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IMPROVING OUTCOMES FOR PATIENTS WITH BEHAVIORAL HEALTH CONDITIONS IN MASSACHUSETTS:

Accelerating the Implementation of the Collaborative Care Model

Working Executive Summary

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Family Practice Group of Arlington, MA

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Mass General Brigham (MGB)

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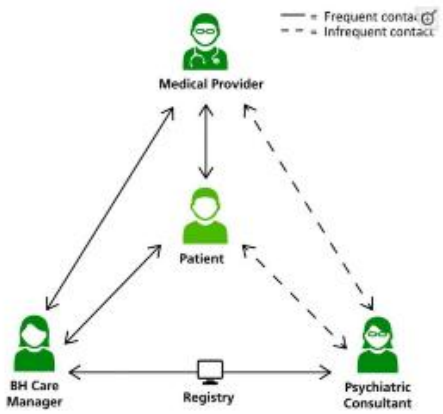
EXECUTIVE SUMMARY

Challenge to be Addressed

One in five Massachusetts residents experiences a mental health condition in any given year. Only half of that number receive treatment[1], and many who do experience fragmented care, with mental health screening and specialty treatment siloed from primary care. This fragmentation of care has contributed to a lag of more than a decade on average between the onset of a behavioral health condition and the diagnosis and treatment of the condition.[2] Too often, clinical intervention occurs because a mental health condition has escalated into a crisis or urgent care episode.

Primary care clinicians are stretched thin[3] – but with the right supports, many unmet behavioral health needs can be addressed in primary care, providing an opportunity for prevention, early intervention, effective treatment and better health outcomes.



While multiple models exist for behavioral integration (BHI) into primary care, one model is supported by a strong body of evidence: the Collaborative Care Model (CoCM), developed 25 years ago at the University of Washington. [4,5] Under this model, patients are screened for one or more behavioral health conditions in primary care. Patients who meet clinical criteria are invited to enroll in CoCM. Primary care providers lead the care team, working with embedded behavioral care managers to provide evidence-based treatments. The primary care team develops a treatment plan, which includes both measurable clinical goals and patient goals. Patient outcomes are measured and tracked in a registry, which the behavioral care manager regularly reviews. Treatment plans are regularly adjusted for patients who are not improving as expected, with support from a psychiatric consultant.

Despite evidence of effectiveness, and the availability of funding mechanisms for its implementation, CoCM adoption remains limited in the Massachusetts health care delivery system.

Background and Purpose

With support from the Bowman Family Foundation and The Goodness Web, the Massachusetts Association for Mental Health (MAMH) is leading an initiative to accelerate the adoption of CoCM across the state's health care system. The initiative has three stages:

- Stage 1: Landscape Review – Conduct Policy and Practice Analysis
- Stage 2: Practice and Philanthropy Identification – Develop Practice Selection Criteria, Solicit Practices Interested in CoCM Adoption, and Formulate Potential Funder List

- Stage 3: Site Selection and Grants Administration - Facilitate Investments in Primary Care Practices to Support CoCM Adoption

Content of This Report

This report presents results from Stage 1 of the MAMH CoCM Initiative . We conducted the following activities to identify the main obstacles and facilitators for CoCM adoption in Massachusetts:

- Rapid review of implementation science theories and selection of a theoretical framework to serve as a model for action;
- Rapid literature review on CoCM;
- Review of the policy environment for CoCM implementation in Massachusetts
- Key informant interviews with policymakers, payers, and providers; and
- Consultation with a coalition of payers and providers focused on behavioral health integration (BHI) in Massachusetts.

After presenting key findings from these research activities, we provide recommendations for Stages 2 and 3 of this initiative including:

- Key obstacles to address, and ways to address them to secure CoCM adoption;
- Proposed selection criteria for practices to receive CoCM implementation support; and
- Funders and other partners to engage in CoCM education, adoption, and support.

Findings

Review of Frameworks for Action

Evidence alone does not drive the uptake of evidence-based interventions like CoCM: it can take many years for research findings to be implemented in health care.[6] A well-established framework for action, also known as a theory of change, can help to accelerate implementation efforts by providing a logical, structured way to plan, guide, and evaluate implementation efforts.

Numerous valid frameworks for action exist, but many are too complex for use within primary care teams, which too often are short-staffed and over-worked. For this reason, we selected the Theory of Constraints[7] as a framework to guide our inquiry and recommendations for the next phase of this initiative.

The premise of the Theory of Constraints is that every complex system has only one major constraint for resolution at any given time: the main limiting factor that is causing the "bottleneck" in a process. Once a goal is agreed upon by participants in a system, the Theory of Constraints process is to identify the most significant constraint, address it, identify the next constraint, address it, and continue until all constraints are removed.

The Theory of Constraints can be used together with other frameworks for action to identify and address constraints. Other useful frameworks for action include the Consolidated Framework for Implementation Research 2.0 (CFIR 2.0) [OBJ], which is the distillation of a vast body of implementation science literature. Frameworks commonly used in healthcare, such as the

trans-theoretical model (also known as the "stages of change" model)[8] and the IHI Model for Improvement, also can be used in conjunction with the Theory of Constraints.[9]

Literature Review Findings

CoCM as an established evidence-based practice.

CoCM is supported by the strongest forms of evidence. More than 90 randomized controlled trials (RCTs), meta-analyses of these RCTs, and systematic literature reviews of RCTs have shown that CoCM improves mental health outcomes, OBJ reduces total cost of care, primarily by reducing physical healthcare costs[10], and may alleviate clinician burnout by increasing their effectiveness in treating patients with behavioral health conditions.[11]

As in all bodies of evidence, there is some variation in effectiveness across studies. As a result, it is important to explore where and how CoCM is most consistently effective.

Evidence of clinical effectiveness is strongest for CoCM implementations with a focus on adults experiencing mild to moderate depression or anxiety – including older adults, veterans, pregnant and postpartum women, and general adult populations. In addition, evidence is continuing to emerge on the effectiveness of CoCM for other conditions, such as substance use conditions and PTSD, and for other populations, such as pediatric patients.

Some studies suggest the benefits of CoCM for depression care are even stronger for racial and ethnic minority patients, including Black adults and Hispanic/Latine adults. [12,13,14]

Practice-based evidence for CoCM to support adoption and guide implementation.

For the purposes of this report, we define practice-based evidence as the practical knowledge that has been developed in the implementation of CoCM.

Research suggests that launching CoCM programs and engaging patients in collaborative care requires:

- Strong leadership support;
- Primary care champions; and
- On-site care manager with a clearly defined role.

Furthermore, clinics are more likely to achieve treatment goals with CoCM if:

- Have an engaged psychiatrist;
- Do not see operating costs as a barrier to participation; and
- Support face-to-face communication (warm handoffs) between the care manager, and primary care physician for new patients.

In addition, language access is key for effective CoCM services in populations with limited English proficiency.[15,16]

Resources are available online for healthcare providers who wish to learn from peers across the nation about their experiences, lessons learned, and tips and tricks in implementing CoCM. These include live webinars, pre-recorded videos, written narratives, podcasts, and examples of documents and systems used by practices. OBJ [17,18]

Population need for timely and effective behavioral health care and policy response to support CoCM in Massachusetts.

Nearly 1 in 5 adults (19.6%) in Massachusetts report experiencing symptoms of depression, anxiety, or both. [obj] While prevalence rates have declined since the COVID-19 pandemic, they continue to be higher than pre-pandemic levels.

Diagnoses may rise in Massachusetts primary care settings over the next few years, because of recent policies and programs that guarantee and actively promote behavioral health screenings and referrals:

- Massachusetts extended health insurance coverage mandate for annual well child screenings under MassHealth to all insurers in a guidance Bulletin issued in 2018 by the Departments of Insurance and Mental Health (DOI and DMH).
- Massachusetts Mental Health ABC Act 2.0, signed into law as Chapter 177 of the Acts of 2022 guarantees an annual mental health wellness exam at no cost to patients; DOI issued a Bulletin with guidance to all insurers in 2023.
- MassHealth Accountable Care Organization Primary Care Sub-Capitation Program: implemented in 2023, requires an annual practice-based behavioral health screening of all attributed patients over the age of 21.
- Behavioral Health Help Line (BHHL) launched in 2023: provides assistance in over 200 languages to connect individuals and families to behavioral health treatment services.
- 25 new Community Behavioral Health Centers (CBHCs) were launched, providing mobile crisis services regardless of ability to pay.
- More than 70 providers, including CBHCs, were designated as Behavioral Health Urgent Care Centers across the Commonwealth.

Primary care clinicians are already stretched thin and may feel more overwhelmed as these provisions increase the size of their patient panels with behavioral health conditions.

While CoCM implementation requires an initial investment of time and resources, with the right supports, it could help primary care clinicians effectively manage large emerging panels of patients with behavioral health conditions.

Behavioral health workforce shortages are shrinking, but demand may still exceed supply.

Although the nation as a whole is experiencing a behavioral health workforce shortage with 35% of the U.S. population living in a mental health professional shortage area, Massachusetts is faring better than other states. As of June 2024, approximately 3.6% of the Massachusetts population was estimated to be living in a mental health professional shortage area.[19]

Nonetheless, demand for services may soon outpace supply due in part to expanded access to screenings and early detection. In addition, MassHealth ACO program rules may have inadvertently caused a maldistribution of the behavioral health workforce in Massachusetts by incentivizing co-location of behavioral health clinicians on primary care teams where they may not have a full caseload.

Key informants interviewed for this initiative suggested that new policies enabling time-sharing of behavioral health clinicians across health care organizations could help to alleviate the

situation. Such time-sharing would facilitate the implementation of CoCM as well, enabling smaller practices to carry the amount of behavioral health clinician time their patient population needs, and their budgets will support.

Key informants also noted that more than half of licensed behavioral health practitioners in Massachusetts do not take insurance, calling into question the significance of the finding that few in Massachusetts live in mental health professional shortage areas.

Even with sufficient workforce, cost impedes access to behavioral healthcare.

Affordability is a long-standing challenge in behavioral healthcare, with low insurance participation by behavioral health clinicians contributing to this issue. A patient experience survey conducted by NORC between December 2021 and April 2022 with funding from the Bowman Family Foundation found that 57% of U.S. patients surveyed who sought mental health or substance use care did not receive any care in at least one case in the preceding 12 months, and of those who did receive care, 39% of those with employer-sponsored plans used at least one out-of-network provider. [20]

Massachusetts historically has had higher insurance participation by behavioral health clinicians compared to the rest of the nation, which may have helped to improve affordability. To further address the issue, MassHealth reports working to keep up with Medicare increases in reimbursement rates for behavioral health services and has expanded the types of professionals who can bill and settings from which services can be delivered and billed.[21],[22],[23],[24]

However, recent reports indicate that CoCM reimbursement rates in Massachusetts are below Medicare rates. Depending on the code billed, MassHealth rates are between 47% and 74% of the published Medicare rates, as compared to rates in other jurisdictions which range up to 120% of current Medicare rates.[25] A poor budget outlook at the state level[26] may impact MassHealth in keeping up with Medicare rate increases and service expansions.

Evidence suggests CoCM can mitigate budgetary challenges by generating cost savings for payers, but copay requirements reduce affordability for patients. Payers would be well-justified to offer first-dollar coverage of CoCM services, and indeed, some already do.

Participation in treatment has improved, but disparities in access may be widening.

The latest available CDC National Health Interview Survey data (October-December 2023) shows that 14.1% of the U.S. adult population had received mental health counseling in the past 12 months, compared to 10.4% for July-September 2021. [27] However, there are warning signs that disparities in behavioral health care access may be widening:

- At a national level, the percentage of those who reported needing behavioral care and did not get access due to cost rose from 4.2% in July-September 2021 to 5.5% in October-December 2023.[28] The end of continuous Medicaid enrollment during the Public Health Emergency, referred to as 'Medicaid unwinding,' may have contributed to this trend.
- As noted above, the Massachusetts ACO primary care sub-capitation program may have inadvertently diverted behavioral health clinicians away from working for safety net providers.
- Among capacity losses affecting safety net populations in Massachusetts is the recent closure of 64 psychiatric beds associated with the failure of the Steward Health system; many of the beds were targeted to older adults with co-occurring health conditions.

Disparities in behavioral healthcare access and outcomes should be proactively addressed and monitored. Given the evidence that CoCM can reduce disparities, accelerating its implementation among providers serving patients covered by all payors can be part of the solution.

Massachusetts is experimenting with multiple Behavioral Health Integration strategies, and CoCM adoption is lagging.

MassHealth has adopted an agnostic stance on models for behavioral health integration (BHI) in primary care, enabling multiple BHI models to operate in Massachusetts. For reference, this report summarizes the key features of four common models: CoCM (also known as "the psychiatric collaborative care model"[29]); the Patient-Centered Behavioral Health (PCBH) model; consultation-liaison psychiatry; and basic co-location of behavioral health providers in primary care practices. However, it the strongest evidence for not only clinical impact but also cost effectiveness is found in growing evidence of the stronger outcomes of CoCM on reducing total cost of healthcare.[30]

Because there is no formal accreditation program for CoCM, it can be challenging to identify successful examples of CoCM implementation in other states. However, based on our own assessment against the standards of the AIMS program at the University of Washington, we have identified several instances of successful CoCM implementation in Massachusetts.

Key informant interview findings suggest CoCM adoption is low in Massachusetts compared to other care integration models. This may be due partly to payment policy issues described below, and partly to other constraints elucidated by key informants, described further below.

High administrative burdens and low reimbursement may disincentivize CoCM adoption relative to other Behavioral Health Integration (BHI) models.

Payment mechanisms exist to support CoCM implementation, but they are perceived as complex, requiring billing up to four distinct codes. Payment mechanisms may vary by payer, state, year, and payment model, are not centrally documented; and present operational challenges when requiring modification to medical records or billing systems.

Lack of a continually updated, centralized, state-specific reference source on payment mechanisms, billing procedures, and reimbursement rates across payers makes it challenging for health care providers to get paid for CoCM implementation. Providers consulted for this report also indicated that payers do not always follow their own stated payment policies, either because operational system updates are lagging payment policy updates; or because rapid staff turnover is reducing institutional memory.

Medicare has established and gradually expanded billing codes for CoCM.[31] The CMS codes have been adopted by Massachusetts and implemented by private payers. However:

- Massachusetts adoption of CoCM billing codes has lagged behind Medicare;
- The lag has been especially long in settings where CoCM may be most needed, including Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs);
- Whereas MassHealth matches Medicare rates for psychotherapy and psychiatric consultation, it pays less than Medicare for CoCM codes;
- CoCM rates for FQHCs and RHCs are lower than for other primary care practices; and

- Whereas primary care practices can bill CoCM codes after working half the allocated time for each CoCM code plus one minute, FQHCs and RHCs must work all of the allocated time.

Value-based payment models provide an alternate financing pathway for CoCM implementation. Some value-based payment arrangements offer upfront investments to fund practice transformation, per-member, per-month fees, and higher payment rates for practices that provide more integrated care or serve patient populations with higher health-related needs.

CoCM is a population health system, accountable to payers and amenable to continuous quality improvement.[32] This makes it a natural fit to help health care organizations thrive under value-based payment arrangements.

However, value-based payment design in Massachusetts may be impeding CoCM implementation because the primary care sub-capitated rates set for behavioral health integration do not require adherence to the CoCM standards for care integration. As noted above, MassHealth ACO program rules may have inadvertently created a maldistribution of the behavioral health workforce in Massachusetts. In addition, MassHealth's behavioral health carve-out means behavioral health expenditures do not count against costs attributable to primary care clinicians, which could incentive clinicians to refer patients needing behavioral health services to outside or specialty services.

Key Informant Interview Findings

Lack of awareness and knowledge gaps concerning CoCM.

A key obstacle to CoCM implementation in Massachusetts is that many clinical and administrative managers and staff at provider and payer organizations remain unfamiliar with the model, despite its performance record with more than 20 years of success. Further, many of those interviewed who had some familiarity with the model questioned its' utility as a single comprehensive solution for behavioral health integration within primary care practices. Some expressed doubt on whether the evidence for CoCM was well established for certain types of specialty practices and patient populations. Others were unclear about the CoCM differentiators – the Core Principles and Team Structure -- when compared to other behavioral health integration approaches.

Despite the strong evidence base, many interviewees indicated that there is skepticism about the clinical benefits and cost savings, and whether the Randomized Clinical Trial (RCT) results were replicable in "real life" practice environments.

Perhaps most important, many practitioners indicated that they did not understand and appreciate the rationale behind implementing CoCM. Many did not understand the clinical characteristics of the population they serve relative to their behavioral health needs; few understood the long lags between onset and treatment for behavioral health conditions. As a result, many practitioners did not appreciate the criticality of addressing mental health within primary care.

Carol Alter, M.D. is the Associate Chair for Clinical Integration and Operations and a professor in the Department of Psychiatry and Behavioral Sciences at Dell Medical School in Texas. She described a fundamental constraint in the knowledge gap as follows:

> *"The greatest misunderstanding of the Collaborative Care Model isn't about the model. It is the lack of awareness that 20% to 30% of patients have a diagnosable mental health condition that could be treated in primary care. No one gets it until they understand what we are solving for. The Collaborative Care Model is about treating mild to moderate mental health conditions in primary care."*

During key informant interviews, it was widely suggested that making the business case for CoCM and its value proposition and hearing directly from practitioners who have successfully implemented COCM, would help address the knowledge gap constraint to COCM adoption in Massachusetts.

Adopting CoCM at primary care practices will enable prevention and earlier intervention, diagnosis and treatment for mental health conditions which results in better health outcomes overall for patients. It can also alleviate pressure from overburdened practitioners.

Need for awareness campaign and education on CoCM benefits.

There was consensus among key informants that education about the CoCM model and its value, and training on how to implement it, are needed to advance the goal of more widespread COCM adoption in Massachusetts. Interviewees cited several tools with potential utility for growing awareness about CoCM and its benefits, as well as for supporting adoption and implementation. These include a policy/issue brief, CoCM adoption map, a policy forum, and a toolkit of resources.

Key informants supported the idea of MAMH hosting a half- day forum to shine a spotlight on CoCM and discuss and educate key Massachusetts healthcare leaders and practitioners about it. The agenda for such a conference could include a panel discussion and presentations by health care leaders who are CoCM proponents, practitioners who have successfully implemented CoCM, and subject matter experts and private vendor companies supporting CoCM adoption. These leaders could address implementation issues including financial, technical assistance, information technology, billing, and workforce challenges. Several key informants expressed interest in their organizations co-sponsoring such an event.

Leadership is imperative to drive and successfully scale CoCM adoption.

Both payer and provider interviewees stressed that having a "champion" to drive CoCM adoption within a healthcare organization is imperative. This includes having both a clinical champion to address care delivery and a business champion to address practice transformation requirements. State government champions are also needed, as well as consensus among major health plans and provider organizations that widespread CoCM adoption is a worthwhile Massachusetts goal. Policymakers, payers, and providers all have a role as champions.

Financial start up and sustainability.

Key informants expressed concerns about providers being able to understand and afford the startup costs, including when to anticipate savings and the break-even point. Providers suggested that information and technical assistance on financial modeling would be helpful for them to predict upfront investments, ROI, and the break-even point before they commit to launching COCM.

Although there was consensus among key informants that offering external funds to practices for COCM startup would be helpful, concerns remained about sustainability after external

investments are exhausted. One PCP who had successfully implemented COCM suggested that any financial modeling for COCM should also include the revenue opportunity derived from freeing up hours of time for the PCP, who can use that time to see more patients and generate additional revenues.

Key informants also identified systematic barriers and disincentives to COCM adoption, which include a sub-cap for ACO payments and FQHC limitations on billing COCM codes.

Complexity, Transformation, and Technical Assistance.

Key informants emphasized that there is significant stress on primary care practices in Massachusetts as service demands continue to increase and reimbursement rates remain inadequate. For practices serving safety net populations, patient pressure and volume have increased with the large immigration influx and the Steward health care system crisis, which led to the contraction and closure of safety net hospitals. The CoCM model is generally perceived as complex, at least initially, and there is apprehension about the disruption and costs of associated practice transformation. Technical assistance is needed for interoperability of EHR's and patient registries, and on billing requirements and implementation.

Clarification on the role and credentials of the CoCM care manager position is important, and practices need assistance on how to recruit individuals and train them. Overall training at the practice level is needed for both clinical and administrative staff during CoCM launch and practice transformation. Having an in-house source of CoCM expertise after launch is helpful.

Lessons Learned from NEHI Payer and Provider Behavioral Health Integration Meetings

MAMH has a history of collaboration with the Network for Excellence in Health Innovation (NEHI) on policy research addressing the integration of behavioral health in primary care. Wendy Warring, NEHI's leader, has deep expertise in the integration of behavioral health and primary care at a national level and, coinciding with the MAMH initiative, is exploring integration in the Commonwealth. The NEHI report from 2023 on scaling care integration is among the grey literature examined for this report.

In May and June 2024, NEHI convened Massachusetts payers, providers, technical assistance providers and other interested parties to discuss ways to advance behavioral health integration (BHI) in Massachusetts. MAMH joined these meetings, which attempted to identify areas of consensus and explore synergies to advance care integration.

Discussions in these meetings echoed many of the points made during key informant interviews, serving as test of the information gathered in the MAMH landscape analysis. Some participants were strongly in favor of expanding CoCM implementation; others cautioned it could not meet every BHI need in every setting for every population; and many highlighted implementation challenges. These challenges included:

- The complexity of the intervention;
- The difficulty of integrating CoCM with electronic health record (EHR) workflows for registry and billing purposes;
- Workforce shortages impacting all CoCM team roles;
- The need for a ramp-up period to build caseload and staffing;
- High startup costs; and

- Low reimbursement rates.

In an important development, several meeting participants expressed interest in working together to overcome the challenges to CoCM implementation. Given the mix of MAMH key informants and NEHI meeting participants, information emerging from both initiatives points to growing consensus in Massachusetts on the value of CoCM and the challenges associated with adoption and implementation. We note that the NEHI and MAMH initiatives catalyzed interest in addressing opportunities for and barriers to CoCM adoption in Massachusetts, and they create an important opportunity to advance this approach.

The NEHI and MAMH initiatives suggest there is substantial consensus among key leaders and stakeholders about the value of CoCM, as well as the challenges associated with widespread adoption in Massachusetts. These initiatives catalyzed interest in addressing these barriers, with NEHI meeting participants and MAMH key informants saying they would like to collaborate with others to advance implementation statewide. This creates an important opportunity for next steps to promote widespread adoption.

Conclusions

Conclusions

The environmental review of collaborative care in the Commonwealth of Massachusetts revealed consensus among primary care providers, payers, and policy leaders on several points, including:

1. There is a lack of awareness and understanding of CoCM and its value proposition.
2. There is a need for multi-stakeholder education about the Collaborative Care Model, its adoption cost and value, and resources for training to support implementation.
3. Leadership is required to drive CoCM advancement at all levels – providers, payers, and policymakers.
4. Resources are needed to cover financial start-up challenges and ensure sustainability.
5. Communications and resources are needed to address perceived practice complexity, practice transformation demands, technical assistance, IT interoperability, and workforce challenges.
6. Expressed agreement among payer leadership that CoCM is the preferred model for behavioral health and primary care integration.
7. Champions or system leaders who articulate CoCM's value in ensuring earlier identification and timely treatment of behavioral health conditions, improving access to services, and mitigating disparities in care are essential to CoCM adoption.

Obstacles and Challenges to CoCM Adoption and Scaling

Key informants report confusion about the Collaborative Care Model, requirements for implementation, and the benefits expected from adoption of this evidence- based practice. These findings are consistent with observations in the peer-reviewed literature.[33]

There is a fair degree of alignment across payers, providers, and thought or policy leaders in their identification of obstacles or challenges to CoCM implementation. These challenges include:

1. **Lack of Awareness and Need for Education and Training on CoCM:**
   - Primary care providers need to be educated about the value of CoCM how it differs from other approaches to behavioral health integration, and its benefits, targeted conditions, and populations.
   - Providers need specific training in CoCM implementation to maximize clinical, quality, and cost improvements.
   - Need for peer-to-peer information sharing will help to persuade skeptical providers and make the business case for adoption.
2. **Scarcity of CoCM Leadership and Champions:**
   - The importance of having leadership and a champion within the organization to drive the implementation was a common theme.
   - This includes both a medical champion and a business champion, as well as a CoCM leader at the practice to ensure smooth ramp-up and sustainability.
   - The handful of health systems that have adopted or are in the process of adopting CoCM have a clinical and administrative champion. Often, this champion is a chief medical officer or care integration officer.
3. **Service Delivery and Financial Stress on Primary Care:**
   - The stress on primary care and the necessity for practice transformation to implement CoCM is challenging.
   - The perception of initial complexity of the model needs to be addressed
   - Opportunities must be taken where feasible for simplification and flexibility to fit current primary care needs.
   - Practices are stretched thin financially due to inadequate reimbursement rates.
4. **Financial Concerns and Challenges:**
   - Start-up investments are needed to cover clinical staffing and technical operations expenses until practice is at scale to support costs.
   - Understanding the financial model, including the break-even point, prior to implementation will inform financial decision-making and management.
   - Complexity of reimbursement, including the need for clear rules and compliance with billing codes, must be addressed at a policy level.
   - Financial sustainability of CoCM once initial funding or incentives dry up depends on enrolling a patient panel of sufficient size, documenting care in the medical record, maintaining a patient registry, mastering billing, and retaining behavioral health practitioners in the practice.
5. **Workforce Issues:**
   - There is a shortage of behavioral health clinicians, and primary care providers often lack experience in hiring such clinicians and effectively integrating them into their practices.
   - There is a need for supervision and professional development for behavioral health clinicians in primary care practices.
   - The role of CoCM care manager needs to be clarified in terms of education, credentials, and clinical vs administrative responsibilities for this position.
   - Access to psychiatrists for consultation is critical.

6. **Cultural Competence:**
   - Ensuring that CoCM reaches people who have the most need, with practitioners who are culturally competent, speak languages of patients, and preferably are from the same background as patients, is a core value for widespread adoption.

While these obstacles and challenges are commonly understood to constrain CoCM adoption, the key constraint preventing CoCM implementation may be different for each provider. As a result, plans are needed at each individual practice to address the identified constraint.

Some obstacles/constraints will need to be addressed at the policy level/payer level to greatly accelerate implementation. However, with the right technical assistance and supports implementation can be expanded in Stage 2 and Stage 3 of the MAMH CoCM initiative in the present policy environment.

Opportunities and Solutions for Expanded CoCM Implementation

Payers, providers, and thought or policy leaders agreed on several solutions that would help overcome challenges to advance Collaborative Care Model (CoCM):

- **Education and Technical Assistance**
  - Increase awareness about CoCM's value and benefits, with a focus on prevention and early intervention, diagnosis, and treatment.
  - Provide technical assistance to providers to support implementation, including billing, registry, and training for practice transformation.
- **Leadership**
  - Identify both a business champion and a primary care clinical champion to initiate and sustain CoCM.
  - Identify and share experiences of peer-providers who have successfully implemented CoCM.
- **Financial**
  - Secure startup funds to cover initial costs and ensure practices do not lose money during the ramp-up to implementation.
- **Workforce**
  - Clarify and simplify the role of CoCM care manager.
  - Increase access to psychiatrists.
  - Address the shortage of qualified behavioral health professionals in the Commonwealth, prioritizing defined care manager positions and psychiatrists.
- **Administrative Simplification**
  - Establish standard definitions of key staffing roles required to deliver CoCM, avoiding overcomplication in roles.
  - Develop infrastructure to integrate CoCM platforms with existing electronic health records.
  - Streamline billing and credentialing processes.
  - Better understand how much flexibility is allowable while still maintaining fidelity to core components of CoCM.
- **Policy, Legislative, or Regulatory Support**
  - Facilitate adoption through public endorsement of the CoCM model, supportive policies, payments, and regulations to incentivize CoCM adoption more widely.

- Implement rate improvements to meet Medicare levels for CoCM services.
- Add a primary care sub-capitation tier for CoCM use.
- Eliminate patient cost-sharing for CoCM services.

Recommendations

Based on our research in connection with this initiative, MAMH has identified the following as priorities for our policy and advocacy agenda:

- **Educate** practitioners, payers, and policymakers on the value of CoCM in more timely meeting patient needs and more cost effectively delivering integrated care. Meetings with state policymakers and healthcare payers are planned for the fall and winter of 2024. Larger public awareness and education efforts will include a poster presentation and dissemination of research, policy, and technical support papers at a winter 2025 Massachusetts Academy of Family Physicians (MAFP) Conference at the Massachusetts Medical Society (MMS) in the winter of 2024, and a Massachusetts Health Policy Forum (MHPF) meeting on CoCM in the spring of 2025. MAMH will further disseminate policy briefs and collaborate with primary care reform education efforts through the Primary Care Task Force of the Massachusetts Health Policy Commission and in support of the MA Primary Care Alliance for Patients (MAPCAP).
- **Mobilize** support for policy, regulatory, and legislative reform in Massachusetts, including filing legislation to reform primary care, increase payment rates for the Collaborative Care Model (CoCM) and Behavioral Health Integration (BHI) to 100% of Medicare rates, and to reduce administrative barriers to billing CoCM codes outside of primary care sub-capitations.
- **Advocate** for regulatory, financing, and legislative reforms to primary care, including a reduction in the administrative burden associated with billing for CoCM and an increase in reimbursement for CoCM as noted above. MAMH will engage state policymakers and fellow primary care and behavioral health reform advocates in support of remedies to regulatory and financial constraints in CoCM adoption.

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