Meadows Mental Health Policy Institute

Policy Background Briefing: Collaborative Care – October 2020

Beyond the physical health consequences of the COVID-19 pandemic, the shutdown, economic recession, and social isolation are leading to **additional behavioral health needs** for Texans.

In April 2020, the Meadows Mental Health Policy Institute (MMHPI) issued the first in a series of reports analyzing the behavioral health impacts of the COVID-19 pandemic. Our initial report projected the impact of a COVID-induced economic recession on increases in rates of suicide, illicit-drug-related deaths, and substance use disorder (SUD). Our second report updated the original report with state-level projections. Other studies have estimated comparable levels of morbidity and mortality.[1]

These reports forecasted how COVID-19-driven unemployment could cause potential increases in mortality from suicide and drug overdose as well as increases in SUD. This modeling assumed that treatment availability would remain stable at pre-pandemic levels, an assumption that is now proving to be excessively optimistic.[2] Since those reports, the Centers for Disease Control and Prevention has released updated drug overdose death statistics, including data showing that drug overdose deaths have been increasing year-over-year[3] and that this trend may be increasing due to COVID-19.[4] Our original projections suggested that for every five-percentage-point increase in the unemployment rate compared to pre-pandemic levels, an additional 4,000 Americans, including 300 Texans, could be lost to suicide; our updated projections add 5,500[5] American drug overdose deaths to pre-COVID-19 levels, including 425 Texans.

In response to the committee's request for information on suicide prevention programs and efforts, MMHPI provides the following recommendation for the Texas Medicaid program:

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[1] Patterson, S., Westfall, J. M., & Miller, B. F. (2020, May 8). *Projected Deaths of Despair During the Coronavirus Recession.* https://wellbeingtrust.org/wp-content/uploads/2020/05/WBT_Deaths-of-Despair_COVID-19-FINAL-FINAL.pdf

[2] National Council for Behavioral Health. (2020, April 15). *COVID-19 economic impact on behavioral health organizations.* https://www.thenationalcouncil.org/wp-content/uploads/2020/04/NCBH_COVID19_Survey_Findings_04152020.pdf?daf=375ateTbd56

[3] Ahmad, F. B., Rossen, L. M., & Sutton, P. (2020, July 15). *Provisional drug overdose death counts*. National Center for Health Statistics. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[4] Alter, A. & Yeager, C. (2020, May 13). *The consequences of COVID-19 on the overdose epidemic: Overdoses are increasing.* http://odmap.org/Content/docs/news/2020/ODMAP-Report-May-2020.pdf

[5] Our earlier models suggested that 4,800 Americans would die from drug overdose deaths. These models have been updated to use more current data from the Centers for Disease Control and Prevention and now reflect an anticipated 5,500 drug overdose deaths per 5% increase in the national unemployment rate. State-level estimates were also updated similarly.

Collaborative Care

The **collaborative care model (CoCM)** is a proven tool to detect and prevent suicide and overdose in primary care before they become crises. Unfortunately, less than one in twenty Americans can currently access it.

CoCM uses a team-based approach to care[6] that routinely measures both clinical outcomes and patient goals over time to increase the effectiveness of mental health and SUD treatment in primary care settings.[7,8] CoCM is an established evidence-based practice that has been shown to reduce depression, bipolar and anxiety disorders, SUD, suicidal ideation, and suicide completion.[9,10] CoCM is also the only evidence-based medical procedure currently reimbursable in primary care — it has been covered by Medicare since 2017[11] and by nearly all commercial payers since 2019[12] — and it is the only model with strong evidence of cost savings.[13,14,15] The potential cost-savings of wide-spread implementation are considerable; a 2013 study found ***savings in Medicare and Medicaid settings of up to 6 to 1 in total medical costs and estimated***

[6] Unützer, J., Harbin, H., Schoenbaum, M., & Druss, B. (2013, May). *The collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes*. Health Home Information Resource Center. http://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf

[7] Nafziger, M., & Miller, M. (2013). *Collaborative primary care: Preliminary findings for depression and anxiety* (Doc. No.13-10-3401). Washington State Institute for Public Policy. http://www.wsipp.wa.gov/ReportFile/1546/Wsipp_Collaborative-Primary-Care-Preliminary-Findings-for-Depression-and-Anxiety_Preliminary-Report.pdf

[8] Alford, D. P., LaBelle, C. T., Kretsch, N., Bergeron, A., Winter, M., Botticelli, M., & Samet, J. H. (2011). Collaborative care of opioid-addicted patients in primary care using buprenorphine: five-year experience. *Archives of Internal Medicine*, *171*(5), 425-431. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/226781

[9] Bower, P., Gilbody, S., Richards, D., Fletcher, J., & Sutton, A. (2006). Collaborative care for depression in primary care: Making sense of a complex intervention: Systematic review and meta-regression. *The British Journal of Psychiatry, 189*(6), 484–493. https://doi.org/10.1192/bjp.bp.106.023655

[10] Unützer, J., Katon, W., Callahan, C. M., Williams, J. W., Jr, Hunkeler, E., Harpole, L., Hoffing, M., Della Penna, R. D., Noël, P. H., Lin, E. H., Areán, P. A., Hegel, M. T., Tang, L., Belin, T. R., Oishi, S., & Langston, C. (2002, December 11). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. *JAMA, 288*(22), 2836–2845. https://doi.org/10.1001/jama.288.22.2836

[11] Center for Medicare and Medicaid Services. (2019, May). *Behavioral health integration services.* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

[12] Alter, C., Carlo, A., Harbin, H., & Schoenbaum, M. (2019, July 3). Wider implementation of collaborative care is inevitable. *Psychiatric News, 54*(13), 6-7. https://doi.org/10.1176/appi.pn.2019.6b7

[13] Unützer, J., Schoenbaum, M., & Druss, B. (2013, May). Previously cited.

[14] Press, M. J., Howe, R., Schoenbaum, M., Cavanaugh, S., Marshall, A., Baldwin, L., & Conway, P. H. (2017, February 2). Previously cited.

[15] Melek, S. P., Norris, D. T., Paulus, J., Matthews, K., Weaver, A., & Davenport, S. (2018, January). *Potential economic impact of integrated medical-behavioral healthcare. Updated projections for 2017*. https://milliman-cdn.azureedge.net/-/media/milliman/importedfiles/uploadedfiles/insight/2018/potential-economic-impact-integrated-healthcare.ashx

$15 billion in Medicaid savings if only 20 percent of beneficiaries with depression receive it.[16] Despite its effectiveness and savings, implementation has been slow.[17]

In August 2020, MMHPI issued a report modeling the extent to which universal access to evidence-based integrated primary care to treat major depression through CoCM could offset a portion of the predicted increases in suicide from the pandemic. In Texas, our models suggest universal access to collaborative care to treat major depression could reduce the number of suicide deaths[18] by between 725 and 1,100 deaths per year.

Recommendation: Add Current Procedural Terminology (CPT) codes 99492-99494 for CoCM to Texas Medicaid, for both children and adults, to increase access to behavioral health services integrated in primary care.

Fifteen other states currently offer CoCM in their Medicaid programs.[19]

[16] Unützer, J., Schoenbaum, M., & Druss, B. (2013, May). Previously cited.
[17] Katon, W., Unützer, J., Wells, K., & Jones, L. (2010). Collaborative depression care: History, evolution, and ways to enhance dissemination and sustainability. *General Hospital Psychiatry*, *32*(5), 456–464. https://doi.org/10.1016/j.genhosppsych.2010.04.001
[18] We calculated a range of suicide deaths that could be prevented if CoCM were expanded. The low-end estimate was calculated by assuming that half of deaths from suicide were caused by depression (based on WSIPP, 2019; http://www.wsipp.wa.gov/TechnicalDocumentation/WsippBenefitCostTechnicalDocumentation.pdf), and the high-end estimate was generated under the assumption that as many as 80% of deaths from suicide are caused by depression, based on Beautrais, A. L., Joyce, P. R., Mulder, R. T., Fergusson, D. M., Deavoll, B. J., & Nightingale, S.K. (1996). Prevalence and comorbidity of mental disorders in persons making serious suicide attempts: A case-control study. *American Journal of Psychiatry, 153*(8), 1009–1014. https://doi.org/10.1176/ajp.153.8.1009
[19] Raney, L. (2020, September). *Cracking the Codes: State Medicaid Approaches to Reimbursing Psychiatric Collaborative Care.* California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2020/09/CrackingCodesMedicaidReimbursingPsychiatricCollaborativeCare.pdf