# PCC Behavioral Health Integration Workgroup Meeting

*February 26, 2026 | 2:00 – 4:00 PM ET*

***Participating Organizations:***

American Academy of Child & Adolescent Psychiatry, American Academy of Family Physicians, American College of Clinical Pharmacy, American College of Physicians, American Psychological Association, Angel Kids Pediatrics, Jefferson Health, Meadows Mental Health Policy Institute, Mental Health America, NAACOS, NCQA, PCDC, Purchaser Business Group on Health, Rhode Island Primary Care Physicians Corporation, UPMC Health Plan

**Thank You to Our Speakers:**

- **Co-Chairs:** Mary Giliberti , *Mental Health America*; Alin Severance, *UPMC Health Plan*
- Don Nease, *University of Colorado Anschutz Medical Campus*
- Margaret French, *Venn Strategies*
- Kevin Roy, *Shatterproof*; Michael Yuhas, *Bowman Family Foundation*

## Welcome & Announcements

Larry McNeely opened the meeting and welcomed participants to the Behavioral Health Integration Workgroup. He noted that the meeting would focus on policy priorities and research highlighting opportunities to expand behavioral health services within primary care. He also acknowledged PCC staff and partners supporting the workgroup's policy activities.

## Co-Chair Remarks

Dr. Alin Severance of UPMC Health Plan emphasized the importance of emerging research supporting behavioral health integration in primary care. He noted that recent studies reinforce the effectiveness and sustainability of collaborative care models and demonstrate the need to reduce systemic barriers that prevent broader implementation.

Mary Giliberti of Mental Health America highlighted the successful advocacy effort that secured behavioral health add-on codes to APCM. She described the achievement as an example of effective collaboration between primary care and behavioral health stakeholders.

Mary emphasized that while the new codes represent important progress, additional challenges remain. In particular, she noted concerns about low reimbursement levels, cost-sharing barriers for patients, and limitations within current statutory authorities that restrict the ability of CMS to waive cost sharing in certain circumstances. She encouraged continued advocacy to ensure these

codes are adequately valued and implemented in ways that promote broader access to integrated care.

She also pointed to the growing policy focus on "whole-person health," including upstream determinants such as sleep, social connection, and purpose. Mary suggested that behavioral health integration within primary care settings plays a key role in advancing these broader health goals.

## CY27 MPFS Behavioral Health Ask for CMS

Larry presented PCC's proposed policy priorities for the upcoming CY 27 MPFS cycle and requested feedback on recommendations that have been submitted to CMS. He explained that PCC is taking a more proactive approach by presenting policy recommendations to CMS before the formal rulemaking process begins.

Larry outlined several priority areas:

- Valuation Reform
- Hybrid Payment Models
- Support Primary Care Participation in ACOs
- Whole-Person Care Thru Lifespan

*View the attached slides for more information.*

Mark Borer of the American Academy of Child & Adolescent Psychiatry raised concerns about payment barriers affecting adoption of CoCM and other behavioral health integration codes. He noted that some billing codes are currently mutually exclusive with CoCM, which creates challenges for psychologists and psychiatrists attempting to bill for services within the same month. Mark suggested a potential workaround that would allow psychologists and psychiatrists to alternate billing for behavioral health services in different months while using interprofessional consultation codes in between. He acknowledged that this approach is not ideal and does not reimburse at the same level but could help mitigate some billing limitations.

Mary emphasized that stakeholders should continue raising concerns with CMS about the valuation of behavioral health codes. She noted that the current payment levels do not adequately reflect the clinical complexity and care coordination required to deliver these services.

Roshini Koli of Meadows Mental Health Policy Institute highlighted innovative work underway at UC Davis, noting that their efforts have begun to demonstrate how integrated behavioral health models can achieve fiscal sustainability when viewed from a population health perspective.

Susan McDaniel of APA reinforced Mark's earlier point about the need for policymakers to better understand the distinction between behavioral health services and CoCM. She noted that while the two approaches can overlap, they often serve different clinical functions, and payment policies should recognize and support both models appropriately.

In closing, Larry asked participants to share any available evidence regarding the adequacy of current behavioral health code valuation. He encouraged members to provide data that demonstrates what reimbursement levels are necessary to support meaningful adoption and implementation.

## Primary Care Provides Medication for Opioid Use Disorder

Dr. Don Nease from the University of Colorado Anschutz Medical Campus presented findings from the HOMER study (Home vs. Office Treatment for Medication-Enhanced Recovery), a national research project examining treatment approaches for opioid use disorder.

The HOMER study evaluated different approaches to initiating medication treatment for opioid use disorder, including office-based induction, home-based induction, and telehealth approaches. The study followed participants for nine months and included practices from across the United States.

Key findings included:

- Primary care practices across diverse geographic settings are successfully providing medication-assisted treatment for opioid use disorder.
- Nearly 40% of study participants were receiving treatment for the first time, indicating that primary care settings can reach patients who may not access specialty addiction treatment services.
- Patients often prefer receiving treatment within trusted primary care relationships, which can reduce stigma and improve continuity of care.

Mary asked whether medication for opioid use disorder conducted at home could be billed in the same way as in-office services, or whether CMS policy changes might be necessary to accommodate this approach if it proves more effective.

Don explained that even when patients complete induction at home, they still engage regularly with their primary care practice. Patients typically visit the clinic to receive their initial prescription and continue returning for follow-up appointments and medication refills.

Larry asked whether the HOMER study confirms findings from prior research or whether it demonstrates new evidence.

Don shared that he believed the study to be the first large national randomized study of its kind and included nine months of follow-up, which represents one of the longest observation periods for studies examining MOUD treatment effectiveness.

Alin asked whether the study provided insight into populations that traditional treatment models may fail to reach. He observed that opioid use disorder often affects individuals who may be able to conceal their condition due to socioeconomic resources and noted that traditional clinic models may deter many individuals from seeking care. He added that home-based treatment options may provide patients with greater privacy and dignity.

Don agreed, noting that receiving treatment through a trusted primary care clinician can significantly reduce stigma and improve access, particularly in rural communities. He also noted that the research team worked with participating practices to provide tools and guidance to help clinicians identify patients who may have opioid use disorder but remain undiagnosed.

Alin concluded the sessions by thanking Don for his work.

## Update from Capitol Hill

Margaret French of Venn Strategies provided an overview of federal legislative and appropriations developments affecting behavioral health and primary care.

She reported that Congress recently passed a major appropriations package that rejected proposed cuts to several public health and behavioral health programs. Instead, the final legislation maintained or increased funding for several key initiatives, including:

- Community Health Center Fund
- National Health Service Corps
- Teaching Health Center Graduate Medical Education programs
- Substance use and mental health block grants
- State opioid response programs

Margaret noted that while Congress demonstrated bipartisan support for these programs, legislative activity remains limited due to political dynamics and the approaching election cycle. Major healthcare legislation is unlikely to advance until late in the year.

Ann Greiner of the PCC highlighted concerns about ongoing efforts to roll back CMS's efficiency adjustment. She emphasized the importance of maintaining momentum toward more equitable valuation of cognitive healthcare services.

## Psychiatric Collaborative Care Model Study Findings

Kevin Roy of Shatterproof and Michael Yuhas of Bowman Family Foundation presented findings from a new national report analyzing the adoption of the Psychiatric Collaborative Care Model (CoCM).

The report examined data from 2018 through 2024 across commercial, Medicare, and Medicaid claims. Key findings included:

- The number of patients receiving collaborative care increased dramatically, with a 26-fold increase among commercially insured patients with behavioral health diagnoses.
- Use among children and adolescents grew substantially, rising from roughly 5% to nearly 20% of cases.
- Some states experienced substantial growth in collaborative care adoption, while others showed minimal uptake.
- Medicaid reimbursement rates varied widely by state, and states with low or absent reimbursement saw significantly lower adoption.

Kevin and Michael emphasized that Medicaid reimbursement levels strongly influence adoption across all payer types. They also noted that reducing patient cost sharing and simplifying billing requirements could significantly increase utilization. Finally, Kevin highlighted evidence showing that collaborative care improves outcomes while reducing overall healthcare costs by addressing behavioral health conditions earlier and preventing downstream complications.

## Closing Remarks

Larry McNeely thanked participants and speakers for their contributions and encouraged continued collaboration among stakeholders to advance behavioral health integration in primary care.