SECOND EDITION
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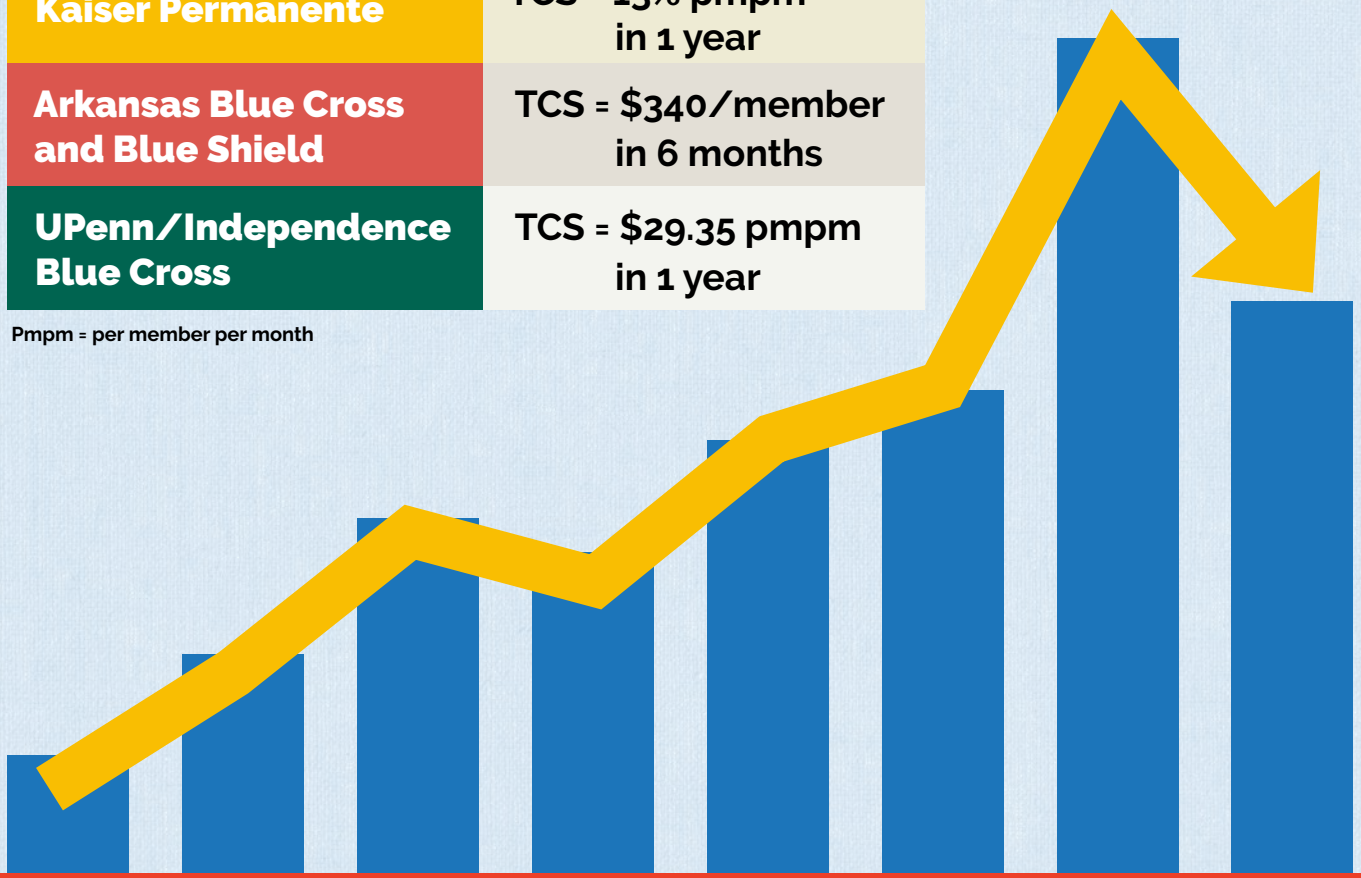
Mounting Evidence That Use of the Collaborative Care Model Reduces Total Healthcare Costs

Total Cost Savings (TCS)

IMPACT Study (included Kaiser Permanente)	TCS = 6x cost of CoCM over 4 years
Kaiser Permanente	TCS = 13% pmpm in 1 year
Arkansas Blue Cross and Blue Shield	TCS = $340/member in 6 months
UPenn/Independence Blue Cross	TCS = $29.35 pmpm in 1 year

Pmpm = per member per month



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Young People in Recovery

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Executive Summary

Difficulty in accessing affordable and effective treatment for mental health and substance use disorders (MHSUDs) has devastating consequences for millions of Americans and their loved ones. From delayed diagnoses and years of unnecessary suffering, to rising rates of suicide and deaths from overdoses, the unmet need for MHSUD treatment has become a national crisis that impacts the vast majority of families living with MHSUDs.

This crisis also impacts payers—many studies incontrovertibly demonstrate that patients with MHSUD conditions incur as much as **3–6 times** higher annual Total Healthcare Costs (THCs), which are driven predominantly by **physical** healthcare expenses. Therefore, key questions for payers to consider are:

- Is there a method to improve access to effective MHSUD care which also leads to lower THCs, and
- If so, can that method be expeditiously implemented on a very broadscale basis, to generate the most benefit for patients and the largest cost savings for payers?

The Collaborative Care Model Increases Access, with Mounting Evidence of THC Reduction

Today, most office-based MHSUD care is delivered, and most psychiatric drugs are prescribed, in primary care. In fact, for many Americans, primary care is the only available source of MHSUD care. **Therefore, the primary care system must play a central role in addressing the MHSUD crisis on a broadscale basis.**

However, primary care providers (PCPs) are typically underprepared, underfunded and ill-equipped to treat MHSUDs, resulting in ineffective care. Fortunately, we have a proven way to correct this problem. The Collaborative Care Model (CoCM) is the gold standard of evidence-based approaches to integrate MHSUD treatment into primary care. It is a true population health solution to address the health equity gap that offers several compelling benefits:

1. CoCM enables PCPs, **supported by** psychiatric consultants and care managers and guided by standardized clinical measures, to **effectively treat a substantial portion of MHSUDs**.
2. CoCM expands access to MHSUD care by enabling psychiatric consultants to help many more patients than would be possible under traditional 1:1 psychiatric care.
3. CMS has created billing codes specifically for CoCM reimbursement.
4. There is mounting evidence that use of CoCM is associated with a reduction in THCs, primarily by reducing **physical** healthcare costs.

This Issue Brief focuses specifically on the fourth benefit of CoCM. Here, we present findings from four studies—all conducted by payers or with payer participation—examining the impact of CoCM on THCs. Two of these are published studies led by researchers at the University of Washington (IMPACT) and the University of Pennsylvania/Independence Blue Cross (UPenn/IBX), respectively. The third study—conducted by Kaiser Permanente Colorado—was previously unpublished. Results from the fourth study—conducted by Arkansas Blue Cross and Blue Shield—were presented at a public conference in September 2025.

We are grateful to Kaiser Permanente for allowing us to present key findings from this study, which demonstrated a 13% THC savings for CoCM versus "treatment-as-usual" in day-to-day primary care settings. Since the time of the study, Kaiser Permanente has undertaken a national effort to build off of the success of the Colorado model and is implementing CoCM in all 8 Kaiser Permanente markets.

While each of these studies has limitations, taken together (using different patient populations, payer mixes and health plan types), they provide evidence that **implementing CoCM in day-to-day primary care is associated with reductions in THCs, and that such reductions may occur as early as six months and may increase over 3–4 years.**

Recommendations to Accelerate Broadscale CoCM Adoption

Medicaid. States not already reimbursing for CoCM codes should do so. For all states, CoCM reimbursement rates should be **at least** equivalent to Medicare reimbursement rates.

Medicare.

- While CMS already reimburses for CoCM billing codes, the rates should be reviewed and increased as necessary to ensure that the assignment of Relative Value Units (RVUs) for CoCM is based on actual experience of primary care systems delivering CoCM.
- To encourage wider adoption of CoCM, minimize documentation and administrative requirements for reimbursement.
- Encourage patient engagement in CoCM by (a) requiring zero patient cost-sharing for CoCM services delivered in accordance with CMS billing requirements, and (b) eliminating limits on follow-up care billed using CPT code 99494 within a billing month.

Commercial Insurers. Insurers should incentivize use of CoCM by:

- Encouraging CoCM adoption through implementation grants, technical support and reimbursement **at least 30% above** Medicare rates. A study by America's Health Insurance Plans (AHIP) demonstrated that, in 2021, the combined average commercial payment for the CoCM codes (99492, 99493, and 99494) and the general behavioral health integration code (99484) was **50% above** Medicare rates.[1]
- Encouraging patient engagement by (a) requiring zero patient cost-sharing for CoCM services delivered in accordance with CMS billing requirements, and (b) eliminating limits on follow-up care billed using CPT code 99494 within a billing month.

Providers. Healthcare systems and primary care practices should implement and/or expand CoCM to enable their practitioners to effectively treat patients with MHSUDs.

There are many private CoCM Service Organzations (CSOs) that offer a wide range of services to help primary care practices and healthcare systems systematize and streamline CoCM implementation and ongoing delivery. A Directory of these organizations is available to assist providers and health systems in identifying and accessing these resources.

Federal and State Regulators. In assessing payers' compliance with mental health parity and network adequacy requirements, regulators should allow in-network CoCM services—when delivered by primary care providers in accordance with CMS billing requirements—to be counted as in-network MHSUD specialist services.

Health Plan Accreditation Organizations. Accreditation organizations should define—and treat as a prerequisite for accreditation—MHSUD network adequacy requirements. In assessing payer compliance with MHSUD network adequacy requirements, payers should be permitted to count in-network CoCM services—when delivered by primary care providers in accordance with CMS billing requirements—as in-network MHSUD specialist services.

Employers/Healthcare Purchasers. Purchasers with self-funded plans should **require** third party administrators to:

- Require zero patient cost-sharing for CoCM services delivered in accordance with CMS billing requirements.
- Eliminate limits on follow-up CoCM care billed using CPT code 99494 within a billing month.

Overview

The difficulty faced by Americans in obtaining timely, affordable MHSUD care has become a national crisis. In 2022, over 59 million adults (23%) 18 and older reported having any mental illness in the past year, and nearly half received no treatment. Similarly, more than 15 million adults (6%) reported having a serious mental illness in the past year, but about a third received no treatment.[2] Overall, there is extensive evidence demonstrating that accessing MHSUD care is far more challenging than accessing care for other health conditions.[3, 4, 5, 6]

For Americans living with MHSUDs and their loved ones, the cost of access barriers is high—including years of unnecessary patient suffering and rising rates of suicide and deaths related to these conditions.[7] There is an urgent need to quickly improve access on a broadscale basis.

Our extensive primary care system—for many Americans, the only source of MHSUD care available[8]—must play a key role in expanding access to **effective** MHSUD care. **More than half** of those who receive office-based MHSUD services receive that care in primary care settings—where they are also being treated for co-occurring physical health conditions.[9] **Most** psychiatric drugs are prescribed by PCPs.[10,11] Additionally, substantial evidence demonstrates that persons with comorbid physical and MHSUD conditions incur as much as **3 to 6 times higher annual THCs—driven heavily by physical healthcare expenses**—than people without MHSUD comorbidities.[11, 12, 13] This can be seen in Figure 1, on the following page, excerpted from Davenport et al., 2020.[12] Analyzing claims for 21 million commercially-insured lives, the authors found that only **5.7% of these individuals**—those with both Medical/Surgical and MHSUD claims—**accounted for 44% of THCs for the entire 21 million people.** Further, THCs for this group were driven heavily by those individuals with mild-to-moderate MHSUDs that can be effectively treated in primary care.

Unfortunately, primary care providers are typically underprepared, underfunded and ill-equipped to adequately identify and treat MHSUDs, as summarized here—thus leading to delayed diagnoses and poor clinical outcomes. It is estimated that only 13% of people diagnosed with a mental health disorder receive minimally adequate treatment in the general medical setting, and this percentage is just 5% for those with substance use disorders.[9] And, while early screening for most medical conditions in primary care settings is considered routine care, this is not the case for MHSUDs.[14]

Fortunately, we do have a proven way to dramatically improve MHSUD clinical outcomes in primary care, and thereby address the MHSUD crisis on a broadscale basis.

Figure 1. Excerpts from Figure 9 of Davenport et al., 2020[12]

Average Annual Healthcare Treatment Costs (Services and Prescription Drugs) per Individual by Behavioral Health Category, 2017 Total Population (21 Million Patients)

	AVERAGE ANNUAL HEALTHCARE COSTS			COSTS RELATIVE TO NO BH	
BH Category*	**Total**	**Behavioral Health**	**Medical/ Surgical**	**Total**	**Medical/ Surgical**
No BH	$3,552	$0	$3,552	1.0x (ref.)	1.0x (ref.)
Any BH (MH and/or SUD)	$12,272	$965	$11,307	3.5x	3.2x
Any MH	$12,221	$1,017	$11,204	3.4x	3.2x
MH, not SMI	$11,856	$789	$11,067	3.3x	3.1x
MH, SMI	$22,460	$7,422	$15,038	6.3x	4.2x
MH, without SUD	$10,855	$772	$10,083	3.1x	2.8x
Any SUD	$19,796	$1,989	$17,807	5.6x	5.0x
SUD, without MH	$12,923	$303	$12,619	3.6x	3.6x
Both MH and SUD	$25,602	$3,413	$22,189	7.2x	6.2x
Total Population	**$5,932**	**$263**	**$5,669**	**1.7x**	**1.6x**

* Note that the "MH, not SMI" and "MH, SMI" categories include some individuals who also have substance use disorders.
Definitions: BH=Behavioral Health; MH=Mental Health; SUD=Substance Use Disorder; SMI=Serious Mental Illness
Source: Davenport, et al., 2020[12]

The Collaborative Care Model

CoCM is a well-established, evidence-based method of integrating MHSUD care into primary care. Under CoCM, the primary care provider retains treatment responsibility for patients with MHSUDs but is supported by a behavioral care manager and a psychiatric consultant. **CoCM provides a natural, practical solution** to quickly close the gap between the need for MHSUD care (especially mild-to-moderate depression, anxiety, and some substance use disorders) and the capacity of our specialty MHSUD delivery system to meet this need. CoCM expands generalized screening and standardized symptom monitoring for MHSUDs to allow **early detection**, intervention and effective treatment—particularly important in more challenging patient populations such as children and adolescents, elderly adults, and patients with SUD.

CoCM also significantly increases the capacity of the existing MHSUD delivery system. One "full-time equivalent" psychiatric consultant can effectively impact MHSUD treatment for as many as 3–8 times more patients under CoCM than could be achieved through traditional 1:1 treatment.[15, 16]

"Given limited access to specialty mental health care in the United States, CoCM allows psychiatric expertise to reach an exponentially larger group of patients ..."[17]

More than 90 randomized controlled trials (RCTs) have demonstrated the positive impact of CoCM on clinical outcomes. Additionally, CoCM has been shown to positively impact patient and provider satisfaction and health equity,[18, 19, 20] and it is endorsed by the 18 leading medical, business, and non-profit organizations listed on the following page. Medicare, most commercial payers, and about 60% of state Medicaid programs reimburse primary care providers for delivering CoCM, using payment codes developed by CMS. In states where all three types of payers reimburse CoCM at adequate rates, CoCM can be financially "self-sustaining" in terms of **provider economics**.

"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,
National Institute of Mental Health

"Our country is in … a growing behavioral health crisis with suicide and overdose deaths at record levels … Many individuals … have difficulty finding a mental health professional … The Collaborative Care Model (CoCM) provides a strong building block to address these problems by ensuring that patients can receive expeditious behavioral health treatment within the office of their primary care physician … this legislation … will expand needed access to high-quality behavioral health care that is proven to be effective."

—Letter by the following organizations in support of legislation to fund implementation of CoCM, September 2021:

Academy of Consultation-Liaison Psychiatry
American Academy of Addiction Psychiatry
American Academy of Child and Adolescent Psychiatry
American Academy of Family Physicians
American Academy of Pediatrics
American Association for Geriatric Psychiatry
American College of Obstetricians and Gynecologists
American College of Physicians
American Medical Association
American Osteopathic Association
American Psychiatric Association
Association for Behavioral Health and Wellness
HR Policy Association and American Health Policy Institute
Meadows Mental Health Policy Institute
National Alliance of Healthcare Purchaser Coalitions
National Association of Social Workers
National Council for Mental Wellbeing
Shatterproof

Payer Economics

CoCM and Total Healthcare Costs (THCs)

Since implementing CoCM requires investment of time, money and personnel resources, **a key question to ask is whether the improved MHSUD access and patient outcomes leads to actual savings for payers with respect to THCs**—costs that are driven predominantly by **physical** healthcare costs. Mounting evidence suggests that the answer to this question is "yes," and that THC savings may persist—and even increase—over time.

Many studies have shown reductions in healthcare costs when CoCM is used. Several examples, along with their key findings, are highlighted in Figure 2.

In this Issue Brief, we focus on the last four studies listed in Figure 2, each of which analyzes THCs. These studies span over a decade, including one (UPenn/IBX) that was published in October 2023, one (Kaiser Permanente) that is being reported here for the first time, and one—Arkansas Blue Cross and Blue Shield—whose results were presented

"... we observed health benefits well beyond reduced depression, such as improved quality of life, improved physical functioning, higher patient satisfaction with care, decreased burden from pain in the 1,001 IMPACT patients with depression and comorbid osteoarthritis, increased adherence to exercise regimens, and improved physical functioning in the approximately 400 patients with type 2 diabetes mellitus."[21]

Figure 2. Studies Showing Reduced Healthcare Costs Under CoCM

Study	Key Findings/Conclusions
Simon et al., 2007[22]	Over a period of 24 months, CoCM patients had approximately $300 lower outpatient (OP) healthcare costs and 61 more depression-free days, compared to patients in usual care.
Katon et al., 2012[23]	CoCM patients had 114 more depression-free days, and lower mean OP health costs of $594 per patient than usual care patients.
Unützer et al., 2008 IMPACT Study, University of Washington[24]	Over 4 years, CoCM group THCs were $3,363 lower than patients receiving treatment as usual. Cost savings occurred in every care category and increased over years 2-4. Two of the sites in this study were Kaiser Permanente facilities, and one of the authors was a Kaiser Permanente employee.
Wolk et al., 2023 UPenn/IBX Study[17]	During the 12 months following initiation of CoCM, THCs were essentially the same (i.e., a non-statistically significant savings of $29.35) for CoCM patients versus matched patients receiving treatment as usual, despite the fact that CoCM patients received more mental health care (i.e., savings accrued in physical health care).
Kaiser Permanente, 2024 (previously unpublished)[25]	During the 12 months following initiation of CoCM in this 2015 study, there was a 13% per member per month (pmpm) THC savings for CoCM patients as compared to the "treatment-as-usual" comparison group.
Arkansas Blue Cross Presentation, 2025[26]	In the 6 months following CoCM access, there was a $340 per member reduction in overall costs.

in a public forum in September 2025. Using different patient populations, payer mixes, health plan types and data sources, these studies, taken together, provide evidence that implementing CoCM in day-to-day primary care is associated with reductions in THCs for payers.

Improving Mood: Providing Access to Collaborative Treatment (IMPACT) Study, 2008[24]

The initial 2002 IMPACT study, a randomized controlled trial, led by researchers from the University of Washington, examined the effectiveness of CoCM treatment for patients with late-life depression.[27] In this trial, 1,801 patients were recruited from 18 participating primary care clinics across five states between July 1999 and August 2001, and assigned to receive either the IMPACT (CoCM) intervention or usual care to treat their depression. IMPACT patients were supported for up to 12 months by a care manager supervised by a psychiatrist and a primary care provider, receiving education, medication management support and problem-solving treatment.

Earlier analyses from the IMPACT study showed improved clinical outcomes with OP care costs slightly higher for CoCM patients in the first 12 months, but lower in the following 12 months.[21]

Figure 3. 4-Year Healthcare Costs[a]

Table 2

	Cost, $			
		Randomized Group		
Cost Category	**Overall Mean**	**Intervention**	**Usual Care**	**Difference**
Outpatient				
IMPACT intervention	--	$522 (495 to 550)	$0 (0 to 0)	$522 (495 to 550)
Mental Health	$661	$558 (362 to 753)	$767 (561 to 974)	-$209 (-494 to 75)
Pharmacy	$7,284	$6,942 (6,062 to 7,822)	$7,636 (6,287 to 8,984)	-$694 (-2,304 to 916)
Other	$14,306	$14,160 (12,899 to 15,421)	$14,456 (12,909 to 16,002)	-$296 (-2,291 to 1,700)
Total[b]	**$22,516**	**$22,182** (20,368 to 23,996)	**$22,859** (20,470 to 25,247)	**-$677** (-3,676 to 2,323)
Inpatient				
Medical	$8,452	$7,179 (5,450 to 8,908)	$9,757 (6,455 to 13,059)	-$2,578 (-6,305 to 1,149)
Mental health and substance abuse	$114	$61 (-8 to 129)	$169 (-2 to 340)	-$108 (-292 to 76)
Total Healthcare During 4 Years				
Overall Total	$31,082	$29,422 (26,479 to 32,365)	$32,785 (27,648 to 37,921)	**-$3,363** (-9,282 to 2,557)

IMPACT indicates Improving Mood: Promoting Access to Collaborative Treatment.

[a]Data are given as mean (95% confidence interval) unless otherwise indicated.

[b]Total outpatient costs include IMPACT intervention costs which only apply in the intervention group.

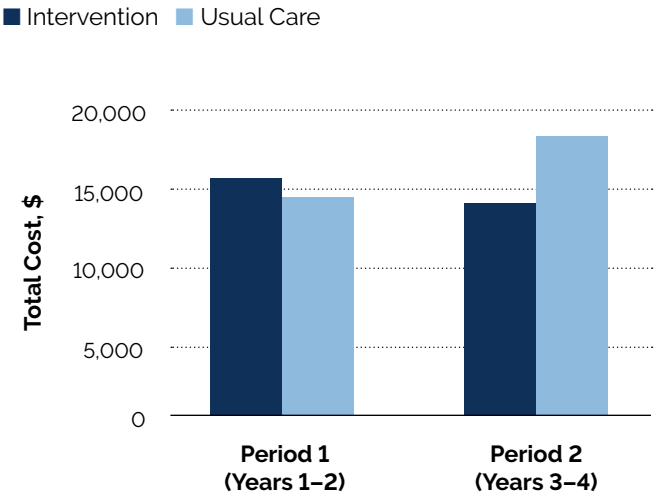
Source: Unützer et al., 2008[24]

In the 2008 study, the authors examined the longer-term effect of the IMPACT program on THCs for 551 patients from two of the original participating health centers (group-model HMOs) that were able to provide complete 4-year medical cost data on these patients. Results are summarized in Figure 3 (Table 2 excerpted from the study), on the previous page. These results, covering a 4-year period following initiation of CoCM, showed cost reductions for CoCM patients in every category of care and indicated a high probability of a large reduction in THCs ($3,363)—**six times the cost of providing CoCM** ($522).

"Intervention patients had lower healthcare costs than usual care patients in every cost category."[24]

Savings were notably greater in years 3 and 4 (See Figure 4, also excerpted from the study).

Figure 4. Total Healthcare Costs



Source: Unützer et al., 2008[24]

"Earlier cost-effectiveness analyses from this trial showed slightly higher costs for intervention patients compared with usual care patients in the initial year (the year that intervention services were provided) and somewhat lower costs in the second year of the study. The present long-term cost analysis (extending the earlier follow-up period by an additional 24 months) suggests that cost savings observed after the conclusion of the 12-month intervention continued in subsequent years, resulting in a high probability of lower total healthcare costs among intervention patients than control patients during 4 years."[24]

University of Pennsylvania/ Independence Blue Cross (IBX) Study, 2023[17]

In this recently-published study, the authors examined insurance claims data from a large regional health insurer—Independence Blue Cross in Philadelphia—to identify patients enrolled in the Penn Integrated Care (PIC) CoCM program offered through the University of Pennsylvania medical system. Under PIC, patients were referred by primary care providers for centralized telephonic intake and triage. Standardized symptom scales were used to assess patients and direct them to the most appropriate care level—including enrollment in the PIC Collaborative Care program for mild to moderate depression, anxiety and alcohol misuse, or, alternatively, referral to community settings for treatment of the most serious conditions by MHSUD specialists.

THCs for the PIC patients were compared to those for a matched control group to determine the impact on total medical, psychiatric, and pharmaceutical costs of a CoCM program funded solely through CoCM billing codes. THCs from a sample of 569 commercially insured and Medicare Advantage patients in eight primary care practices who were enrolled in the PIC program were compared over a period of 12 months to THCs for a matched control group of 569 patients using difference-in-differences regression analysis. Costs for CoCM-related (PIC) services—reimbursed via CoCM billing codes—were counted as medical (primary care) costs in the analysis.

Results from the UPenn/IBX study, summarized in Figure 5, showed mean THC savings (non-statistically significant) of $29.35 per member per month (pmpm) for PIC patients compared to the matched control group. This is despite PIC patients having incurred $34.11 pmpm more in primary care claims directly attributed to receiving CoCM care and $19.91 pmpm more for other (non-CoCM) behavioral healthcare claims—underscoring that CoCM's impact on THCs is driven primarily by **reductions in physical healthcare costs.**

Figure 5. Healthcare Costs (pmpm): PIC Versus Control Group Patients

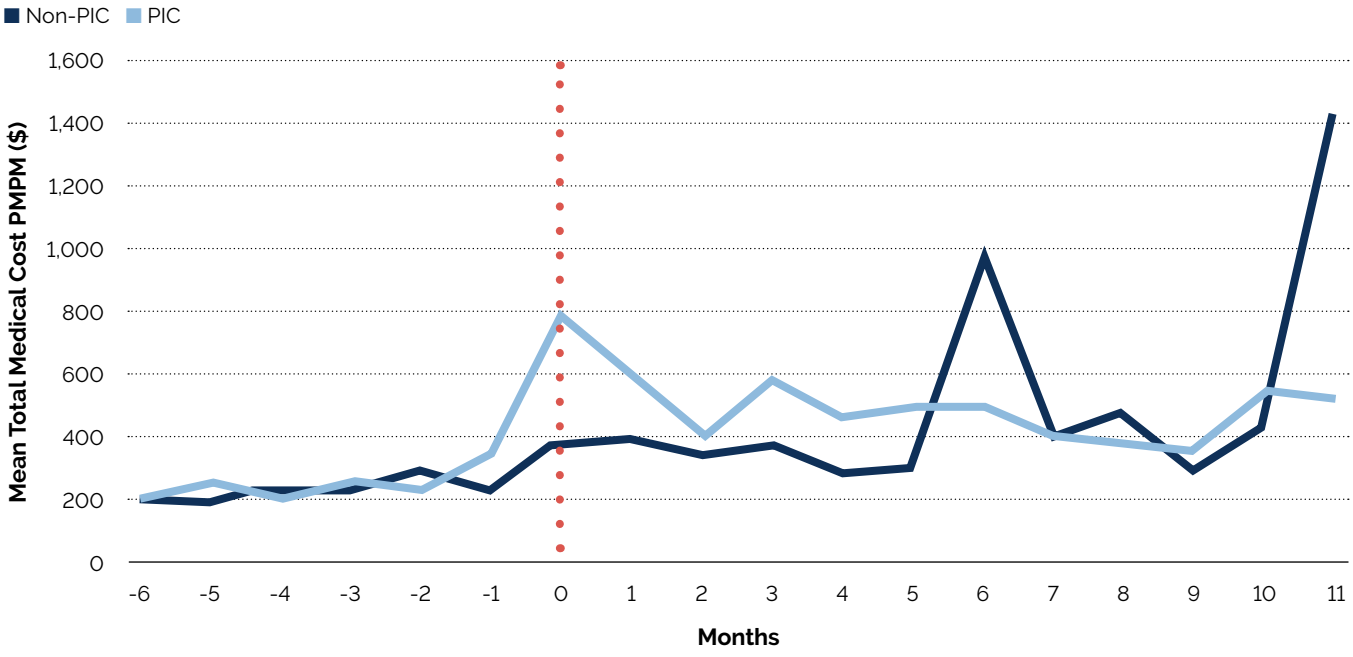
MHSUD Costs	$19.91 Higher for PIC Group
PIC Medical (CoCM)	$34.11 (PIC Group Only)
Non-MHSUD Costs*	$72.46 Lower for PIC Group
Inpatient Costs*	$91.34 Lower for PIC Group
Total Healthcare Costs*	**$29.35 Lower for PIC Group**

* Differences are non-statistically significant

Source: Adapted from Table 2 of Wolk et al., 2023,[17] using amended labels to conform to terms used in this Issue Brief. Figures are not additive. All dollar amounts are from Table 2 of Wolk et al., 2023.[17]

As shown in Figure 6 (excerpted from the UPenn/IBX study), THCs (labeled Total Medical Costs) for PIC patients began to drop after the third month in the program (labeled Month 2 in the Figure, as Month 0—the first month of the study—was defined as the month CoCM was initiated), dropping below the costs for control patients at Month 7 (labeled Month 6 in Figure 6).

Figure 6. Mean Total Medical Costs PMPM From the 6 Months Prior to PIC Implementation Through 12 Months of PIC Implementation, Excerpted from Wolk et al., 2023[17]



PIC, Penn Integrated Care; PMPM, per member per month

Source: Wolk et al., 2023[17]

While the difference in THC savings between the groups was not statistically significant, the authors concluded that CoCM did not increase THCs, and that a modest investment in CoCM services is likely, at worst, to be cost neutral while greatly expanding the "reach" of the pool of psychiatric consultants.

The UPenn/IBX and IMPACT studies both analyzed patients in real-world primary care practices. While results of these studies are not directly comparable because the UPenn/IBX study included a wider range of patient ages and diagnoses and analyzed only 12 months, both studies point toward reductions in THCs when CoCM is implemented.

"These findings…should reassure insurers that coverage of the new [CoCM] billing codes affords improved access to mental health care without increasing overall spending."[17]

Kaiser Permanente Colorado Study, 2024[25]

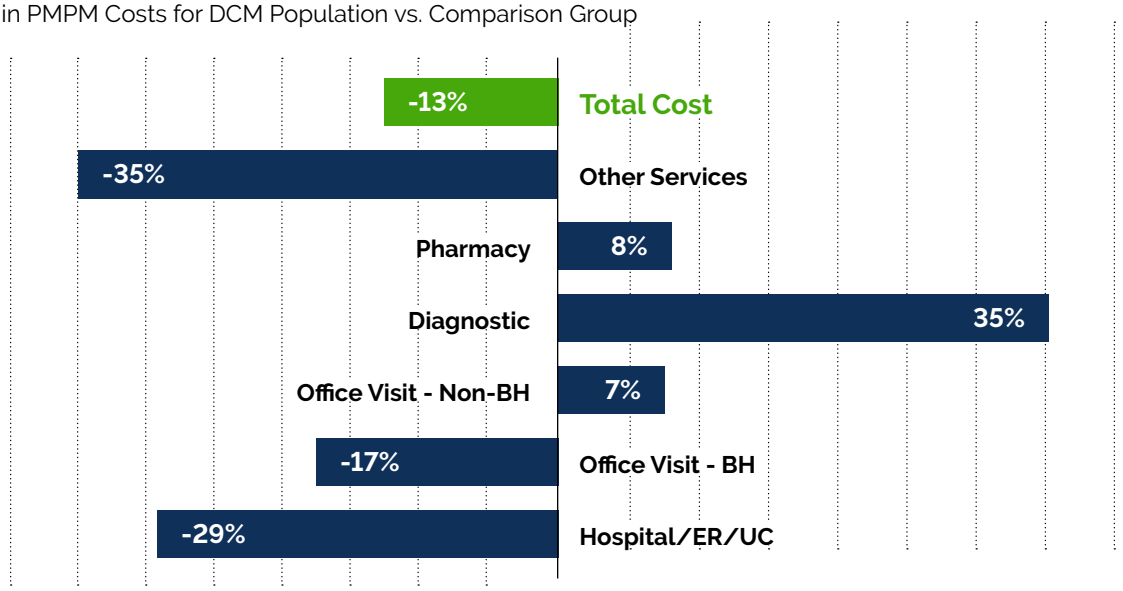
Study of Total Healthcare Costs for Patients Receiving CoCM Compared to Patients Receiving Treatment as Usual (Previously Unpublished)

In 2015, Kaiser Permanente Colorado conducted a study for the purpose of determining the THCs of 1,525 adult patients receiving CoCM in day-to-day primary care practice. All patients receiving CoCM in the study were in Kaiser Permanente's Depression Care Management (DCM) program, had a new diagnosis of mild to moderate depression, and had not (prior to entering the program) received antidepressant medication. In this study, the only treatment intervention was antidepressant medication and care management in accordance with CoCM.

The THCs of the 1,525 CoCM adult patients were compared to such costs for adult patients with similar characteristics, who received "treatment as usual" in primary care during the same time period. The CoCM group and the comparison group included patients with commercial, Medicare and Medicaid plans.

Figure 7. Kaiser Permanente Colorado Change in PMPM Costs

% Change in PMPM Costs for DCM Population vs. Comparison Group



Source: Kaiser Permanente, 2024, from a study undertaken in 2015[25]

THCs were measured using the following categories:

1. Hospital/ER/Urgent Care (UC)
2. Office Visits — Behavioral Health (BH)
3. Office Visits — Non-Behavioral Heath (Non-BH)
4. Diagnostic
5. Pharmacy
6. Other Services

As shown in Figure 7, during the 12 months following initiation of care, there was a 13% THC savings for CoCM versus the comparison group. This savings occurred even though the protocol of this study included a limited intervention.

Since the time of the study, Kaiser Permanente has undertaken a national effort to build off of the success of the Colorado model. This effort has involved broadening the model to include, among other features, additional mental health diagnoses (e.g., anxiety), expanding criteria to include non-medication treatment options, and supporting implementation and spread in all 8 Kaiser Permanente markets.

Arkansas Blue Cross and Blue Shield Analysis 2025[26]

Arkansas Blue Cross and Blue Shield (Arkansas Blue Cross) began reimbursing for CoCM services in 2020 and, since that time, the number of members being treated under CoCM has grown dramatically. Between 2020 and 2022, Arkansas Blue Cross paid CoCM claims for **334** patients. Over the following two years, the plan paid CoCM claims for **13,250** patients.

Among the 13,250 patients treated under CoCM during 2023 and 2024:

- ER use decreased **10%**
- Hospitalizations decreased **33%**
- Pharmacy adherence increased **3%**
- There was a **$340/member** reduction in overall cost 6 months following CoCM access

Summary and Recommendations

Across the IMPACT, UPenn/IBX, Kaiser Permanente, and Arkansas Blue Cross data, two themes emerge:

1. We can cost-effectively close the MHSUD access gap substantially through broadscale implementation of CoCM, which expands access to effective MHSUD care by strengthening the capability of primary care providers to treat most common MHSUDs.
2. **There is mounting evidence that use of CoCM is associated with a reduction in THCs, and that such savings may occur as early as the first 6 months and may increase over 3–4 years.**

Recommendations to Accelerate Broadscale CoCM Adoption:

Medicaid. States not already reimbursing for CoCM codes should do so. For all states, CoCM reimbursement rates should be **at least** equivalent to Medicare reimbursement rates.

Medicare.

- While CMS already reimburses for CoCM billing codes, the rates should be reviewed and increased as necessary to ensure that the assignment of Relative Value Units (RVUs) for CoCM is based on actual experience of primary care systems delivering CoCM.
- To encourage wider adoption of CoCM, minimize documentation and administrative requirements for reimbursement.
- Encourage patient engagement in CoCM by (a) requiring zero patient cost-sharing for CoCM services delivered in accordance with CMS billing requirements, and (b) eliminating limits on follow-up care billed using CPT code 99494 within a billing month.

Commercial Insurers. Insurers should incentivize use of CoCM by:

- Encouraging CoCM adoption through implementation grants, technical support and reimbursement **at least 30% above** Medicare rates. A study by America's Health Insurance Plans (AHIP) demonstrated that, in 2021, the combined average commercial payment for the CoCM codes (99492, 99493, and 99494) and the general behavioral health integration code (99484) was **50% above** Medicare rates.[1]
- Encouraging patient engagement by (a) requiring zero patient cost-sharing for CoCM services delivered in accordance with CMS billing requirements, and (b) eliminating limits on follow-up care billed using CPT code 99494 within a billing month.

Providers. Healthcare systems and primary care practices should implement and/or expand CoCM to enable their practitioners to effectively treat patients with MHSUDs.

There are many private CoCM Service Organizations (CSOs) that offer a wide range of services to help primary care practices and healthcare systems systematize and streamline CoCM implementation and ongoing delivery. A Directory of these organizations is available to assist providers and health systems in identifying and accessing these resources.

Federal and State Regulators. In assessing payers' compliance with mental health parity and network adequacy requirements, regulators should allow in-network CoCM services—when delivered by primary care providers in accordance with CMS billing requirements—to be counted as in-network MHSUD specialist services.

Health Plan Accreditation Organizations. Accreditation organizations should define—and treat as a prerequisite for accreditation—MHSUD network adequacy requirements. In assessing payer compliance with MHSUD network adequacy requirements, payers should be permitted to count in-network CoCM services—when delivered by primary care providers in accordance with CMS billing requirements—as in-network MHSUD specialist services.

Employers/Healthcare Purchasers. Purchasers with self-funded plans should **require** TPAs to:

- Require zero patient cost-sharing for CoCM services delivered in accordance with CMS billing requirements.
- Eliminate limits on follow-up CoCM care billed using CPT code 99494 within a billing month.

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Bowman Family Foundation

The Bowman Family Foundation ("BFF") is a private foundation qualifying as a 501(c)(3) nonprofit organization. The primary mission of BFF is to improve the lives of people with mental health and substance use conditions. BFF also provides funding to support the education and welfare of children.

For more information:

thebowmanfamilyfoundation.org