



Medicaid & Collaborative Care for Substance Use Disorder and Mental Health

White Paper



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Executive Summary

- Medicaid is the single largest payor for mental health services in the U.S.
- Only 20 percent of patients receive behavioral health care in a specialty setting, making primary care the de facto mental health system in the U.S.
- Collaborative care is an integrative treatment approach to improve treatment for behavioral health disorders in the primary care setting.
- Covid-19 has likely increased the prevalence of behavioral disorders and this spike is expected to continue post pandemic, due to the impact of the economic shut down.
- Medicaid enrollees with behavioral health conditions, including substance use disorders, account for approximately 20 percent of enrollees, but over half of Medicaid spending.
- Collaborative care is the most effective primary care intervention to address the rise in behavioral health disorder prevalence and cost associated with COVID-19.
- Over 70 randomized controlled trials demonstrate that collaborative care improves health outcomes and is cost-effective for individuals with substance use disorders.
- 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.
- The implementation of collaborative care in Medicaid can save the program approximately 15 billion per year or two percent of total annual Medicaid spending.
- Almost all national commercial insurers as well as Medicare reimburse the codes, but very few Medicaid programs cover collaborative care.
- CMS developed three codes specific for collaborative care and one for general behavioral health integration. Codes were also created by CMS for use by federally qualified health centers and rural health clinics.

Recommendations

- The health and cost benefits of collaborative care implies that all Medicaid programs should cover the Collaborative Care Model via the existing CPT codes.
- States can use the Medicaid Health Home designation and/or Section 1115 waivers to cover startup costs associated with collaborative care.

Behavioral Health Integration

Mental health and substance use disorders are some of the most common illnesses in the United States. In 2017, 46.6 million individuals - 18.9 percent of all U.S. adults - experienced a mental illness in the past year; 18.7 million people - 7.6 percent of all U.S. adults - had a substance use disorder.ⁱ Despite the high prevalence of behavioral health disorders, treatment gaps remain. Almost 60 percent of adults with a mental illness and over 90 percent of individuals with a substance use disorder aged 12 and older did not receive treatment in 2017.ⁱⁱ

Medicaid populations are particularly vulnerable to high need and high cost behavioral health conditions. Medicaid is the single largest payor for mental health services in the U.S. and is increasingly playing a larger role in paying for substance use disorder services. In 2015, while covering 14 percent of the general population, Medicaid covered 21 percent of adults with a mental illness, 26 percent of adults with a serious mental illness, and 17 percent of adults with a substance use disorder.ⁱⁱⁱ Medicaid enrollees with behavioral health conditions are at higher risk of comorbid chronic physical conditions, to rate their overall health poorly, and to use health care service more intensively than other beneficiaries. Indeed, research demonstrates that Medicaid enrollees with behavioral health conditions account for approximately 20 percent of enrollees but over half of Medicaid spending.^{iv}

Collaborative Care Model

Individuals receiving mental health care often do so outside of behavioral health settings.^v Only 20 percent of adult patients with a mental disorder are seen by mental health specialists, making the primary care system the de facto mental health system for most adults with common mental disorders.^{vi} While many individuals prefer receiving treatment for behavioral health disorders within the primary care setting, primary care providers report serious limitations in their abilities to care for behavioral health needs and to support mental health and addiction treatment specialists.

While efforts to improve treatment for common mental disorders within the primary care settings have been attempted, including screening for common disorders, provider education, development of treatment guidelines, and specialist referrals, few have shown to be as effective as strategies to integrate behavioral and primary health care. One such approach is called collaborative care, which is by far the integration intervention with the most evidence for improved clinical outcomes and cost savings. Over the past 15 years, over 70 randomized controlled trials have formed a robust evidence-base for this integrated treatment approach. Collaborative care involves the delivery of integrated care through a collaborative team, including:^{vii, viii, ix}

- Primary care provider: Usually a family physician, internist, nurse practitioner, or physician's assistant.
- Care management staff: A member of the clinical team (e.g., nurse, clinical social worker, or psychologist) who is trained to provide evidence-based care coordination, brief behavioral interventions, and may support physician prescribed treatments.
- Psychiatric consultant: Usually a psychiatrist who advises the primary care treatment team.

Collaborative care relies on measurement based care to track patient progress through validated clinical rating scales. If improvements are not achieved, adjustments are made by the primary care treatment team with input from the psychiatric consultant. Patients who continue to not clinically improve are referred to specialty behavioral health care.

Improved Health Outcomes

Over 70 randomized controlled trials establish the robust evidence-base supporting collaborative care.^x Trials in collaborative care have been conducted in diverse health care settings, including with both private and public providers; a variety of financing mechanisms, including fee for service and capitation; and different patient populations and geographic areas. Studies have also shown the success of collaborative care for different mental health conditions, including depression, anxiety disorders, bipolar disorder, and schizophrenia.^{xi, xii, xiii, xiv, xv, xvi} This literature consistently demonstrates that collaborative care improves behavioral health outcomes compared to usual care. A randomized clinical trial of collaborative care used in the treatment of depression also observed that the intervention was associated with decreases in the risk of cardiovascular disease, suggesting that collaborative care may be an important primary prevention strategy for chronic disorders.^{xvii} Collaborative care has also been shown to reduce health inequities between racial and socioeconomic groups.^{xviii, xix, xx}

While the majority of research has focused on mental health conditions, over 50 percent of individuals with a mental health disorder have a comorbid substance use disorder, suggesting that implementing the Collaborative Care Model for the primary treatment of mental health disorders may affect substance use disorder outcomes.^{xxi, xxii} Independent of mental illness, researchers and clinicians have also demonstrated that the Collaborative Care Model can be leveraged to improve care for substance use disorder treatment. The evidence base demonstrates that regular follow-up, pharmacological therapy, psychosocial interventions, promotion of medication adherence, and case management are all important features of substance use disorder treatment. Since collaborative care aims to increase care coordination amongst providers, it may be particularly useful in encouraging collaboration among all of the practitioners involved in a patient's substance use disorder treatment team.^{xxiii}

Indeed, evidence from the SUMMIT Randomized Clinical Trial found that collaborative care for opioid and alcohol use disorder, compared to care without integration, increased both the proportion of patients receiving evidence-based treatment and the number achieving abstinence at six months. Specifically, 39.0 percent of patients received treatment in the collaborative care group compared to 16.8 percent of the control group; 32.8 percent of individuals in the collaborative care group achieved abstinence compared to 22.3 percent of the control group.^{xxiv} Other studies have similarly found collaborative care to effectively provide treatment to patients with substance use disorder.^{xxv, xxvi}

Cost Benefits

Behavioral health disorders rank among the most costly medical conditions.^{xxvii} In addition to the health benefits of collaborative care, several studies have demonstrated that collaborative care is cost-effective compared to care without integration. For example, the Improving Mood Promoting Access to Collaborative Treatment (IMPACT) Trial enrolled 1,800 depressed older primary care patients into a randomized control trial of a collaborative care management program for depression. Findings from this study observed that the program was associated with substantially lower total health care costs compared to care without integrations.^{xxviii} The authors observed that an initial investment in collaborative care of \$522 in year 1 returned a net cost savings of \$3,363 over years 1-4 or a return on investment of \$6.50 per dollar spent.^{xxix, xxx} Other studies have found similar cost benefits among patients with comorbid diabetes,^{xxxi, xxxii} anxiety and panic disorder,^{xxxiii} and serious mental illness.^{xxxiv} Today's cost of implementing a collaborative care program would approximate \$900 per program participant with the costs mostly incurred during the first year. The net savings associated with this initial investment approximate \$5,200 per program participant over four years or \$1,300 per year.



“The Collaborative Care Model is one of very few specific interventions in medicine that have been shown via multiple RCTs to reduce disparities by race/ethnicity and/or socioeconomic status in patients’ access to care, quality of care, and outcomes.”

Michael Schoenbaum, PhD Senior Advisor for Mental Health Services, Epidemiology, and Economics, Division of Services and Intervention Research National Institute of Mental Health

Source: The Path Forward. Accelerating the Path Forward During Turbulent Times: The Case for Collaborative Care During Covid-19 (2020).

Collaborative Care Model and Medicaid

Some of the earliest research and demonstrations on collaborative care targeted Medicaid populations. The largest randomized controlled trial of the collaborative care model to date, the IMPACT study discussed above, enrolled 1,801 adults enrolled in both fee for service and capitated Medicare and Medicaid coverage. IMPACT patients were high need; in addition to depression, patients averaged over three chronic medical disorders. **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.**^{xxxv, xxxvi} The IMPACT collaborative care model was also endorsed by both patients and primary care providers.^{xxxvii} Additional research on Medicaid patients similarly finds that collaborative care improves outcomes for Medicaid beneficiaries.^{xxxviii, xxxix}

Researchers have used data measuring the cost of the Collaborative Care Model for other patient populations to estimate how the widespread implementation of collaborative care in Medicaid programs may affect costs. **The findings suggest that the implementation of collaborative care for the 20 percent of Medicaid recipients with diagnosed depression could save the program approximately 15 billion per year or 2 percent of total annual Medicaid spending.**^{xi}



Collaborative Care Codes

In 2016, the Center for Medicare and Medicaid Services (CMS) authorized the reimbursement of collaborative care for Medicare beneficiaries by creating three temporary G-codes: G0502, G0503, and G504. They also created a fourth billing code, G0507, for behavioral health care management services that do not meet the collaborative care criteria. These codes were eventually transitioned to largely identical CPT codes: 99492, 99493, 99494, and 99484 (see Table 1 for a description of each code). The codes function as a case rate by reimbursing for the cumulative time treating practitioners and their staff spend managing patients using the Collaborative Care Model over the course of a month. The codes intend to cover the full cost of delivering collaborative care.

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).

CMS also deemed collaborative care and general behavioral health integration services billable by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). However, unlike other treatment providers, only one collaborative care code is available to RHCs and FQHCs. This code, G0512, is the average of G0502 and G0503. There is no analogous G0504 code, meaning that there is no additional payment to RHCs or FQHCs for time spent beyond the first 70 or 60-minutes in a month. See Table 2 for a list of collaborative codes and other behavioral health integration codes available to RHCs and FQHCs.

Table 2: Collaborative Care G-Codes for FQHCs and Rural Health Clinics

G-Code	Description	Payment/Patient
G0512	First 70-minutes in first calendar month and at least 60-minutes in subsequent months	\$141.83
G0511	Care management services, minimum 20 minutes per month	\$66.17

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

Medicaid and Collaborative Care Today

The robust evidence base demonstrating that collaborative care improves health outcomes and is cost-effective justifies the widespread reimbursement of collaborative care codes by all payors. Currently Medicare and many major commercial payors reimburse for these codes. While Medicaid beneficiaries with opioid addiction are twice as likely than their uninsured peers and peers with private insurance to receive treatment,^{xii} Medicaid remains the insurer with the least consistency across the country in paying for collaborative care. While a few Medicaid agencies have initiated pilot programs, it is unclear why the pilot is needed given the over 70 randomized controlled trials showing the benefits of collaborative care, including for Medicaid patients,^{xlii, xliii, xliv} across a diverse range of care settings, communities, and health conditions.

Unlike Medicare where the collaborative care codes were integrated nationwide, Medicaid programs are implemented at the state level. States vary on if and how they reimburse for collaborative care. Some states and localities have been effective in implementing successful collaborative care programs. For example, in Washington State, the Mental Health Integration Program, sponsored by the Community Health Plan of Washington and Public Health - Seattle King County, implemented collaborative care in partnership with over 30 community mental health centers and more than 100 community health centers. The statewide program serves the Medicaid managed care population, as well as additional safety-net populations in some counties.^{xlv} CareOregon, a Medicaid managed care organization in Oregon, has provided training and support to primary care clinics to implement similar program to the Washington model. Despite these examples, many Medicaid programs still do not reimburse for collaborative care at all or limit coverage to specific populations.^{xlvi}

State Medicaid programs that reimburse for collaborative care codes:

- Arizona
- Illinois
- Iowa
- Kentucky
- Montana
- Nebraska
- North Carolina
- New Hampshire
- New Jersey
- New York
- Pennsylvania
- Rhode Island
- Utah
- Washington

Source: American Psychiatric Association (2019). Coverage for Psychiatric Collaborative Care Management Codes (CPT Codes 99492-99494).

Payment Models for Medicaid and Collaborative Care

The significant health and cost benefits associated with collaborative care demonstrate that Medicaid programs across the country should reimburse for these services. Medicaid programs can increase collaborative care use in a variety of ways. The most comprehensive way states can ensure providers incorporate collaborative care into their care delivery is by requiring that all Medicaid plans, including fee for service programs and managed care organizations, cover the collaborative care codes. States can also decide to approach their managed care and fee for service programs in different ways. For example, some states may modify the state Medicaid fee for service plan so that it covers the collaborative care codes, while not mandating contracted managed care entities provide reimbursement. In addition, managed care organizations can elect to reimburse for the collaborative codes even if the state plan does not.

Widespread implementations of the Collaborative Care Model have used a variety of different payment approaches, including full capitation, case-rate payments, and fee-for-service billing. For instance, the first known state Medicaid program to embrace collaborative care, the Community Health Plan of Washington, participated in the Washington State Mental Health Integration Program (MHIP), which provided collaborative care to vulnerable populations, including unemployed adults, veterans and their family members, the temporarily disabled, low-income mothers, children, the uninsured, and older adults. MHIP was financed through a partnership between the Community Health Plan of Washington, the State of Washington, more than 100 community health clinics, and 30 community mental health centers. The program supplemented traditional fee-for-service reimbursement for collaborative care providers with adjusted lump sum payments for on-site care managers.^{xlvii} Beginning in 2009, a pay-for-performance component was added to MHIP's reimbursement. The payment strategy tied 25 percent of the annual program to meeting pre-determined quality indicators, including timely follow-up of patients in the program, psychiatric consultation for patients who do not show for clinical appointments, and regular tracking of medications used.^{xlviii}

New York State Medicaid initiated reimbursement for collaborative care in 2015 through the Collaborative Care Medicaid program (CCMP). Similar to MHIP, CCMP provided value-based reimbursement using a monthly case-rate payment. The pay-for-performance component withheld 25% of the monthly, patient-level payment until patients either improved clinically or had their treatment plan adjusted due to their lack of clinical improvement after 6 months.^{xlix}

Covering collaborative care startup costs

Implementing effective collaborative care programs may require substantial practice change. Barriers to change may include lack of trained staff and existing care management infrastructure. **States can use flexibilities available within the Medicaid program to cover the startup costs of collaborative care.** Below we discuss two available approaches: (1) Section 1115 Demonstration Projects and (2) Medicaid Health Homes.

Section 1115 Demonstration Projects

Several states have used their 1115 waiver capacities to authorize incentive payments and facilitate integrated care implementation and development. While no waiver specifically refers to collaborative care, collaborative care falls within the integrated care programs eligible for incentive payments discussed below.

Massachusetts included within its Section 1115 waiver, most recently updated on June 26, 2019, incentive payments to accountable care organizations (ACOs), certified community partners, social service organizations, providers, sister agencies, full-time staff, and contracted vendors that will facilitate delivery system reform, including integrated care. Eligible activities include (1) start up and ongoing support for ACO development, infrastructure, and new care delivery models; (2) support for ACOs to pay for traditionally non-reimbursed flexible services to address health-related social needs; (3) transitional funding for certain safety net hospitals to support the transition to ACO models and to smooth the shift to a lower level of ongoing Safety Net Provider funding; (4) support to Community Partners for care management, care coordination, assessments, counseling, and navigational services; (5) support to Community Partners for infrastructure and capacity building; and (6) initiatives to scale up statewide infrastructure and workforce capacity to support successful reform implementation.

New Hampshire's 1115 waiver includes an incentive payment program aimed at increasing care coordination, provider capacity, and the use of alternative payment models. The Integrated Delivery Network Transformation Fund provides system transformation funding to networks of providers, or Integrated Delivery Networks (IDNs), who meet pre-defined milestones related to four project objectives: creating behavioral health capacity, promoting integration of physical and behavioral health providers, promoting smooth transitions across the continuum of care, and ensuring IDNs participate in alternative payment models. IDNs are regional coalitions of providers that apply collectively for incentive funds. The incentive payments aim to increase capacity across providers and community social service agencies, expand provider capacity, develop new expertise, and improve care transitions.

Washington uses its 1115 demonstration project to authorize incentive payments to self-governing organizations responsible for managing and coordinating partnership providers, or Accountable Communities for Health, for regional projects aimed at health systems and community capacity, financial sustainability through participating in value-based payment, bi-directional integration of physical and behavioral health, community-based whole-person care, and health equity and racial disparities. Projects related to physical and behavioral integration may include: co-location of providers; adoption of evidence-based standards of integrated care; and use of team-based approaches to care delivery that address physical, behavioral and social barriers to improved outcomes for all populations with behavioral health needs. Along with directly promoting integration of care, the projects will promote infrastructure changes by supporting the IT capacity and protocols needed for integration of care, offering training to providers on how to adopt the required changes; and creating integrated care delivery protocols and models.

Medicaid Health Homes

States can use the Affordable Care Act Health Home provision (Section 2703) as a scalable mechanism for implementing and paying for collaborative care in Medicaid. The ACA created an optional Medicaid State Plan benefit for states to establish Medicaid Health Homes. Beneficiaries eligible for Health Homes include those that have two or more chronic conditions, have one chronic condition and are at risk for a second, or have a serious and persistent mental health condition. Chronic conditions include, among others, mental and substance use disorders. Medicaid Health Homes are required to manage the full continuum of care for beneficiaries, including physical, behavioral, and long-term service and supports. Health Home services include comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow up, patient and family support; and referral to community and social support services. States receive an enhanced 90 percent FMAP for specific Health Homes services provided during the first eight quarters in which the program is effective.¹

The Collaborative Care Model provides an evidence-based approach to meeting the Health Home requirements, including physical and behavioral integration. States have substantial flexibility in designing Health Home services and how these services are delivered. Consequently, states can use this flexibility to design Health Home models that support collaborative care. While the Health Home model cannot pay for services provided to beneficiaries that do not meet the chronic conditions requirements, the enhanced FMAP can provide some coverage of the initial startup costs associated with collaborative care training and infrastructures. Financing for evidence-based collaborative care for common mental and substance use disorders can then be supported by requiring state fee for service and managed care programs cover the existing collaborative care codes.

Conclusion

Collaborative care is an evidence-based solution to addressing the adverse health and cost consequences associated with untreated behavioral health disorders experienced by Medicaid beneficiaries. Collaborative care aligns with a variety of different payment approaches, and states can use existing federal programs to cover startup costs needed to implement collaborative care across provider and program settings. The clear patient and cost benefits paired with available financing mechanisms demonstrate that Medicaid programs across the country should prioritize reimbursement of the Collaborative Care Model.

Shatterproof's Medicaid & Collaborative Care in Substance Use Disorder White Paper was prepared by Amanda Mauri, MPH. We would also like to thank Henry Harbin, MD and Michael Yuhas, MA of The Path Forward initiative for their contributions and feedback. Many Shatterproof staff provided input and we would like to thank Kevin Roy and Courtney Hunter for their contributions.

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