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Collaborative Care (CoCM) – Adequate Medicaid Reimbursement is Critical for Broadscale Implementation

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concert

RESEARCH & EVALUATION

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Overview

The Collaborative Care Model (CoCM) is an evidence-based approach to identify and treat patients with behavioral health conditions, predominantly depression and/or anxiety, in primary care and other non-behavioral healthcare settings. CoCM was recognized in 2017 by Centers for Medicare & Medicaid Service (CMS) with dedicated CPT codes for Medicaid reimbursement, and these codes have now been adopted by most commercial insurers. The inception of the CPT codes increased the number of organizations who began to both adopt and implement CoCM; however, it has been repeatedly demonstrated that without the ability to refer patients across all payers (including Medicaid), providers do not completely or adequately adopt CoCM. To date, only slightly more than half of states have added the CoCM codes onto their Medicaid fee schedules.

Concert Health is a behavioral health organization that provides CoCM services to primary care and specialty medical providers in 19 states. CoCM services from Concert Health include staff training, use of Concert's electronic patient registry, and ongoing patient and provider support through Concert's behavioral care managers and psychiatric consultants. Concert's experience has afforded the organization a unique perspective on the importance of CoCM reimbursement by all payers – including state Medicaid agencies – in fostering wider adoption of CoCM. Implementing CoCM for only a portion of a provider's patient panel can be prohibitively inefficient and costly. Further, excluding reimbursement for Medicaid patients – arguably those who are most in need – is seen as creating two "levels" of care to which many providers are unwilling to subscribe. It is clear that without reimbursement by state Medicaid agencies, provider adoption of CoCM will remain limited even for commercial and Medicare patient populations.

CoCM is a proven method of expanding access to effective mental health care in primary care settings, and evidence continues to mount that it is associated with reductions in total healthcare costs. It is therefore imperative that mental health advocates and employers with self-funded health plans urge the passage of state legislation that provides for the reimbursement of CoCM under Medicaid – at rates that are at least equivalent to Medicare reimbursement for CoCM.

This issue brief compares CoCM adoption by Concert Health's clients across 10 states: 1) those that provide for CoCM reimbursement under Medicaid as a result of state legislation, 2) those that do not provide CoCM reimbursement under Medicaid, and 3) those where medical provider organizations have chosen to provide CoCM care for Medicaid patients although the state has not passed legislation for CoCM reimbursement[1] ("Organizational Support).

There are a total of 49,849 patients included in this analysis. Observations (in most states) go through the end of November 2023.

Federally Qualified Health Centers (FQHC's) and Rural Health Clinics (RHCs) are included in the analyses. Connecticut is included in the analyses as a non-passage state despite having recently started reimbursing CoCM, as CoCM reimbursement in CT only recently started and the data is not yet sufficient for in-depth analysis of the pre- and post- passage timeframes across all payer sources. However, encouraging early data from the first two months of Connecticut providing Medicaid reimbursement is presented at the end of this brief.

1 The format of "Organizational Support" varies by provider, including some that offer CoCM for Medicaid patients broadly and others who have a more limited charity care process.

Adoption of Collaborative Care across Payor Sources

In states that have passed Medicaid reimbursement for CoCM, providers refer a higher number of patients covered under "all" insurance types relative to states that have not passed Medicaid reimbursement for CoCM, regardless of whether there is organizational support. To demonstrate this, Figure 1 and Table 1 show the average number of patients per provider by state and insurance type.

Figure 1. Average Number of CoCM Patients per Provider per Year – by State Passage Status and Insurance Type

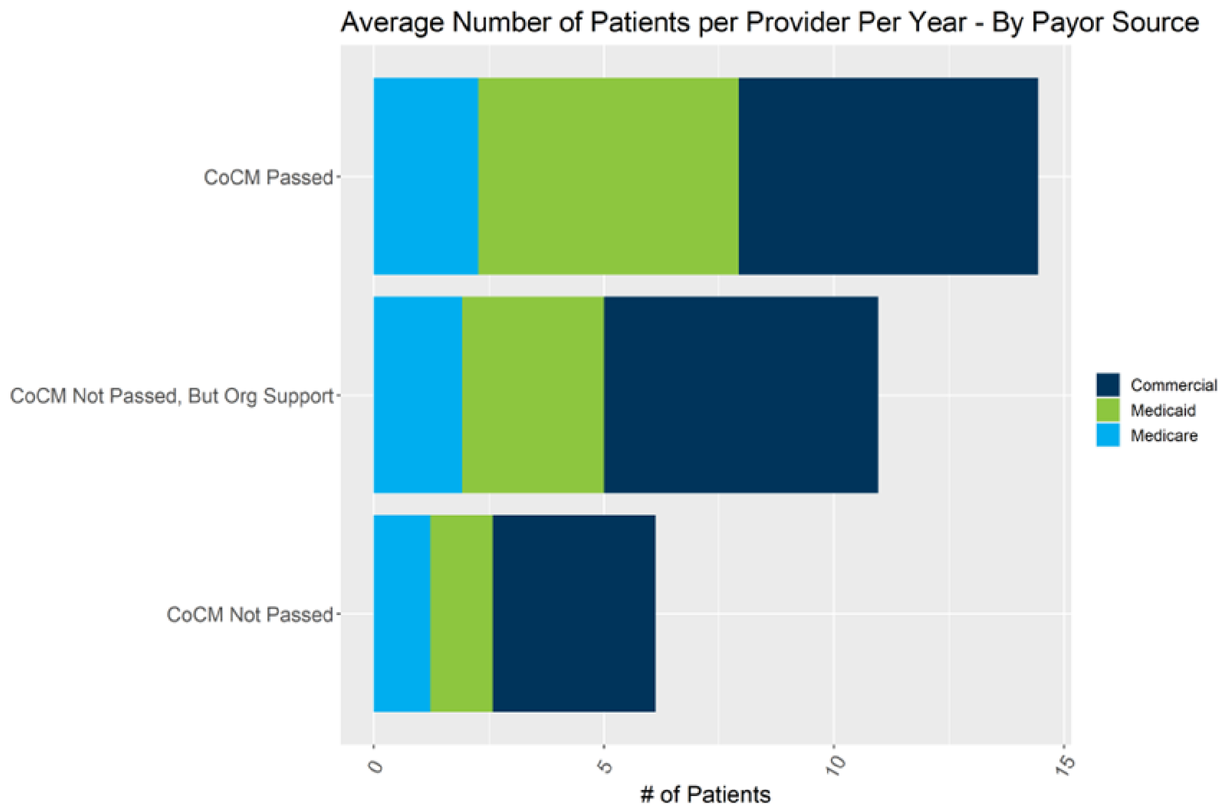


Table 1. Average Number of CoCM Patients per Provider per Year - by State Passage Status and Insurance Type

CoCM Passage Status	Commercial	Medicaid	Medicare
CoCM Passed (a) ([3] states)	6.51	5.67	2.26
CoCM Not Passed, But Org Support (a) ([4] states)	5.96	3.09	1.91
CoCM Not Passed ([3] states)	3.54	1.35	1.23

Notes: "Organizational Support" means that at least one of Concert's provider clients provides CoCM to Medicaid patients even though the state has not passed legislation providing for Medicaid payment to providers for CoCM services. In some cases Medicaid MCOs reimburse providers for CoCM despite legislation not having been passed. CT began allowing Medicaid reimbursement in Sept. 2023; however, in this Table, data are from prior to this date in CT.

(a) Statistically significantly different from CoCM Not Passed (t-test for total patients)

(b) Statistically significantly different from CoCM Not Passed, But Org Support (t-test for total patients)

The details with respect to the above data, by state, are summarized in Table 2.

Table 2. By State: Average Number of Patients Referred to CoCM per Provider per Year, by State Passage Status and Insurance Type

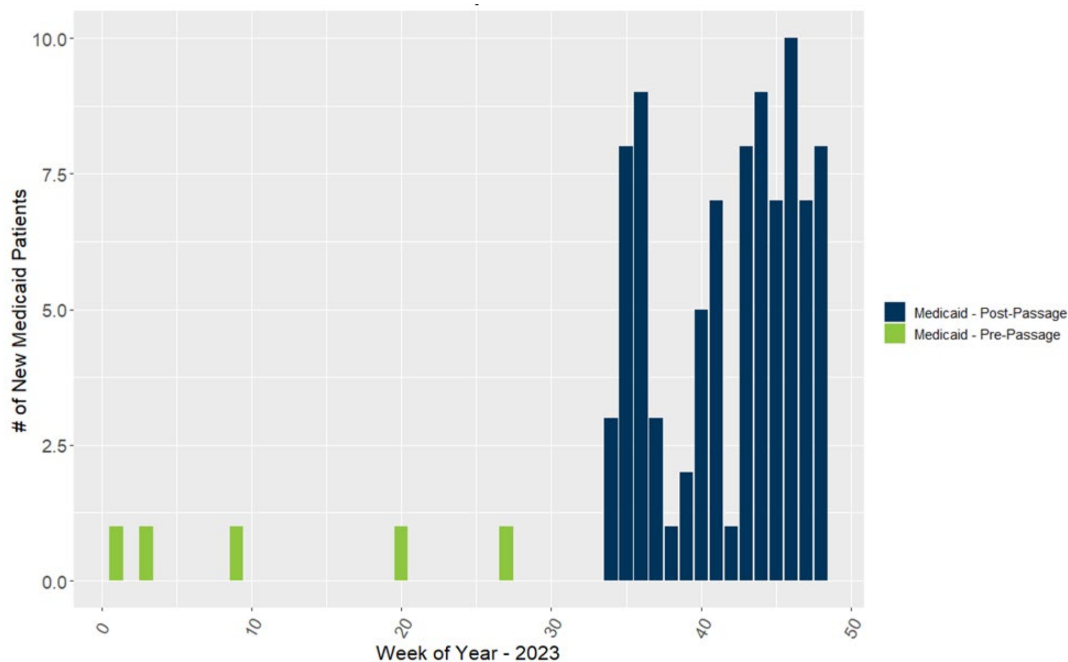
CoCM Passage Status	State	Commercial	Medicaid	Medicare
CoCM Passed	AZ	8.95	3.76	2.70
CoCM Passed	CA	7.92	6.05	2.78
CoCM Passed	NY	5.90	6.24	2.10
CoCM Not Passed, But Org Support	MO	3.99	2.85	1.52
CoCM Not Passed, But Org Support	FL	7.75	3.11	2.14
CoCM Not Passed, But Org Support	GA	2.43	2.21	1.62
CoCM Not Passed, But Org Support	OK	3.91	2.81	1.73
CoCM Not Passed	AR	3.80	2.00	1.57
CoCM Not Passed	CT*	3.52	1.00	1.18
CoCM Not Passed	FL	4.78	1.00	1.00

Notes: "Organizational Support" means that at least one of Concert's provider clients provides CoCM to Medicaid patients even though the state has not passed legislation providing for Medicaid payment to providers for CoCM services. In some cases Medicaid MCOs reimburse providers for CoCM despite legislation not having been passed. Some organizations have chosen to support individuals with Medicaid coverage as part of the services; others have chosen to put patients with Medicaid through their charity care process.

Recent Experience in Connecticut

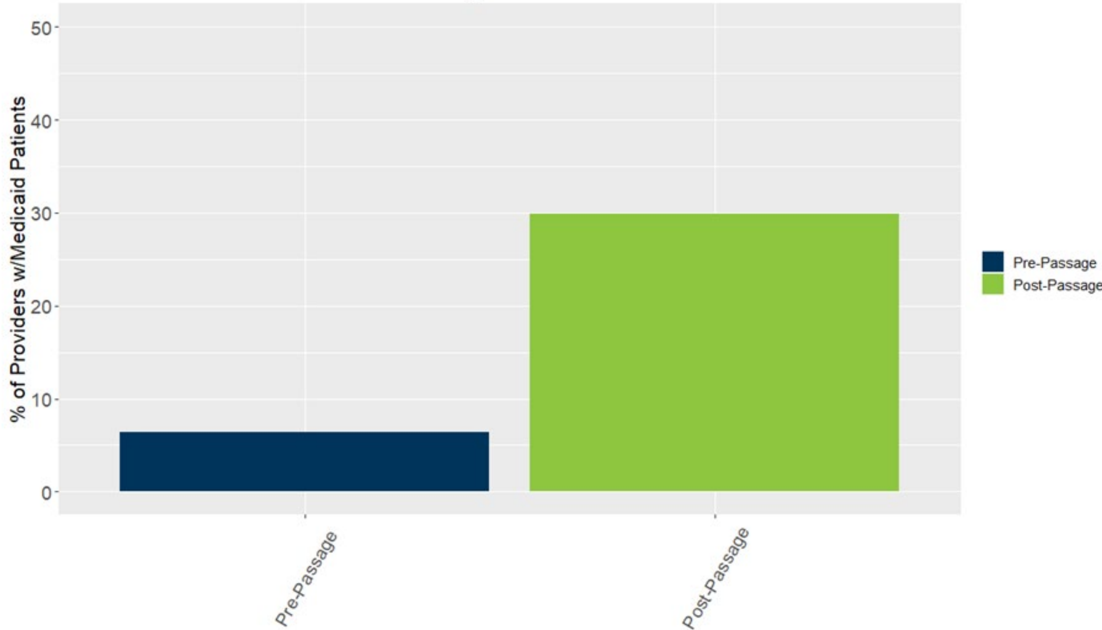
Connecticut is one of the most recent states to start reimbursement for Medicaid patients receiving CoCM – beginning in September of 2023. There has been an immediate increase in Medicaid patient referrals, as evidenced by Figure 2, which shows the number of new Medicaid patients referred by week.

Figure 2. Connecticut Medicaid — Patients Enrolled by Week



In Connecticut, there was a corresponding significant increase in provider adoption of CoCM for Medicaid patients after reimbursement began, with only around 6% of providers referring Medicaid patients before reimbursement started in September of 2023, and nearly 30% of providers referring patients after September, as shown in Figure 3

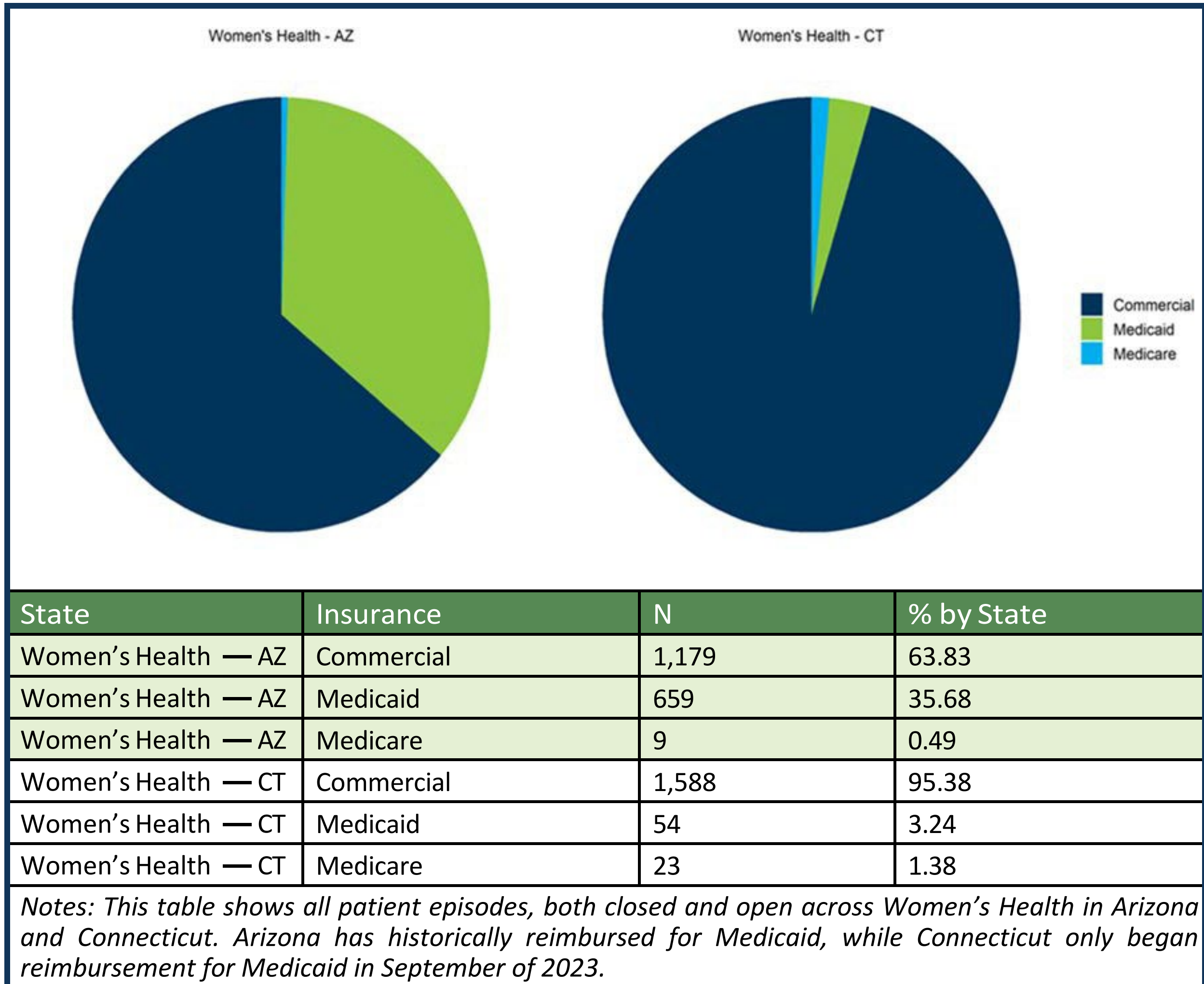
Figure 3. Connecticut Provider Adoption — Percent of Providers Referring Medicaid Patients to CoCM



While it is too early to see the impact on patients with commercial insurance and Medicare in Connecticut, there are encouraging signs within health care organizations in the state that indicate the number of patients with all types of insurance being referred to CoCM will increase as a result of this Medicaid payment policy change. According to Matthew Saidel, the Chief Medical Officer for Women's Health Connecticut, prior to Medicaid reimbursement being allowed, *"Medicaid patients required an entirely different workflow and different providers for behavioral health referrals. Not only were they less likely to be referred, but the confusion was discouraging for all our providers and made them less likely to refer for even commercially insured patients."* With reimbursement now allowed, Saidel expects referrals of patients across all payer sources to *"increase due to the ease of the process,"* which conforms with the "value of Health Equity and reinforces the principle that behavioral health is an essential pillar of women's healthcare" according to Saidel.

At Women's Health, for example, which operates in both Arizona and Connecticut and has very similar patient population sizes, the differences in the patient mix are substantial, as Medicaid patients have made up only around 3% of the patients in Connecticut while making up over 35% of the patients in Arizona, as demonstrated in Table 3 and visualized in the pie chart. Over time, it is likely that Connecticut will begin to see the distribution of patients across payer sources even out. Importantly, the ease of access will likely increase for patients with all types of insurance because the availability of reimbursement for Medicaid patients may drive CoCM adoption by more providers.

Table 3. Women's Health — Total Patients by Insurance — AZ vs. CT



State	Insurance	N	% by State
Women's Health — AZ	Commercial	1,179	63.83
Women's Health — AZ	Medicaid	659	35.68
Women's Health — AZ	Medicare	9	0.49
Women's Health — CT	Commercial	1,588	95.38
Women's Health — CT	Medicaid	54	3.24
Women's Health — CT	Medicare	23	1.38

Notes: This table shows all patient episodes, both closed and open across Women's Health in Arizona and Connecticut. Arizona has historically reimbursed for Medicaid, while Connecticut only began reimbursement for Medicaid in September of 2023.

Additionally, Women's Health Arizona providers refer a higher number of both commercial and Medicaid patients to CoCM relative to Women's Health Connecticut providers, as shown in Table 4.

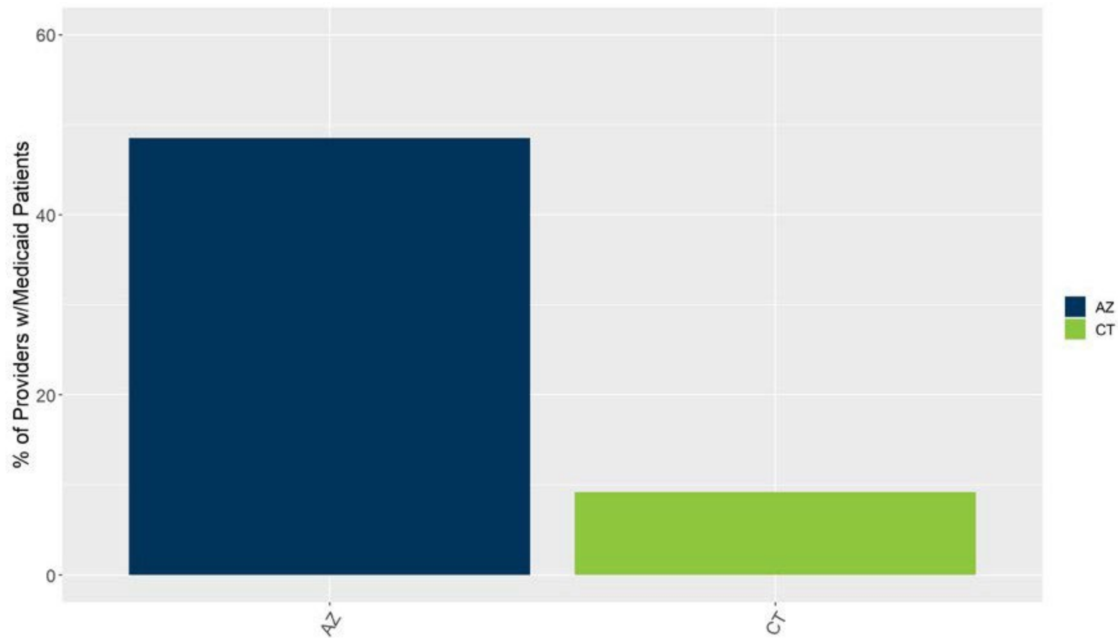
Table 4. Average Number of CoCM Patients per Provider per Year - by State and Insurance Type

State	Commercial	Medicaid	Medicare
Women's Health - AZ	5.26	3.33	1.12
Women's Health - CT	3.81	1.59	1.15

Notes: CT began allowing Medicaid reimbursement in Sept. 2023, however, these data are from prior to this date in CT. Data are across all years in Concert dataset.

When comparing provider referrals at Women's Health in Arizona and Connecticut, there is also a significantly higher number of providers who referred Medicaid patients in Arizona relative to Connecticut prior to Connecticut beginning to allow reimbursement, specifically just under 50% of providers in Arizona compared to only about 9% of providers in Connecticut, as shown in Figure 4.

Figure 4. Women's Health Provider Adoption – Percent of Providers Referring Medicaid Patients to CoCM — AZ vs. CT



Conclusion

There is a misconception that even if Medicaid in a state does not reimburse the CoCM codes, the Medicare and commercial populations will have access to CoCM -- this analysis addresses this misconception. Without a clear path to reimbursement across an entire patient panel (Medicare, Commercial, and Medicaid), providers appear much less likely to offer CoCM care to any patients. Subsequent research can examine the observed pattern across other states, as well as further demonstrate that providers hesitate to adopt CoCM if they believe (a) it will require checking payer status for each patient, or (b) it cannot be offered, in an economically feasible manner, to their underserved populations.

Economic feasibility requires not only that Medicaid pays for the CoCM codes, but that the level of, and restrictions on, reimbursement be reasonable. At the time of this analysis, there are 30 states that have added the CoCM codes to the Medicaid fee schedule. However, there are several states which have put restrictions on the fee schedule, for example carving out Federally Qualified Health Centers and/or reimbursing at levels well below Medicare. These levels are too low to support sustainable care delivery.

The message is clear that for broadscale adoption of CoCM, reasonable Medicaid reimbursement must be in place. This will increase provider participation and benefit all patients – Medicare, Commercial, and Medicaid. Any piecemeal approach to reimbursement will limit service delivery and access for all patients.