

Mandatory Documented Consent and Cost-Sharing Impede Access to Collaborative Care Psychiatry



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We appreciate the thoughtful comments of Clare McNutt, PA-C, MSHS, and Andrew Carlo, MD, MPH, and will respond to the concerns they raised.

First, the authors point out that CoCM mirrors Chronic Care Management (CCM), and there are indeed similarities between these services. However, one important difference in the consent is that CoCM requires third party case consultation and treatment recommendations by a psychiatrist. These requirements place CoCM closer to referral for consultation instead of care coordination described in CCM. We believe the general consent process for referral to a subspecialist should cover CoCM and that requiring explicit consent for psychiatry consultation creates an issue with parity between mental and physical health care. We do partially support the idea that the behavioral health manager could ease the burden of documenting consent to CoCM; however, ensuring primary care providers inform patients of the referral is essential for many patients to accept the CoCM.

Second, our solution to CoCM cost-sharing is to eliminate it altogether. McNutt and Carlo suggest adding CoCM to the list of United States Preventive Services Task Force (USPSTF) preventive services that are Grade A or B, because these services have no cost-sharing for private insurers due to the Affordable Care Act (ACA). Indeed, the USPSTF recommendation for depression screening do comment that CoCM is a potential pathway for intervention for those patients who screen positive for depression.¹ However, USPSTF recommends preventive care services and not treatment modalities, and therefore will likely be unable to grade CoCM.

We do believe that eliminating cost-sharing can be achieved and that strategies depend on the insurer. For Medicare, removal of the 20% cost-sharing requirement would require legislation, similar to the Chronic Disease Management Act of 2023 which was introduced in March 2023 to add CCM codes to the list of services that are not subject to cost-sharing. For Medicaid, cost-sharing is determined at the

state level. Currently, 19 states cover CoCM and nearly all ($n = 18$) states do not have copayment requirements.² However, 26 states do not cover CoCM and coverage is unknown in six states.² For private insurers, they could decide to eliminate cost-sharing, because of its known effectiveness. Thus, we disagree with McNutt and Carlo's suggestion for how to eliminate CoCM cost-sharing, but believe that a combination of forward-thinking private insurers, state Medicaid agencies, and legislators could eliminate CoCM cost-sharing and lead to greater adoption of CoCM.

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