POLICY PROFILE

State Medicaid Agency Approval of Collaborative Care Model Reimbursement Codes

RAND-USC SCHAEFFER OPIOID POLICY TOOLS AND INFORMATION CENTER

Formally integrates new Current Procedural Terminology (CPT) codes to fund collaborative care model (CCM) in primary care settings. The codes are designed to reimburse billing practitioners for the cumulative time the health care team spends delivering components of CCM each calendar month.

A panel of experts rated how they expect this type of policy to affect four outcomes: *opioid use disorder (OUD) treatment engagement*, *OUD treatment retention*, *OUD remission*, and *opioid overdose mortality*. Another panel of experts rated the policy on four implementation criteria: *acceptability* to the public, *feasibility* of implementation, *affordability* from a societal perspective, and *equitability* in health effects.

POLICY RECOMMENDATION ACCORDING TO EXPERT RATINGS

OPPOSE	UNCERTAIN	SUPPORT

SUMMARY OF EXPERT RATINGS

OUTCOMES	EFFECT RATING		
OUD Treatment Engagement	HARMFUL	LITTLE-TO-NO	BENEFICIAL
OUD Treatment Retention	HARMFUL	LITTLE-TO-NO	BENEFICIAL
OUD Remission	HARMFUL	LITTLE-TO-NO	BENEFICIAL
Opioid Overdose Mortality	HARMFUL	LITTLE-TO-NO	BENEFICIAL
CRITERIA	**IMPLEMENTATION RATING**		
Acceptability	LOW	MODERATE	HIGH
Feasibility	LOW	MODERATE	HIGH
Affordability	LOW	MODERATE	HIGH
Equitability	LOW	MODERATE	HIGH

SUMMARY OF EXPERT COMMENTS

- Experts expect better reimbursement to facilitate treatment engagement through primary care settings; they expect minimal effects on treatment (due to the significant staffing and funding required) and no impacts on remission and overdose mortality.
- Experts think the public generally approves policies that facilitate higher-quality, coordinated, patient-centered medical care—especially for chronic conditions.
- Experts view precedent from other chronic conditions and substance use treatment as evidence of feasibility. However, new Medicaid benefits could lead to state affordability concerns.
- Experts believe equitability of this policy depends on the quality of implementation.

THE PANELS AND RESULTS INFORMING THIS POLICY PROFILE ARE FULLY DOCUMENTED IN

Smart, R., Grant, S., Gordon, A. J., Pacula, R. L., & Stein, B. D. (2022). Expert panel consensus on state-level policies to improve engagement and retention in treatment for opioid use disorder. *JAMA Health Forum*, 3(9), e223285. As of July 31, 2023: https://www.rand.org/t/EP69031.html

Grant, Sean, Rosanna Smart, Adam J. Gordon, Rosalie Liccardo Pacula, and Bradley D. Stein. (2023). Expert views on state policies to improve engagement and retention in treatment for opioid use disorder: A qualitative analysis of an online modified-Delphi process. *Journal of Addiction Medicine*. As of December 4, 2023: https://www.rand.org/t/EP70324.html

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To view this Policy Profile online, visit www.rand.org/t/RBA3054-21.

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Outcomes Summaries

OUD TREATMENT ENGAGEMENT

Percentage of people meeting the criteria for an OUD diagnosis who receive two or more OUD treatment services (including medication for OUD) within 34 days of initiating treatment.

EFFECT RATING	SUMMARY OF EXPERT OPINION	REPRESENTATIVE QUOTATIONS
BENEFICIAL	Providing reimbursement could facilitate engagement in OUD treatment through primary care settings.	"This may convince providers to spend the necessary time to facilitate treatment engagement, and/or to hire [behavioral health] specialists that can do so"
LITTLE-TO-NO	Does not address a major barrier to treatment engagement.	"This policy does not seem to be a mechanism that would attract individuals into care per se"
HARMFUL	N/A	N/A

OUD TREATMENT RETENTION

Percentage of people meeting the criteria for an OUD diagnosis who remain continuously enrolled in OUD treatment services for at least six months.

EFFECT RATING	SUMMARY OF EXPERT OPINION	REPRESENTATIVE QUOTATIONS
BENEFICIAL	Reimbursement could facilitate continuous, higher-quality care (e.g., through allied health professionals).	"Being able to bill for the time of the whole team can be helpful towards increasing retention rates in treatment—there is an incentive to provide whole-person care, which should produce better outcomes for a person with OUD. These individuals tend to have co-morbid issues"
LITTLE-TO-NO	Requires significant staffing and funding to have an impact.	"I think the funding would have to be pretty robust and the requirements minimal. I don't, unfortunately, see that happening. I am not sure the additional billing of 120 minutes per month would cover [staff] to make it happen"
HARMFUL	N/A	N/A

Outcomes Summaries

OUD REMISSION

Percentage of people meeting the criteria for an OUD diagnosis who do not experience OUD symptoms (other than a craving, desire, or urge for opioid) for at least 12 months.

EFFECT RATING	SUMMARY OF EXPERT OPINION	REPRESENTATIVE QUOTATIONS
BENEFICIAL	Continuous, higher-quality care should translate into more OUD remission.	"Connecting folks to treatment at the primary care setting and collaborating with treatment experts could make a marginal difference in long-lasting treatment and recovery"
LITTLE-TO-NO	Limited evidence linking this policy with OUD remission	"Unclear how this would affect treatment remission"
HARMFUL	N/A	N/A

OPIOID OVERDOSE MORTALITY

Per capita rates of fatal overdose related to opioids, including opioid analgesics (e.g., oxycodone), illegal opioids (e.g., heroin), and synthetic opioids (e.g., fentanyl).

EFFECT RATING	SUMMARY OF EXPERT OPINION	REPRESENTATIVE QUOTATIONS
BENEFICIAL	Continuous, higher-quality care should translate into less overdose mortality, especially if treatment includes harm reduction components (e.g., naloxone education).	"Better coordination between treatment providers and primary care providers will result in fewer overdose deaths"
LITTLE-TO-NO	This policy does not address overdoses by those not engaged in treatment through the health care system.	"Mortality rates are affected by much more than health care system design"
HARMFUL	N/A	N/A

Implementation Criteria Summaries

ACCEPTABILITY

The extent to which the policy is acceptable to the general public in the state or community where the policy has been enacted.

IMPLEMENTATION RATING	SUMMARY OF EXPERT OPINION	REPRESENTATIVE QUOTATIONS
HIGH	Public generally approves of policies that facilitate higher-quality, coordinated, patient-centered medical care—especially for chronic conditions and addressing the overdose crisis.	"There is precedence and ongoing support for collaborative care models for other populations and conditions (e.g., older adults, disabilities/dual disabilities, co-occurring chronic conditions, etc.) and therefore would be general acceptance among provider and patient population"
MODERATE	Vast majority of the general public is not likely to be aware of or have an opinion about this policy.	"I'll bet not one 100th of the population even understands this"
LOW	N/A	N/A

FEASIBILITY

The extent to which it is feasible for a state or community to implement the policy as intended.

IMPLEMENTATION RATING	SUMMARY OF EXPERT OPINION	REPRESENTATIVE QUOTATIONS
HIGH	Builds on precedent of models for other chronic conditions and early examples for substance use treatment.	"There is precedence and ongoing discussions on coordination models. There is particular interest in supporting access to peer services in particular and so very much momentum to feasibility"
MODERATE	Faces significant staffing, training and technical assistance, and billing issues that serve as barriers to implementing the policy as planned.	"This seems like making the code change would be easy, but training and getting [providers] to use it and understand how to do it well is another story. The [Screening, Brief Intervention and Referral to Treatment] codes story seems analogous"
LOW	N/A	N/A

Implementation Criteria Summaries

AFFORDABILITY

The extent to which the resources (costs) required to implement the policy are affordable from a societal perspective.

IMPLEMENTATION RATING	SUMMARY OF EXPERT OPINION	REPRESENTATIVE QUOTATIONS
HIGH	Integrated and coordinated care are increasingly common, making changes from the status quo more minor and thus less costly, especially given long-term societal cost-benefits.	"Collaborative care models are increasingly common and thus systems are in place to expand"
MODERATE	Entails new Medicaid benefits, which are costly to states.	"Many at the state level would view it as unaffordable—unless they contract with [Medicaid managed care organizations]'s for Medicaid and make them cover it without increasing the amount paid per client"
LOW	N/A	N/A

EQUITABILITY

The extent to which the policy is equitable in its impact on health outcomes across populations of people who use opioids.

IMPLEMENTATION RATING	SUMMARY OF EXPERT OPINION	REPRESENTATIVE QUOTATIONS
HIGH	Directly targeting Medicaid should improve access to care among societally underserved and disadvantaged populations.	"This is a policy that has the possibility of increasing equity in that it will serve Medicaid patients. This reflects a targeted vulnerable population approach"
MODERATE	Depends on the quality of implementation: potential to improve equity if implemented well and potential to increase disparities if not.	"If well implemented it should increase access to treatment for many people who have opioid use disorder, however, unless it has explicit programming and protections built in to engage and make accessible to groups historically excluded from care, including Black, Latinx, and Native American populations, then there is a substantial risk that it will exacerbate underlying racial and ethnic inequities"
LOW	Potential to be implemented poorly and inequitably, leading to disparate outcomes.	"Likely will not impact equity as I suspect well-resourced centers will be the ones who start to use the new CPT codes and just get enhanced billing for the care they have already been providing"

This Policy Brief was developed by the RAND-USC Schaeffer Opioid Policy Tools and Information Center (OPTIC), a multidisciplinary research center dedicated to improving the effectiveness of opioid policies by enhancing opioid policy science. OPTIC is a collaboration between the RAND Corporation and the USC Leonard D. Schaeffer Center for Health Policy and is funded by the National Institute on Drug Abuse (P50DA046351). RAND is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors. RAND® is a registered trademark.

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