pcc primary care collaborative

Convening + Uniting + Transforming

Behavioral Health Integration Committee Meeting

Thursday, February 26, 2026 | 2:00 – 4:00pm

agenda

Welcome & Announcements	*Ann Greiner, Larry McNeely* *PCC*
Co-Chair Remarks & Roll Call	*Mary Giliberti, MHA* *Alin Severance, UPMC Health Plan*
CY27 MPFS Behavioral Health Ask for CMS	*Larry McNeely, PCC* *Mary Giliberti, UPMC Health Plan*
Primary Care Provides Medication for Opioid Use Disorder	*Don Nease* *University of Colorado*
Update from Capitol Hill	*Venn Strategies*
Psychiatric CoCM Model Study Finding	*Kevin Roy, Shatterproof* *Michael Yuhas, Bowman Family Foundation*
Wrap Up and Next Steps	*Larry McNeely, PCC*

pcc primary care collaborative

Convening + Uniting + Transforming

Welcome & Annoucements

PCC Team

Innovation in Behavioral Health Model

- The IBH Model for Cohort II is a seven- year, voluntary model beginning in January 2027
- The model focuses on **advancing and promoting integrated care in behavioral health settings**. It will test the impact of a **value-based payment model** aligned across Medicaid and Medicare that supports an integrated care delivery framework in specialty behavioral health organizations.
- IBH focuses on adults with moderate to severe mental health conditions and/or SUD
- **CMMI hosting a webinar** on March 5 for interested states to hear from awardees in Cohort I. Applications open now – June 3, 2026

pcc primary care collaborative

Convening + Uniting + Transforming

Co-Chair Remarks & Roll Call

Mary Giliberti | MHA
Alin Severance | UPMC Health Plan

pcc primary care collaborative

Convening + Uniting + Transforming

CY27 MPFS Behavioral Health Ask for CMS

Larry McNeely | PCC
Mary Giliberti | Mental Health America

SOLUTION: Accurate Valuation

Systematic overvaluation → Undervaluation of PC, prevention

- ✓ Improve **Efficiency Adjustment** w/ corresponding updates to clinical labor & equip PE inputs; expand lookback from 5 years to 10
- ✓ Reform **Global Surgical Codes.**
- ✓ Develop **more Empiric Data Sources**
- ✓ **Expert Panel** to advise CMS on data sources and valuation - potentially housed at MedPAC.

AND Congress must do its part too – See BHN's Doc Caucus Letter

SOLUTION: Hybrid PC Payment

To scale hybrid/pc cap tomorrow, address APCM barriers today:

- ✓ **Eliminate administratively burdensome cost-sharing!**
- ✓ **Address fear of audits** with guidance to practices and health systems on APCM & add-on billing requirements.
- ✓ Support **multipayer alignment** by encouraging APCM & BHI add-on in MA & guidance for state Medicaid programs.

Support PC Participation in ACOs

- ✓ **A New ACO PC Flex cohort** in CY 2027 to gain further experience implementing capitation in MSSP.
- ✓ **A defined timeline toward broadly available primary capitation option** in MSSP, drawing on lessons from prior models
- ✓ **Support APCM & BHI add-on adoption in ACOs** thru a) prospective payment and b) removal from benchmark calculations.

Whole-Person Care Thru Lifespan

- ✓ Seek clarifications re: non-covered Preventive Med Visits (99381-99397) – Key for child PC payment
- ✓ Extend telehealth parity for FQHC/RHCs
- ✓ Cover **Health & Well-being Counseling** (under gen. supervision)
- ✓ Pay for **immunization counseling**

pcc primary care collaborative

Convening + Uniting + Transforming

Primary Care Provides Medication for Opioid Use Disorder

Don Nease | University of Colorado

Primary Care provides medication for opioid use disorder

John M Westfall, Linda Zittleman, Camille Hochheimer, David Wolff, Doug Fernald, Ben Sofie, Cory Lutgen, L. Miriam Dickinson, **Donald E Nease Jr**, HOMER Patient and Clinician Advisory Committee

DARTNet Institute
Informing Practice Improving Care

SNOCAP
State Network of Colorado Ambulatory Practices & Partners

Department of Family Medicine
UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

HOMER

Health Affairs Scholar, 2026, 4(1), qxaf253
https://doi.org/10.1093/haschl/qxaf253
Advance access publication: January 8, 2026
Research Article

Health Affairs Scholar
EMERGING & GLOBAL HEALTH POLICY
OXFORD

Primary care provides medication for opioid use disorder: findings from the HOMER study

John M. Westfall[1,2,*], Linda Zittleman[1], Camille Hochheimer[1], David Wolff[3], Doug Fernald[1], Ben Sofie[1], Cory Lutgen[2], L. Miriam Dickinson[1], Donald E. Nease[1], and the HOMER Patient and Clinician Advisory Council[3]

[1]Department of Family Medicine, University of Colorado School of Medicine, Aurora CO, 80045, United States
[2]DARTNet Institute, Aurora, CO 80045, United States
[3]HOMER Patient and Community Advisory Council, United States
*Corresponding author: DARTNet Institute, Aurora, CO 80045, United States. Email: Jack.westfall@Dartnet.info

Abstract

Context: Changes in regulations related to medication for opioid use disorder (MOUD) have expanded access to MOUD in primary care. However, there has been concern that primary care practices are unwilling or unable to treat patients with OUD.

Objective: To describe the practices and patients enrolled in the Patient-Centered Outcomes Research Institute (PCORI)–funded HOMER (Comparing Home, Office, and Telehealth Induction for Medication Enhanced Recovery) research study who delivered MOUD as part of routine primary care practice.

Results: A total of 79 practices from 25 states expressed interest in participation. Sixty-two practices signed up for HOMER. Practices were typical of US primary care, accepting a variety of payers, including commercial insurance, Medicaid, Medicare, and uninsured patients, and caring for patients of across a spectrum of adult ages, races and ethnicity, education, and income. The majority had health insurance (82%). Most patients reported using prescription opioids (59%), while 41% reported other opioid use. Greater than 40% of participating patients reported no prior medication treatment for OUD.

Conclusion: The finding that nearly half of patients had no prior treatment supports the importance of primary care as a crucial component of MOUD. Practices in HOMER were similar to practices across the country. Patients enrolled were typical of family practice patients. Policies that support primary care MOUD may improve access to patients.

Key words: opioid use disorder; medication for opioid use disorder; primary care; OUD; MOUD.

Introduction

The opioid epidemic has continued despite aggressive efforts to limit prescribing opioids, decrease the flow of illicit opioids, and increase access to treatment for opioid use disorder (OUD). While deaths from opioid overdose have fallen, there are still over 80 000 deaths per year from drug overdose.[1-3] Changes in regulations related to medication for OUD (MOUD) have expanded access to buprenorphine. Emergency room programs may offer short-term treatment for patients presenting in withdrawal and referral to ambulatory MOUD programs.[4] Formal addiction treatment centers are not equipped to manage the huge influx of patients seeking treatment.[5] Soon after expanding access to buprenorphine there was optimism that patients could receive initial and long-term treatment in primary care.[6-8] However, many patients may not know that their primary care team can provide MOUD.[9] Other reported barriers to primary care providing MOUD include lack of resources, lack of interest, and lack of time in an already busy clinic schedule.[10-12] Early-career family physicians may not feel adequately trained to provide MOUD.[13] As primary care consolidates into larger health systems, there may be less interest from hospital system administrators to offer MOUD.[14,15] Taking on new patients with OUD may be less attractive to primary care practices.[16]

More recently, there has been a concern that primary care practices are becoming less willing or able to treat patients with OUD.[17] State and federal opioid policy has focused on temporary pop-up clinics and mobile treatment vans[18,19] and telehealth.[20-23] While well intended, these efforts syphon resources away from primary care and disrupt existing continuity relationships.[24] There appears to be an ongoing misconception that primary care may not be interested in offering MOUD.[25-27] Several recent publications report on low uptake of MOUD among trained primary care professionals.[28,29] Because some primary care physicians are now refusing to prescribe opioids to patients with chronic pain, there may be a belief they are also unwilling to provide MOUD.[30]

However, many primary care practices can and do offer medication for OUD.[8,31-33] More information about primary care practices that provide MOUD and the patients they reach is needed to reinforce clinical best practices, help patients understand their treatment setting options, and inform policies that support primary care delivery of treatment of OUD. As part of a national Patient-Centered Outcomes Research Institute (PCORI-)–funded comparative effectiveness study

Received: October 20, 2025; Revised: December 16, 2025; Accepted: December 24, 2025
© The Author(s) 2026. Published by Oxford University Press on behalf of Project HOPE - The People-To-People Health Foundation, Inc.
This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial License (https://creativecommons.org/licenses/by-nc/4.0/), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited. For commercial re-use, please contact reprints@oup.com for reprints and translation rights for reprints. All other permissions can be obtained through our RightsLink service via the Permissions link on the article page on our site—for further information please contact journals.permissions@oup.com.

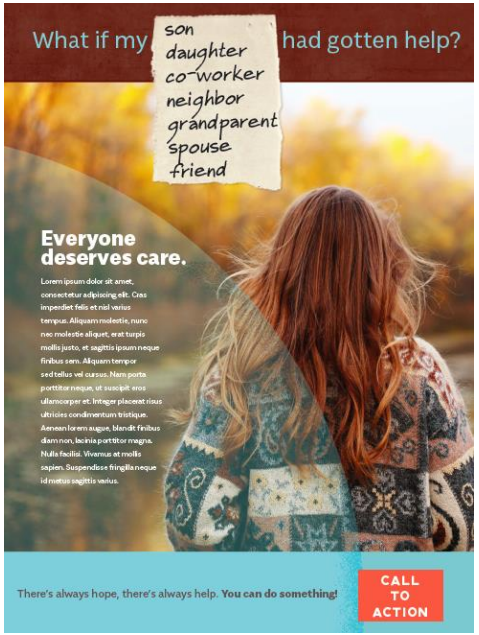
Downloaded from https://academic.oup.com/healthaffairsscholar/article/4/1/qxaf253/8417010 by University of Colorado Anschutz Medical Campus user on 25 February 2026

HOMER

- HOMER = Home vs. Office treatment for Medication Enhanced Recovery
- National Randomized Comparative Effectiveness Trial 2020– 2025
- PCORI IHS-2019C1-16167

Why HOMER?

- Grew from work emanating from listening sessions with our Colorado practice-based research network clinicians and patients
  - “Help us with this opioid problem!” – 2013 SNOCAP priority setting
- IT-MATTTRs – AHRQ funded study aiming to increase availability of MOUD in rural Colorado – created a training program for primary care practices on implementation
- 2018-19 - Questions about location for “induction” emerged
  - PCORI study proposed to address these



2020 – 2025: a few things happened!

- COVID-19 – resulted in addition of a telehealth arm
- Primary care losses – diminished recruitment
- Reluctance of patients *and clinicians* for randomization – adaptation to a comprehensive cohort design
- …but like Odysseus – we finally made it home



The Odyssey of HOMER: Comparative Effectiveness Research on Medication for Opioid Use Disorder During the COVID-19 Pandemic

Linda Zitelman, MSPH
John M. Westfall, MD, MPH
Benjamin Sofis, MSW
Cory Lutges, MHA
Douglas Fernald, MA
Tristen L. Hall, PhD, MPH
Camille J. Hochheimer, PhD
Melanie Murphy, PA-C, MBA
Mant Felzen, MA
L. Miriam Dickinson, PhD
Brian K. Manning, MPH
Joseph LeMaster, MD, MPH
Donald E Nease Jr, MD

ABSTRACT

The usual challenges of conducting primary care research, including randomized trials, have been exacerbated, and new ones identified, during the COVID-19 pandemic. HOMER (Home versus Office for Medication Enhanced Recovery; subsequently, Comparing Home, Office, and Telehealth Induction for Medication Enhanced Recovery) is a pragmatic, comparative-effectiveness research trial that aims to answer a key question from patients and clinicians: What is the best setting in which to start treatment with buprenorphine for opioid use disorder for this patient at this time? In this article, we describe the difficult journey to find the answer. The HOMER study began as a randomized trial comparing treatment outcomes in patients starting treatment with buprenorphine via induction at home (unobserved) vs in the office (observed, synchronous). The study aimed to enroll 1,000 participants from 100 diverse primary care practices associated with the State Networks of Colorado Ambulatory Practices and Partners and the American Academy of Family Physicians National Research Network. The research team faced unexpected challenges related to the COVID-19 pandemic and dramatic changes in the opioid epidemic. These challenges required changes to the study design, protocol, recruitment intensity, and funding conversations, as well as patience. As this is a participatory research study, we sought, documented, and responded to practice and patient requests for adaptations. Changes included adding a third study arm using telehealth induction (observed via telephone or video, synchronous) and switching to a comprehensive cohort design to answer meaningful patient-centered research questions. Using a narrative approach based on the Greek myth of Homer, we describe here the challenges and adaptations that have provided the opportunity for HOMER to thrive and find the way home. These clinical trial strategies may apply to other studies faced with similar cultural and extreme circumstances.

Ann Fam Med 2024;22:444-450. https://doi.org/10.1370/afm.3149

"Passage home! Never. Surely, you're plotting something else, goddess, urging me—in a raft—to cross the ocean's mighty gulfs. So vast, so full of danger not even the deep-sea ships can make it through, swift as they are and buoyed up by the winds of Zeus himself."

—from The Odyssey by Homer

INTRODUCTION

The usual challenges of conducting primary care research, including randomized trials, were exacerbated during the COVID-19 pandemic.[1,2] Research teams across the translational spectrum, from basic science to clinical research, faced obstacles in nearly every aspect of a study, including site and participant recruitment, protocols that required in-person assessment or treatment, related travel for participants as well as investigators, and the daily tasks of managing a research team through virtual communication.[3-5] Research studies suffered serious delays, and some reported full shutdown until pandemic restrictions were lifted.[6]

Researchers developed numerous methods to mitigate the negative impact of COVID-19 on their patients and their research.[7] After an initial decline in the number of studies in the United States, there was an overall increase in research, due to the enormous efforts to study COVID-19.[8] Research on other topics declined throughout the pandemic. Research institutions reacted to the pandemic by modifying current research, increasing virtual components of research among team members and study participants, and pivoting research toward COVID-19.[9-11]

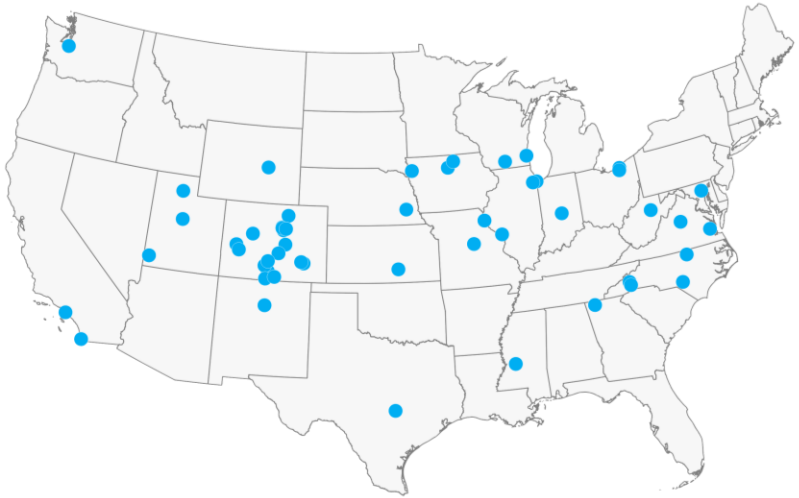
Conflicts of interest: authors report none.

CORRESPONDING AUTHOR
Linda Zitelman
University of Colorado
13001 E. 17th Ave
Fitzsimons Innovation Campus
MS8, AO1, Room 4210
Aurora, CO 80045
Linda.Zitelman@cuanschutz.edu

One thing hasn't changed…

- Persons with opioid dependency still struggle to find treatment despite:
  - Waiver removal
  - ED programs
  - Pop up clinics
  - Mobile treatment vans
- 2022 CDC estimates - 25.1% of persons receive treatment
- Delivery in primary care could help

Practice Characteristics (N=79)



Practice Characteristics	N (%)
Practice Type	
Federally Qualified Health Center	26 (35%)
Hospital-based or health system owned clinic	25 (33%)
Private practice/clinician-owned solo or group practice	19 (25%)
	3 (4%)
Community Health Center	15 (20%)
Academic Medical Center	2 (3%)
Non-federal government clinic	1 (1%)
Free and Charitable Clinic	7 (9%)
Rural Health Clinic	5 (7%)
Other clinic type	26 (33%)
	35 (44%)
Practice Staff	**Median (range)**
Clinicians (MD, DO, NP, PA)	5 (1,69)
Registered Nurses	1 (1,24)
Licensed Practica Nurses	0 (1,15)
Medical Assistants	3 (1,25)
Certified Nursing Assistant	0 (1,12)
Front desk staff	3 (1,30)
Practice Managers/Administrators	1 (1,18)
Behavioral Health providers	1 (1,40)
Medical records staff	0 (1,9)

Participant Characteristics

HOMER

Participant characteristic	Overall N = 294[1]	Study arm: Randomized N = 150[1]	Study arm: Choice N = 144[1]	p-value[2]
Age – mean (SD)	38.0 (17.0,83.0)	36.0 (18.0,83.0)	38.0 (17.0,72.0)	0.19
Female	148 (50.7%)	78 (52.3%)	70 (49.0%)	0.56
American Indian or Alaska Native	22 (7.5%)			0.43
Asian	2 (0.7%)			0.24
Black or African American	24 (8.2%)			0.60
Pacific Islander	2 (0.7%)			0.24
White	233 (79.3%)			0.14
Other race	16 (5.4%)			0.27
Hispanic, Latino/a, or Spanish origin	53 (18.4%)	19 (12.9%)	34 (24.1%)	0.014
Previous OUD treatment	**177 (60.6%)**	**81 (54.4%)**	**96 (67.1%)**	**0.026**
Education				0.34
Some high school or less	50 (17.1%)			
High school graduate	138 (47.3%)			
Some college or technical school	78 (26.7%)			
College graduate	26 (8.9%)			
Marital status				0.27
Married/partnership	84 (32.7%)			
Divorced/Separated/Widowed	74 (28.8%)			
Never married	99 (38.5%)			
Annual Household Income				0.10
Less than $15,000	112 (44.3%)			
$15,000 to less than $35,000	66 (26.1%)			
$35,000 or more	75 (29.6%)			
Health Insurance	210 (87.9%)	110 (90.2%)	100 (85.5%)	0.27

Our take home messages

- **YES! Primary Care Provides Medication for Opioid Use Disorder**

- HOMER provides a snapshot of primary care and family medicine practices and patients that provide and receive MOUD in daily clinical practice**.**
- **Nearly half of patients had no prior treatment** supporting the importance of access to MOUD in primary care.
- Practices and patients in HOMER are similar to family medicine practices and patients across the country.
- Policies that support MOUD in primary care may improve access for patients.

We gratefully acknowledge the HOMER Patient and Clinician Advisory Group for their robust participation in and the HOMER study. Their input helped shape the HOMER research methods, recruitment and interpretation of results. Fred Crawford, Erin Zook, David Wolff, Maret Felzien, David Bauerly, Emily Brown, Melanie Murphy, Andrea Dreckman, Jammie Martinez, Lori Heeren, Norah Sanchez.

pcc primary care collaborative

Convening + Uniting + Transforming

Update from Capitol Hill

Venn Strategies

pcc primary care collaborative

Convening + Uniting + Transforming

Psychiatric CoCM Model Study Finding

Kevin Roy | Shatterproof
Michael Yuhas | Bowman Family Foundation

New Study Finds Use of Psychiatric Collaborative Care Model Has Expanded Rapidly for Children and Adults, but With Enormous Disparities Among States

Key organizations call on 14 state Medicaid agencies to reimburse for CoCM to improve patient outcomes and reduce total healthcare costs for Medicaid, Medicare and commercial plans

Presented to:
PCC Behavioral Health Integration Workgroup Meeting
February 26, 2026

Shatterproof
Stronger than addiction

BOWMAN FAMILY FOUNDATION

Evidence That CoCM Improves Outcomes

- Since 2002, an extensive evidence base has accrued regarding the benefits of CoCM. More than 90 randomized controlled trials (RCTs), supplemented by multiple meta-analyses and "real world" studies in day-to-day primary care settings, have demonstrated the positive impact of CoCM on patient outcomes, and patient and provider satisfaction.
- As shown in Large Reductions in Suicide Risk, Attempts and Deaths Demonstrated by Three "Real World" Studies in Primary Care, studies have documented the substantial impact of CoCM on suicide risk, showing risk reduction in more than 50% of "at risk" patients.

Evidence That CoCM Lowers Total Healthcare Costs

- CoCM has been shown to be effective in reducing Total Healthcare Costs (THCs) through reductions in medical expenditures. Results from four key studies are summarized below.
- Savings in THCs have been realized as soon as within 6 months and have increased over 3–4 years.

Study Name/Payer Involved	Size and Timing of Savings
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

Key Findings

(Full report can be found here)

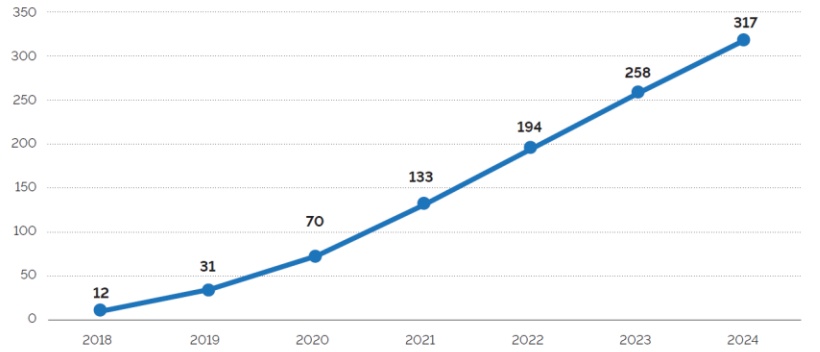
Between 2018 and 2024 (2018-2023 for Medicaid/Medicare data):

- **Rapid national growth – particularly for children and adolescents**
- **Enormous disparities among states**
  - **Similar disparities for Medicaid, Medicare and commercial**
- **Medicaid and commercial reimbursement rates vary widely by state**
- **Most commercial CoCM delivered by family/internal medicine, pediatric providers**

Key Findings: Rapid National Growth

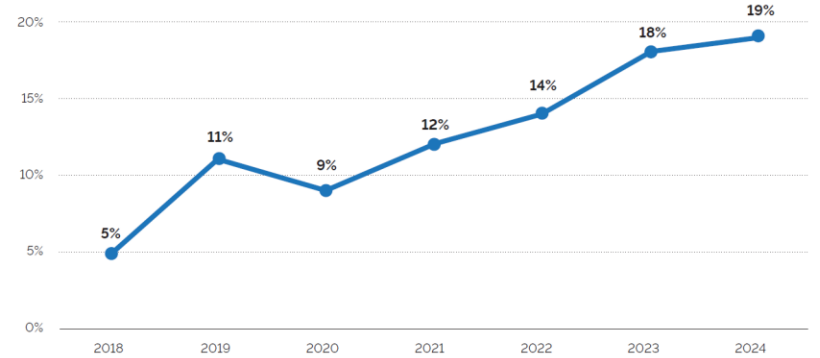
- CoCM use among commercially-insured patients (per 100,000 patients with MHSU Dx) grew **26-fold**
- The number of commercially-insured CoCM patients who were children and adolescents increased **148-fold**, and the percentage of CoCM patients who were children and adolescents **quadrupled**

Figure 1B. National Use Rate of Commercially Insured CoCM Patients per 100,000 Patients with an MHSU Diagnosis[i]



Source: FAIR Health data

Figure 2B. National Percentage of Commercially Insured CoCM Patients Who Were Children and Adolescents[k]



Source: MHTARI analysis of FAIR Health data

- **Medicaid/Medicare use patterns were similar** to commercial – rapid national growth (including for children and adolescents in Medicaid)

Key Findings: Enormous Disparities Among States

- Many states had virtually no commercial CoCM use while others saw dramatic growth. For example:
  - In 2024, CoCM use rates (per 100,000 commercially-insured patients with an MHSU diagnosis) were:
    - **1,304 in AZ** (**11x** increase from 2018)
    - **1,175 in WI** (**65x** increase from 2018)
    - **1,013 in UT** (**338x** increase from 2018)
  - In 2024, CoCM commercial use rates were **< 50 in 16 states** (ID, MN, SD, KY, WV, AL, KS, RI, IA, NE, IN, LA, ND, MS, WY, AK).
    - Most of these did not post **Medicaid** FFS CoCM reimbursement rates on their websites as of January, 2026
    - Others did not have **Medicaid** FFS CoCM reimbursement in some or all of the years examined (2018-2024)
    - Almost all had very low **Medicaid** use through 2023
- **Medicaid/Medicare** use patterns showed similar disparities among states

Key Findings: Commercial CoCM Reimbursement Varies Widely By State

- **In 2024,** average commercial CoCM reimbursement – as a % of Medicare – ranged from **90%** (HI) to **277%** (CA).
- Adequate commercial reimbursement – while essential – has not, itself, generated high commercial use in most states that do not have Medicaid FFS reimbursement for CoCM.

States in blue boxes were ranked 25th or higher (i.e., "top half") in terms of commercial reimbursement but nonetheless had low Medicaid and commercial use (i.e., "bottom half").

Figure 4. 2024 Mean Ratio of Commercial CoCM Reimbursement to Medicare CoCM Reimbursement (Sorted High to Low)[q, r]

Rank	State	Mean
1	California	277%
2	Wisconsin	276%
3	Oregon	245%
4	Idaho	234%
5	Minnesota	233%
6	Massachusetts	203%
7	Washington DC	199%
8	New Hampshire	196%
9	Rhode Island	193%
10	Vermont	190%
11	New Mexico	184%
12	Washington	183%
13	Iowa	183%
14	Maine	178%
15	West Virginia	174%
16	Georgia	174%
17	Alabama	173%
18	Kansas	170%
19	North Carolina	166%
	USA (National)	**162%**
20	Montana	162%
21	Illinois	158%
22	Maryland	156%
23	South Dakota	147%
24	Louisiana	147%
25	South Carolina	147%
26	Tennessee	145%
27	Virginia	143%
28	Pennsylvania	140%
29	Florida	140%
30	Utah	140%
31	New York	139%
32	Ohio	137%
33	Missouri	137%
34	Arkansas	135%
35	Michigan	134%
36	Colorado	133%
37	Nevada	132%
38	New Jersey	131%
39	Nebraska	130%
40	Indiana	128%
41	Arizona	123%
42	Connecticut	123%
43	Kentucky	115%
44	Oklahoma	115%
45	Texas	113%
46	Delaware	108%
47	Hawaii	90%
N/A	Alaska	-
N/A	Mississippi	-
N/A	North Dakota	-
N/A	Wyoming	-

Source: Mean commercial reimbursement data from FAIR Health; Identification of blue states by MHTARI using data from FAIR Health and RTI

Key Findings: Medicaid FFS CoCM Reimbursement Varies Widely By State

- **In January 2026**, **Medicaid** FFS CoCM reimbursement rates also varied considerably:
  - **14** states paid **90% or more** of Medicare rates for 99492 or 99493
  - **13** states paid **70–89%** of Medicare rates for 99492 or 99493, < 90% for both
  - **8** states paid **< 70%** of Medicare rates for both 99492 and 99493
  - **16** states did not post Medicaid FFS reimbursement rates to their websites for either 99492 or 99493*

*Notes:

- See notes related to these 16 states in the Summary Analysis.
- Medicaid plans (including some in this group) often pay some portion of "patient out-of-pocket expenses" for certain categories of Medicare-Medicaid "dual eligible" patients, which is one reason why most states have had at least a minimal volume of Medicaid CoCM patients. For those categories of patients, Medicare is the primary payer and Medicaid will reimburse the patient cost sharing.
- Data through 2023 shows that use of CoCM in these states was typically low for both Medicaid FFS and Medicaid MCO patients; however, Medicaid MCO use was substantial in 2 of the 16 states (MN and TN).

Key Findings: Most Commercial CoCM Delivered by Family/Internal Medicine, Pediatricians

Figure 8. Top 10 Provider Types with the Largest Percentage of CoCM Services for Commercially Insured Patients in 2023[ao]

Provider Taxonomy	Specialty	% of all CoCM claim lines billed in 2023
207Q00000X	Family Medicine	36.8%
207R00000X	Internal Medicine	20.9%
208000000X	Pediatrics	14.3%
363LF0000X	Nurse Practitioner - Family	8.5%
363A00000X	Physician Assistant	3.3%
207V00000X	Obstetrics & Gynecology	2.8%
363L00000X	Nurse Practitioner	2.2%
363LA2200X	Nurse Practitioner - Adult Health	1.1%
363AM0700X	Physician Assistant - Medical	1.0%
363LP0200X	Nurse Practitioner - Pediatrics	0.6%
	Subtotal	91.5%
	All Other Providers	8.5%
	Total	100%

Source: FAIR Health data

Key Insights – Provider/Patient/Payer Economics

(From the Report, Study Overview and Key Insights, pages 4-6)

- No or restrictive Medicaid reimbursement drives low use for patients with all types of insurance.
  - With few exceptions, in states where Medicaid Fee-for-Service (FFS) did not reimburse for CoCM, its use was minimal in Medicaid, Medicare and commercial plans.
- Patient "out-of-pocket" expenses limit CoCM use – even in states with adequate Medicaid and commercial reimbursement.
- Greater CoCM use would reduce Total Healthcare Costs for all payers.
  - If all Medicaid payers offered adequate reimbursement, CoCM use would increase, and it would increase further if patient cost-sharing was reduced or eliminated.
- The requirement to use code G0512 appears to drive very low use by FQHCs and RHCs – even in states with otherwise adequate Medicaid reimbursement.

Recommendations to Increase CoCM Use in All States

Broadscale adoption of CoCM will improve clinical outcomes and, based on mounting evidence, will reduce Total Healthcare Costs. To facilitate adoption, it is imperative to have supportive regulatory policies as well as reimbursement levels and billing policies that encourage providers to deliver CoCM and encourage patients to engage in CoCM. Therefore, we recommend:

HHS/CMS should use all available means to:

- Increase Medicare FFS reimbursement rates for CoCM to reflect the clinical value of CoCM and encourage use, which reduces total healthcare costs.
- Ensure that Medicaid reimbursement for CoCM is at least equivalent to FFS Medicare, and that patient cost-sharing is waived wherever possible.
- Eliminate billing code G0512 for FQHCs/RHCs that furnish CoCM to Medicaid patients—as was done for Medicare patients starting January 1, 2026.
- For Medicare and Medicaid, minimize administrative billing requirements such as patient consent and pre-authorization, to encourage provider adoption.

Recommendations to Increase CoCM Use in All States

Medicaid programs in all states should:

- Authorize FFS CoCM reimbursement **and** establish rates at least equivalent to Medicare FFS reimbursement (as already done in many states—see Group 1 in Appendix D1).
- Align with Medicare policy by allowing FQHCs and RHCs to use CoCM billing codes 99492, 99493, 99494 and G2214—in lieu of the more restrictive billing code G0512 (which disincentivizes the provision of CoCM).
- Use the same criteria as Medicare for patient eligibility to receive CoCM.
- Require Medicaid MCOs to do all of the above as well.

Recommendations to Increase CoCM Use in All States

Employer and other Commercial Plans should:

- Reimburse for CoCM, and set such reimbursement at a level equal to at least 160% of Medicare FFS reimbursement (currently the average is 162%).
- Eliminate all patient out-of-pocket expenses for CoCM wherever permissible.

All Payers should:

- Allow use of CoCM billing code 99494 as frequently as justified by patient needs.
- Reimburse providers for CoCM separately from, and in addition to, any care management fees, primary care capitation, or other bundled/global payments—**OR** increase such payments to specifically cover the costs of the CoCM services being provided.

Recommendations to Increase CoCM Use in All States

Regulators and Accreditation Organizations should, when assessing MHSU parity compliance and network adequacy, allow in-network CoCM services—if delivered per CMS billing requirements—to count as in-network MHSU specialist services.

Providers should implement CoCM and take advantage of the many available resources and expertise now available, including those identified in the Directory of CoCM Service Organizations.

Supporters of the Recommendations in the Report

(From the Press Release for the report)

37 prominent organizations support the report's recommendations, urging:

- All states to adequately reimburse for CoCM, and
- All stakeholders (e.g., HHS, CMS, employers, commercial insurers, regulators, accreditation organizations, and providers) to support broadscale use of CoCM by taking the steps recommended in the new study (page 7):

Supporters of the Recommendations in the Report

Payers, Providers, and Provider Associations

- Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington
- American Academy of Child and Adolescent Psychiatry (AACAP)
- American College of Physicians (ACP)
- American Psychiatric Association (APA)
- Blue Cross Blue Shield of Michigan (BCBSM)
- Children's Hospital Colorado
- Children's National Hospital, Department of Psychiatry & Behavioral Sciences, and Community Mental Health CORE
- Department of Psychiatry, Perelman School of Medicine, University of Pennsylvania
- Kaiser Permanente
- Mass General Brigham Department of Psychiatry
- National Alliance of Healthcare Purchaser Coalitions
- National Association of State Mental Health Program Directors (NASMHPD)
- National Council for Mental Wellbeing

Supporters of the Recommendations in the Report

Advocates and Philanthropies

- 1440 Foundation
- Accelerate The Future
- American Association on Health and Disability (AAHD)
- American Foundation for Suicide Prevention (AFSP)
- The Austin & Gabriela Hearst Foundation
- The Bowman Family Foundation
- BrainFutures
- The Goodness Web
- Inseparable
- The Jed Foundation (JED)
- Joe & Sandy Samberg Foundation
- The Kennedy Forum (TKF)
- Lakeshore Foundation
- Meadows Mental Health Policy Institute (MMHPI)
- Mental Health America (MHA)
- Mindful Philanthropy
- National Alliance on Mental Illness (NAMI)
- NHMH - No Health without Mental Health
- Policy Center for Maternal Mental Health
- Shatterproof
- Sylvan C. Herman Foundation
- Treatment Advocacy Center (TAC)
- Walker Family Foundation
- West Health

Questions?

pcc primary care collaborative

Convening + Uniting + Transforming

Wrap Up & Next Steps

Larry McNeely | PCC