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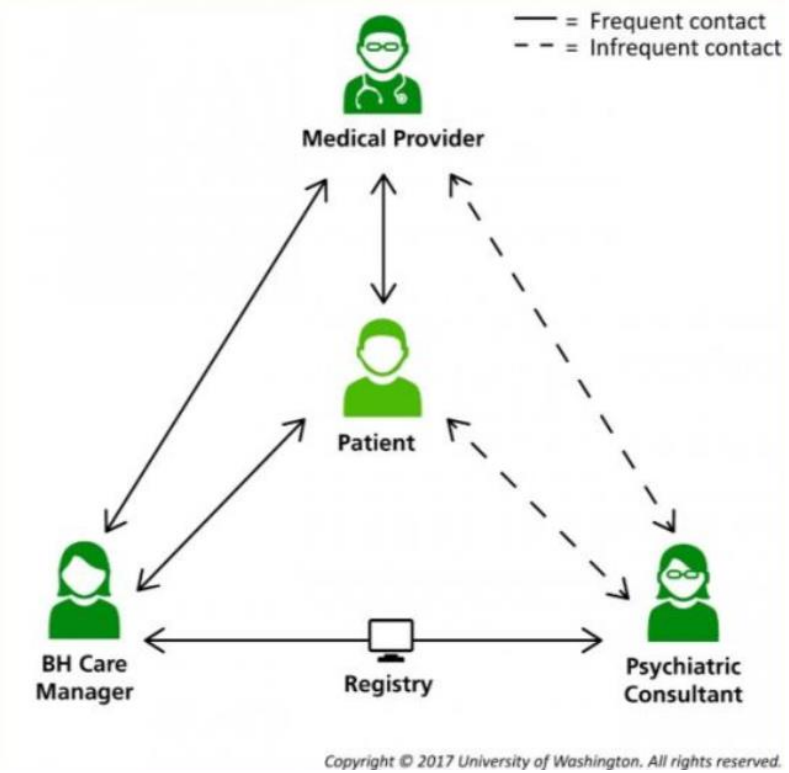
The Collaborative Care Model (CoCM) for SUD

Who We Are and What We Do

- Founded in 2012, **Shatterproof is a national nonprofit dedicated to ending the addiction crisis in the United States.** We focus on ending the stigma of addiction and ensuring treatment in the United States is based on proven research.
- Our policy team **advocates for evidence-based policies** that will advance addiction treatment access and quality.
- Shatterproof **works with states to promote behavioral health and substance use disorder care integration.**
- We are a grassroots organization supported by donors large and small.

Collaborative Care Model (CoCM)

- CoCM is an integrated treatment approach to improve outcomes for behavioral health disorders in the primary care setting.
- The CoCM care team includes:
  - Primary care provider: Usually a family physician, internist, nurse practitioner, or physician's assistant.
  - Care manager: A member of the clinical team (e.g. nurse, clinical social worker) trained to provide evidence-based care coordination.
  - Psychiatric consultant or addiction specialist: Usually a psychiatrist who advises the primary care treatment team.
- Collaborative care relies on **universal screening** and **measurement-based care** to track patient progress through validated clinical rating scales.



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Integration in Behavioral Healthcare

- The Collaborative Care Model (CoCM) has shown in more than 80 randomized controlled trials to improve health outcomes.

- Why CoCM?
  - 50% of individuals with a mental health disorder have a comorbid SUD
  - Only 20% of patients in need of behavioral healthcare receive it in specialty setting
  - Primary care can connect patients with specialty care when needed
  - Health equity: one of very few interventions in healthcare shown to reduce disparities by race/ethnicity and/or socioeconomic status in patients' access to care, quality of care, and outcomes.
  - Cost savings shown with implementation of CoCM through overall reduced healthcare costs of Medicaid patients

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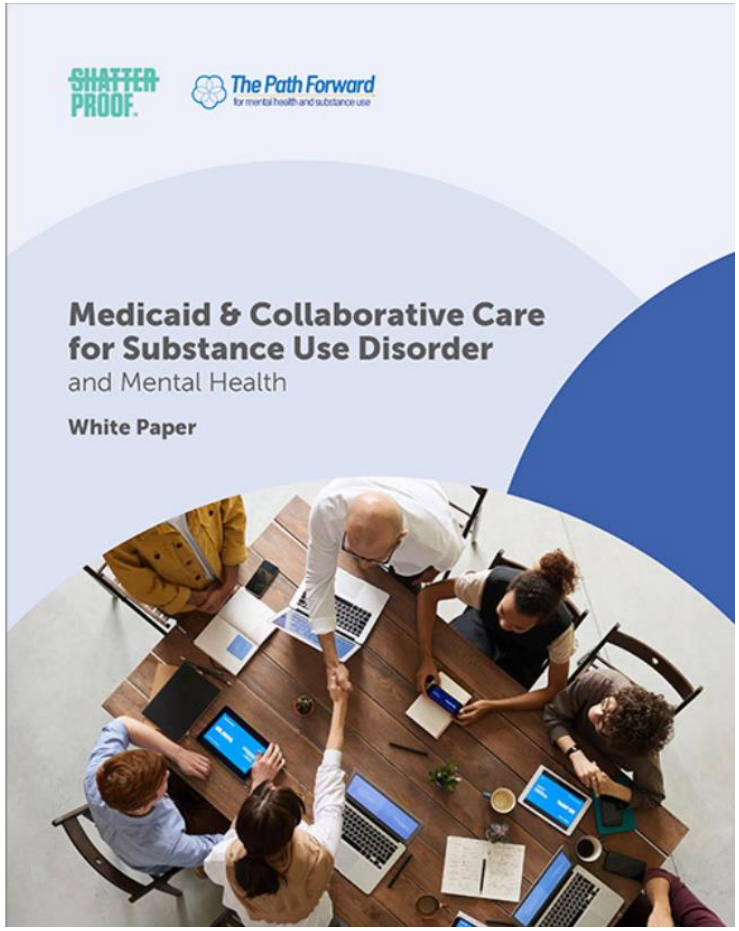
Improved Health Outcomes

- Compared to patients receiving care without integration, patients enrolled in the IMPACT program experienced improvement in their depression over 12 months, had less physical pain, better social and physical functioning, and improved overall quality of life.

- Collaborative care used in the treatment of opioid and alcohol use disorder, compared to usual care, has been shown to **increase both the proportion of patients receiving evidence-based treatment** and the number achieving abstinence at 6 months. **Abstinence improved 47% over the control.**



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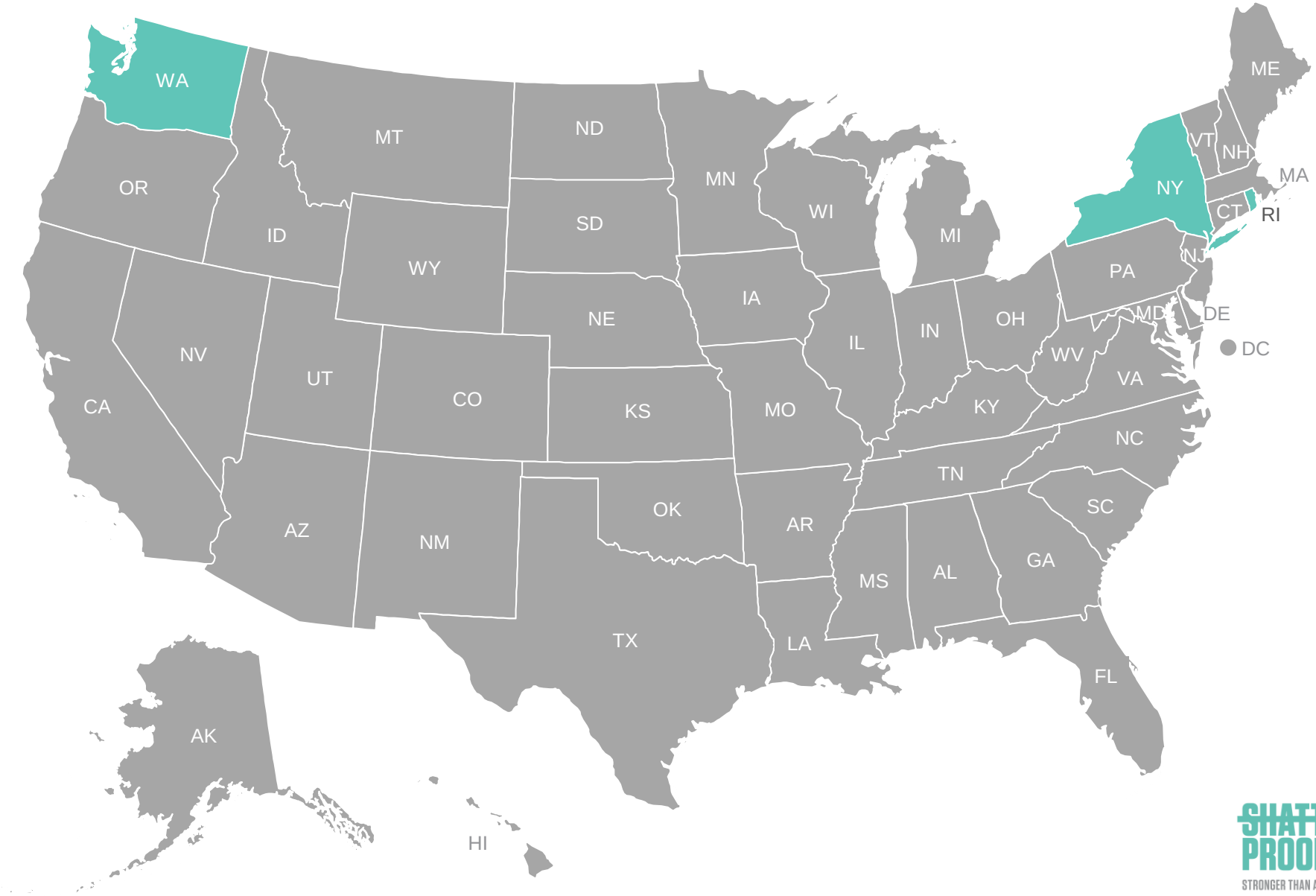
States Medicaid Coverage: 2015-2017



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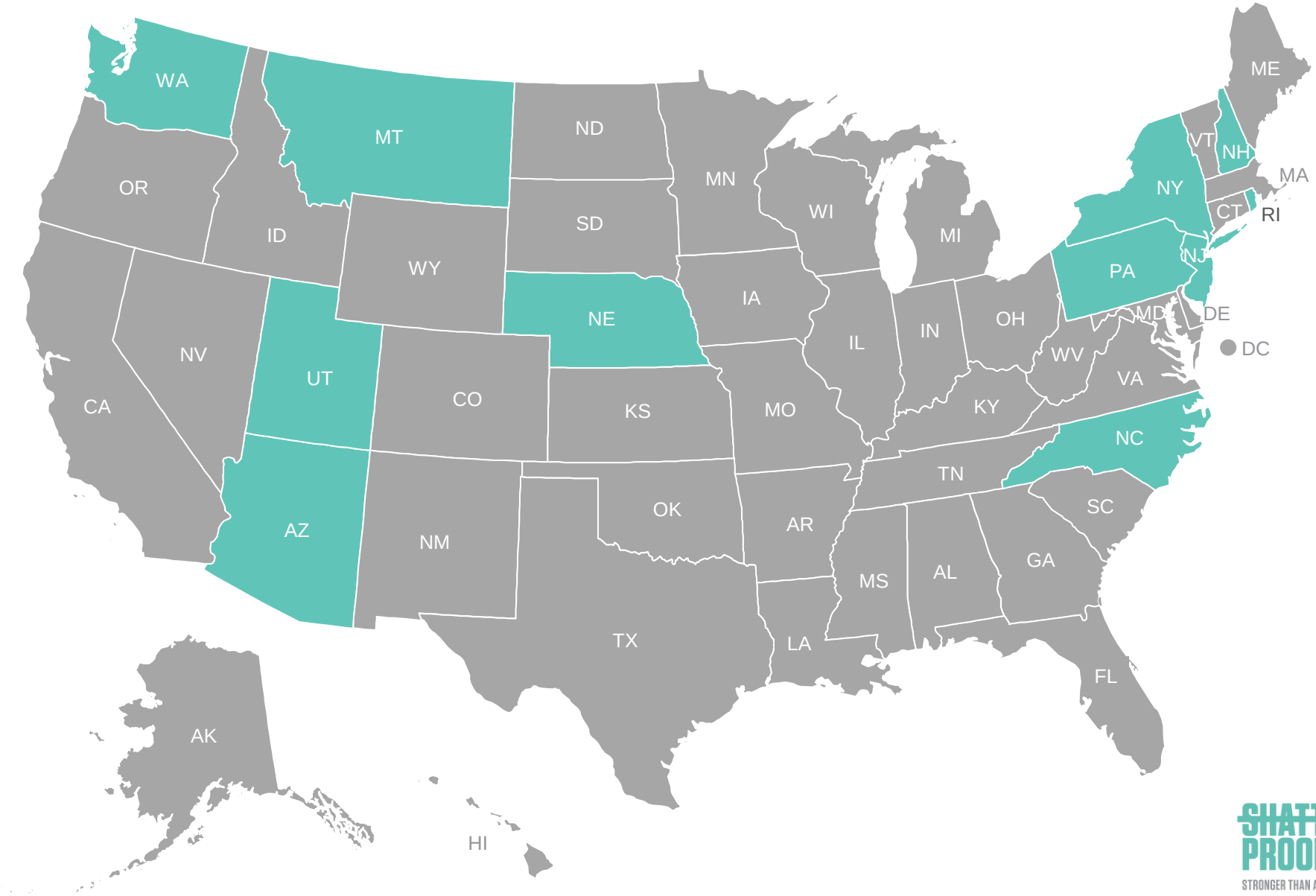
States Medicaid Coverage: 2017-2018



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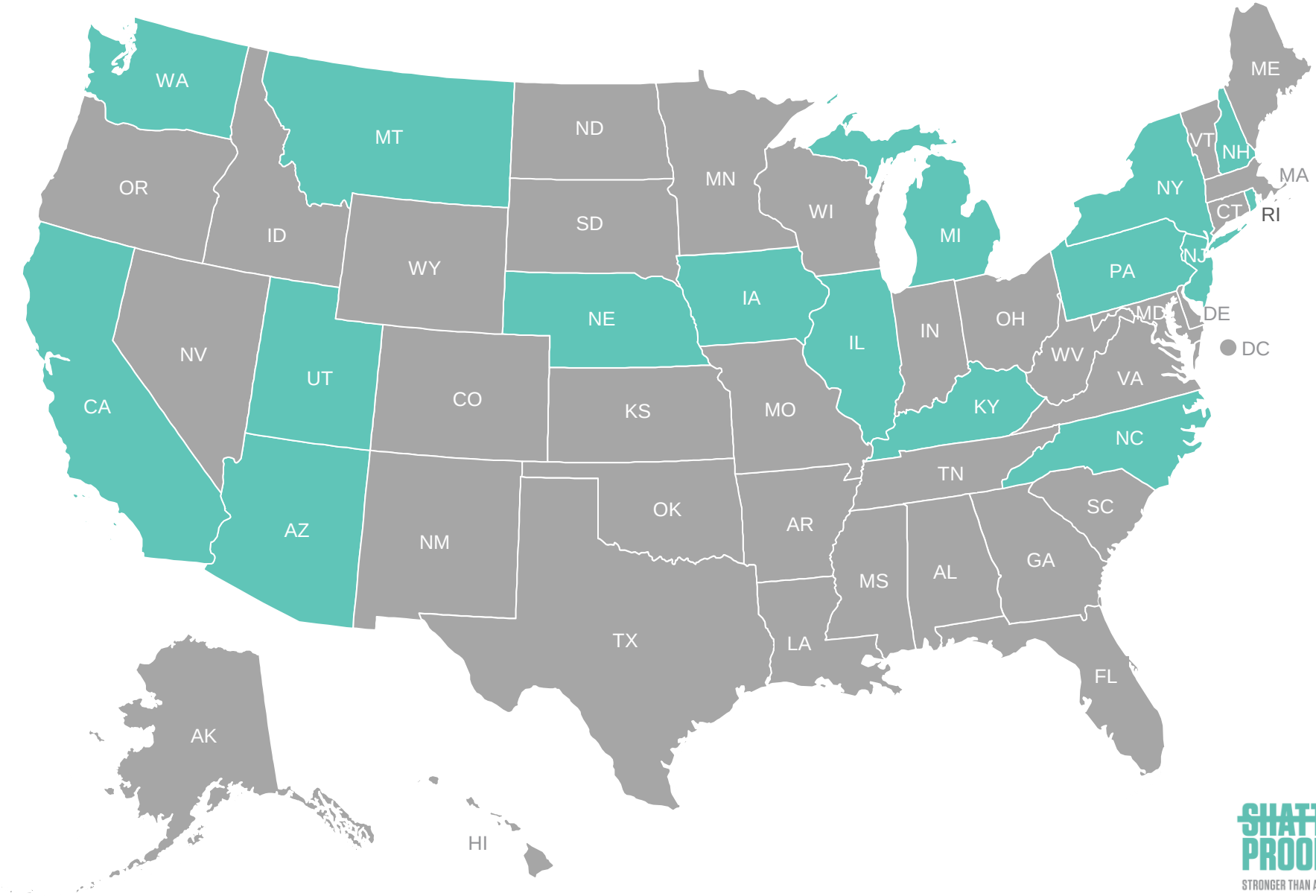
States Medicaid Coverage: 2019-2020



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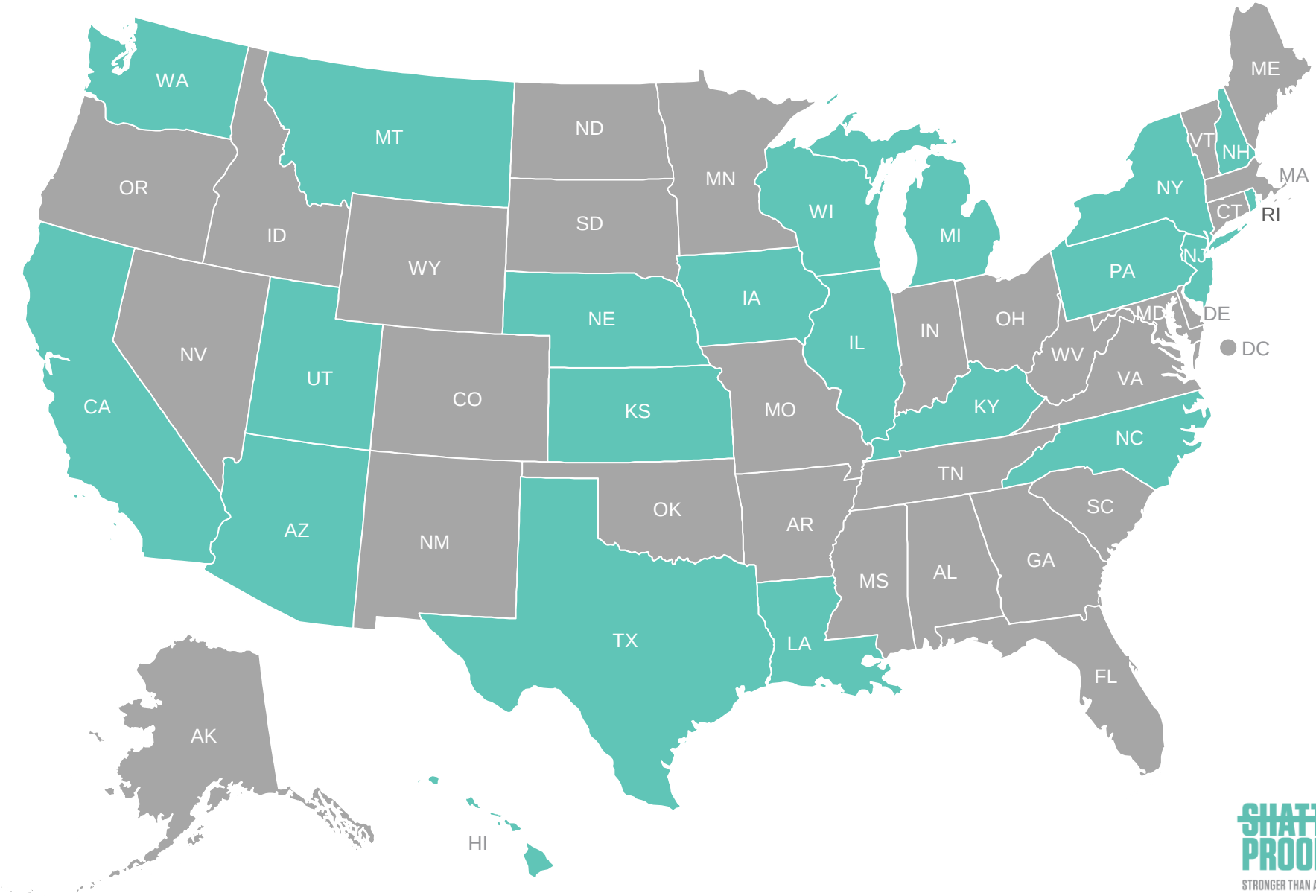
States Medicaid Coverage: 2021-2022



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Cost Savings

- Medicaid enrollees with behavioral health conditions, including SUD, account for 20 percent of enrollees, but over half of Medicaid spending.
- Integration results in lower healthcare spending overall, particularly among patients with comorbid conditions.

  It is projected that between 9% and 17% could be saved by effectively integrating medical and behavioral care – representing potential savings of between $38 and $68 billion (Milliman 2017)

- Most commercial insurers, Medicare and 22 state Medicaid programs reimburse CoCM.
- Return on investment within years 1-4 of CoCM implementation:

  $6.50 per every $1 spent

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State Examples

Arizona

Arizona provides integrated care to Medicaid enrollees through carved-in benefit design with their MCO partners. They began covering the collaborative care codes starting in 2018.

Arizona reimburses for the Medicaid G-0512 code, additionally allowing their Federally Qualified Health Centers (FQHCs) to bill for collaborative care.

North Carolina

North Carolina also implemented integrated care by covering the collaborative care codes in 2018 within the Medicaid physician fee schedule. The state had MCO contracts at the time. They are beginning the CoCM model within pediatric and pregnant populations.

NC has implemented a requirement for the behavioral care manager to be licensed in mental health treatment (i.e., clinical social worker)

Recommendations for State Medicaid

- Turn on the existing CPT codes to cover the Collaborative Care Model.
- Help support state implementation and system transformation to improve overall health outcomes, resolve health inequities and save costs.

"Half of behavioral patients had very little to no spending on behavioral treatment—less than $68 per year—and another 25% had very limited spending on behavioral treatment—between $68 and $502 per year. This is despite having been diagnosed or treated by a healthcare professional for a behavioral illness. This is a tragedy. And now we know this population accounts for more than half of our total healthcare spending. **Tremendous savings and improved outcomes are achievable if these individuals who deserve care are identified early and provided with prompt evidence-based behavioral treatment**." - Henry Harbin, MD, adviser to The Path Forward and former CEO of Magellan Health.

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State Activity

- California added the Collaborative Care Model codes as part of its Medicaid program as of December 2020.
- Texas and Wisconsin are covering the codes as of June 2022.
- Legislation passed in Connecticut and Louisiana to cover the codes in Medicaid and for private insurers.

- We are having meaningful conversations in the following states:
  - Colorado
  - Connecticut
  - Florida
  - Nevada
  - Oregon
  - Virginia

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Appendix

1) G-Codes and CPT Codes

Table 1: Collaborative Care G-Codes and CPT Codes

G-Code	CPT Code	Description	Payment/Patient (Non-facilities)*	Payment/Patient (Facilities)*
G0502	**99492**	First 70-minutes in first calendar month – collaborative care	**$156.99**	**$90.22**
G0503	**99493**	First 60-minutes in subsequent month - collaborative care	**$126.31**	**$81.20**
G0504	**99494**	Each additional 30 minutes in month - collaborative care	**$63.88**	**$43.31**
G0507	**99484**	Care management services, minimum 20 min per month	**$48.00**	**$32.84**

Note: "Non-Facilities" refers to primary care settings. "Facilities" refers to hospital or other facility settings. Reimbursement amount provided is the national payment amount, meaning no modifiers are applied.

Source: Medicare Physician Fee Schedule (Centers for Medicare and Medicaid Services, 2020).