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PCC Behavorial Health Workgroup Meeting

Thursday, July 24, 2025

agenda

I.	Welcome & Announcements	Ann Greiner & Larry McNeely, Primary Care Collaborative
II.	Updates HR 1	Primary Care Collaborative American Psychological Assocation Families USA
III.	Medicare PFS NPRM: Informing the PCC Response	Larry McNeely Chiyedza Mvundura Primary Care Collaborative
IV.	Behavioral Health Integration in Pediatric Setting	Andrew Riley Oregon Health & Science University
V.	Wrap Up & Next Steps	Larry McNeely Primary Care Collaborative

PCC Updates Shared Principles

Shared Principles signers have agreed to a greater emphasis on the need for prevention and lifestyle changes to combat the chronic disease epidemic as federal policymakers also have increased such calls. These revisions:

- reinforce the role of the **community**;
- emphasize **wellbeing** in addition to **detecting and treating disease**;
- better highlight the importance of **health promotion** as well as **prevention**;
- acknowledge the **wellbeing of clinicians and staff**;
- address **conditions for health**; and
- underscore **whole-person care** as described in NASEM's report "Implementing High-Quality Primary Care."

Part of **PCC's Whole Person-Care Initiative** supported by **Ardmore Institute of Health** and **Healing Works**.

Upcoming Webinar



On July 29, join us for a webinar exploring how employers are developing innovative new approaches that expand access to whole-person primary care.

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Updates HR 1

Primary Care Collaborative
American Psychological Association
Families USA

Medicaid Rules

Topic	Summary	Effective Date
Medicaid Rule Implementation (Secs. 71101, 71102, 71111)	Prohibits the implementation and enforcement of the Medicare Savings Program (MSP) eligibility, Medicaid and CHIP eligibility and enrollment, and nursing home staffing rules until September 30, 2034.	July 4, 2025
Medicaid: Provider Taxes and State Directed Payments		
Provider Taxes (Secs. 71115, 71117)	Freezes the current provider tax thresholds for all states for two years and reduces the allowable level of provider taxes for expansion states by 0.5% each year until it reaches 3.5% in FY 2032. Modifies the criteria for determining provider taxes are generally redistributive.	Oct 1, 2028, for the tax thresholds July 4, 2025, for the generally redistributive requirement
State-Directed Payments (Sec. 71116)	Sets the payment limit for state directed payments to 110% of Medicare rates for non-expansion states and 100% of Medicare rates for expansion states. For states that newly expand Medicaid, all state directed payments will be subject to this provision, even if previously approved. Existing state directed payment limits would be reduced by 10% annually to reach the Medicaid allowable rate.	July 4, 2025 Grandfathered payments will begin to reduce by 10% annually with the rating period on or after Jan 1, 2028

Source: NASHP, 2025

Medicaid Expansion Population

Topic	Summary	Effective Date
Redetermination (Sec. 71107)	Requires semi-annual redeterminations for the expansion population.	Jan 1, 2027
Community Engagement Requirements (Sec. 71119)	Requires states to establish community engagement requirements as a condition of eligibility for able-bodied adults between 19 and 64 years old. Requires 80 hours of work or equivalent qualifying activity in the month(s) preceding eligibility determinations and between redeterminations. Includes mandatory and optional exceptions, expectations for state communication and verification processes, and grants to states for creating needed systems.	The Secretary of HHS must promulgate guidance by June 1, 2026. States must establish community engagement requirements beginning Jan 1, 2027. (With the exception of one year delay for hardship good faith effort if granted by the HHS Secretary)

Source: NASHP, 2025

Medicaid Expansion Pop Cont.

Title	Summary	Date
Cost-Sharing Requirements (Sec. 71120)	Requires states to impose cost-sharing on certain services for Medicaid expansion adults with incomes above 100% of the Federal Poverty Level (FPL). Cost-sharing will be at a rate determined by the state and must be above $0 but may not exceed $35 per service. The total aggregate amount for the family may not exceed 5% of the family income. Certain types of services will be exempted, including primary care, prenatal care, pediatric care, emergency room care (except for non-emergency care provided in an emergency room), mental health and substance use disorder services, and services to certain community health centers.	Oct 1, 2028
Expansion FMAP Incentive (Sec. 71114)	Sunsets the 5% enhanced FMAP incentive for the traditional Medicaid population for states that expand Medicaid after Jan 1, 2026.	Jan 1, 2026

Source: NASHP, 2025

Medicaid Eligibility and Enrollment Requirements and Procedures

Title	Summary	Date
Retroactive Coverage (Sec. 71112)	Limits retroactive coverage for the traditional Medicaid population to the two months preceding enrollment and to the month preceding enrollment for the expansion population.	Jan 1, 2027
Deceased status checks (Secs. 71104, 71105)	Requires quarterly deceased status checks and disenrollment for beneficiaries and providers.	Jan 1, 2027, for beneficiaries; Jan 1, 2028, for providers
Multi-state enrollment (Sec. 71103)	Adds a requirement for HHS to create a system to prevent individuals from being enrolled in Medicaid in multiple states, and for states to submit social security numbers to such a system and to verify addresses and act when multiple state enrollment is identified.	Process established by Jan 1, 2027, with states submitting information by Oct 1, 2029

Source: NASHP, 2025

Medicaid Eligibility and Enrollment Requirements and Procedures Cont.

Title	Summary	Date
Reduction of good faith waiver (Sec. 71106)	Annually, HHS issues estimates of improper payment rates in Medicaid based on a review of states' programs through the Payment Error Rate Measurement (PERM) program. Currently, states are required to repay HHS if their error rate is above 3%, or they may work with HHS to correct the errors through corrective action plans through a "good faith waiver." The new law reduces the amount of erroneous excess payments the HHS Secretary may waive and expands the definition or erroneous excess payments to include services to individuals who are ineligible for federal reimbursement. In addition, the law limits the ability of the HHS Secretary to waive payments associated with administrative errors of the state. This change may result in additional federal recoupments and affect state cost-sharing levels.	Oct 1, 2030
Asset Ceiling (Sec. 71106)	Creates a non-waivable ceiling of $1 million home equity values for allowable assets for LTC eligibility.	Jan 1, 2028

Source: NASHP, 2025

Immigrant Coverage

Topic	Summary	Effective Date
Emergency Medicaid FMAP (Sec. 71110)	Reduces the FMAP for emergency Medicaid services provided to "unlawfully present aliens" that would otherwise qualify for Medicaid expansion to the standard FMAP, rather than the expansion FMAP of 90%.	Oct 1, 2026
Medicaid Eligible Populations (Sec. 71109)	Limits Medicaid eligibility to US citizens, lawful permanent residents, certain Cuban or Haitian immigrants, and individuals living in the US through a compact of free association.	Oct 1, 2026
Marketplace Eligible Populations (Sec. 71301)	Limits premium tax credit eligibility for lawfully present immigrants to only a category of "eligible alien," which is defined as: an individual who is an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act; an alien granted the status of Cuban and Haitian entrant; or an individual who lawfully resides in the U.S. in accordance with a Compact of Free Association.	Jan 1, 2027

Source: NASHP, 2025

Immigrant Coverage Cont.

Topic	Summary	Effective Date
Medicare Eligible Populations (Sec. 71201)	Limits Medicare eligibility to only citizens or individuals lawfully admitted for permanent residence under the Immigration and Nationality Act; an alien granted the status of Cuban and Haitian entrant; or an individual who lawfully resides in the U.S. in accordance with a Compact of Free Association.	Jan 4, 2027
Tax Credit Eligibility for Individuals Subject to the 5-year bar (Sec. 71302)	Prohibits premium tax credits for individuals under 100% FPL subject to the 5-year bar under Medicaid.	Jan 1, 2026

Source: NASHP, 2025

Other

Topic	Summary	Effective Date
Rural Provider Relief Fund (Sec. 71401)	Appropriates $50 billion to states to support rural providers. Requires a rural health transformation plan and approval of awards.	Approval of awards by Dec 31, 2025, for funding allocated to states FY2026-2030
Family Planning Service Providers (Sec. 71113)	Prohibits federal funding for specified family planning and abortion service providers.	July 4, 2025-July 3, 2026
Extension of Telehealth Deductible (Sec. 71306)	Permanently establishes that lack of a deductible for telehealth and remote care will not prohibit a plan from being treated as a high-deductible plan.	Jan 1, 2025
Flexibility for use of High-Deductible Plans and Direct Primary Care (DPC) under Health Savings Accounts (HSAs) (Secs. 71307, 71308)	Redefines high-deductible health plans to include bronze and catastrophic plans available as individual coverage through a marketplace for the purposes of being paired with an HSA. Establishes an exemption for DPC so that they are not disqualifying coverage for HSAs. Spending on DPC must fall below a specified cap and may not include certain services such as procedures requiring anesthesia, prescriptions, or certain laboratory services. Allows DPC to be an allowable expense covered by HSAs.	Jan 1, 2026

Source: NASHP, 2025

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Medicare PFS NPRM: Informing the PCC Response

Larry McNeely | Primary Care Collaborative
Chiyedza Mvundura| Primary Care Collaborative

2021: Barriers to Integrated Primary Care In Trad. Medicare

Level of Payment

1) Cognitive Services (Primary care and Behavioral Health) are systematically undervalued
2) Core PC services not reimbursed (G2211); BHI underutilized due to administrative burden (CoCM, General BHI)

Mode of Payment

1) FFS Dominant
2) Flexible Hybrid or Capitated Payment to PC Practices Unavailable

Incremental PCC BHI Wins in MPFS

CY 2023

- ✓Reimbursement for General BH Integration services when CP or LCSW is the focal point of care integration

CY 2024

- ✓Increased valuation of General BH Integration Care Management codes
- ✓CSWs, MHCs & MFTs can bill Health Behav. Assessment & Integration codes

CY 2025

- ✓Codes to cover Safety Planning Interventions & Post Crisis Care Follow up
- ✓Codes to expand interprofessional consultation services
- ✓Codes for Digital Mental Health Treatment devices

MPFS Begins to Strengthen PC

- ✓**CY 2021:** Office and Outpatient E&M Reevaluation
- ✓**CY 2024:** G2211 (add-on code for office/outpatient visits that build longitudinal relationships with patients and address the majority of a patient's health care needs with consistency and continuity over longer periods of time.)
- ✓**CY 2025:** Advanced Primary Care Management
  - Bundled PMPM payment: including care mgmt. & tele-care;
  - Better Health – NOW's View:
    - APCM is mini hybrid payment
    - Build on it!
    - But still need a viable path for BHI AND Cost-sharing relief

2025: Barriers to Integrated Primary Care In Trad. Medicare

Level of Payment

1) Some progress on uncovered/unreimbursed services BUT
2) Systemic bias against cognitive services unaddressed
3) BHI underutilized due to administrative burden

A. Mode of Payment

1) FFS Still Dominant
2) Full Hybrid or Capitated Payment to PC Practices Still Not in Reach For Most

CY 2026 MPFS Proposed Rule

- **Efficiency Adjustment Addresses Imbalanced Cognitive Payment**
  - Gradually reduces payment over time for procedures, imaging, other services
  - Savings go back into MPFS overall payment
  - Exempts (E/M), care management services, behavioral health services, telehealth, and maternity codes with a global period of MMM.
  - Proposal to rely on Empiric Data in future valuation

CY 2026 MPFS Proposed Rule

- **Indirect Practice Expense**
  - **"recognize greater indirect costs for practitioners in office-based settings compared to facility settings."**
  - **Reduce by 50% the Indirect Practice Expense for facility-based services**
  - **Corresponding Increase in Indirect Practice Expense payment for Non-Facility-based**
- **Potential for a BIG WIN for Independent PC Practices!**

CY 2026 MPFS Proposed Rule

Add-on BHI/CoCM Codes → A Step Toward Hybrid

- Available to practices billing Adv. Primary Care Mgmt
- No time tracking !
- Same Valuation as Existing Codes

CY 2026 MPFS Proposed Rule

Request for Information related to APCM and Prevention:

- How CMS should consider application of cost sharing for APCM services?
- Should prev services like AWV be included in APCM?
- Other changes to support prevention and mgmt. of chronic disease?
- Policies to increased participation of primary care practitioners in ACOs
- Should CMS consider new payments to Shared Savings Program ACOs for prospective monthly APCM payments to be delivered to primary care practices that satisfy the APCM billing requirements, with the payments reconciled under the ACO benchmark?

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Behavioral Health Integration in Pediatric Settings

Andrew Riley | Oregon Health & Science University

Integrated Primary Care and Mental Health Service Utilization: A Meta-Analysis

JULY 24, 2025 – PRIMARY CARE COLLABORATIVE BHI WORK GROUP

ANDREW R. RILEY, PHD
PROFESSOR OF PEDIATRICS
DOERNBECHER CHILDREN'S HOSPITAL
OREGON HEALTH & SCIENCE UNIVERSITY

PIPCRC
Pediatric Integrated Primary Care Research Consortium

Team Members

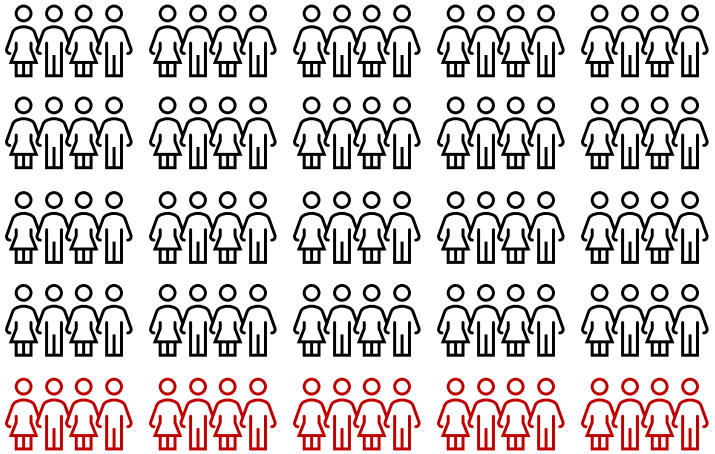
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- Elizabeth T. Koval, PhD - *Riley Hospital for Children*
- Helen Hughes - *The Ohio State University*

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Pediatric Integrated Primary Care Research Consortium

To stimulate, facilitate, conduct and disseminate collaborative research and scholarship to advance the science, practice, and policy of pediatric integrated primary care, ultimately to enrich the lives of young people and their families

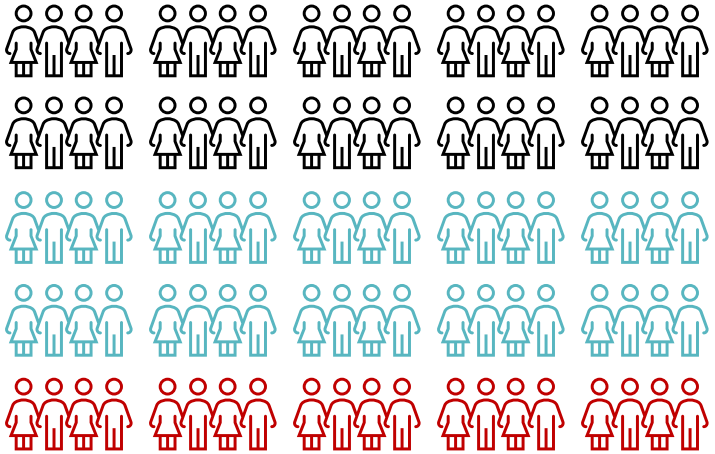
Background



- About 20% of kids meet criteria for mental health disorder at any given time

Bitsko et al., 2022, *MMWR Supplements;* Hodgkinson et al., 2017; Rodgers et al., 2022

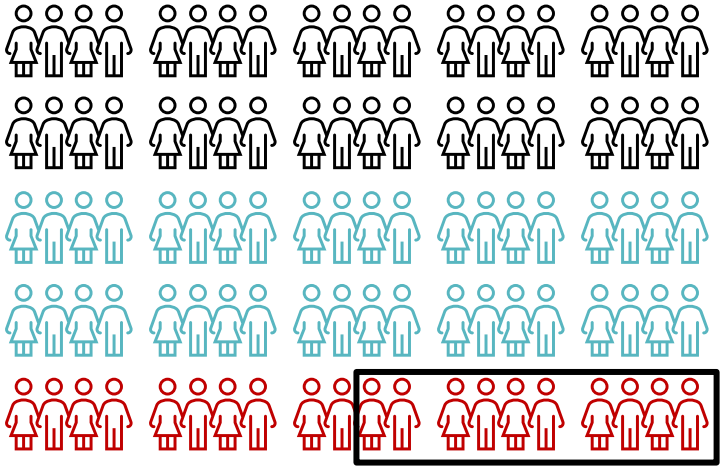
Background



- About 20% of kids meet criteria for mental health disorder at any given time
- Another 40% have significant impairment/distress

Bitsko et al., 2022, *MMWR Supplements;* Hodgkinson et al., 2017; Rodgers et al., 2022

Background



- About 20% of kids meet criteria for mental health disorder at any given time
- Another 40% have significant impairment/distress
- About 10% receive mental health services
  - < 50% of those who are referred to services will access them
  - Access is inequitable across racial, ethnic, and socioeconomic lines
  - Barriers: Transportation, childcare, parental leave from work, stigma, workforce shortages

Bitsko et al., 2022, *MMWR Supplements;* Hodgkinson et al., 2017; Rodgers et al., 2022

Background



Journal of Pediatric Psychology
AN OFFICIAL JOURNAL OF THE SOCIETY OF PEDIATRIC PSYCHOLOGY

Journal of Pediatric Psychology, 2024, **00**, 1–18
https://doi.org/10.1093/jpepsy/jsae038
Systematic Review

OXFORD

A systematic review and meta-analysis of pediatric integrated primary care for the prevention and treatment of physical and behavioral health conditions

Cody A. Hostutler [1,*] PhD, Jeffrey D. Shahidullah,[2] PhD, Jennifer A. Mautone,[3] PhD, Tiffany M. Rybak [4,5] PhD, Chimereodo Okoroji,[4,5] PhD, Teryn Bruni,[6] PhD, Kevin G. Stephenson, PhD, Leah Vance Utset, MD, Kurt A. Freeman,[7] PhD, Leah LaLonde,[1] PhD, Andrew R. Riley [7] PhD

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- Meta-analysis of 27 studies (N = 6,879) comparing integrated care to enhanced usual care, or waitlist control
- Integrated care > controls (*SMD* = .19, [0.11, 0.27])
  - Symptom change
  - Behavioral change
  - Quality of life
  - No significant difference between models/levels of integration*

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Rationale

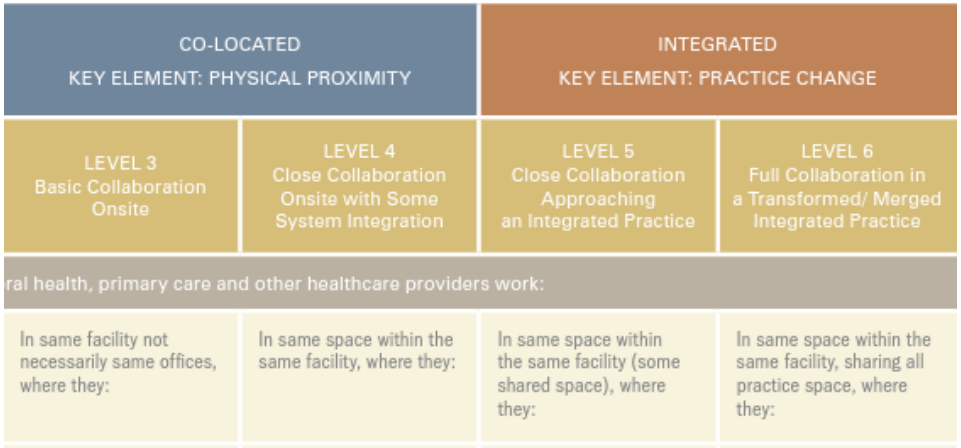
- We know that integrated primary care (IPC) is effective, but the mechanisms of action are not entirely understood
- Individual studies suggest IPC models increase access to care, but this has never been subjected to meta-analysis
- Overarching conceptualization: Models of integration (e.g., Collaborative Care Model, Primary Care Behavioral Health Model, co-located model) exert effects by increasing access to and utilization of evidence-based interventions (e.g., CBT, parent training, medication management)
  - *Hypothesis 1:* IPC significantly increases the use of mental health care compared to usual and enhanced usual care
  - *Hypothesis 2:* IPC significantly reduces use of offsite specialty mental health services

Method

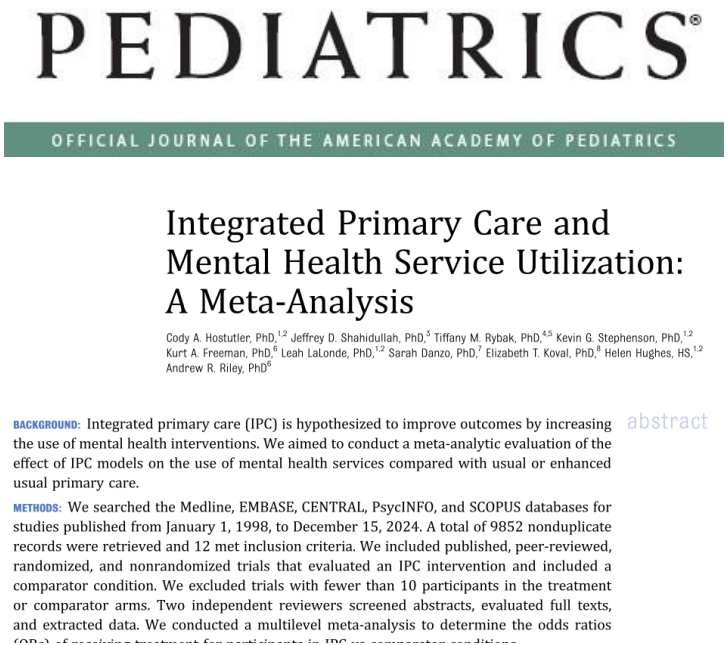
- Eligibility Criteria
  - Based in United States
  - Participants aged 0-21 years
  - IPC intervention with on-site MH staff
  - Targeting and existing mental health, physical health, developmental, or substance use condition
  - Reporting at least one of:
    - Receipt of any treatment
    - Receipt of a minimally adequate dose of treatment (study defined)
    - Receipt of a full course of treatment (study defined)
    - Receipt of offsite specialty mental health services

Method

- Other Variables extracted
  - Level of integration
    - Dichotomized based on SAMHSA framework
  - Whether controls included “referral support”
  - Participant demographics
- Analyses
  - Calculated Odds Ratios via multilevel mixed effects meta-analysis
  - Moderators
    - Outcome type
    - Model of integration (co-located or integrated)



Results



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OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Integrated Primary Care and Mental Health Service Utilization: A Meta-Analysis

Cody A. Hostutler, PhD,[1,2] Jeffrey D. Shahidullah, PhD,[3] Tiffany M. Rybak, PhD,[4,5] Kevin G. Stephenson, PhD,[1,2] Kurt A. Freeman, PhD,[6] Leah LaLonde, PhD,[1,2] Sarah Danzo, PhD,[7] Elizabeth T. Koval, PhD,[8] Helen Hughes, HS,[1,2] Andrew R. Riley, PhD[6]

abstract

BACKGROUND: Integrated primary care (IPC) is hypothesized to improve outcomes by increasing the use of mental health interventions. We aimed to conduct a meta-analytic evaluation of the effect of IPC models on the use of mental health services compared with usual or enhanced usual primary care.

METHODS: We searched the Medline, EMBASE, CENTRAL, PsycINFO, and SCOPUS databases for studies published from January 1, 1998, to December 15, 2024. A total of 9852 nonduplicate records were retrieved and 12 met inclusion criteria. We included published, peer-reviewed, randomized, and nonrandomized trials that evaluated an IPC intervention and included a comparator condition. We excluded trials with fewer than 10 participants in the treatment or comparator arms. Two independent reviewers screened abstracts, evaluated full texts, and extracted data. We conducted a multilevel meta-analysis to determine the odds ratios

- Nine studies (N = 2,742)
  - 6 RCTs
  - 2 cluster RCTs
  - 1 nonrandomized
- Integration model
  - 3 co-located
  - 6 integrated
- Target conditions
  - 5 externalizing concerns/ADHD
  - 3 internalizing concerns
  - 1 substance use

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Results

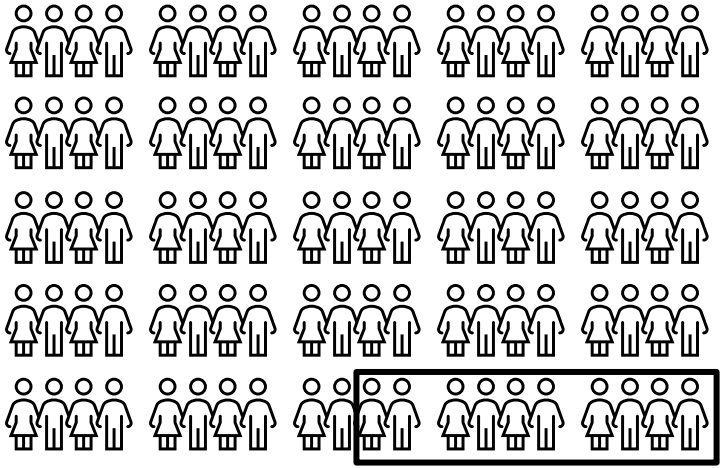
- Receipt of services
  - Any intervention: **OR = 12.23** (95% CI, 3.64– 41.07)
  - Minimum therapeutic dose: **OR = 10.92** (95% CI, 3.28–36.32)
    - *Range:* 3-8 sessions
  - Full course: **OR = 19.17** (95% CI, 3.02–121.53)
    - *Range:* 6-14 sessions

- Other outcomes
  - IPC slightly reduced the odds of utilizing offsite mental health services: OR = -1.53 (0.51–4.56)
  - Effects were stronger compared to referral support than no referral support
  - Level of integration did not moderate outcomes
  - Two studies disaggregated utilization by race or ethnicity
    - Ngo et al. (2009) IPC had greater impact on receipt of treatment for Black (3.65x control) and Latino (3.35x) than White (1.99x) participants
    - Sterling et al. (2018) Hispanic participants in IPC > 2x likely to receive intervention compared to physician SBIRT only

Limitations

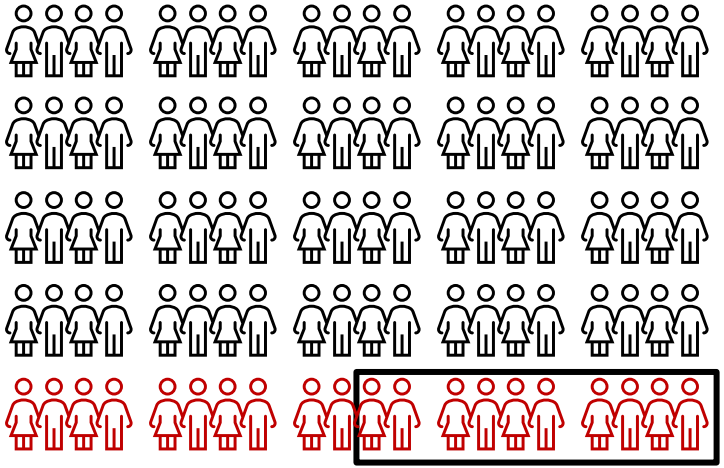
- Relatively small number of studies meeting inclusion criteria
- Significant heterogeneity
- All studies were pre-COVID-19
  - Some evidence shifts to telehealth reduced access for underserved groups (Chakawa et al., 2021)
- IPC trials often fail to report external validity indicators, so generalizability is difficult to assess (Callejo-Black et al., 2020)
- Differences between models/levels of integration may be especially hard to detect
  - Reporting of integration models is often inadequate
  - Clinical trial methodology artifacts given focus on specific populations/treatments

Clinical Trials vs. Clinical Practice



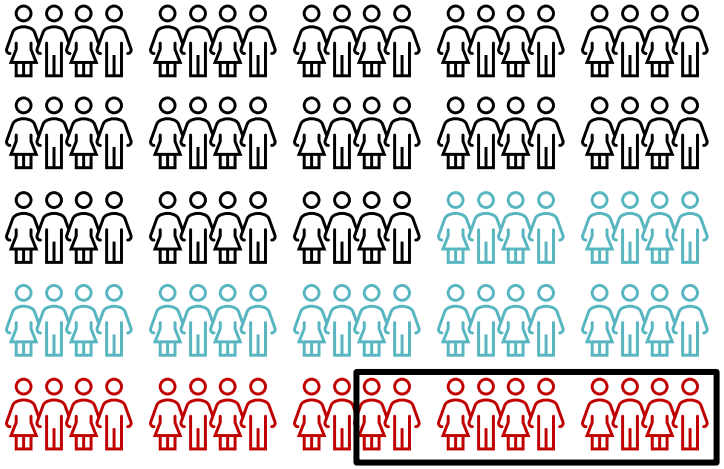
- Eligible for clinical trial

Clinical Trials vs. Clinical Practice



- Eligible for clinical trial
- Likely to be seen in co-located practice

Clinical Trials vs. Clinical Practice



- Eligible for clinical trial
- Likely to be seen in co-located practice
- Likely to be seen in integrated practice

- Program evaluation studies suggest highly integrated models may be especially effective for increasing access (e.g., Chakawa et al., 2020; Hostutler et al., 2023)

Conclusions

- Investment in BHI is one of the best ways to increase youth access to MH treatment and reduce disparities
  - Reduction in offsite utilization may also alleviate strained systems
- Ongoing balance of internal/external validity factors is important for a science that both rigorous and pragmatic
- Understanding the relative pros and cons of different levels of integration will require better measurement and reporting of model components
  - Different policies incentivize different models, so understanding relative tradeoffs is vital for informing advocacy



Thank you!

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Pediatric Integrated Primary Care Research Consortium:
https://pipcrc.weebly.com/

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Convening + Uniting + Transforming

Wrap Up & Next Steps

Larry McNeely | Primary Care Collaborative