settings

Larry introduced Andrew Riley from the Oregon Health & Science University.

Andrew presented his research on pediatric behavioral health integration and began by sharing data to set the context:

- 20% of kids meet the criteria for mental health disorder at any given time
- Another 40% have significant impairment/distress
- Only about 10% receive mental health services

Andrew noted that while integrated primary care (IPC) has proven effective, the mechanisms driving its success are not fully understood. His team's research aimed to explore this further through two primary hypotheses:

1. IPC significantly increases the use of mental health care compared to usual and enhanced usual care.
2. IPC significantly reduces the use of offsite specialty mental health services.

The study was a meta-analysis of nine U.S.-based studies. Eligibility criteria included participants aged 0–21 and the presence of an onsite mental health provider involved in the intervention.

The research found that integrated primary care models significantly increased the number of patients receiving mental health interventions. Specifically:

- IPC increased the odds of receiving any mental health intervention compared to usual or enhanced usual care (OR = 12.23).
- IPC also increased the odds of receiving a full course of treatment—defined as 6 to 14 sessions—compared to usual or enhanced usual care (OR = 19.17).

Both the slides and article are linked in the follow-up email. He asked that the article not be published or widely distributed at this time.

Ann thanked Andrew for his presentation and noted that the CMS Innovation Center is planning to develop a model focused on pediatric care. She expressed hope that behavioral health will be a central component of the model's design. Ann encouraged Andrew to consider sharing his research findings with the Innovation Center to help inform their work.

Andrew added that he leads the integrated behavioral health program at Oregon Health & Science University. He emphasized that local policy decisions play a significant role in either facilitating or hindering the implementation of integrated behavioral health services.

Ann added that this reflects a broader, ongoing challenge, that while there are models that demonstrate clear effectiveness, the payment reforms needed to support them is not consistent from state to state. She noted that another persistent challenge, particularly in pediatric care, is demonstrating ROI.

Andrew agreed and shared that his team has explored ways to assess value, especially in higher-integration models. For example, they have examined whether integrated care helps divert children (specifically those who screen positive for suicidality) from emergency room visits. However, Andrew added that conducting ROI research is resource-intensive and can present significant challenges.

He noted that there is growing interest in the pediatric space in identifying where value can be captured, and that there are researchers actively working on this question.

Dominique asked whether national or site-specific data exists on the prevalence of personality disorders or similar conditions and if there was a way to compare past data with current findings to assess the impact of integrated care. She shared from her own experience that when a social workers was embedded, it often helped to address early signs of depression or other issues before they developed into more serious conditions.

Andrew responded that national prevalence data does exist, especially as universal screening has become more common. He shared that part of the goal of the consortium he is involved with is to collect this type of data across multiple sites, which can offer more robust insights than data from a single clinic.

Susan McDaniels of American Psychological Association asked whether Andrew's behavioral health team is interprofessional, or if it is composed entirely of psychiatrists or psychologists.

Andrew responded that his team is multidisciplinary. He closed by thanking the group for the opportunity to present and invited anyone interested in collaborating to reach out to him at rileyand@ohsu.edu.

Larry thanked everyone for joining and closed the meeting.