

Unlocking the Power of Integrated Care: Transforming Healthcare through Behavioral Health Integration

Facilitator:

Stephanie Turner, RN, MSN | VP Population Management, UNC Health Alliance

Speakers:

Dr. Matthew Press, Associate Professor, Penn Medicine

Dr. Nate Sowa, Associate Professor, Associate Vice Chair of Virtual and Integrated Care

Dr. Ish Bhalla, Medical Director, Blue Cross and Blue Shield of North Carolina

Agenda

- 1. Current state behavioral health problem**
- 2. Overview of Collaborative Care Management (CoCM) as an Integrated Care Model**
- 3. CoCM evolution - operational success, outcomes, blockers and partnerships**
- 4. Business case for ACOs**

Collaborative Care Model of Integrated Mental Health

Evidence, Policy, and Implementation

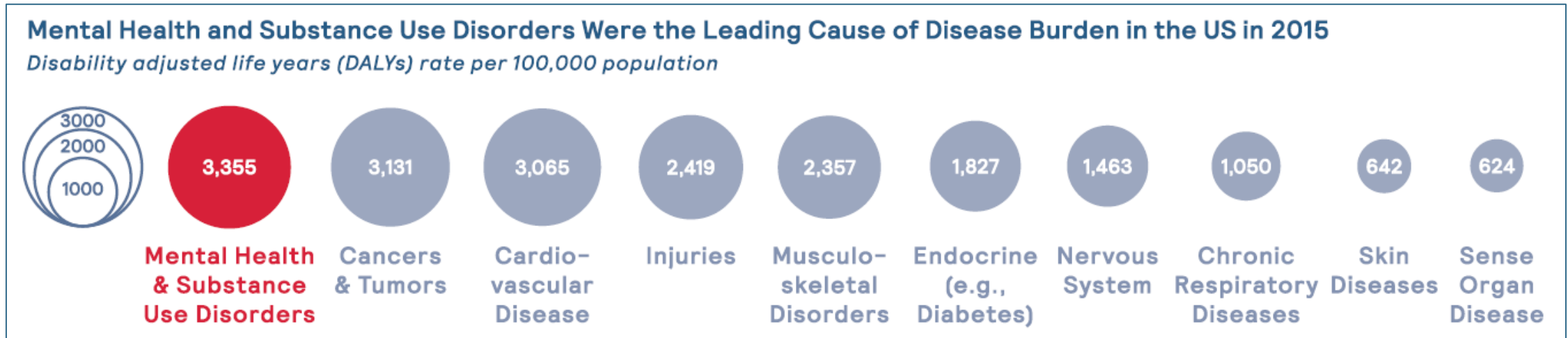
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April 2024—NAACOS



Mental health problems are major cause of morbidity and mortality



JAMA. 2017;318(5):415.10.1001/jama.2017.8558

Table 3. All-Cause Deaths Attributable to Mental Disorders by Diagnosis

Cause	Pooled RR (95% CI)	Prevalence, %	PAR, %	No. of Deaths Attributable to Mental Disorders, in Millions ^a
Disorders				
All mental	2.22 (2.12-2.33)	26.1 ^b	14.34	8.00
Mood	1.86 (1.73-2.00)	10.6 ^b	4.90	2.74
Anxiety	1.43 (1.24-1.64)	14.3 ^b	4.30	2.41
Psychoses	2.54 (2.35-2.75)	1.04 ^c	0.63	0.35

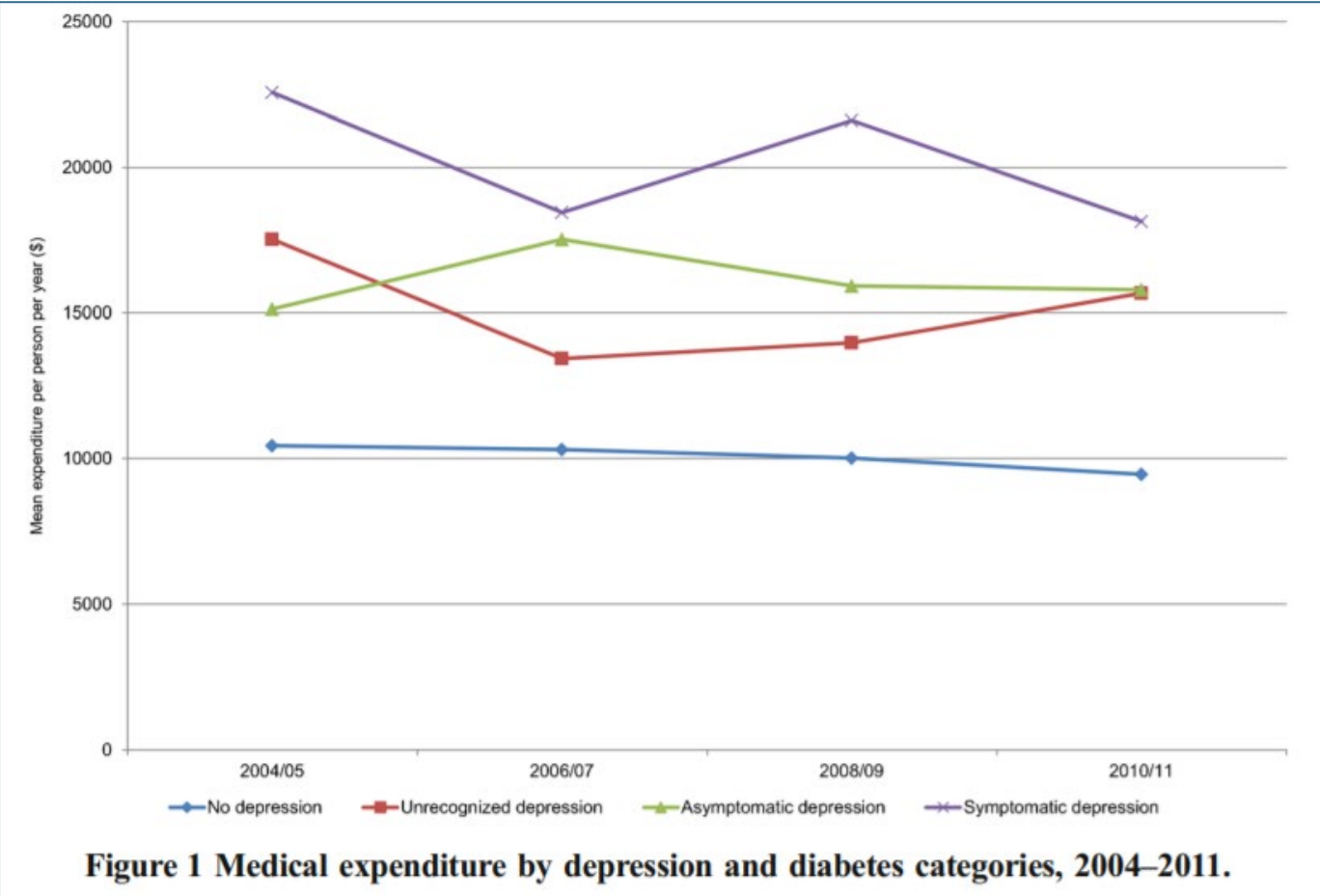
Abbreviations: PAR, population attributable risk; RR, relative risk. World Mental Health Surveys in 17 countries.³¹

^a On the basis of the World Health Organization estimate of 56 million deaths worldwide in 2012.³³ ^c Prevalence of self-reported lifetime diagnosis from the World Health Organization World Mental Health Surveys in 52 countries.³²

^b Median lifetime prevalence of estimates from the World Health Organization

JAMA Psychiatry. 2015;72(4):334-341

Mental health is a major driver of health care spending

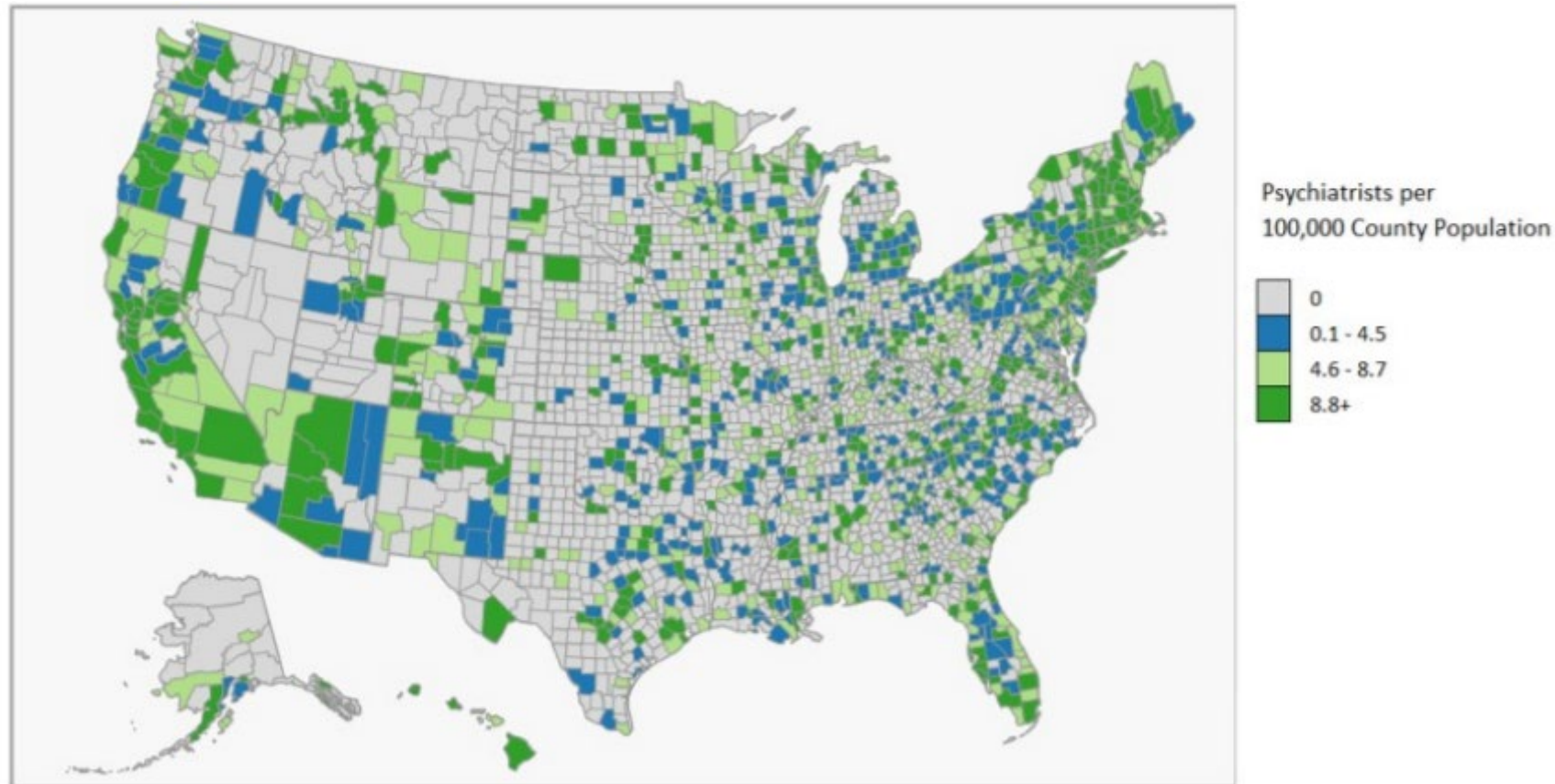


Egede. JGIM. 2016

POPULATION	BEHAVIORAL HEALTH DIAGNOSIS	MEMBER MONTHS	MEDICAL
COMMERCIAL	NO MH/SUD	1,674,000,000	\$327
	NON-SPMI MH	246,000,000	\$765
	SPMI	85,000,000	\$700
	SUD	30,000,000	\$980
	TOTAL	2,021,000,000	\$399
MEDICARE	NO MH/SUD	597,000,000	\$736
	NON-SPMI MH	23,000,000	\$1,899
	SPMI	31,000,000	\$1,872
	SUD	11,000,000	\$1,943
	TOTAL	656,000,000	\$839
MEDICAID	NO MH/SUD	577,000,000	\$391
	MH/SUD	144,000,000	\$957
	TOTAL	721,000,000	\$504
TOTAL	NO MH/SUD	2,848,000,000	\$425
	MH/SUD	551,000,000	\$923
	TOTAL	3,399,000,000	\$506

Milliman Research Report. Potential economic impact of integrated medical behavioral healthcare January 2018

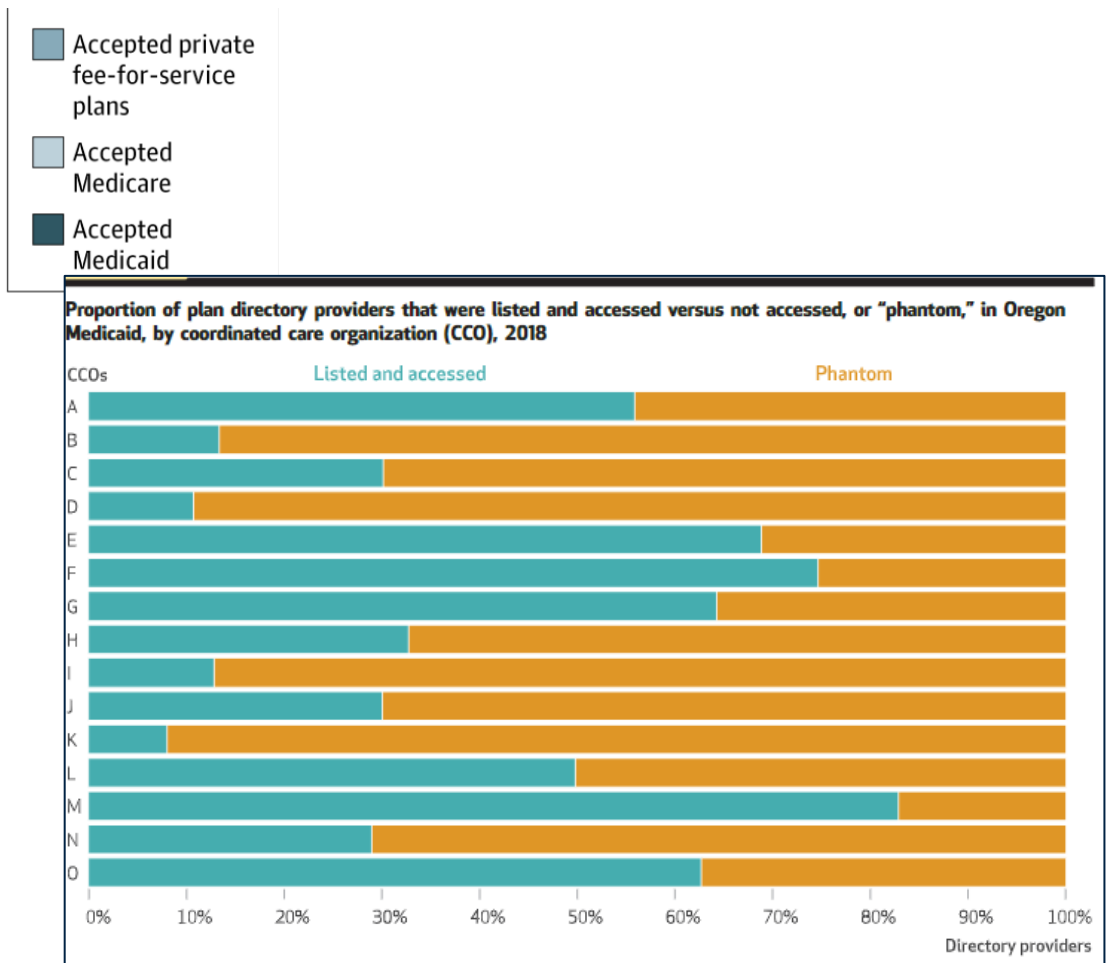
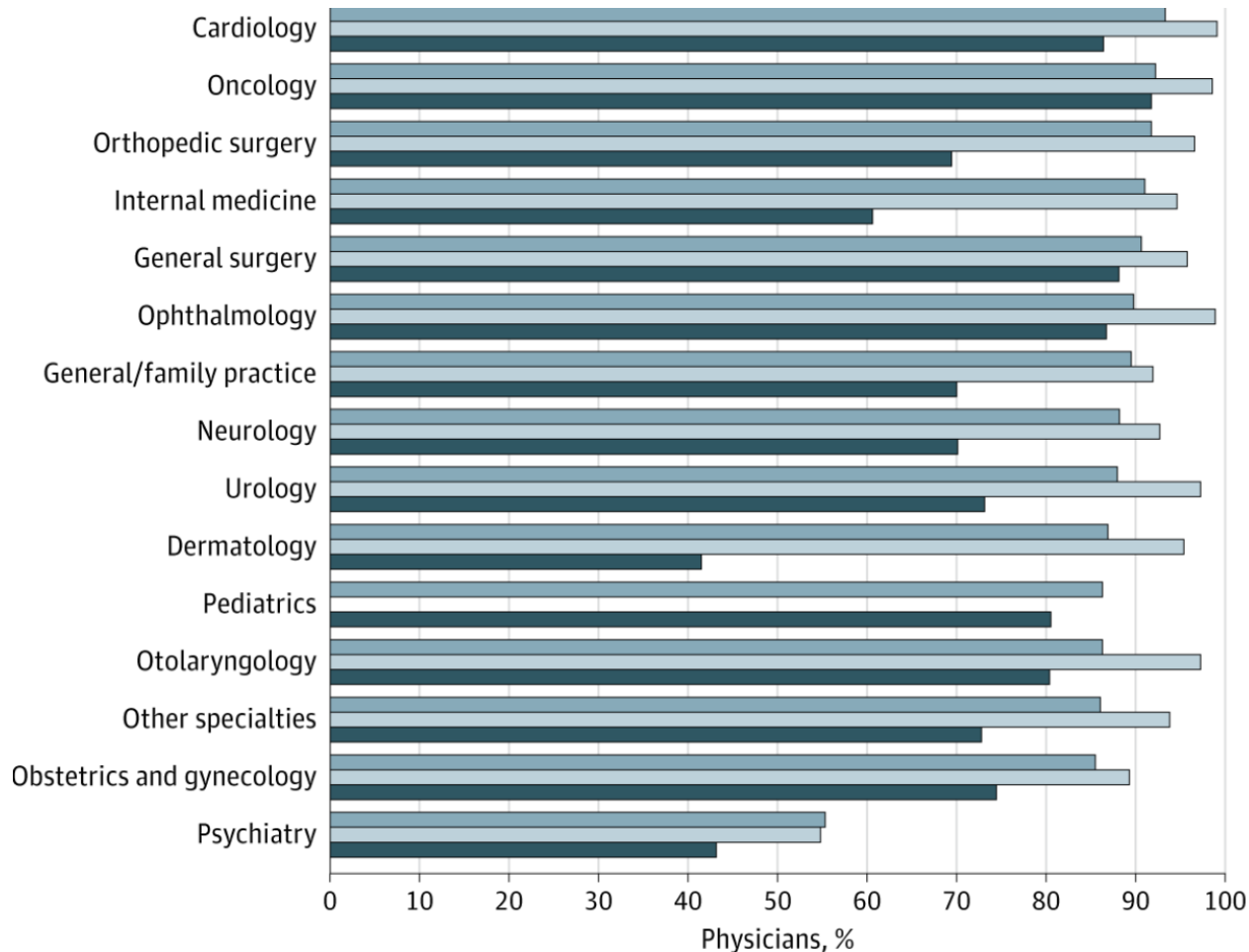
Less than half of U.S. counties have a single psychiatrist



University of Michigan Behavioral Health Workforce Research Center. Estimating the Distribution of the U.S. Psychiatric Subspecialist Workforce. Ann Arbor, MI: UMSPH; 2018.



Most psychiatrists do not accept insurance; those that do often have no real access



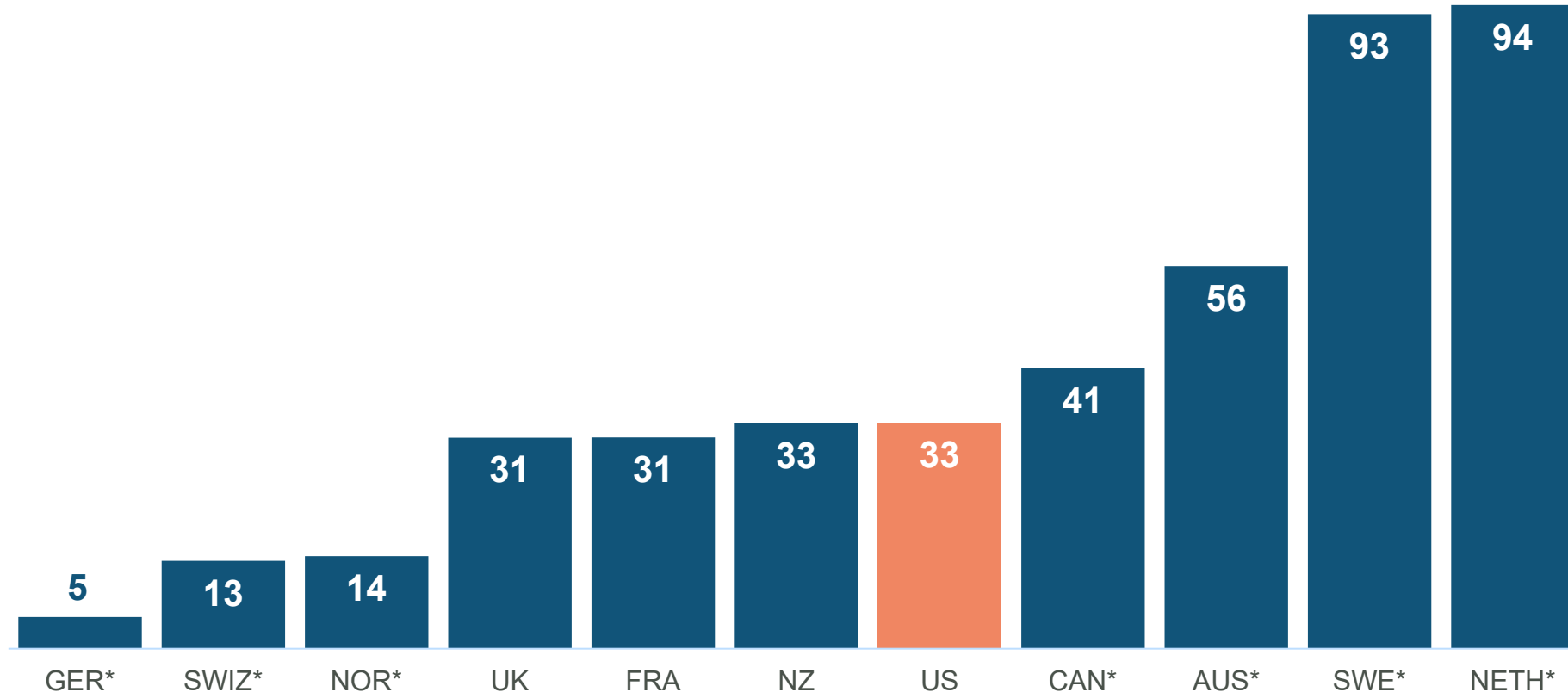
Bishop TF, Press MJ, Keyhani S, Pincus HA. JAMA Psychiatry. 2014;71(2):176-181.

Zhu J, Charlesworth CJ, Polsky D, McConnell KJ. Phantom networks: discrepancies between reported and realized mental health access in Medicaid. Health Aff (Millwood). 2022;41(7):1013-22.



One-third of U.S. primary care physicians have mental health providers in their practice, compared with nearly all in the Netherlands and Sweden.

Percentage of primary care providers who report that psychologists or other mental health workers work on their team in their main practice to provide care for their patients

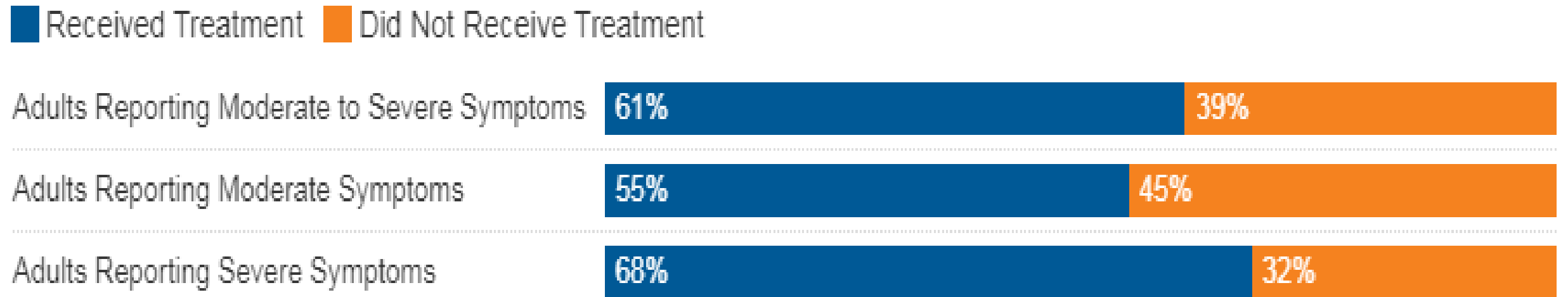


Note: * Statistically significant difference from US at $p < .05$ level.

Data: Commonwealth Fund 2019 International Health Policy Survey of Primary Care Physicians. Data for SWE not available.

Nearly One-third of Adults Reporting Severe Symptoms of Anxiety and/or Depression Were Not Receiving Treatment

Share of adults reporting symptoms of anxiety and/or depression, by severity of symptoms and receipt of treatment, 2019

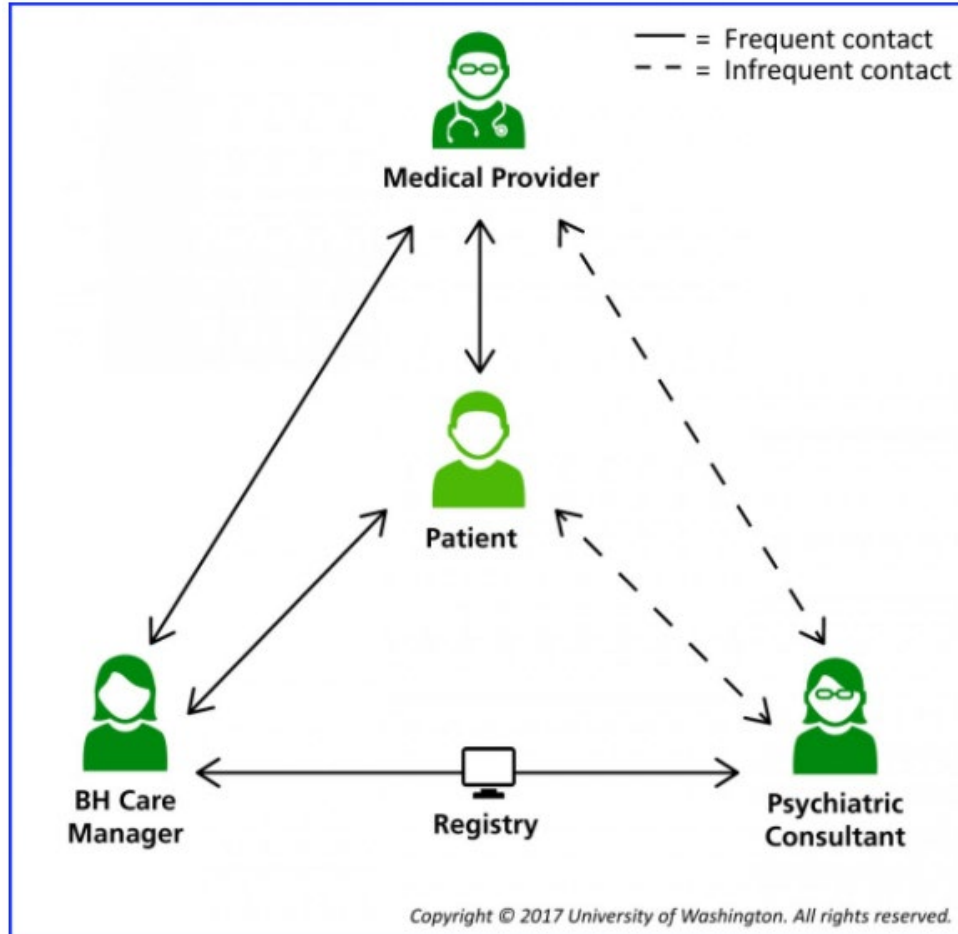


NOTE: Moderate symptoms refers of anxiety and/or depression to a score of 10 to 14 on the GAD-7 scale and/or PHQ-8 scale; severe symptoms refers to a score of 15 or higher. Mental health treatment refers to receiving counseling and/or taking prescription medication for mental health in the past year.

SOURCE: KFF analysis of National Health Interview Survey (NHIS), 2019 • [PNG](#)



The Collaborative Care Model (CoCM) is an evidence-based, systematic approach to integrating physical and mental health care



- ▶ Team-based
- ▶ Measurement-driven
- ▶ Proactive
- ▶ Population-level

80+ RCTs showing improved mental health outcomes in a variety of settings



Trusted evidence.
Informed decisions.
Better health.

Cochrane Database of Systematic Reviews

Main results

We included seventy-nine RCTs (including 90 relevant comparisons) involving 24,308 participants in the review. Studies varied in terms of risk of bias.

The results of primary analyses demonstrated significantly greater improvement in depression outcomes for adults with depression treated with the collaborative care model in the short-term (SMD -0.34, 95% CI -0.41 to -0.27; RR 1.32, 95% CI 1.22 to 1.43), medium-term (SMD -0.28, 95% CI -0.41 to -0.15; RR 1.31, 95% CI 1.17 to 1.48), and long-term (SMD -0.35, 95% CI -0.46 to -0.24; RR 1.29, 95% CI 1.18 to 1.41). However, these significant benefits were not demonstrated into the very long-term (RR 1.12, 95% CI 0.98 to 1.27).

The results also demonstrated significantly greater improvement in anxiety outcomes for adults with anxiety treated with the collaborative care model in the short-term (SMD -0.30, 95% CI -0.44 to -0.17; RR 1.50, 95% CI 1.21 to 1.87), medium-term (SMD -0.33, 95% CI -0.47 to -0.19; RR 1.41, 95% CI 1.18 to 1.69), and long-term (SMD -0.20, 95% CI -0.34 to -0.06; RR 1.26, 95% CI 1.11 to 1.42). No comparisons examined the effects of the intervention on anxiety outcomes in the very long-term.

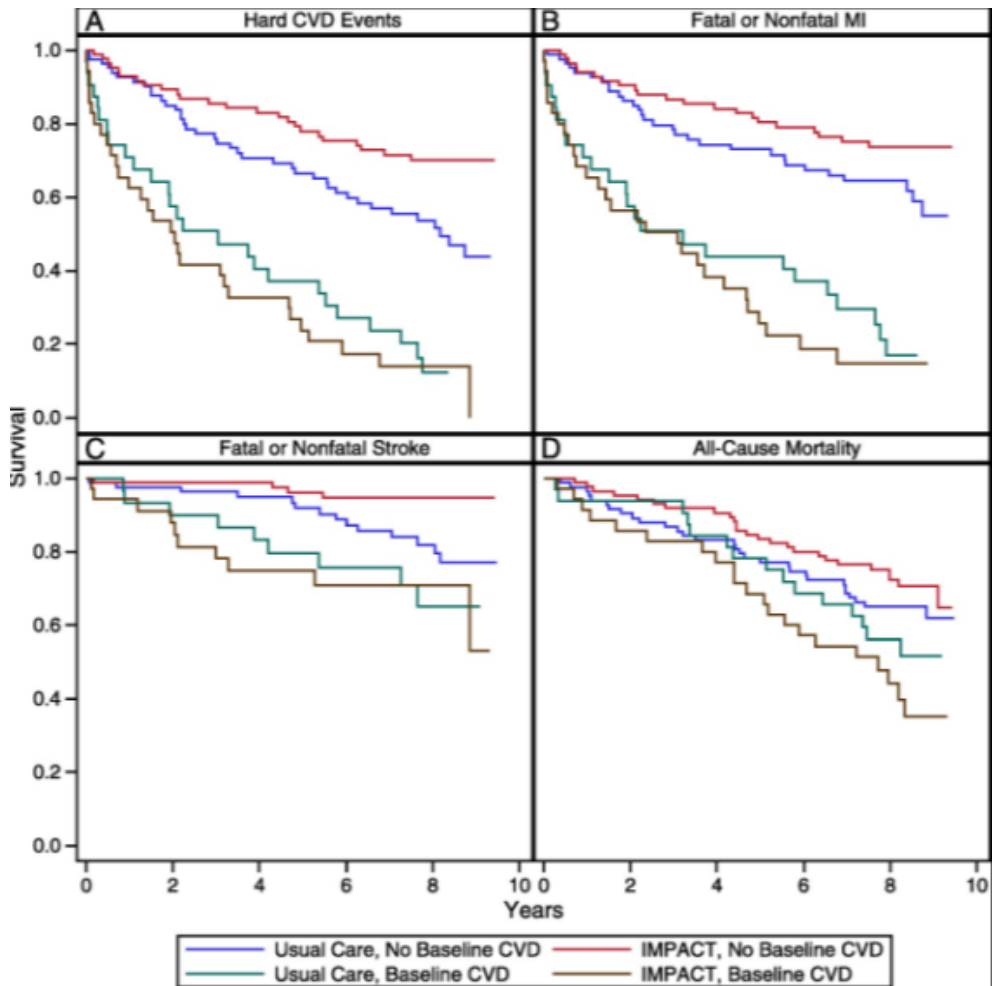
There was evidence of benefit in secondary outcomes including medication use, mental health quality of life, and patient satisfaction, although there was less evidence of benefit in physical quality of life.

Authors' conclusions

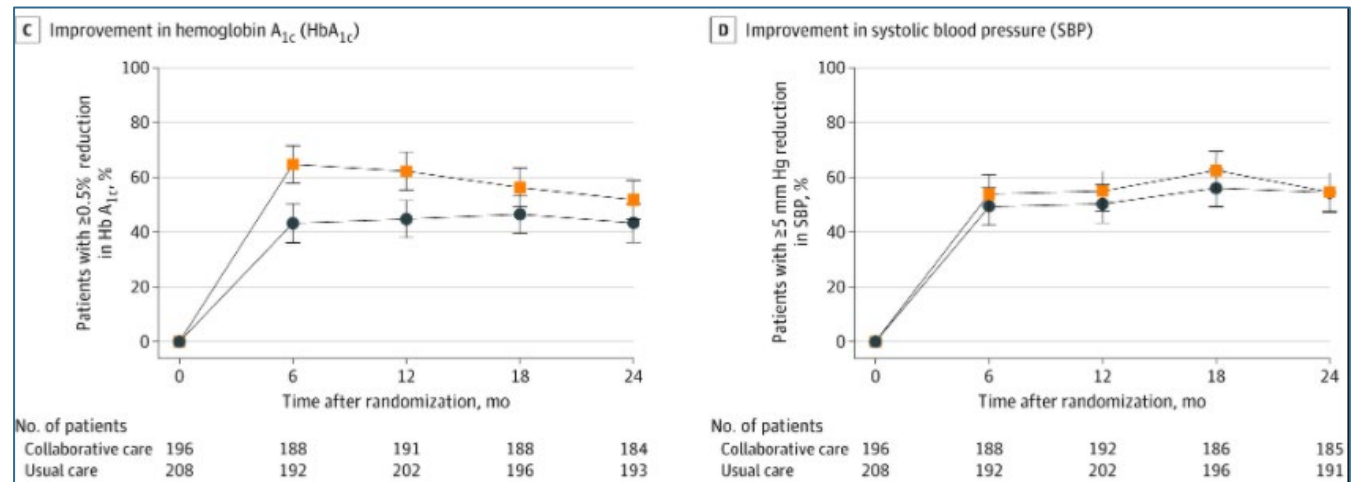
Collaborative care is associated with significant improvement in depression and anxiety outcomes compared with usual care, and represents a useful addition to clinical pathways for adult patients with depression and anxiety.

Cochrane Review. 2012

CoCM improves medical comorbidity outcomes



Psychosomatic Medicine 76(1):29-37, January 2014.



JAMA. 2020;324(7):651-662.

CoCM reduces utilization and total medical spending

Service Utilization ^d	No. TBC Events (Incidence Per 100 Person-Years)	No. TPM Events (Incidence Per 100 Person-Years)	IRR (95% CI)	
Hospital admissions	15 427 (9.45)	17 334 (10.62)	0.89 (0.85 to 0.94)	<.001
Emergency department visits	29 555 (18.11)	38 383 (23.52)	0.77 (0.74 to 0.80)	<.001
Ambulatory sensitive visits	5350 (3.28)	6948 (4.26)	0.77 (0.70 to 0.85)	<.001
PCP visits	380 036 (232.83)	408 641 (250.35)	0.93 (0.92 to 0.94)	<.001
Specialty visits	348 507 (213.51)	355 619 (217.87)	0.98 (0.97 to 0.99)	.02 (NS)
Urgent care visits	90 852 (55.66)	91 770 (56.22)	0.99 (0.97 to 1.02)	.74 (NS)

JAMA. 2016;316(8):826–834.

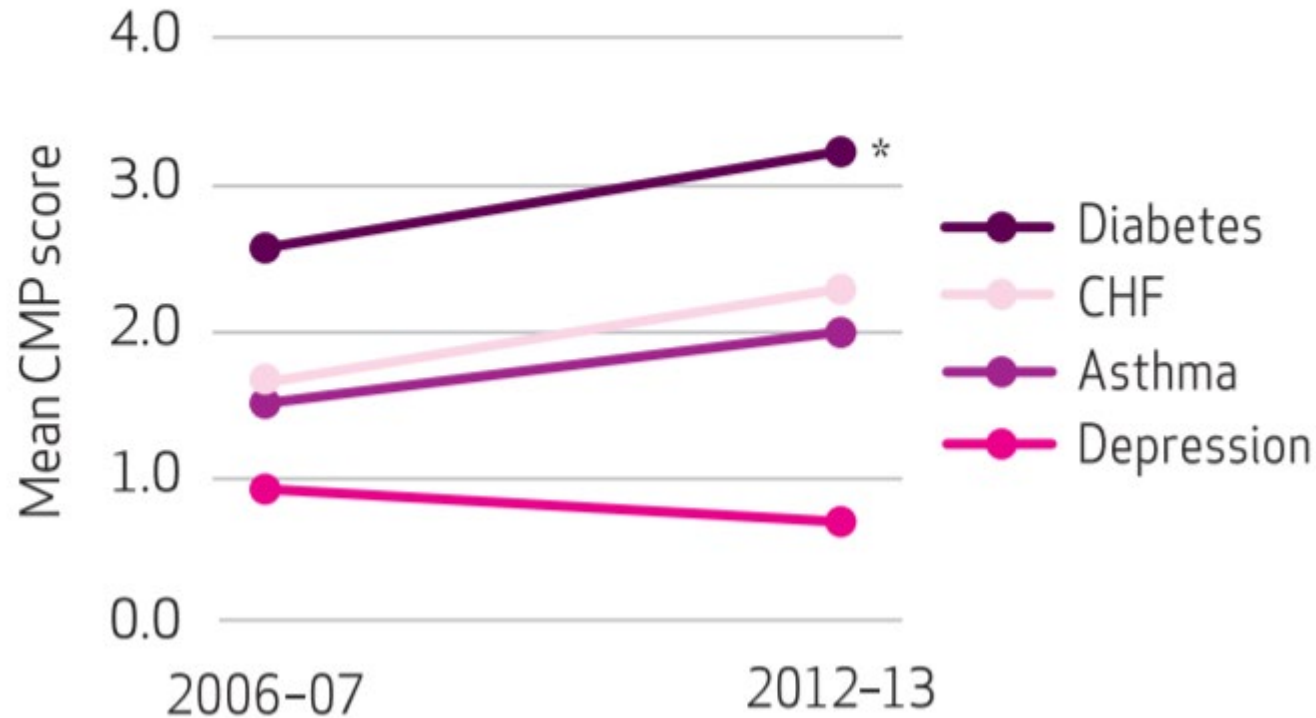
Cost Category	Cost, \$			
	Overall Mean	Randomized Group		Difference
		Intervention	Usual Care	
Outpatient				
IMPACT intervention	—	522 (495 to 550)	0 (0 to 0)	522 (495 to 550)
Mental health	661	558 (362 to 753)	767 (561 to 974)	–209 (–494 to 75)
Pharmacy	7284	6942 (6062 to 7822)	7636 (6287 to 8984)	–694 (–2304 to 916)
Other	14 306	14 160 (12 899 to 15 421)	14 456 (12 909 to 16 002)	–296 (–2291 to 1700)
Total[†]	22 516	22 182 (20 368 to 23 996)	22 859 (20 470 to 25 247)	–677 (–3676 to 2323)
Inpatient				
Medical	8452	7179 (5450 to 8908)	9757 (6455 to 13 059)	–2578 (–6305 to 1149)
Mental health and substance abuse	114	61 (–8 to 129)	169 (–2 to 340)	–108 (–292 to 76)
Total Healthcare During 4 y				
Overall Total	31 082	29 422 (26 479 to 32 365)	32 785 (27 648 to 37 921)	–3363 (–9282 to 2557)

► \$6 returned on a \$1 investment

AJMC. 2008; VOL. 14, NO. 2

Despite its benefits, uptake of CoCM has remained limited

Changes in the use of care management processes for four conditions in large primary care practices



“It may be that US primary care practices are unaware of these approaches, **lack the resources and incentives to implement them**, or feel better prepared to address the needs of patients with chronic medical illnesses than the needs of those with chronic behavioral illnesses.” (emphasis mine)

Bishop TF, Ramsay PP, Casalino LP, Bao Y, Pincus HA, Shortell SM. Health Aff (Millwood). 2016;35(3):394-400.

Medicare created new codes to reimburse CoCM in 2017



The NEW ENGLAND JOURNAL of MEDICINE

*Widespread implementation of CoCM
and other effective BHI services could
substantially improve outcomes for millions
of Medicare beneficiaries and produce
savings for the Medicare program.*

Perspective
FEBRUARY 2, 2017

Medicare Payment for Behavioral Health Integration

Matthew J. Press, M.D., Ryan Howe, Ph.D., Michael Schoenbaum, Ph.D., Sean Cavanaugh, M.P.H.,
Ann Marshall, M.S.P.H., Lindsey Baldwin, M.S., and Patrick H. Conway, M.D.

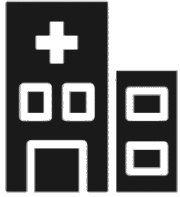
The codes are fee-for-service, time-based, provider reimbursement

CPT Code	Clinical Staff Threshold Time
CoCM First Month (99492)	70 minutes per calendar month
CoCM Subsequent Months (99493)	60 minutes per calendar month
CoCM Any Month (G2214)	30 minutes per calendar month
Add-On CoCM Any Month (99494)	Each additional 30 minutes per calendar month

SERVICE COMPONENTS

- Initial assessment by the primary care team
- Care planning by the primary care team, jointly with the patient, with care plan revision for patients whose condition is not improving adequately. Treatment may include pharmacotherapy, psychotherapy, and/or other indicated treatments
- Behavioral health care manager performs proactive, systematic follow-up using validated rating scales and a registry
- Regular case load review with psychiatric consultant – The primary care team regularly (at least weekly) reviews the beneficiary's treatment plan and status with the psychiatric consultant and maintains or adjusts treatment, including referral to behavioral health specialty care as needed

Primary Care at Penn Medicine



~100
Primary Care
Practices



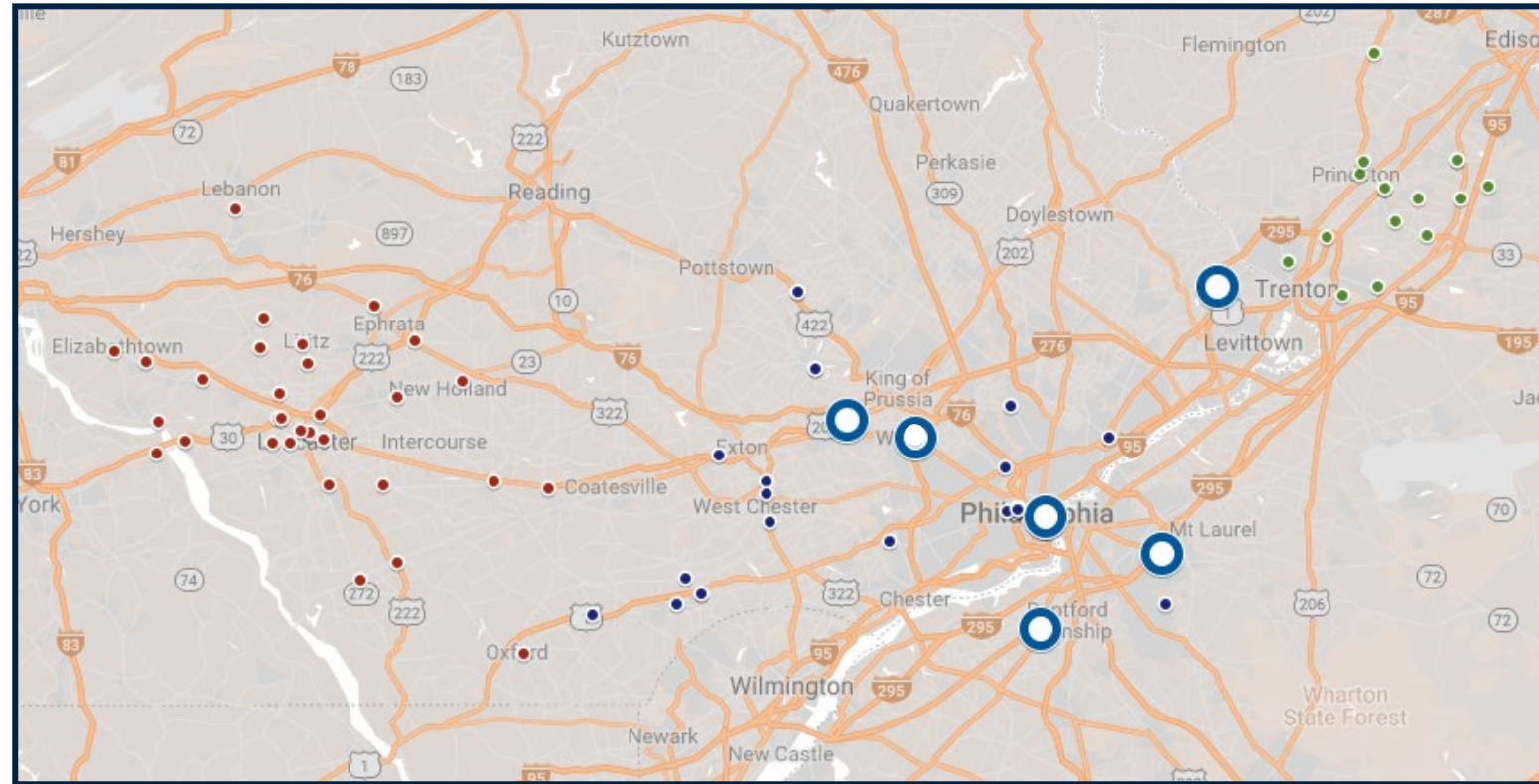
~500 Physician/APP
FTEs



~600,000 Active
Patients



+1M Patient
Visits



CPUP DGIM
CPUP Family Medicine
CPUP Geriatrics
Regional Physicians Primary Care
LGHP Primary Care

**Penn
Medicine
Primary
Care**

CCA ●
CPUP ●
LGHP ●
Princeton ●
Practice of the Future ●

The Science of Advanced Primary Care:

Best Practices for a New Care Delivery Model

Traditional Primary Care

Car breaks down

Local mechanic fixes the problem

See mechanic again when your next problem arises



Reactionary, fixing issues as they arise.

Advanced Primary Care

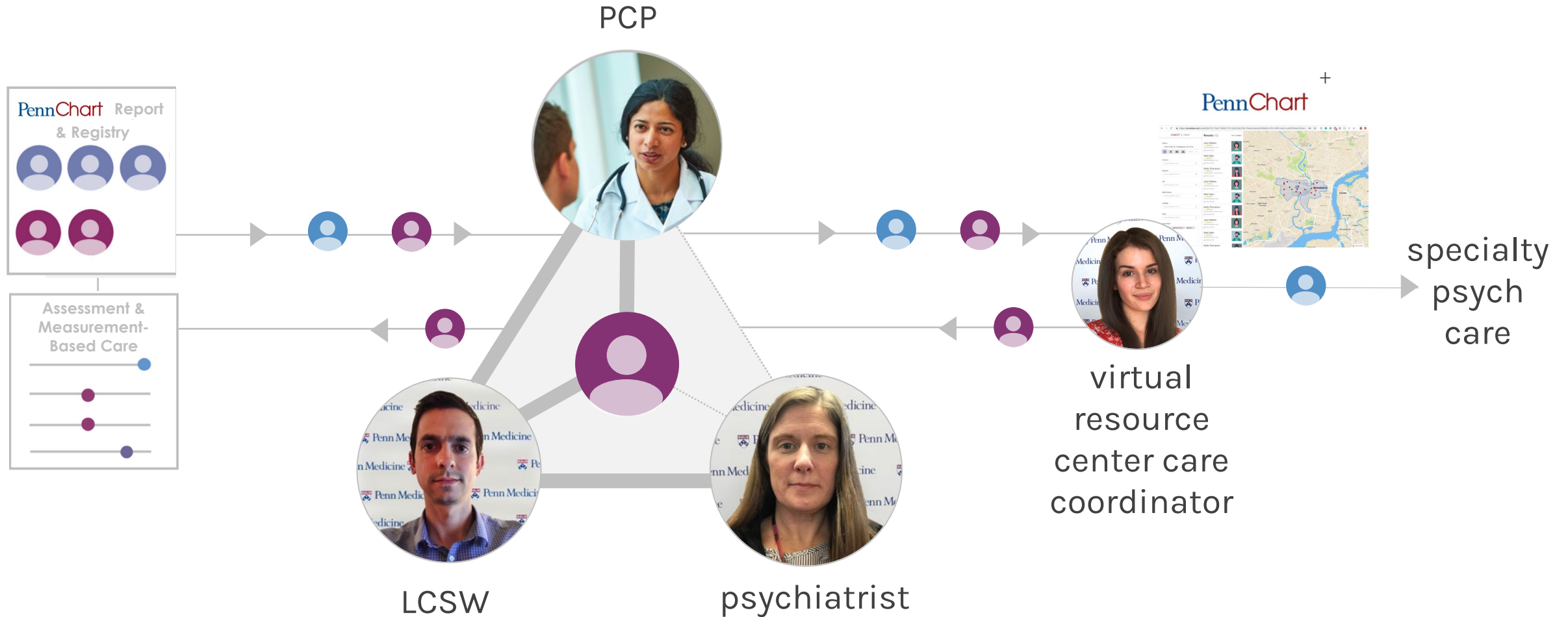
Car develops problem

Pit crew fixes it

Crew proactively monitors and optimizes performance

Team-based, proactive, leveraging the expertise and resources of a high-performing system

Penn Integrated Care (PIC) is a CoCM program with the addition of centralized assessment and triage



Patients are triaged based on a detailed assessment

PIC IN PRIMARY CARE

MHCM embedded in the practice, in consultation with a psychiatrist and supervised by the PCP, provides brief, evidence-based interventions.



SUBSTANCE USE DISORDER CARE

Providers and resources that focus on substance use treatment, including acute care and intensive outpatient programs.



SPECIALTY MENTAL HEALTH CARE

Psychiatrist, psychologist, and/or other licensed mental health clinician provides longer term interventions for severe mental health conditions.



SELF-DIRECTED CARE

Resource Center follows patient for two months and refers to a higher level of care if patient's symptoms worsen. Self-directed resources provided.

PIC provides several services to patients...efficiently



MENTAL HEALTH CARE MANAGER

Carry 80 patients at a time for 2-6 months, and use a population health, registry-based approach.



BRIEF INTERVENTIONS

Behavioral activation, motivational

VIEWPOINT

COVID-19: BEYOND TOMORROW

Harnessing Collaborative Care to Meet Mental Health Demands in the Era of COVID-19

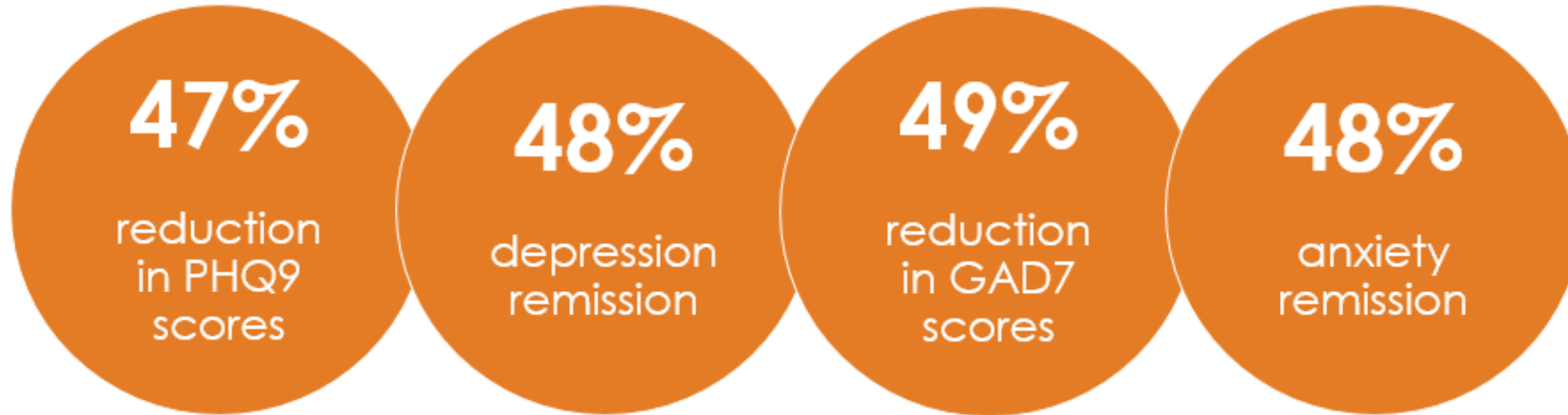
Carlo AD, Barnett BS, Unützer J. Harnessing Collaborative Care to Meet Mental Health Demands in the Era of COVID-19. JAMA Psychiatry. Published online October 21, 2020.



CONSULTATION AND COLLABORATION

MHCMs collaborate with PCPs on a daily basis and have weekly meetings with consulting psychiatrists to review their panel and cases.

Over 30,000 patients treated in 6 years across 35+ practices



**“This is the single most impactful program I’ve seen in my 25 years at Penn”
-Penn PCP**

No increase in total medical spending

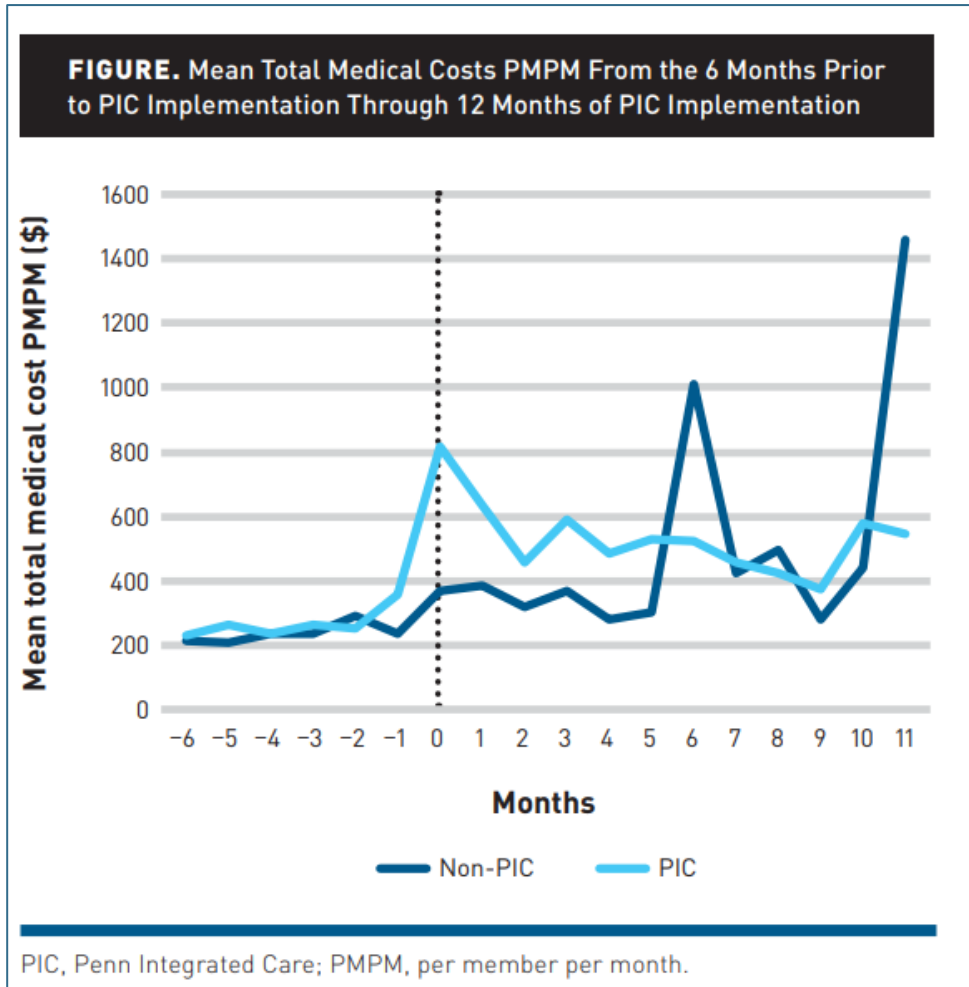


TABLE 2. Differences in Cost by Category^a

Outcome	Difference
Total medical cost	
Overall	-\$29.35
Behavioral health	\$19.91
Non-behavioral health	-\$72.46
PIC cost	\$34.11
Inpatient cost	-\$91.34
Emergency department	
Overall	\$7.44
Behavioral health	-\$0.36
Non-behavioral health	\$8.04
Urgent care center	\$0.46
Retail clinic	\$0.20
Primary care	
Overall	\$40.29
Behavioral health	\$0.00
Non-behavioral health	\$11.50
PIC cost	\$34.11

PIC, Penn Integrated Care.

^aSignificant ($P \leq .05$) differences are bolded.

Wolk CB, Wilkinson E, Livesey C, Oslin DW, Connolly KR, Smith-McLallen A, Press MJ. Impact of the collaborative care model on medical spending. Am J Manag Care. 2023 Oct;29(10):499-502. doi: 10.37765/ajmc.2023.89438. PMID: 37870543.

Barriers to use of CoCM billing codes remain

- ▶ Internal and external contextual factors
 - Buy-in from key stakeholders (leadership, finance, IT, primary care, psychiatry)
 - Selection of the CoCM care team
 - Payer mix and CoCM reimbursement
- ▶ CoCM components
 - Patient consent
 - Time accrual mechanisms
 - EHR registry integration or interoperability
 - Billing revenue/workflow
- ▶ Financial sustainability

Carlo AD, Corage Baden A, McCarty RL, Ratzliff ADH. Early Health System Experiences with Collaborative Care (CoCM) Billing Codes: a Qualitative Study of Leadership and Support Staff. *J Gen Intern Med.* 2019 Oct;34(10):2150-2158.



Pathway to Collaborative Care Management (CoCM) at UNC Health

Nate Sowa, MD, PhD

Assistant Professor

Associate Vice Chair of Virtual and Integrated Care

UNC Department of Psychiatry

UNC Health: Delivering high quality care from the mountains to the coast



Licensed Beds

4,453



Medical Staff

4,925



Employed MDs

2,875



ED Visits

507,367



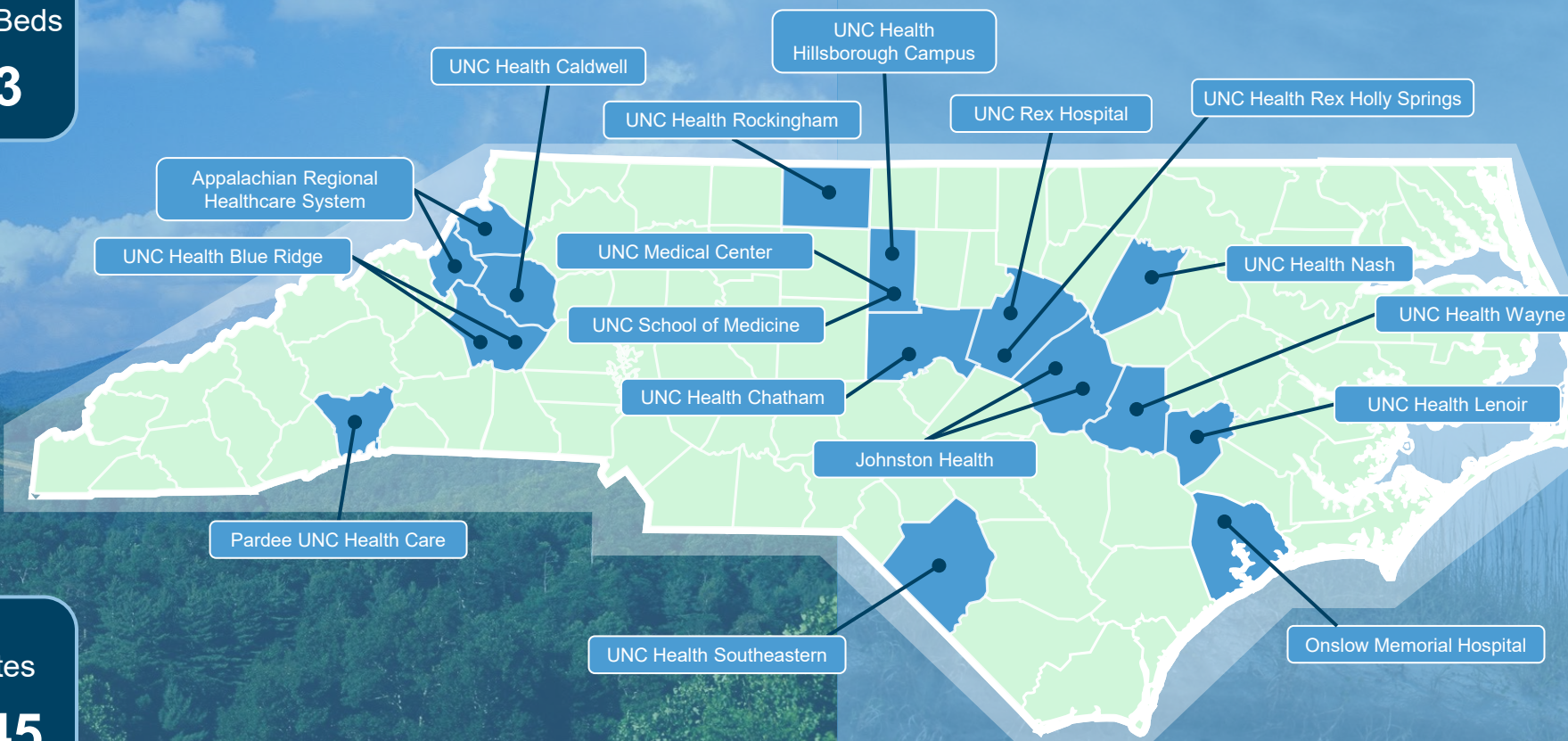
Teammates

43,045

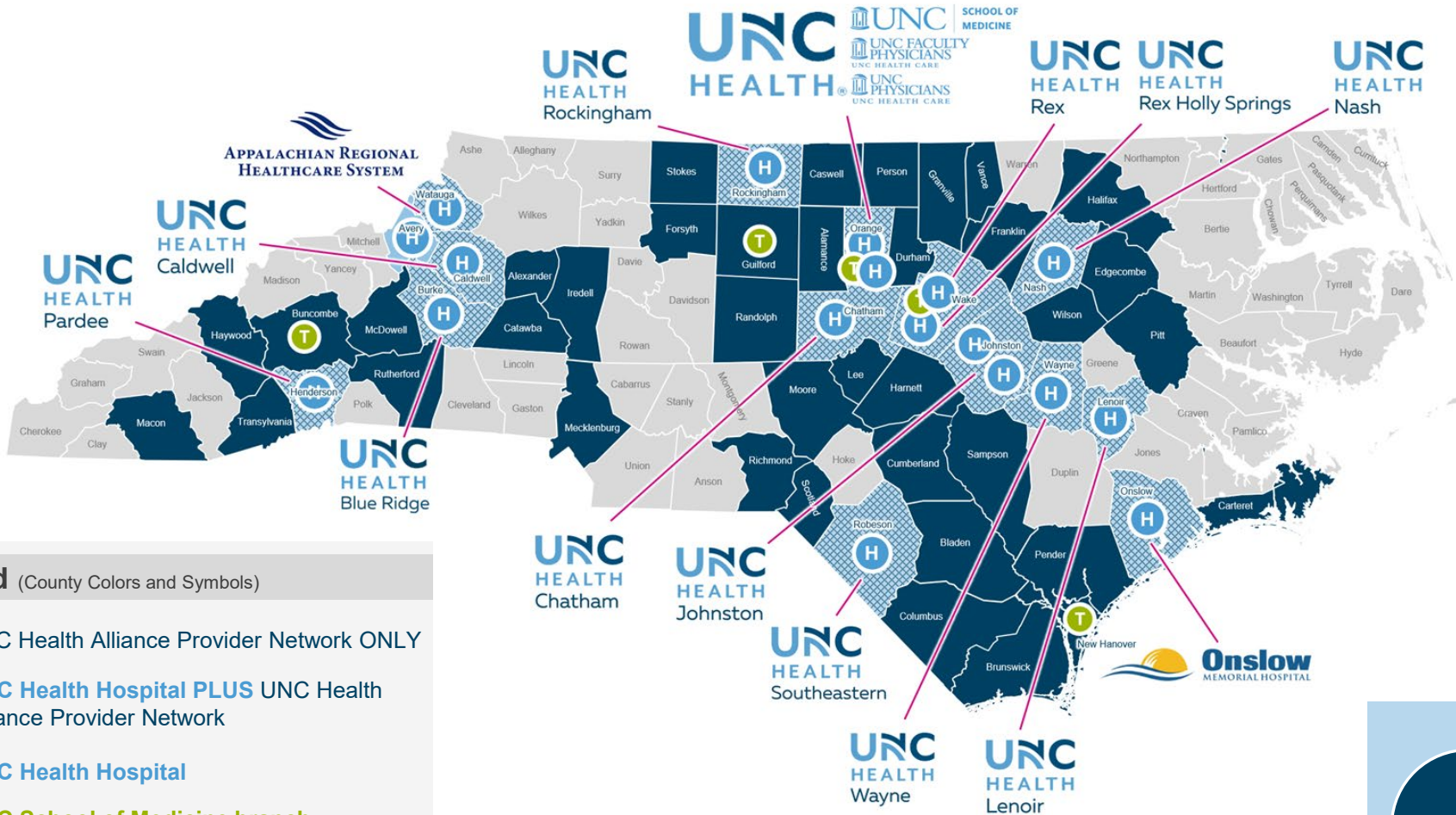


Net Revenue

\$6.86 B

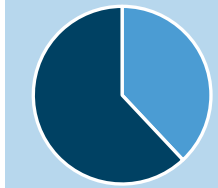


UNC Health Alliance's state-wide network strengthens our health system with independent practices



UNC Health Alliance Provider Network

1,120 Locations	52 Counties	13 Hospitals
8,260 Providers	with	2,860 Independent Providers
1,824 Primary Care Providers	and	6,436 Specialty Providers
174 Specialties & Subspecialties Covered	SNF preferred network; home health preferred network	



Community-based palliative care and hospice programs

- 35% Independent Providers
- 65% UNC Health Employed Providers

As of October 2023

Legend (County Colors and Symbols)

- UNC Health Alliance Provider Network ONLY
- UNC Health Hospital PLUS UNC Health Alliance Provider Network
- UNC Health Hospital
- UNC School of Medicine branch campuses and teaching sites

Collaborative Care Management (CoCM) at UNC

- Initially launched on small scale within UNC Family Medicine Chapel Hill in fall/winter 2018

Challenges

- Limited payer reimbursement
 - Limited tools in Epic to facilitate workflow
-
- Spring/Fall 2019 – Launch pilot of CoCM within specialty care practice (Inflammatory Bowel Disease)
 - Support from UNC Practice Quality & Innovation (in-kind)
 - ✓ Developed Epic reporting to use as patient registry
 - ✓ Created CoCM enrollment process
 - ✓ Created mechanism to calculate minutes for time-based billing

Example Patient Registry (Psychiatrist View)

My Department's Patients Enrolled in BHCMP/CoCM with Psychiatric Case Review [95667485] as of 8/29/2023 2:27 PM

Re-run Report Refresh Selected Select All

Sex	Age	Last CoCM Psych Case Review	Last BHCMP Outreach Date	BHCMP Enroll PHQ-9 Date	BHCMP Enroll PHQ-9 Score	Last PHQ-9 Score	Last PHQ9 Date	PHQ-9 Change	BHCMP Enroll GAD-7 Date	BHCMP Enroll GAD-7 Score	Last GAD-7 Score	Last GAD-7 Date	GAD-7 Change	Antidepressant Meds	Primary Plan	Secor
Female	22 y.o.	08/21/2023	08/24/2023	11/21/2022	19	4	06/28/2023	-2	11/21/2022	14	5	06/28/2023	-1	FLUoxetine (PROZAC) 20 MG capsule [1914203974]. buPROPion (WELLBUTRIN SR) 100 MG 12 hr tablet [1856711656]. traZODone (DESYREL) 50 MG tablet [1914203973]	60004-BCBS BLUE OPTIONS/PP... (NC ONLY)	
Female	39 y.o.	08/21/2023	08/24/2023	11/01/2022	15	12	07/13/2023	2	11/01/2022	7	8	07/13/2023	2	buPROPion (WELLBUTRIN XL) 300 MG 24 hr tablet [1879265437]. citalopram (CELEXA) 40 MG tablet [1789956930]	62001-STATE HEALTH PLAN	6210 SHP SECC EMPL HRA
Female	55 y.o.	06/19/2023	08/28/2023	01/05/2023	19	13	07/19/2023	-1	01/05/2023	11	5	07/19/2023	0	DULoxetine (CYMBALTA) 60 MG capsule [1842426231]. buPROPion (WELLBUTRIN SR) 150 MG 12 hr tablet [1866421930]. traZODone (DESYREL) 50 MG tablet [1866421909]	20002-MEDICARE PART A AND PART B	3000 MEDI

Selected rows: 1 42 results

Example Patient Registry (Care Manager View)

My Department's Patients Enrolled in Behavioral Health Care Management Program (BHCMP/CoCM) [95667748] as of Tue 8/29/2023 3:36 PM

Re-run Report Refresh Selected Select All

Sex	Age	BHCMP Time Spent This Month	20 Min BHCMP Time Remaining This Month	36 min BHCMP Time Remaining this month	BHCMP Time Spent Last Month	Last BHI/CoCM Date Billed	Last CoCM Psych Case Review	Last BHCMP Outreach Date	Next BHCMP Outreach Date	Recent BHCMP Outreach Outcome	Last PHQ-9 Score	Last PHQ9 Date	%PHQ-9 DECREASE	PHQ-9 Change	Last P4 Suicide Risk Screen
Female	22 y.o.	35	0	1	41	07/31/2023	08/21/2023	08/24/2023		Patient Portal Message	4	06/28/2023	76	-2	
Female	39 y.o.	35	0	1	115	07/31/2023	08/21/2023	08/24/2023		Patient Portal Message	12	07/13/2023	20	2	
Female	55 y.o.	40	0	0	110	07/31/2023	06/19/2023	08/28/2023		General	13	07/19/2023	-30	-1	
Female	70 y.o.	60	0	0	80	07/31/2023	04/10/2023	08/02/2023		General	0	08/14/2023		-3	
Male	55 y.o.	125	0	0	120	07/31/2023		08/28/2023		General	7	08/22/2023	56	-5	06/28/2023
Male	72 y.o.	174	0	0			08/14/2023	08/22/2023		Telephone: Completed	15	08/22/2023	-36	0	08/22/2023
Female	72 y.o.	125	0	0	41	07/31/2023	08/21/2023	08/29/2023		Telephone: Completed	8	08/17/2023	33	-2	
Female	23 y.o.	25	0	11	77	07/31/2023	07/17/2023	08/21/2023		General	13	08/18/2023	32	1	04/14/2023

Selected rows: 1 42 results

CoCM Expansion

- 2021 – UNC Health system-level funded CoCM launch (\$92k)
 - Combined support with gift from the Anonymous Trust (\$120k annually for 2 years)
 - Operationalized through UNC Health Alliance (UNCHA) Population Management
 - Partnership with UNC Faculty Physicians, UNC School of Medicine (Dept of Psych), UNC Physicians Network
- 2022 - UNC HA implementation
 - Professional expenses (\$50k pre-implementation and \$440k year 1)
 - Project Management, analytics, clinical leadership, care managers, Psychiatrist
 - Created training materials
 - Recruited practices
 - Modified existing Epic tools as needed
 - Worked with analytics to develop data dashboard
 - Care launched January/February

Leading the Way: CoCM Milestones in CY 2022

Q1

- January – Reviewed billing and reimbursement **training**
- February – **Implement** in 7 initial clinics in 3 counties
- February – Met with **BCBSNC** to create **attestation** for future CoCM service reimbursement
- March – **Celebrate** each initial clinic referring at least one patient

Q2

- April through June – PDSAs to **optimize** workflows
- May – **BCBSNC began accepting CoCM billing**

Q3

- July – CoCM **coverage by all payers**
- August 25th – Services **expand** to another primary care clinic
- September – First **break even** month

Q4

- October – **Monitor** rebounding outcome metrics
- October 7th – Services **expand** to additional practice
- October – Consolidate Epic templates to **improve operational efficiency** and eliminate waste
- November 11 – Expand to **Geriatrics sub-specialty clinic**
- December– Dashboard is **live**

Leading the Way: CoCM Milestones in CY 2023

Q1

- January – **Analysis** reimbursement trends
- February – CoCM caseload at capacity and on **waitlist**
- March – **Celebrate** 1 year anniversary
- March – Worked with BCBSNC to **review denials**

Q2

- May – Reached out to payors to look into billing denials
- June – Submitted SBAR for using psychotherapy CPT codes

Q3

- Potential expansion of CoCM in the East region
- Implement use of psychotherapy CPT codes

Q4

- **NC DHHS to reimburse CoCM services at 120% of Medicare as of 12/1**
- **Better than break-even by \$4k FY23**

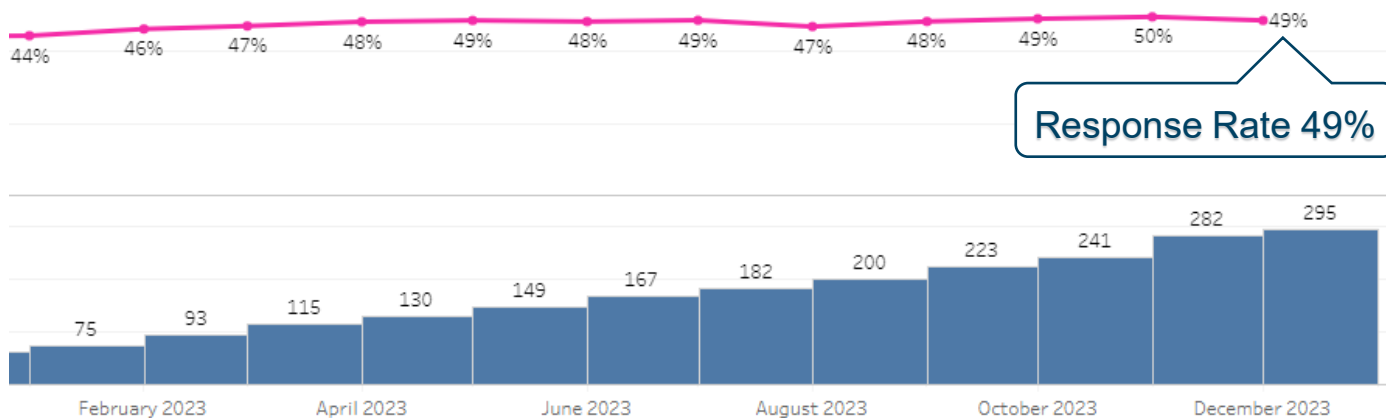
CoCM Enrollment



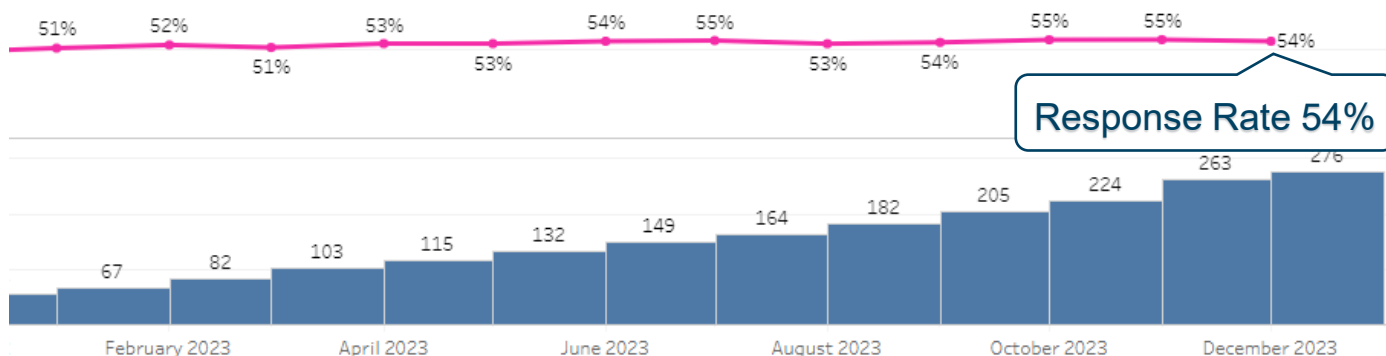
UNC Health Experience (1 of 2)

Improved Clinical Outcomes with CoCM

Depression



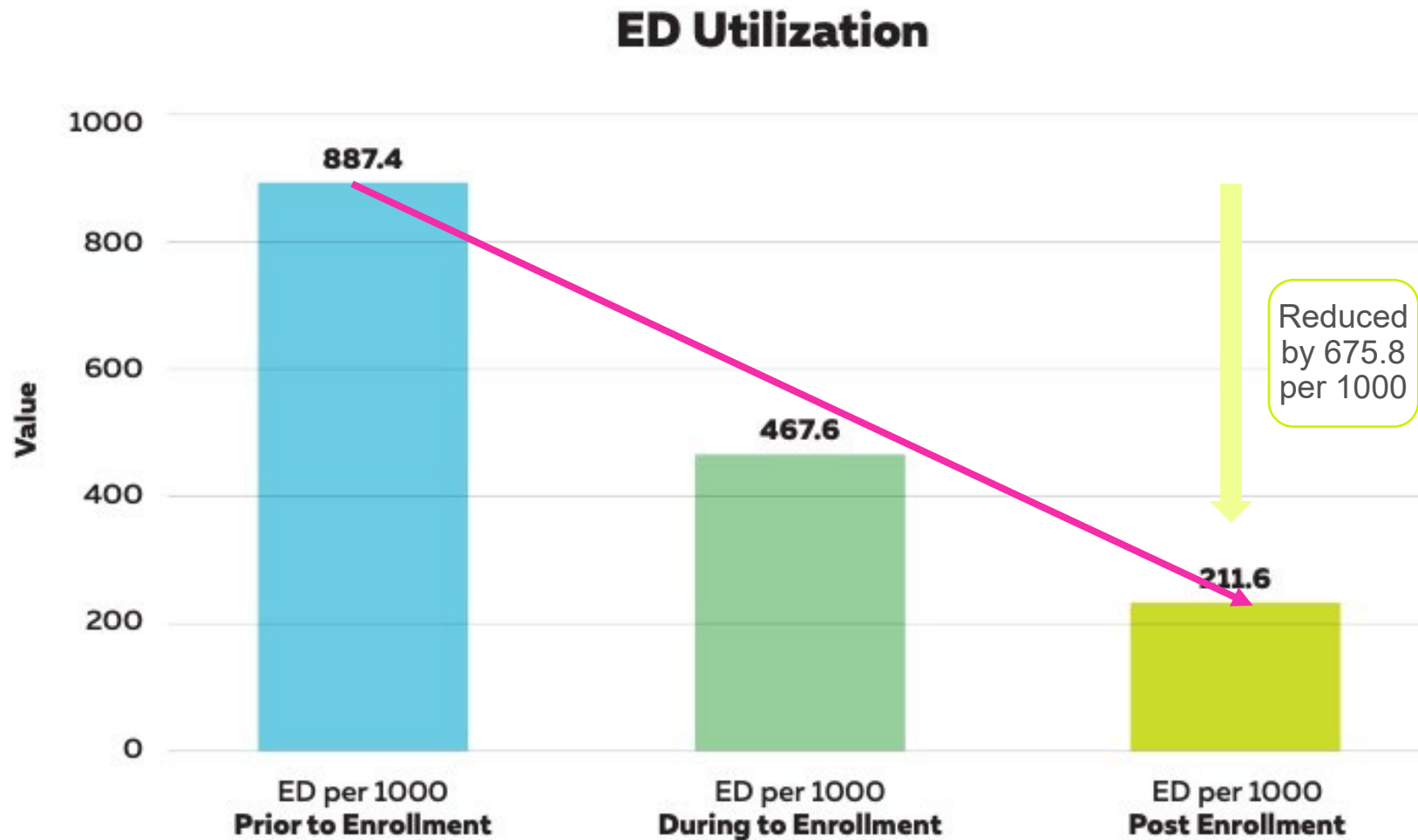
Anxiety



Response is defined as \Rightarrow 50% reduction in either PHQ-9 or GAD-7 from enrollment date

UNC Health Experience (2 of 2)

Decreased Emergency Department Utilization with CoCM



UNC Facilitators of CoCM?

Cultural

Leadership

PCPs

Financial

Implementation \$\$

Support from
payors

Structural

CIN

Dashboard &
Registry support

Virtual care

UNC Barriers to CoCM?

Cultural

**PCP
engagement**

**Referral
mentality**

Financial

Billing infrastructure

Expansion

Sustainability

Structural

Workforce

Virtual model

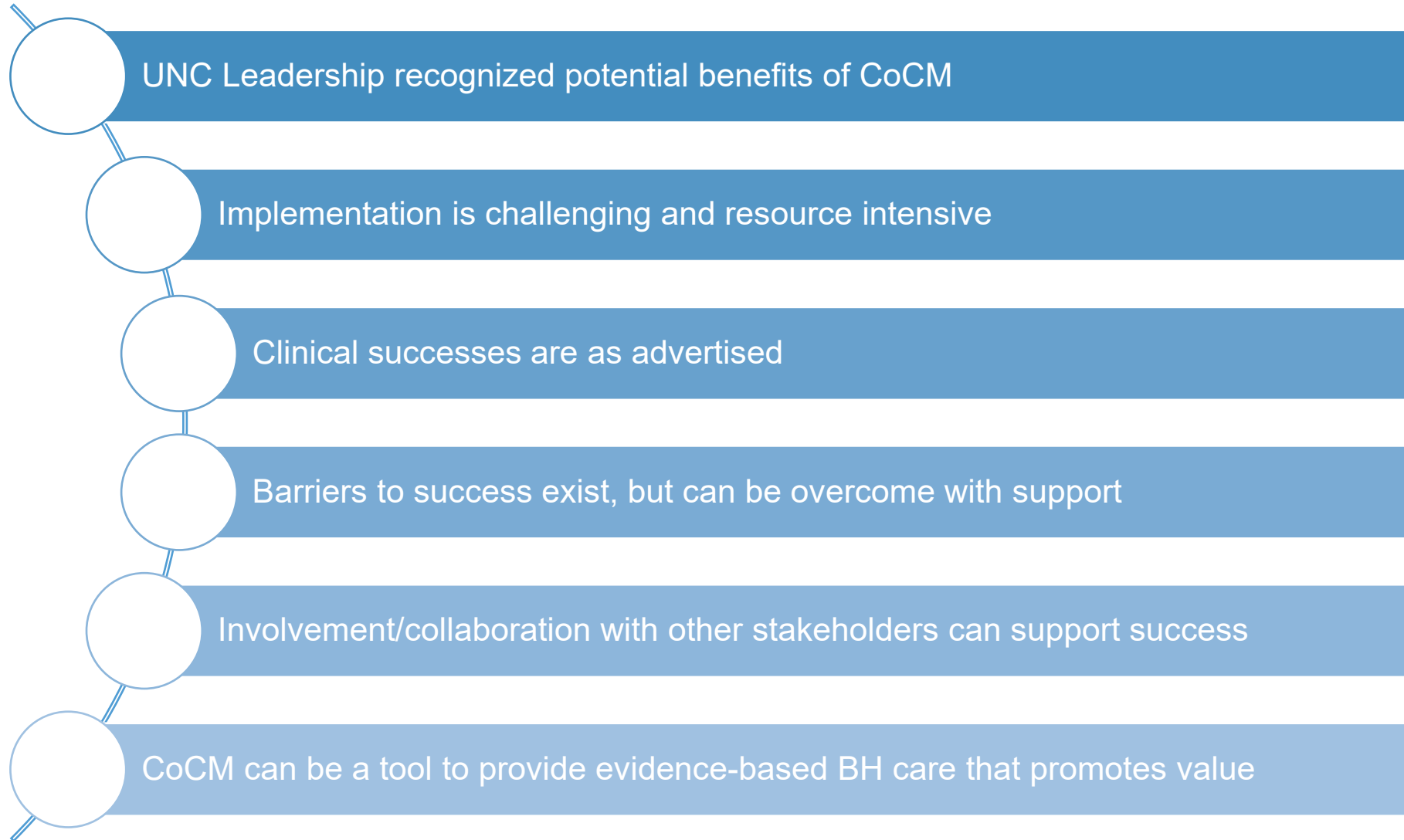
CoCM within North Carolina

- Jan 2022 – NC Medicaid launched CoCM Consortium
- Over 18 months, created a roadmap to promote CoCM adoption and implementation
- Facilitated by several workgroups
 - Clinical Advisory Workgroup – best practices for implementation
 - Logistic Workgroup – registry development and contracts
 - Alignment Workgroup – align payors
 - Communications and Training Workgroup – [practice support and training resource materials](#)

CoCM Roadmap

Steps	Strategies	Actions
<p>Step 1: Aligning Reimbursement Across Payors</p> <p>Goal: Align coverage, requirements and payment across payors to validate that CoCM is an endorsed model worth adopting and reduce administrative burden for providers.</p>	<p>Ensure Coverage of the Same CoCM Codes</p>	<ul style="list-style-type: none"> • NC Medicaid added coverage of additional CoCM codes to align with Medicare coverage. • The Consortium confirmed and promoted widespread commercial adoption of CoCM codes.
	<p>Align Requirements to Bill</p>	<ul style="list-style-type: none"> • NC Medicaid and other insurers aligned with Medicare requirements on who can serve as the behavioral health care manager.
	<p>Make Reimbursement Sustainable</p>	<ul style="list-style-type: none"> • NC Medicaid increased reimbursement for CoCM codes from 70% to 120% of Medicare.
	<p>Remove Beneficiary Copays</p>	<ul style="list-style-type: none"> • NC Medicaid and other insurers removed beneficiary copays for CoCM services.
	<p>Step 2: Promoting Streamlined Operations for Adoption and Ensuring Fidelity</p> <p>Goal: Encourage uptake by providing primary care practices with practice resources to make adopting CoCM as easy as possible and ensure that CoCM is implemented with fidelity.</p>	<p>Provide and Fund 1:1 Training for Providers</p>
<ul style="list-style-type: none"> • Consortium members created learning opportunities for their members (e.g., working sessions at annual meetings, peer-to-peer “solutions” sessions for practice managers). 		
<p>Establish Psychiatry Connections</p>		<ul style="list-style-type: none"> • The Consortium identified 20+ psychiatrists willing to act as psychiatric consultants. • The Consortium developed a model contract for psychiatrists and primary care providers to use.
<p>Customize and Fund a Statewide Registry</p>		<ul style="list-style-type: none"> • The Consortium developed a customized registry with a set of assessments for adults, children and adolescents. • NC Medicaid contracted with a Consortium member to provide Medicaid enrolled providers with free access to the customized state registry (\$4K-\$7.4K per practice per year) for up to three 3 years.

Summary



Collaborative Care Model: *Blue Cross Blue Shield NC*

Blue Cross and Blue Shield of North Carolina



- About 5.8M members covered
- 44-62% market share in North Carolina
- Blue Premier Value based program
 - \$438 million in shared savings by improving quality and reducing costs in the program's first four years, including over \$117 million in 2022.

Blue Premier Value Based Program



- Blue Premier debuted in 2019 as a program that shifted cost and quality accountability to risk-bearing entities such as Accountable Care Organizations (ACOs), which consisted of health-system based and independent provider aggregators.
- Blue Premier was created to reimburse providers for overall health outcomes versus rewarding providers strictly on volume of services.
- Providers and ACOs are paid shared savings and other reimbursements based on their performance against total cost of care and quality targets and benchmarks.
- Blue Premier now includes all major NC health systems and more than 800+ independent practices.

Blue Premier has yielded some of the best participation statistics and outcomes in the industry



100%
Of Largest NC Health Systems in Blue Premier in '22:

UNC, Duke, Novant, Atrium, WKCC, WFBH, Cone, CaroMont, Vidant, Mission



68%
Eligible Medical Expense aligned with BP Contracts in '22



56%
Of Independent Primary Care Practices.

6 ACO Aggregators: Aledade, Ajilon, Evolent, CCPN, Caravan & CHES

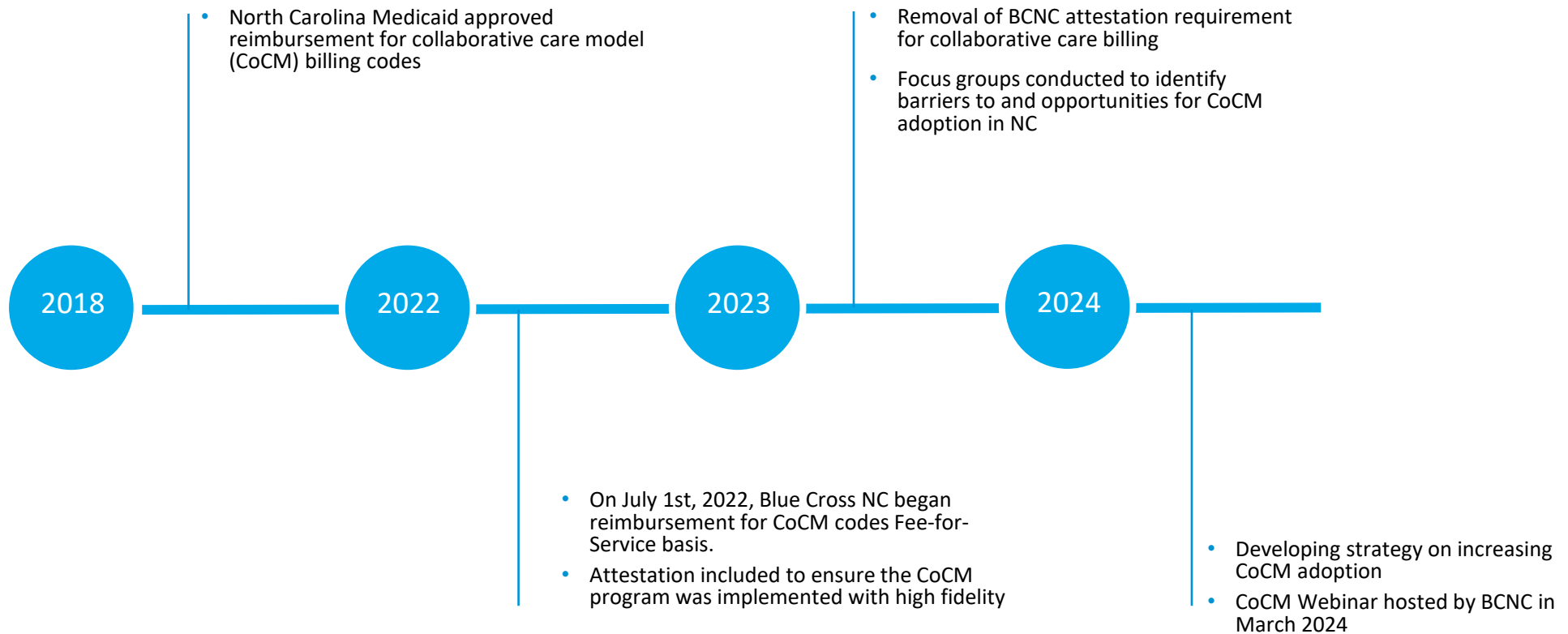


55%
Eligible Membership accessing BP Providers in '22



1.4M
Number of Eligible Members aligned with BP Providers

Blue Cross NC CoCM Evolution



Business Case for Collaborative Care



Revenue	+	Savings*	-	Costs	=	Return
Quality Risk coding		Number of eligible members Savings rate per episode		Number of eligible members % Penetration Number of sessions per treated member Average reimbursement per session		

Analysis showed a 1-2 year investment until collaborative care would yield a positive return on investment

*Savings rate ramps up over time to account for lag between the intervention and reduction in physical and behavioral health utilization

Collaborative Care Findings



Overview: During 2023, the BCNC BH team engaged a variety of providers in interviews around the Collaborative Care Model

Topic	Barriers	Solutions
Billing	Existing administrative burden and centralized billing knowledge	Comprehensive understanding of CoCM billing requirements prior to program launch
Staffing	Low provider availability; BH Case Managers	Utilize flexible solutions such as telehealth, practice sharing, local implementation, and operation support organizations
Cost	Difficult to expand and maintain because of current operational cost	Reduction in patient leakage to external BH resources, long-term benefits in patient health and retention
Training & Perception	Administrative burden, patient engagement, third-party vendor engagement	Importance of an internal CoCM champion, patient success stories, evidence of model success measured and reported

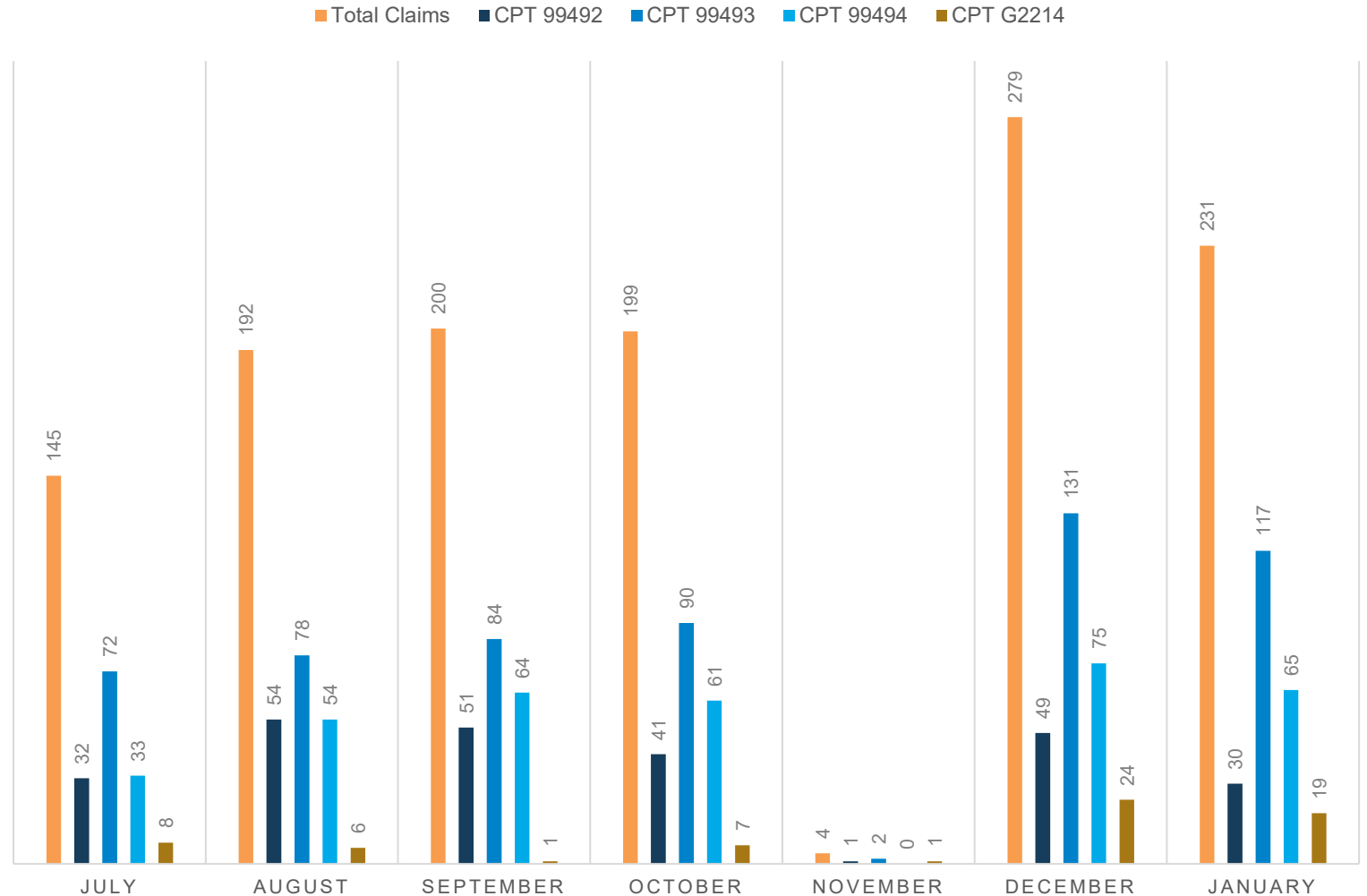
Blue Cross NC CoCM Analysis



Summary Details:

- 3,566 attested providers
- 5% of total attested providers have submitted claims (163)
- 1250 total claims
- 38% applied a copay (476)
- \$166,197.68 total paid amount
- 330-600 members

BLUE CROSS NC COLLABORATIVE CARE

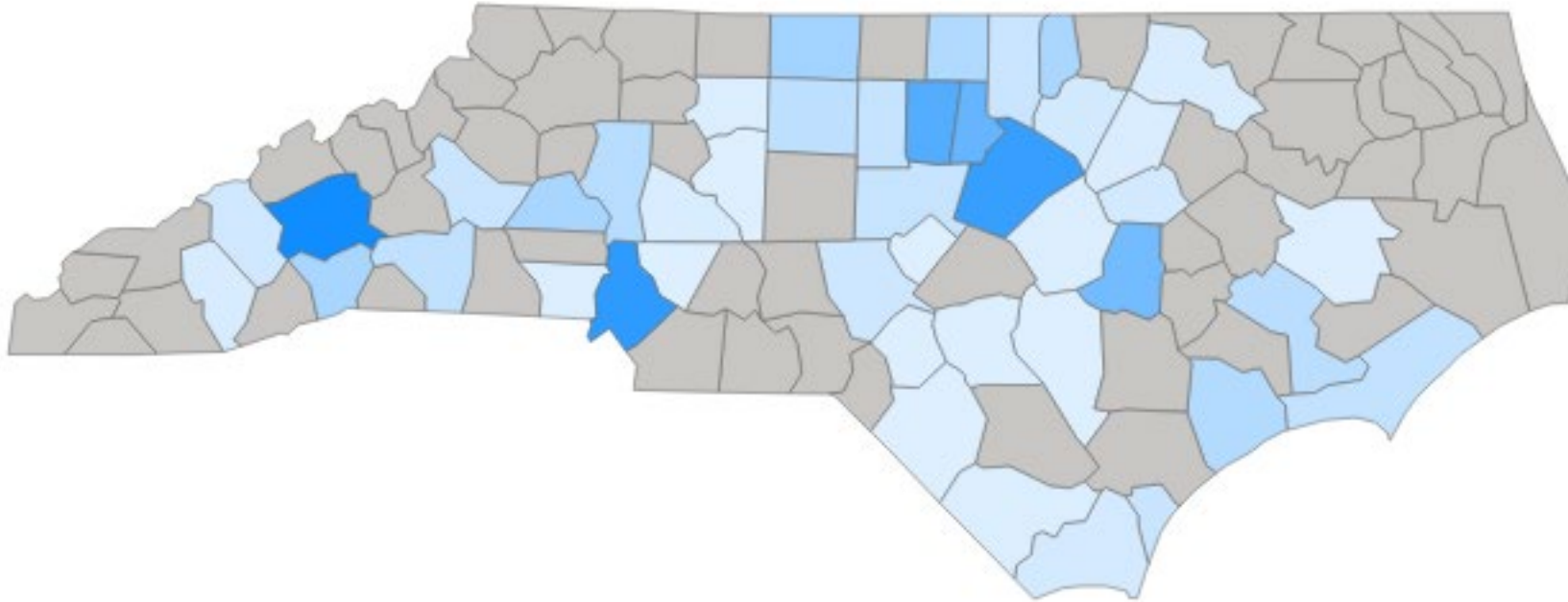


CoCM Utilization



CoCM Utilization

Provider Map | # Unique Members





Thank you.

Questions?

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Appendix

CoCM Resources and Information

UW AIMS Center – <https://aims.uw.edu/>

APA - <https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care>

NC AHEC - <https://www.ncahec.net/practice-support/collaborative-care-2/>

NC Medicaid - <https://medicaid.ncdhhs.gov/blog/2022/12/15/nc-medicaid-enhancements-integrated-physical-and-behavioral-health>

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Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

Reinert, M, Fritze, D. & Nguyen, T. (October 2021). “The State of Mental Health in America 2022” Mental Health America, Alexandria VA.

SHEPS Health Workforce NC: <https://nchealthworkforce.unc.edu/interactive/supply/>

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