Collaborative Care Model Policy Summit 2025 – Raleigh, NC

Collaborative Care at a Crossroads

The Collaborative Care Model (CoCM) stands as one of the most evidence-based approaches in modern healthcare. With more than 110 randomized controlled trials confirming its effectiveness, the model consistently delivers improved patient outcomes, higher provider satisfaction, and significant cost savings—often achieving a 6:1 return on investment.[1,2] Yet despite this extraordinary evidence base, access to Collaborative Care remains uneven across the United States. Implementation continues to depend less on evidence or patient need and more on whether local policies, payers, and infrastructures support it.

This gap between proof and policy is what drew 70 clinicians, policymakers, payers, and advocates to Raleigh, North Carolina, in October 2025. Hosted by the Collaborative Family Healthcare Association (CFHA) and partners including Concert Health, the University of Washington AIMS Center, Community Care of North Carolina, the North Carolina Academy of Family Physicians, and the North Carolina Area Health Education Centers (NC AHEC) program, the **Collaborative Care Model Policy Summit** sought to convert years of fragmented progress into a coordinated policy movement. It followed earlier CFHA summits in Asheville (2009) and Charlotte (2016), which helped spark state-level reforms.

The Summit's design reflected the collaborative ethos of the model itself. A diverse planning committee—comprised of leaders from North Carolina's CoCM Consortium, CFHA leadership, national Collaborative Care experts, and practicing clinicians—worked together over several months to shape the agenda. Their combined expertise ensured that the program balanced state-specific perspectives from the host state with national implementation lessons, representing the full ecosystem required to advance effective policy.

A Shared Sense of Urgency

From the opening remarks, participants aligned on a clear theme: **the evidence is no longer in question—policy is the frontier**.

Keynote speaker **Clare McNutt, PA-C, MSHS**, Senior Vice President of Health System Innovation at the Meadows Mental Health Policy Institute, presented compelling data illustrating both the trajectory of Collaborative Care adoption and the continued progress needed to fully realize its potential. Between 2018 and 2022, the number of patients receiving CoCM under public payers grew sixfold, and by 2023, commercial payer participation expanded more than

[1] Reist, C., Petiwala, I., Latimer, J., Raffaelli, S. B., Chiang, M., Eisenberg, D., & Campbell, S. (2022). Collaborative mental health care: A narrative review. *Medicine, 101*(52), e32554. https://doi.org/10.1097/MD.0000000000032554

[2] Unutzer, J., Katon, W. J., Fan, M. Y., Schoenbaum, M. C., Lin, E. H., Della Penna, R. D., & Powers, D. (2008). Long-term cost effects of collaborative care for late-life depression. *The American Journal of Managed Care, 14*(2), 95-100.

twentyfold. Yet in 2022, fewer than 5,000 physicians billed Medicaid for these services, and nearly half of U.S. metropolitan statistical areas had no Medicare claims at all.[3]

McNutt characterized the current moment as a "policy tipping point," describing a model that is clinically mature but structurally under-supported. She outlined key federal levers, including the *Collaborate in an Orderly and Cohesive Manner (COCM) Act*, which was signed into law in 2022 and created federal grants for implementing and evaluating behavioral health integration models, including CoCM. The *COMPLETE Care Act*, which would strengthen Medicare reimbursement and remove barriers to access, has been introduced in the Senate and House of Representatives. Her recommendations emphasized ensuring Medicaid coverage in every state, adjusting rates to reflect the true cost of delivering care, modernizing billing codes, and removing patient cost-sharing requirements that deter participation by classifying CoCM as preventive care.

The View from the Frontline

In her remarks, **Dr. Jennifer Thomas**, Medical Director of Integrated Behavioral Health at Morris Hospital & Healthcare Centers and CFHA's National Medical Co-Director for Integrated Care, gave voice to the primary care experience that underpins Collaborative Care. "Primary care is where most people begin their health journey," she reminded attendees, noting that roughly three-quarters of antidepressant prescriptions in the United States are written by primary care providers.[4] The Collaborative Care Model, she explained, transforms this reality into an opportunity by embedding behavioral health expertise into primary care teams, supporting clinicians through structured consultation, and improving patient outcomes dramatically.

Dr. Thomas described Collaborative Care as a vehicle for achieving the **Quintuple Aim**: improving population health, reducing total cost of care, enhancing patient and provider experience, and advancing equity. Still, she cautioned that the greatest barriers are not clinical but financial and operational, characterized by fragmented billing structures, uneven training, and misaligned incentives that make sustainability difficult even for practices that believe in the model.

From Policy to Practice: Lessons from Collaborative Care Implementation

The Summit's expert panel, moderated by **Dr. Virna Little**, Co-Founder of Concert Health, brought together leaders from across the country who are advancing Collaborative Care within vastly different contexts. Their stories offered both a candid look at the barriers to implementation and a blueprint for what success can look like when policy, financing, and clinical practice align.

---

[3] Davenport, S., Mager, M., & Darby, B. (2025). *Trends in the adoption of the Collaborative Care Model: Analysis of variation by payer and region, 2018-2023*. Milliman. https://pathforwardcoalition.org/report/milliman-analysis-collaborative-care-heat-map/

[4] Simon, G. E., Stewart, C., Beck, A., Ahmedani, B. K., Coleman, K. J., Whitebird, R. R., Lynch, F., Owen-Smith, A. A., Waitzfelder, B. E., Soumerai, S. B., & Hunkeler, E. M. (2014). National prevalence of receipt of antidepressant prescriptions by persons without a psychiatric diagnosis. *Psychiatric Services, 65*(7), 944-946. https://doi.org/10.1176/appi.ps.201300371

In North Carolina, **Dr. Keith McCoy** described how their Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMHDDSUS), in collaboration with the state's Medicaid program, has built momentum for Collaborative Care through structured incentives and practice-level support. Rather than providing open-ended grants, North Carolina designed the incentive-based, Collaborative Care Model (CoCM) Capacity Building Fund program that ties funding to clear milestones. Practices receive incremental payments as they complete foundational steps—engaging with AHEC training, designating a clinical champion, hiring a care manager and consulting psychiatrist, and enrolling patients. This approach minimizes administrative burden while ensuring progress, allowing practices to "earn" each stage of implementation rather than simply receive funds. Dr. McCoy credited the state's success in part to the leadership of passionate champions within DMHDDSUS and Medicaid, who were willing to invest political capital to move behavioral health integration forward. "You can't just throw implementations at people," he reflected. "You have to reward movement toward real deliverables."

Dr. Virna Little expanded on that theme. Drawing from her experience leading national implementation efforts, she observed that successful programs are rarely left to chance but rather they are guided by concrete expectations from the outset. "We've learned to be more prescriptive," she noted, emphasizing the importance of early benchmarks for patient engagement. "Setting clear goals within the first 30, 60, and 90 days," she said, "helps practices build momentum and prevents early enthusiasm from fading." The conversation underscored that accountability—when paired with coaching and technical assistance—is not a barrier to adoption but a catalyst for sustained change.

From New York, **Heidi Sansbury, MBA, LMSW**, Manager of Behavioral Health Integration at Primary Care IPA, illustrated how persistent advocacy and practical innovation can translate evidence into measurable outcomes. Working with an independent network of 25 primary care practices, Sansbury helped pilot CoCM in small, resource-limited clinics that initially doubted its feasibility. The results were striking: emergency room visits and hospitalizations decreased by nearly 30%, specialty referrals dropped by a similar margin, and medication adherence improved by roughly 25%. Sansbury attributed this success to embedding behavioral health managers directly within practices and building a strong relationship with local universities to host and train interns, expanding the workforce pipeline. Yet she also acknowledged that scaling CoCM in New York continues to require sustained policy advocacy—particularly around eliminating patient cost-sharing for CoCM services, simplifying billing and reporting processes, and aligning reimbursement rates across payers. "Primary care practices want to do this," she explained, "but the structure around them has to make it possible."

Jennifer Lyons, MSN, APRN, PMHNP-BC, Director of Behavioral Health at AdventHealth, shared how a large, multi-state hospital system has made Collaborative Care both clinically and financially sustainable. "Money is mission," she said, describing how her team links financial outcomes directly to the organization's faith-based goal of delivering whole-person care. Regular cross-departmental meetings among finance, clinical leaders, and primary care teams ensured that CoCM performance was measured not only by patient outcomes but also by the model's ability to sustain itself financially. That alignment has paid off—AdventHealth launched its

Collaborative Care program with an initial $5 million grant and has since maintained operations through internal savings and improved performance on quality measures.

Finally, **Dr. Jill Donelan**, Vice President of Clinical Operations at Mirah, discussed the national effort to adapt Collaborative Care for pediatric populations. She and her colleagues have developed new screening and measurement-based care tools tailored to children and adolescents, addressing a major gap in the model's reach. While instruments such as the PHQ-9 and GAD-7 are well validated for adults, she explained, they are less effective for younger age groups, requiring innovation in both screening and monitoring. Dr. Donelan's workgroup has produced updated guidance and "Version 2" of a pediatric pathway designed to help practices identify appropriate tools, track symptom improvement, and connect screening data to short-term, evidence-based interventions that can be delivered in primary care. Looking ahead, she argued that Collaborative Care in pediatrics should evolve toward a preventive model—one that allows early intervention before a formal diagnosis is required. "If we can remove the diagnosis requirement," she said, "we could shift from reaction to prevention, catching kids before symptoms become crises."

Across all of these perspectives, a common message emerged: **the success of Collaborative Care depends not only on clinical design but also on the infrastructure around it**. Whether through Medicaid incentive programs, hospital system alignment, or grassroots advocacy in small practices, progress happens when financial, educational, and policy systems move together. The states, systems, and sites represented at the Summit demonstrated that while approaches differ, the destination is shared—a more coordinated, equitable, and sustainable foundation for behavioral health integration nationwide.

What Participants Said

Following the panel, **Monica Harrison, MSW, LCSW**, of the University of Washington AIMS Center, led a live polling session inviting attendees to identify the most urgent policy priorities for scaling Collaborative Care. Top responses included achieving Medicaid reimbursement parity, expanding eligibility for FQHCs and CCBHCs, increasing workforce investment, and creating a shared advocacy network for continued collaboration.

Evaluation results reinforced these priorities. Participants described the Summit as "energizing" and "a vital step toward coordinated national advocacy." Many emphasized the value of networking and learning from other states' successes and setbacks. One attendee wrote, "*It's evident there's a lot of passion behind this. We just need to push the billing pieces across the finish line.*" Another requested "a collective 'what's not working' paper" to help inform policymakers—an idea that helped inspire this white paper itself.

From Momentum to Action

By the end of the evening, consensus had crystallized around several key ideas. First, the Collaborative Care Model has long since proven its value; the work ahead is to make that value universal. Expanding access requires more than isolated payer reforms—it demands a

coordinated strategy across Medicaid, Medicare, and commercial plans, informed by clear federal guidance and state-level follow-through.

Second, the workforce pipeline must be strengthened. Attendees stressed that the sustainability of CoCM depends on the availability of trained care managers and psychiatric consultants, supported by supervision, technical assistance, and fair compensation. Educational institutions, professional associations, and health systems all have a role to play in embedding Collaborative Care into training and practice standards.

Finally, participants underscored the importance of maintaining the coalition built through this event. The momentum generated in Raleigh should not fade when the meeting ends. Instead, it should evolve into an ongoing infrastructure for collaboration with a national learning and advocacy community committed to ensuring that Collaborative Care is accessible, reimbursable, and integrated across all settings.

Charting the Path Ahead

Moving forward, the policy priorities identified at the Summit offer a clear roadmap for both federal and state action:

- **Establish full Medicaid coverage and payment parity** for CoCM codes (99492-99494, G2214) across all states.
- **Eliminate patient cost-sharing** under Medicare and commercial insurance.
- **Include FQHCs, RHCs, and CCBHCs** as eligible billing entities in all states.
- **Simplify billing and reporting requirements** to reduce administrative burden.
- **Invest in workforce and infrastructure**, including technical assistance grants and academic training pipelines.

For CFHA and its partners, the next phase involves transforming this shared agenda into coordinated advocacy. That includes developing a policy learning network, sharing best practices across states, and monitoring evolving CMS guidance related to Collaborative Care. The 2025 Summit demonstrated that the national community is ready and aligned that what remains is sustained effort.

With generous thanks to our sponsors:

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

concert


NCAFP
Community Care
OF NORTH CAROLINA