

Executive Summary

Mental health leaders, medical leaders, and employers from across Minnesota resoundingly express that integrated behavioral health care in primary care, specifically the Collaborative Care Model (CoCM), is a solution that must be expanded.

With increased need for mental health and substance use disorder services, the Collaborative Care Model has been demonstrated to more effectively use the constrained resources of psychiatry and psychotherapy. Even prior to the Covid-19 pandemic, it was estimated that the country would need four times as many mental health providers as were practicing at the time in order to meet the need.¹

Nationally, the Collaborative Care Model is increasingly gaining momentum as a needed solution, but is yet to be prioritized in Minnesota. The [Collaborative Care Model](#) has overwhelming evidence of better outcomes, along with improved patient and provider satisfaction and potential cost savings (see accompanying paper). [New federal legislation has been introduced specifically aimed at advancing this model of care](#), supported by multiple medical and mental health associations and employers. The Collaborative Care Model in primary care has also been named as part of the solution in a new [bipartisan call for national mental health reform](#). With all these benefits, why hasn't this service gained more traction?

A major challenge is that integration contests the status quo for how healthcare is historically delivered and paid. We must bridge the historical silos that exist between mental health and addiction and primary care, including different cost centers, different medical records and privacy laws. Financing of behavioral health historically and currently emphasizes fee-for-service, face-to-face visits, however with Value Based Payment (VBP) rapidly becoming a larger part of the healthcare financing equation, healthcare systems are now at risk financially if their quality numbers are not at goal (which are harder to achieve with a growing mental health burden). The Collaborative Care Model can help meet quality goals within VBP contracts; at the same time the model is advanced by VBP.

Four main actions are needed:

- **Advance and support the Collaborative Care Model as a priority model.**
- **Support the operational and financial innovation that integration requires, as it challenges the historical structural divide between mental health/SUD, and primary care.** Incorporate the model into Value Based Payment contracts, and ensure leadership persistence for integration.
- **Ensure financial sustainability. One clear path towards sustainability is to arrange reimbursement across all commercial and public payors and service lines for the Collaborative Care Model codes and Behavioral Health Integration codes.** This is not currently the case as it is not covered for Medicaid and MinnesotaCare patients.
- **Establish a regional center for excellence to support advancement of the Collaborative Care model.** Consider sharing of workforce (psychiatry), training, implementation support, measurement and monitoring of progress, alignment of care delivery/payor/state efforts.

See the full [white paper](#) for specific recommendations for both health care organizations and collective action, as well as further findings on needs and opportunities.

¹ Burke et al. BMC Health Serv Res. 2013