

## Meadows Mental Health Policy Institute

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### The Collaborative Care Model – May 2026

The **Collaborative Care Model (CoCM)** is an established, team-based approach<sup>1</sup> to integrated care that routinely measures both clinical outcomes and patient goals over time to increase the effectiveness of mental health and substance use disorder (SUD) treatment in primary care settings.<sup>2,3</sup> Under the model, a primary care provider, a behavioral health care manager, and a psychiatric consultant work together to detect and provide established treatments for common behavioral health problems, measure patients' progress toward treatment targets, and adjust care when appropriate. CoCM is a data-driven, patient-centered approach that multiplies the expertise of scarce behavioral health clinicians up to 8.3 times through task sharing, technology, structured teamwork, and telehealth.<sup>4</sup>

### Evidence Supporting CoCM

CoCM is extensively supported by scientific studies, with over 90 randomized controlled trials demonstrating its clinical efficacy.<sup>5</sup> An evidence-based practice, CoCM has been shown to reduce depression, bipolar and anxiety disorders, SUD, suicidal ideation, and suicide completion.<sup>6,7</sup> In 2020, the Meadows Institute issued a [report](#) modeling the extent to which universal access to CoCM could offset a portion of the predicted increases in suicide from the pandemic. In Texas, our models suggested universal access to CoCM to treat major depression could reduce the number of suicide deaths<sup>8</sup> by between 725 and 1,100 deaths per year.

### CoCM Financing

CoCM is currently the only integrated mental health model reimbursed in primary care with dedicated Current Procedure Terminology (CPT) codes. Covered by Medicare since 2017,<sup>9</sup> nearly all commercial payers since 2019,<sup>10</sup> and **37 state Medicaid programs** to varying degrees,<sup>11</sup> CoCM has a clear pathway for long-term financial sustainability and increasing treatment access.

The potential cost-savings of widespread implementation are also significant, with a 2008 study finding ***savings of up to \$6 in total medical costs for every \$1 spent on CoCM.***<sup>12</sup> ***A subsequent 2013 publication estimated \$15 billion in nationwide Medicaid savings if every beneficiary with diagnosed depression were to receive CoCM services (~20% of total Medicaid beneficiaries).***<sup>13</sup> Despite its effectiveness and savings, adoption has been slow.<sup>14,15</sup>

### Policy Implementation

In 2021, the Texas Legislature passed **87(R) SB 672**, adding reimbursement for CoCM in Texas Medicaid, for both children and adults, to increase access to behavioral health services

integrated in certain primary care settings. Notably, in its fiscal analysis, the Legislative Budget Board determined the cost of providing CoCM reimbursement would be mostly offset by decreased costs related to reduced hospitalizations and utilization of other services. In 2025, Texas Medicaid added expanded reimbursement for CoCM to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) through Healthcare Common Procedure Coding System (HCPCS) code G0512.

While these changes expanded access, Texas Medicaid requires all providers and clinics to complete an online attestation before offering CoCM services, as well as prior authorization for services beyond six months. These requirements are not part of Centers for Medicare & Medicaid Services (CMS) policy and pose barriers to widespread program adoption.

### Recent Federal Changes

Effective January 1, 2026, CMS announced the retirement of HCPCS code G0512 for FQHCs and RHCs, allowing the use of CPT codes 99492-99494. This represents a meaningful shift in the CoCM billing structure for FQHCs and RHCs, as HCPCS code G0512 requires meeting a full 60-minute threshold and does not allow billing for additional time. In contrast, CPT codes 99492-99494 allow use of the 50% + one minute time rule and associated add-on codes, creating greater billing flexibility.

Several states have already adopted CMS guidelines and replaced HCPCS code G0512 with CPT codes 99492-99494 for FQHCs and RHCs in their Medicaid programs. However, in Texas, HCPCS code G0512 was retired in January 2026 without an alternative, leaving FQHCs and RHCs with no avenue to obtain Medicaid reimbursement for CoCM services.

Since January, the Health and Human Services Commission has worked to address this issue. As a result, on June 1, 2026, effective for dates of service on or after January 1, 2026, FQHCs and RHCs will be able to use CPT codes 99492-99494 and HCPCS code G2214 to obtain Medicaid reimbursement for CoCM services.

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<sup>1</sup> 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](http://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf)

<sup>2</sup> 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](http://www.wsipp.wa.gov/ReportFile/1546/Wsipp_Collaborative-Primary-Care-Preliminary-Findings-for-Depression-and-Anxiety_Preliminary-Report.pdf)

<sup>3</sup> 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>

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- <sup>4</sup> Carlo AD, McNutt C, Talebi H. Extending the Clinical Impact of Mental Health Clinicians Using the Collaborative Care Model (CoCM). *Journal of General Internal Medicine*. In Press. <https://doi.org/10.1007/s11606-024-08649-2>
- <sup>5</sup> Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, Dickens C, Coventry P. Collaborative care for depression and anxiety problems. *Cochrane Database of Systematic Reviews* 2012, Issue 10. Art. No.: CD006525. DOI: 10.1002/14651858.CD006525.pub2. Accessed 26 January 2024.
- <sup>6</sup> 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>
- <sup>7</sup> 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>
- <sup>8</sup> 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>
- <sup>9</sup> Press MJ, Howe R, Schoenbaum M, Cavanaugh S, Marshall A, Baldwin L, Conway PH. Medicare Payment for Behavioral Health Integration. *N Engl J Med*. 2017 Feb 2;376(5):405-407. doi: 10.1056/NEJMp1614134. Epub 2016 Dec 14. PMID: 27973984.
- <sup>10</sup> 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>
- <sup>11</sup> Meadows Mental Health Policy Institute. (2026, January). State Medicaid Coverage for Collaborative Care Management Codes. [https://mmhpi.org/wp-content/uploads/2026/01/State-Wide-Project-2025\\_01142026.pdf](https://mmhpi.org/wp-content/uploads/2026/01/State-Wide-Project-2025_01142026.pdf)
- <sup>12</sup> Unützer J, Katon WJ, Fan MY, Schoenbaum MC, Lin EH, Della Penna RD, Powers D. Long-term cost effects of collaborative care for late-life depression. *Am J Manag Care*. 2008 Feb;14(2):95-100. PMID: 18269305; PMCID: PMC3810022.
- <sup>13</sup> Unützer, J., Schoenbaum, M., & Druss, B. (2013, May). Previously cited.
- <sup>14</sup> 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>
- <sup>15</sup> Katelnick DJ, Williams MD. Large-Scale Dissemination of Collaborative Care and Implications for Psychiatry. *Psychiatr Serv*. 2015 Sep;66(9):904-6. doi: 10.1176/appi.ps.201400529. Epub 2015 Jun 1. PMID: 26030320.