



## **Cracking the Codes:** State Medicaid Approaches to Reimbursing Psychiatric Collaborative Care

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## About the Author

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## Background

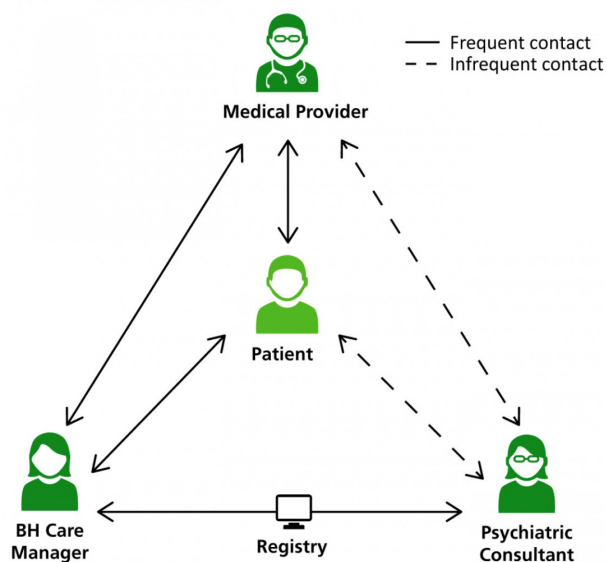
Integrating behavioral health into primary care is an important way to increase access to effective behavioral health treatment while maximizing the capacity of our very limited behavioral health workforce. There are many approaches to integration, but the Collaborative Care Model (CoCM) has the most robust evidence base, especially for anxiety and depression.<sup>1</sup> Compared to the usual primary care approach to managing behavioral health needs, in which a provider either refers the patient to a specialist or manages needs on their own, CoCM offers supports for the providers and delivers superior clinical outcomes for common, less complex behavioral health conditions.

In 2002, one of the earliest significant trials of CoCM, known as Improving Mood Promoting Access to Collaborative Treatment (IMPACT), demonstrated that the model doubles the effectiveness of the treatment of depression in elderly adults.<sup>2</sup> Since then, more than 80 randomized controlled trials<sup>3</sup> have demonstrated CoCM's clinical effectiveness for patients across many age groups, races, and ethnicities and with a range of common diagnoses, including depression, anxiety,<sup>4</sup> PTSD,<sup>5</sup> attention deficit hyperactivity disorder, and substance use disorder.<sup>6</sup> The trials also showed the model could work in both rural and urban settings and across multiple payers including Medicaid.<sup>7</sup> Furthermore, CoCM proved cost-saving, returning \$6.50 for every dollar spent according to one study looking at older adults<sup>8</sup> and demonstrating savings in multipayer populations with diabetes and depression.<sup>9</sup> Less is known about the model's cost-effectiveness in Medicaid, an important avenue for future inquiry given the strong evidence of its clinical effectiveness for low-income populations.

Researchers also wanted to demonstrate that CoCM could be effective outside the controlled and rigid environment of a randomized trial. In 2012, the Centers for Medicare & Medicaid Services (CMS) funded a large study of real-world CoCM implementation spanning multiple community settings in eight states, including California, and reaching more than 3,000 patients.<sup>10</sup> That randomized trial, known as Care of Mental,

Physical and Substance-use Syndromes (COMPASS), revealed two key findings: (1) CoCM was about as clinically effective in the real world as in prior trials,<sup>11</sup> and (2) CoCM could not be sustainably financed without new billing codes to support the work of the collaborative team, as illustrated in Figure 1.<sup>12</sup> In response to the latter finding and feedback from stakeholders, CMS ultimately created a set of new billing codes unique to CoCM and issued them in 2016.

Figure 1. Schematic of the CoCM Team



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Source: University of Washington Advancing Integrated Mental Health Solutions Center, "Collaborative Care: Team Structure."

**CoCM only becomes economically viable for a practice when all payers reimburse the codes. If more of these payers adopt the codes, the hope is more practices will in turn adopt CoCM, and ultimately, more patients will benefit.**

When new codes are released by CMS, they can be immediately used by providers for Medicare enrollees, but state Medicaid agencies and commercial carriers make independent decisions regarding if, when, and at what rate they will reimburse the new codes. Those non-Medicare payers can also choose to add their own requirements or restrictions to the codes. Currently, the majority of commercial carriers reimburse for the CoCM codes, also known as the Psychiatric Collaborative Care Codes, but just 17 state Medicaid agencies do. This uneven adoption of CoCM codes among payers is a barrier to the model's spread, as evidenced by financial modeling studies showing that CoCM only becomes economically viable for a practice when all payers reimburse the codes.<sup>13</sup> If more of these payers adopt the codes, the hope is more practices will in turn adopt CoCM, and ultimately, more patients will benefit.

This paper examines the progress of states whose Medicaid agencies are reimbursing the CoCM codes to identify lessons learned and best practices, and to inform the approaches of other states in the future. While the focus of this paper is on state-level implementation, the approaches and lessons learned also apply to individual Medicaid managed care plans, which have the flexibility to pay for integrated care using these codes or other value-based payment approaches in many states. For example, at least one of Oregon's Medicaid Coordinated Care Organizations has elected to reimburse the codes,<sup>14</sup> and in Chicago, the Medical Home Network accountable care organization reinvested savings from its risk-based payer contracts to implement collaborative care.<sup>15</sup>

## The CoCM Model

The Collaborative Care Model extends the capability of primary care teams to identify and treat people with common, less complex behavioral conditions like depression and anxiety.<sup>16</sup> It adds two new members with behavioral health expertise to the primary care team, and they provide treatment in tandem with the primary care provider (PCP). The model also includes other elements, such as a patient registry and validated screening tools, designed to standardize care and follow-up. All these components are requisite for any practice intending to fully implement CoCM. If one or more these components are absent, there is scarce evidence that the model remains effective, either clinically or financially.

As defined by CMS,<sup>17</sup> the team members required to implement CoCM include:

- ▶ **Behavioral care manager (BCM).** Someone with formal education or specialized training in behavioral health, which could include a range of disciplines including social work, nursing, or psychology. Importantly, CMS does not require a minimum education requirement or licensure.<sup>18</sup>
- ▶ **Psychiatric consultant.** A psychiatrist, psychiatric advanced practice nurse, or psychiatric-certified physician assistant.<sup>19</sup> In practices where CoCM is used to treat substance use disorders, the consultant can also be any physician that has completed an addiction medicine fellowship.

CoCM requires specific tasks be completed, primarily by the BCM, with the goal of reaching a clinically significant reduction in symptoms. These tasks are reflected in the CoCM billing code requirements and necessitate changes to the standard primary care workflow. They include:

- ▶ PCP assesses the patient using a validated rating scale and presents CoCM treatment option and copay (if applicable) for patient consent.
- ▶ BCM develops an individualized treatment plan with the patient and psychiatric consultant.

- ▶ If needed, the PCP prescribes psychotropic medications, with guidance from the psychiatric consultant.
- ▶ BCM engages patient in treatment either in person or by televideo or phone using brief evidence-based interventions, such as motivational interviewing and problem-solving therapy, as directed by the treating PCP.
- ▶ BCM regularly assesses the patient using validated rating scales, working toward defined treatment targets (e.g., a 50% reduction in PHQ-9 score and remission of depression defined as a PHQ-9 score <5).
- ▶ BCM enters patient data (e.g., PHQ-9 scores, contact dates, etc.) into a registry, using it to track patient follow-up and progress over time with the PCP and psychiatric consultant.
- ▶ BCM participates in weekly caseload review with the psychiatric consultant and adjusts care for patients who are not improving.
- ▶ BCM partners with patient on relapse prevention planning and returning patient to usual primary care once treatment targets are met, or refers to higher level of specialty behavioral health care if not improving.

## Medicare’s Payment Model: CoCM Billing Codes

As mentioned above, reimbursing CoCM used to be difficult because the model includes some aspects that do not neatly map to traditional therapy and medical fee schedule billing codes, also known as Current Procedural Terminology (CPT) codes. Particularly incompatible aspects included the psychiatric consultation, registry tracking, and follow-up. CMS introduced the unique CoCM CPT codes in 2016 to address these issues and help improve the model’s potential for financial sustainability.

### Billing

CoCM codes (see Table 1) are billed by the patient’s PCP<sup>20</sup> under their National Provider Identifier (NPI) number. The codes generate monthly care management fees to reimburse the time and activities of the BCM and psychiatric consultant, and the PCP’s collaboration with this team. Although the BCM and the psychiatric consultant may have their own NPI numbers, they are not allowed to bill these codes independently. Instead, they are treated as part of

**Table 1. Collaborative Care CPT Codes**

DESCRIPTION	MEDICARE REIMBURSEMENT (NONFACILITY RATE)
<b>99492</b> First month of collaborative care, 70 minutes	\$157
<b>99493</b> Subsequent months of collaborative care, 60 minutes	\$126
<b>99494</b> Each additional 30 minutes of collaborative care (up to two per month without prior authorization)	\$64
<b>G0512</b> Single monthly (inclusive of all time frames) rate for 60 minutes or more of collaborative care in Federally Qualified Health Clinic / Rural Health Clinic settings	\$142

Note: CMS also developed CPT code 99484 for “Other behavioral health integration models” in recognition that some providers may not be able to furnish or want to provide all the requirements for CoCM. For this code, at least 20 minutes of care coordination must be delivered by either the medical provider or another member of the team.

Source: Centers for Medicare & Medicaid Services, “[Physician Fee Schedule Search Tool](#).”

the primary care team (contracted or on staff) and are reimbursed using the payment received by the PCP for billing these codes. BCMs qualified to bill traditional diagnostic, evaluation, and therapy codes for Medicare recipients are allowed to bill for those services in the same month that CoCM codes are billed, but time spent on those additional activities may not be included in the time applied to the CoCM codes. Likewise, if the psychiatric consultant directly evaluates a patient, they can bill traditional evaluation and management codes, but their time cannot be counted toward the monthly CoCM calculation.

### Time Stamping/Tracking

The time used to provide CoCM must be tracked for each patient each calendar month, and the CoCM code can only be billed if these time specifications and the task requirements described above are met at the end of each calendar month. Medicare CPT coding rules consider the time requirement met when the time exceeds the halfway point. For example, the 99492 code specifies 70 minutes of treatment by the BCM during the first month of CoCM. Accordingly, the code can be billed when at least 36 minutes of CoCM has been provided. For the subsequent-month code (99493) that specifies 60 minutes of care, the code can be billed when at least 31 minutes of time has been reached.

It is important to note that when the original CoCM trials were conducted, time requirements were not part of the model. CMS modeled the CoCM codes after the existing chronic care management (CCM) code (99490), which also has time requirements.<sup>21</sup> As it turns out, time tracking has posed an additional implementation and administrative burden that was not fully anticipated. The effects of that additional burden have yet to be thoroughly studied but may include constraining caseload sizes, which in turn makes financial sustainability and scale harder to achieve.

## Federally Qualified Health Centers and Rural Health Clinics

In 2018, CMS created a separate, single CPT code (G0512) for CoCM to be billed monthly by Federally Qualified Health Centers and Rural Health Clinics. It requires BCMs to complete 60 minutes or more of collaborative work per patient per month and requires the same tasks be completed as the 99492–94 codes.<sup>22</sup>

## Medicare Uptake Since 2016 Rollout of Codes

Table 2 reflects the most up-to-date information on CoCM code usage for Medicare enrollees. Adoption of the codes has been low for Medicare providers,<sup>23</sup> particularly relative to the significant growth in adoption of the CCM codes (mentioned above) after which the CoCM codes were modeled. Medicare claims for CCM have increased from approximately one million in 2015 to four million in 2018.

**Table 2. Use of Collaborative Care Codes in Traditional Medicare, United States, 2017 and 2018**

	DESCRIPTION	2017	2018*
<b>99492</b>	First month	845	3,381
<b>99493</b>	Subsequent months	813	5,884
<b>99494</b>	30 minute add-on	596	2,903

\*Adjusted by CMS to address data issues.

Source: Medicare Part B FFS data, 2017–2018. Custom data request provided to the author.

One likely reason for this discrepancy between the adoption of CCM codes and CoCM codes is that a high percentage of the patients who benefit from chronic care management are Medicare patients, so practices can still justify adopting workflows for chronic care management even if not all payers reimburse for it. In addition, the CCM model is more likely to leverage existing practice staff. Further possible barriers to adoption of the CoCM codes are described below.

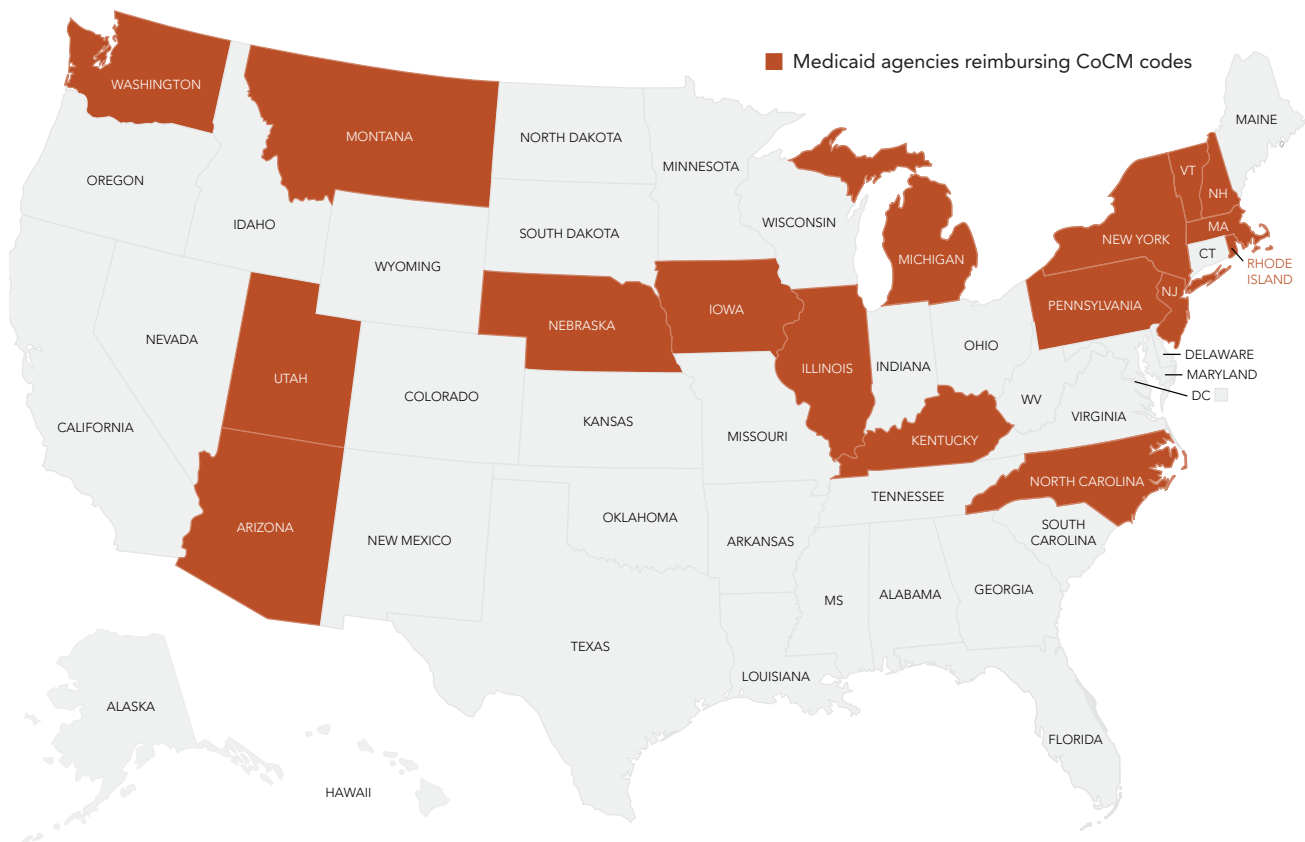
# Findings from a Review of State Medicaid Approaches to Implementing CoCM Codes

Although CMS has established requirements for providers billing the CoCM codes for Medicare enrollees, other payers, including state Medicaid authorities, can choose either to copy the CMS guidance, to revise the guidance, or to decline to implement the codes altogether. For this paper, an understanding was sought of

state-by-state differences in how Medicaid agencies are choosing to implement and reimburse the CoCM codes. Information was either gleaned from publicly available provider guidance documents or from the author's contacts in the field.<sup>24</sup> In states where neither was available, it was assumed the state was following Medicare guidance.

As of August 2020, 17 states (see Figure 2) are reimbursing the codes in their Medicaid programs. Most of these states have only activated the codes since 2019. Just a few have multiple years experience with the codes.

Figure 2. State Medicaid Programs Currently Reimbursing CoCM, as of August 2020



Source: The author reviewed online the Physician Fee Schedule for all 50 states and DC, and looked for any Medicaid provider bulletins for states that had codes listed in the Physician Fee Schedule.



Table 3 summarizes the ways in which state Medicaid agencies' implementation policies differ from Medicare's. Notably, some states' policies are more restrictive than Medicare, adding complexity for practices implementing CoCM. Table 4 summarizes the range of Medicaid reimbursement rates found across 15 of the 17 states for each for the main CoCM codes (see page 8). New York's rates are not included because the state uses a different code, and Illinois's are excluded because the state has not yet published

its rates.<sup>25</sup> A key finding is that most state Medicaid agencies provide reimbursement below the Medicare rate, averaging about 75% of Medicare rates. While this is consistent with typical rate setting for state Medicaid programs, it may not be sufficient to spur uptake. For example, New Hampshire Medicaid has seen very low uptake of CoCM, and Montana's lower reimbursement rates for FQHCs may present challenges for clinics and their patients.

**Table 3. Overview of State-Specific Differences in Implementation Policies**

	MEDICARE REFERENCE	STATE MEDICAID POLICIES THAT DIFFER FROM MEDICARE	COMMENTS
<b>Attestation required</b> (signed document stating provider is providing key elements of CoCM)	No attestation required, retrospective audit used instead in cases of suspected fraudulent billing.	New York and Washington require attestation.	
<b>Diagnoses allowed</b>	No diagnostic exclusions	Michigan prohibits serious mental illness diagnoses and using CoCM for medication-assisted treatment for opioid use disorder.  New York limits diagnosis to depression and anxiety disorders only.	Research shows CoCM is effective for depression, anxiety, PTSD, and substance use disorder.
<b>Prior authorization (PA) requirements</b>	Medicare requires PA only if provider wants to use more than two 99494 add-on codes.	Michigan requires PA at 6 months. Washington requires PA at 6 and 12 months.	Research shows an episode of CoCM care is typically 6 to 9 months, but can be longer, or as short as 3 to 6 months.
<b>Team credentials</b>	BCM can come from a range of disciplines but must have "some formal or specialized behavioral health training." Psychiatric consultant can be MD or NP.	Michigan requires psychiatric consultant to be a psychiatrist. North Carolina requires BCM to be a licensed mental health therapist.	One study shows nonlicensed paraprofessionals can do BCM work adequately. <sup>26</sup>
<b>Required metrics reporting</b>	None	New York has required list.	Enables states to track and report quality measures such as National Quality Forum 1884/1885 (depression response at 6 and 12 months) and 710/711 (depression remission at 6 and 12 months).
<b>Billing provider limitations</b>	Any provider qualified to use evaluation and management codes, except psychiatrists Separate code for FQHCs	Arizona does not allow nephrologists and other specialists to bill. Only Arizona, Michigan, Montana, New York, and Washington allow FQHCs to bill.	

Source: Author analysis.



**Table 4. CoCM Reimbursement Rates for Medicaid and Medicare, by Code**

	MEDICAID-ONLY RANGES <sup>27</sup> (NONFACILITY; FEE-FOR-SERVICE)	MEDICAID-ONLY (MEAN)	MEDICARE <sup>28</sup> (NATIONAL NONFACILITY)	MEDICAID RATE AS A PERCENTAGE OF NATIONAL MEDICARE RATE (AVERAGE)
<b>99492</b>	\$56 (New Hampshire) to \$176 (Montana)	\$114	\$157	73%
<b>99493</b>	\$51 (New Hampshire) to \$140 (Montana)	\$94	\$126	74%
<b>99494</b>	\$27 (New Hampshire) to \$82 (Montana)	\$49	\$64	76%

Note: These data can change. Authors recommend checking the state Physician Fee Schedule regularly for updates.

Source: The author reviewed online Physician Fee Schedules for all 50 states and DC, looked for any Medicaid provider bulletins for states that had codes listed in the Physician Fee Schedule.

### General Behavioral Health Integration — CPT Code 99484

At the same time as the CoCM codes were rolled out, Medicare also introduced an additional code for behavioral health integration services that do not conform to the specific Collaborative Care Model. All state Medicaid programs except those in Illinois, Michigan, North Carolina, New York, and Washington are reimbursing this code, which only requires 20 minutes of time per calendar month and can be delivered by a broader set of team members or the PCP alone.<sup>30</sup> Like the CoCM codes, some specific tasks must be performed to bill the 99484 code.

## Barriers to Uptake

Nearly four years after Medicare first launched the CoCM billing codes, a few common barriers to adoption have become clear. First and foremost, busy primary care providers can be hesitant to adjust workflows and take time to learn how to work in the team-based approach CoCM requires. Stigma around behavioral health conditions also remains a persistent and pervasive barrier. Others include:

**Time tracking.** Providers repeatedly point to the process of tracking or “stamping” the time spent on collaborative care as one of the most burdensome requirements of the CoCM codes. Essentially, at the

end of each calendar month the BCM must count all the minutes they have spent doing the required tasks and then match them to the given code to see if they can bill for each patient on their registry. This requires developing a tracking system to collect this information for a caseload of 60 to 80 patients that could pass scrutiny if there were ever an audit of the practice site.

**Registry.** The use of a registry to track patient progress is a key population management tool and a requirement for CoCM, but a registry is not yet a standard feature of most electronic health record (EHR) systems. Without this feature, providers must double-enter certain data into a separate registry tool or modify other business intelligence tools, a process that can be time-consuming and costly. According to adopters in the field, Epic is the only major EHR vendor that can construct a data set adequate to meet CoCM’s tracking requirements.

**Workforce.** Finding psychiatric consultants can be challenging due to the well-documented shortage of psychiatrists and advanced practice practitioners.<sup>31</sup> Many BCMs also do not arrive on the job with training in the principles and practice of collaborative care, and providing appropriate training is not a trivial task.<sup>32</sup> Furthermore, not all PCPs have the desire or the appropriate training to manage behavioral health conditions, and not all behavioral health providers want to work in a primary care setting.

Giving providers funding for technical assistance can lessen some of the aforementioned training barriers and encourage uptake. For example, New York State has an extensive technical assistance program for clinics that want to implement CoCM provided by the Office of Mental Health under contract with the University of Washington AIMS Center. The Montana Primary Care Association provided grant funding for eight primary care clinics to implement CoCM. However, technical assistance cannot solve the final barrier: reimbursement.

**Reimbursement.** The financial sustainability of CoCM faces dual barriers: the number of payers adopting the codes and the rates paid for the codes. Multiple approaches<sup>33</sup> have demonstrated that the CoCM codes can generate revenue over and above the costs of implementation only when all payers are reimbursing at or near Medicare rates.<sup>34</sup>

## Best Practice Recommendations for Medicaid Reimbursement of CoCM

Despite these barriers, the research for this paper revealed some promising practices that can guide adoption of these codes by other state Medicaid programs. In drawing lessons from the experiences of the 17 states actively reimbursing CoCM codes it is important to note that most are still only one or two years into implementation, so this is an early look at an evolving field. Promising practices include:

**Align with Medicare codes and rules where possible.** Doing so reduces administrative complexity and optimizes implementation flexibility. In particular, follow Medicare's lead in allowing billing by PCPs and specialists (including those at FQHCs) for a full range of diagnoses. Similarly, replicate Medicare's rules around BCM eligibility, which allow a broad set of paraprofessional and licensed disciplines to fill that

role. Set rates at or close to Medicare rates to help make CoCM more financially feasible for primary care clinics to adopt.

**Consider requiring attestation.** Attestation involves requiring a provider to sign a document stating that all key elements of CoCM are being provided. While this additional step can be a barrier, New York and Washington — two Medicaid agencies that require attestation before CoCM reimbursement — have found it useful in ensuring provider fidelity to the model.

**Consider providing or funding technical assistance.** Because the initial barriers to implementing the CoCM codes can seem daunting for practices, technical assistance can act as an impactful catalyst. Implementation aspects that can benefit from technical assistance include provider training, registry development, workflow implementation, and practice assessment.

## Conclusion

As COVID-19 catalyzes an increase in behavioral health needs, the case for implementing CoCM is only growing clearer and more urgent. That is especially true for the people of color and with lower incomes being hit hardest by COVID-19 and the underlying inequities that have exacerbated this pandemic. The strong evidence demonstrating CoCM's effectiveness for those populations should compel all Medicaid programs to make this service available to their enrollees. Seventeen Medicaid programs have already taken that step, and their early experiences offer valuable lessons that should help other states and managed care plans refine their approaches to reimbursing and regulating this promising care model.

## Appendix A. Key State Experiences — Interviews with New York and Washington State Medicaid Authorities

Due to the relatively low numbers of adopters and the relatively short time since reimbursement began, there is limited public data on states' varied approaches to implementation. To gather more in-depth information on how states are implementing these codes, key staff in two states were interviewed. New York began using CoCM codes for Medicaid enrollees in 2015, predating even Medicare's implementation of the codes. As a result, the state has developed a rich set of insights into its implementation experience, and has also created many resources and guidelines for providers. Washington State Medicaid was the first to use the Medicare billing codes that CMS launched in 2016 and provided guidelines and requirements for providers.

### NEW YORK

#### Collaborative Care Medicaid Program

New York's provider community was an early adopter of CoCM, with grant-funded implementations ongoing for many years before Medicare began to reimburse. As there was no CPT code available at the time for collaborative care, the state started a Collaborative Care Medicaid Program and devised their own code for reimbursing providers: T2022. The program is administered from the Office of Mental Health (OMH) and the reimbursement procedure has been in place for five years. A major differentiator between New York Medicaid's code and the Medicare codes is that the state does not require providers to track minutes per month. Other billing specifications and implementation aspects include:

**Attestation.** Goes beyond Medicare by listing the required elements of CoCM and requiring the PCP or clinic to sign a form (see Appendix B) guaranteeing that all elements of CoCM are being provided. The state believes that by making providers explicitly commit to fully implementing the model before billing for it, they are likely to more closely replicate the version of CoCM proven by all the clinical trials. Modified or partial versions of that model have not been proven to deliver equally effective results.

**Diagnosis restrictions.** Limitations on diagnoses are used to manage the Medicaid budget allocated to CoCM. However, they can also restrict the growth of the model. New York has restricted reimbursement to patients with anxiety disorders or depression or both.

Many practices do not see the investment in CoCM as worthwhile if it cannot be used for the many other mental health needs their patients have. The state is looking at adding substance use diagnoses, which CoCM has proven effective at treating, but a separate agency funds substance use disorder, so the process is more complicated.<sup>35</sup> The state is also considering reimbursing CoCM for pediatric patients with attention deficit hyperactivity disorder.

**Care manager credentials.** The BCM does not have to be licensed, although licensing is strongly encouraged so the manager can bill additional psychotherapy codes as needed to increase revenue and cover costs.

**Key tasks required.** At least one clinical contact per month (in person or virtual) is required, along with the administration of at least one validated measurement tool (i.e., PHQ-9 or GAD7). In addition, at least one face-to-face meeting every 90 days is required (a PCP visit can fulfill this criterion). However, counting minutes is not required (New York uses its own codes that predate the CMS codes).

**Metrics reporting.** Providers must submit a set of required metrics. Using those data, the state is regularly seeing 40% to 50% of patients achieving a 50% reduction in depressive symptoms, consistent with the literature on CoCM.

**Uptake.** Has been constant but less than OMH would like to see. As mentioned above, limiting the diagnoses to depression and anxiety is a contributing factor, along with the other aforementioned common barriers to implementing CoCM. Providers have reported that the claims process is also cumbersome, which has caused some issues with reimbursement.

**Virtual CoCM.** A pilot to test virtual CoCM is underway to help address the workforce shortages that limit adoption in more rural areas of the state. A toolkit is being designed for virtual CoCM.

**Implementation science exploration.** There is ongoing interest by OMH in better understanding which qualities lead to more successful implementation and in defining barriers and solutions.

**Technical assistance.** The state has provided several supports to increase adoption of CoCM, including administering learning collaboratives and offering a web-based Care Management Tracking System registry for optional use.

## WASHINGTON

### Washington State Health Care Authority

Washington Medicaid began reimbursing the CoCM codes shortly after Medicare. The decision to reimburse was funded through legislative action, so reimbursement is required unless the law is changed. In the state budget, \$1.7 million was set aside, as the state decided that CoCM would not produce sufficient overall health care savings to offset the cost of reimbursing it. In addition, the legislation required reimbursement at Medicare rates for the first year. Code 99484, which reimburses for other models of integrated care, was not included in the legislation. Other key aspects of implementation include:

**Attestation.** Both interviewees believe attestation is a good thing because it holds providers accountable to delivering the CoCM to fidelity. The attestation step has caught some providers who “try to bend the model to what they want to provide” and are missing certain components. Attestation is approved at the Medicaid Health Care Authority (HCA) level and then sent to the Medicaid managed care plans for oversight.

**Care manager credentials.** Care managers do not have to be licensed.

**FQHC billing.** FQHCs have a Prospective Payment System (PPS) rate higher than the CoCM rate, so some forgo billing CoCM codes and instead opt to bill the PPS rate for a single visit, which pays more.

**Metric reporting.** No metrics are required to be reported to the state authority.

**Low uptake.** The state attributes low uptake to the model being “too complex” to implement for most primary care practices without significant technical assistance. Providers have expressed a desire for “start-up” funding, and the HCA has said it is “not in a position to fund training.” The state urges sites to understand the implementation challenges upfront, especially the time tracking requirement, and to “identify champions” to help foster full adoption.

**Policy clarity for Medicaid coding.** There is no official guidance on whether providers have to complete the entire required time interval for Medicaid billing or if they can abide by Medicare’s rule, which allows billing once more than half of the required time has been worked. This has caused confusion and still needs to be clarified.

## Appendix B. Attestation Examples from New York and Washington, January 2020



### NEW YORK STATE MEDICAID COLLABORATIVE CARE PROVIDER CERTIFICATION

If you are a primary care provider seeking supplemental monthly case rate Medicaid payment for Collaborative Care, please see these terms.

Article 28 of the Public Health Law allows primary care practices to deliver Collaborative Care health services to patients with certain behavioral health diagnoses. Prior approval from the Commissioner of the Department of Health and the Commissioner of the Office of Mental Health, or their designees, must be obtained. Submit your application in the format described below.

1. NYS Collaborative Care Medicaid Program Requirements
  - Includes introductory billing guidance and pay-for-performance standards
2. Appendix 1 – State Approved Registries
3. Three (3) Part Provider Application:
  - ✓ Site Applicant Demographics
  - ✓ Medical Director Attestation
  - ✓ CEO Letter of Support (addressed to Dr. Jay Carruthers, MD, Medical Director)

Completed applications should be sent to [NYSCollaborativeCare@omh.ny.gov](mailto:NYSCollaborativeCare@omh.ny.gov), along with a letter of support from the applying organization's CEO or executive director.

Questions should be directed to the same email address.

## TERMS FOR PROVIDERS PARTICIPATING IN NYS COLLABORATIVE CARE MEDICAID PROGRAM (CCMP)

If you are a primary care provider seeking supplemental monthly case rate Medicaid payment for Collaborative Care please see these terms.

Article 28 of the Public Health Law allows primary care practices to deliver Collaborative Care health services to patients with certain behavioral health diagnoses. Prior approval from the Commissioner of the Department of Health and the Commissioner of the Office of Mental Health, or their designees, must be obtained. Submit your application to the Commissioner of the Office of Mental Health, in the format described below.

**Eligibility Criteria:** A Primary Care clinic must deliver the following essential elements of Collaborative Care:

- **Trained Behavioral Health Care Managers** in the primary care setting who oversee and provide mental health care support; screening; patient engagement, education and follow-up; ongoing patient contact; monitoring of adherence with psychotropic medications; mental health and substance disorder referrals; brief interventions appropriate for primary care settings; and related activities. Some acceptable individuals for this role are: LCSW, LMSW, BSW with appropriate supervision, LMHC, LMFT, RN with behavioral health training (for job description see: <http://aims.uw.edu/collaborative-care/team-structure/care-manager> )
- **Designated Psychiatric Consultant** who provide caseload-focused consultation at least weekly with the Depression Care Managers or primary care providers on patients, for those not responding to care. Psychiatrist, or Psych NP with Psychiatrist backup, can provide caseload supervision remotely (e.g. by phone or video) but must have access to the patient care registry.
- **Use of a state-approved patient care registry\*** for ongoing performance monitoring that includes the delivery of services; patient responses through routine use of the relevant screening tool; and ongoing performance improvement. \*see Appendix 1 for details
- **Trained primary care providers** in screening and providing evidence-based, stepped care for certain behavioral health diagnoses.

Additional factors considered in determining who will receive this supplemental payment include:

1. Past performance delivering Collaborative Care
2. Capacity to scale up Collaborative Care

### Billing NYS Medicaid for Collaborative Care

Payment for Collaborative Care services will only be made for patients that meet diagnostic criteria for behavioral health conditions approved by OMH; Patients' scores are actively tracked in a registry; and who receive evidence-based BH care in a primary care setting by primary care providers, where trained Behavioral Health Care Managers (BHCM) are in place and actively providing services; and where a designated consulting psychiatrist regularly reviews, with either the primary care provider or the BCHM, the needs of all patients under care who are not improving and makes recommendations for changes in treatment as needed.

NOTE: The Behavioral Health Care Managers may provide evidence-based treatments such as brief, structured psychotherapies or work with other mental health providers when such treatment is indicated and within the scope of their training and licensure. If Behavioral Health Care Managers provide psychotherapeutic treatment, they will require the clinical licensure/certifications to do so (e.g., Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, Licensed Master Social Worker, Certified Counselor, Licensed Psychologist, Licensed Registered Nurse, or Nurse Practitioner; BSW can provide these services when under supervision of a Masters Social Worker). If BH care managers perform all functions except the delivery of psychotherapeutic treatment, they can be a paraprofessional (e.g., Bachelor's or Associate level Counselor, Mental Health Aide, Behavioral Health Aide, Medical Assistant, Vocational Nurse, or Nursing Assistant). If the BCHM is not licensed, there must be a process in place to provide therapy to patients that need it, ideally without having to refer all of these patients out.

Billing shall be on a monthly basis. To bill for services for a Medicaid patient receiving Collaborative Care, the primary care provider and/or Behavioral Health Care Managers must:

- Enter the patient into a state-approved *registry* based on an initial diagnosis of the PCP and completion of an initial assessment and treatment plan by the Behavioral Health Care Manager
- Have a minimum of one clinical contact with the patient and a completed symptom scale (e.g. GAD-7, PHQ-9) every 30 days; [A "clinical contact" is defined as a contact in which monitoring may occur and treatment is delivered with corroborating documentation in the patient chart. This includes individual or group psychotherapy visits and telephonic engagement as long as treatment is delivered.]
- Have seen the patient face-to-face with a licensed provider for at least 15 minutes at least once during the most recent three months (90 days); this may be their PCP, Licensed BCHM or other licensed professional staff.
- Keep a record of all patient contacts; and
- Consult for one hour or more per week, depending on case load, with a designated consulting psychiatrist regarding patients in the registry, including all patients who are not improving in terms of their symptom scores. This psychiatrist cannot bill Medicaid for the Collaborative Care consultation work unless they perform in-person evaluations and consultation services.



After a patient scores positive on the screening tool, is diagnosed with a Behavioral Health condition by a primary care provider, has an initial assessment and treatment plan done by the Behavioral Health Care Manager, and has been entered into the approved registry, billing for Collaborative Care may begin.

The initial monthly payment for this service shall be \$112.50. This amount shall be subject to periodic adjustment by NYS.

For Article 28 practices, there is the potential to earn an additional 25% quality incentive payment. This “retainage” shall be paid to the provider retroactively after the patient has completed at least three months of Collaborative Care based on attestation that the provider has complied with all aspects described above, as well as all applicable billing and programmatic guidelines AND approval has been granted by NYS or its designee. Please note, the retainage does not apply to non-Article 28 practices due to their unique billing processes. To qualify for the retainage, the patient must have been enrolled in the Collaborative Care program for a minimum of 3 months of treatment and in addition to being in full compliance with the terms of this program, the provider must document in the patient record that one of the following outcomes was achieved:

- Demonstrable clinical improvement, as defined by:
  1. A drop in the relevant symptom score to below ‘positive’ level; for PHQ-9 and GAD-7, this is below 10
  2. Or a 50% decrease in the symptom score from the level of the original score
- In cases where there was no demonstrable clinical improvement, there must be documentation in the medical record of one of the following:
  1. Psychiatric consultation (defined here as review of the case by the designated collaborative care psychiatrist with either the care manager or primary care provider) and a recommendation for treatment change by the psychiatric consultant
  2. Change in treatment (e.g., change in medication\*, change in psychotherapy type or frequency, or completed referral to more intensive specialty mental health treatment).  
*\*Please note, change in dosage may constitute a change in medication only if the dose change does not represent a titration up to treatment dose, but a true modification of the patient’s course. In order to capture this, we will limit the window for change in dose to between 6 weeks and 12 weeks after starting treatment.*

A patient is limited to 12 months of Collaborative Care treatment. The 12 months do not have to be consecutive. However, with prior approval from the Office of Mental Health’s Medical Director, or designee, an additional 12 months is permitted at two-thirds of the monthly rate of the initial 12 months if the treatment team demonstrates the need for ongoing depression care management. The retainage rules above also apply to the second 12 month period.



**Billing Start Date:** Certified providers in compliance with all requirements described herein will be given an approval date after which they can begin billing. Services for a given month will be billed on the first of the next month, i.e. January 2018 services would then be billed in February 1, 2018; and so forth, such that all services delivered are billed during the subsequent month. Claims must be submitted within 90 days of the date of service to avoid timely filing denial. **Sites will be notified when they are approved and eligible to bill.** The Collaborative Care program will be subject to audit by a designated NYS entity. In cases where the provider has failed to comply with all clinical and reporting requirements, rates codes will be inactivated and payments will be recovered.

**NOTE: SBIRT Billing** - When appropriate, billing for SBIRT services delivered may also occur, using existing fee-for-service or managed care payment methods. This payment would be in addition to that paid for Collaborative Care.



## APPENDIX 1: State-Approved Depression Care Registry\*

Effective management of common behavioral health conditions requires the ability to track clinical outcomes for populations of patients and to support systematic changes in treatment for patients who are not improving as expected. This measurement-based, treatment-to-target approach is one of the core principles of Collaborative Care and is essential in ensuring stated goals are being met. It requires a systematic method of tracking information on all patients being treated for behavioral health conditions, like anxiety or depression. How it is done is much less important than that it is done.

Registries must be able to support the following functions:

- ✓ Track clinical outcomes and progress at the individual patient and caseload levels.
- ✓ Track population-based outcomes.
- ✓ Prompt treatment to target by summarizing patient's improvement and challenges in an easily understandable way, such as charts.
- ✓ Facilitate efficient case review, allowing providers, including the psychiatric consultant, to prioritize patients who need to be evaluated for changes in treatment or who are new to the caseload.
- ✓ Able to extract the relevant data for the required quarterly reporting to NYS OMH.
- ✓ Able to supply de-identified reports to outside auditors to demonstrate regulatory compliance, intensity of clinical contacts, staffing ratios, and outcomes.

Sites use a variety of programs to perform these functions.

- Many clinics begin their Collaborative Care programs using a spreadsheet as a registry.
- The AIMS Center offers a Patient Tracking Spreadsheet Template for providers to use.
- The AIMS Caseload Tracker is a cloud-based, HIPAA compliant registry that was introduced in 2017. This simple registry is useful for integrated care sites when the psychiatric consultant has direct access to the EHR.
- The AIMS Center offers an online, HIPAA compliant Care Management Tracking System (CMTS) that is particularly useful for healthcare organizations using multiple EHRs and diverse primary care practices. NYS OMH has designed a build that address all reporting criteria. If you are interested in using CMTS, please contact [NYSCollaborativeCare@omh.ny.gov](mailto:NYSCollaborativeCare@omh.ny.gov) for information on access to this version.
- Some organizations have customized registry builds for their EHR or in a care management software system.

For more information on registry requirements and the various options, see <https://aims.uw.edu/sites/default/files/CollaborativeCareRegistryRequirements.pdf>



**NYS COLLABORATIVE CARE MEDICAID PROGRAM CERTIFICATION:  
PROVIDER APPLICATION**

Please provide all the information requested below. Organizations seeking certification for multiple sites must complete a separate application for *each* site, patient volume, and readiness data. Groups of sites that share leadership and process may only submit one workflow and one letter of support for all.

Incomplete applications will not be processed.

Complete applications should be sent to [NYSCollaborativeCare@omh.ny.gov](mailto:NYSCollaborativeCare@omh.ny.gov)

**Name of point of contact for this application:**

**Email:**

**Phone:**

**Name of Practice:**

**Physical Address:**

**Zip code + 4:**

**Mailing Address (if different from above):**

**County:**

**Facility License Type: (FQHC / Article 28 / Private Practitioner) \_\_\_\_\_**

*(\*Private Practitioner, NON-Art 28, see Appendix 2\*)*

*\*For private practitioners, you will also need to submit names, Medicaid IDs, and NPIs for each individual physician. (See Appendix 2).*

**Clinic Medicaid ID #\*:**

**and Locator Code:**

**Clinic NPI:**

**Clinic Director (if applicable):**

**Medical Director:**

**Name of current BH Care Manager(s) with associated NYS license:**

**Current BH Care Manager FTE:**

**Planned staffing FTE:**

**How many Primary Care Providers (MD/DO, NP, PA) are at this site? \_\_\_\_\_**

**Total annual patient volume at your site:**

**Number of patients currently receiving collaborative care at your site, If any:**

**Anticipated maximum number of patients enrolled in collaborative care at any given time:**

**What EMR does the practice use?**

**Are you already providing Collaborative Care services?**

**If not, when do you anticipate starting?**



**Current Collaborative Care Registry:** \_\_\_\_\_

Your registry should be able to perform the following functions? (check all that apply):

- Ability to track and manage caseloads toward evidence-based care delivery – a core registry design feature
- Supports treatment to target and caseload review for BH care manager with psychiatrist consultation for those not improving
- Supplies reports to program managers and clinical leadership to monitor progress toward goals, including processes of care, quality of care and patient outcomes metrics
- Able to supply de-identified reports to outside auditors to demonstrate regulatory compliance, intensity of service, staffing ratios, process measures, such as screening, diagnose and enrollment rates, and clinical outcomes

**Staffing:**

In order to participate in the Collaborative Care Learning Network, proper staffing is required. Please provide the contact information for the team members listed in this table. For more information, see the Team Roles Flyer for definitions of each role.

Role	Name	Degree/ licensure	Email address	Telephone Number
Program Lead				
BH Care Manager				
PCP Champion				
Psychiatric Consultant				
Billing & Data Lead				

The BH Care Manager should have training in one or more of the following psychotherapy interventions.

- True Behavioral Activation
- Problem Solving Therapy
- Cognitive Behavioral Therapy
- Interpersonal Therapy

The BH Care Manager should devote at least .5 FTE to the role. A CM may be shared between sites, but sharing 1.0 FTE between more than two sites is not recommended. If the CM is not available for a minimum amount of time, hand-offs are not consistent, and the CM becomes distant from the Primary Care team. This impact both provider and patient engagement. If the CM is not available every day, there should be a formal process to supplement the hand-off and for the CM to follow up in a timely manner.

Find a CM job description and details on the recommended type of candidate on the AIMS website:

<https://aims.uw.edu/resource-library/care-manager-role-and-job-description>



**Case Review:**

A key component of Collaborative Care is the weekly, 1-hour systematic case review of patients who are not improving between the care manager and the psychiatric consultant. Please enter the set day and time each week your care manager and psychiatric consultant will meet, whether this will occur in person or over the phone, and whether the consultant has access to your clinic’s EHR and/or registry.

Note, even if you do not believe you have significant caseload to warrant a full hour each week, it is recommended that you continue to meet for one hour. This reserves the time in case needs change later on, but also allows the CM to ask questions of the psychiatric consultant that they may not otherwise have the opportunity to, such as guidance on pharmacology.

Case Review:

**Workflow:**

Please submit your Collaborative Care workflow along with this application. In addition to the basic Collaborative Care workflow elements, the reviewers will also be looking for the following processes to be addressed:

- Consistent administration of BH Screening tools (75% or more), review, and recording of scores
- Ability to do a live warm connection (warm handoff) between PCP and care manager some or most of the time and plan for when this is not possible
- Communication plan in place for getting PC recommendations to the PCP and monitoring the PCP’s response

**VIOLATIONS SUBJECT TO PENALTY:** Clinics participating in the Collaborative Care described above must comply with the terms and standards set forth by NYS DOH and OMH and are subject to audit. Reimbursement is contingent on full compliance therein. Clinics found to be in violation of standards will be subject to financial penalty.

**CLINIC MEDICAL DIRECTOR ATTESTATION:** I, [clinic medical director], understand the terms and standards for participation for the NYS Medicaid Collaborative Care Program and attest that [practice name] meets all specified eligibility requirements, including currently having in place all the required service elements for delivering Collaborative Care (e.g. state-approved patient care registry, outside caseload consultant psychiatrist(s), Behavioral Health Care Manager(s), and primary care providers trained to deliver Collaborative Care for depression). Furthermore, I understand full compliance with the terms and standards above is required for reimbursement; and that failure to comply may result in financial penalty.

Name:

Title:

Signature: \_\_\_\_\_

Date:

\*\*Please attach to this application:

1. Letter of support from the Executive Leadership of your organization or health system demonstrating support for this implementation and commitment to the standards.

**Incomplete Applications will not be reviewed**





## Attestation for Collaborative Care Model (CoCM)

This attestation is for any single provider or provider group to attest that they are actively providing care consistent with the core principles and specific function requirements with the Collaborative Care Model (CoCM) as described in the agency's Collaborative Care Model Guidelines.

### Submission on behalf of individual billing provider or billing group practice:

Individual billing provider

Billing address:	Billing NPI number:
Billing/lead provider must be one of the following provider types: (Check your provider type.) <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> ND <input type="checkbox"/> ARNP	Telephone number:
Email:	
<b>NOTE: requires each billing provider submit an attestation</b>	
Provider Name:	

Billing group practice

Billing provider name:	Billing NPI number:
Servicing provider name(s):	Servicing provider(s) location:
Servicing provider(s) NPI:	
Billing address:	Telephone number:
CoCM lead provider must be one of the following provider types: (Check the provider type of provider[s] in your practice.) <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> ND <input type="checkbox"/> ARNP	Email:

**NOTE:** attestation must cover all servicing providers within the practice attesting that they are actively leading care consistent the core principles and specific function requirements with the CoCM, and ensure new medical providers that will be leading the collaborative care are trained in CoCM.

If your practice bills under one base location and has several servicing locations, each servicing location must submit an attestation to provide and be reimbursed for CoCM service.

For practices with multiple sites with their own billing NPI's, each site must submit its own attestation.

If there are multiple providers within the practice, you are attesting that those individuals being identified as the servicing provider on the claim billing the CoCM services, are one of the above provider types, are trained and actively providing care consistent with the core principles, and specific function requirements for CoCM.

You attest that your practice is actively providing care in a Collaborative Care Model as described in the agency guidelines. This CoCM includes the following required principles:

**(Check each to verify.)**

- Patient Center Team Care
  - I. Primary care/medical provider leading the collaborative care team
  - II. Behavioral health care manager working with the lead medical provider
  - III. Psychiatric consultation working with the lead medical provider
  - IV. Beneficiary-client
- Team structure with staff identified in the guideline
- Measurement-based treatment to target using validated tools
- Accountable care using a registry

I have received and reviewed the CoCM guidelines, understand them, have received training, and have implemented the CoCM consistent with said guidelines, and agree to comply with said guidelines. By signing this attestation, you are attesting that you, the individual, or the group practice are actively practicing a collaborative care model consistent with that described in the agencies CoCM guideline. If at any time you, the individual, or the group practice no longer meets the requirements for CoCM, you will immediately notify the agency by contacting provider enrollment at 360-725-2144.

The person signing this form must have the authority to attest that the CoCM guidelines are being adhered to.

Print name and title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Fax, mail or scan and email this completed and signed form to:

Provider Enrollment  
PO Box 45562  
Olympia, WA 98504-5562  
Or fax to 360-725-2144, Attn: Provider Enrollment  
Or email [providerenrollment@hca.wa.gov](mailto:providerenrollment@hca.wa.gov)

## Endnotes

1. *Dissemination of Integrated Care within Adult Primary Care Settings: The Collaborative Care Model* (PDF), Amer. Psychiatric Assn. and Academy of Psychosomatic Medicine, 2016.
2. Jürgen Unützer et al., "Collaborative Care Management of Late-life Depression in the Primary Care Setting: A Randomized Controlled Trial," *JAMA* 288, no. 22 (2002): 2836–45, doi:10.1001/jama.288.22.2836.
3. Janine Archer et al., "Collaborative Care for Depression and Anxiety," *Cochrane Database of Systematic Reviews* 10 (2012): CD006525, doi:10.1002/14651858.CD006525.pub2.
4. Peter Roy-Byrne et al., "Delivery of Evidence-Based Treatment for Multiple Anxiety Disorders in Primary Care: A Randomized Controlled Trial," *JAMA* 303, no. 19 (2010): 1921–8, doi:10.1001/jama.2010.608.
5. Charles C. Engel et al., "Centrally Assisted Collaborative Telecare for Posttraumatic Stress Disorder and Depression Among Military Personnel Attending Primary Care: A Randomized Clinical Trial," *JAMA internal Medicine* 176, no. 7 (2016): 948–56, doi:10.1001/jamainternmed.2016.2402.
6. Katherine E. Watkins et al., "Collaborative Care for Opioid and Alcohol Use Disorders in Primary Care: The SUMMIT Randomized Clinical Trial," *JAMA Internal Medicine* 177, no. 10 (2017): 1480–88, doi:10.1001/jamainternmed.2017.3947.
7. Jürgen Unützer et al., *The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes* (PDF), Centers for Medicare and Medicaid Services, May 2013.
8. Jürgen Unützer et al., "Long Term Cost Effects of Collaborative Care for Late-Life Depression," *Amer. Journal of Managed Care* 14, no. 2 (Feb. 2008): 95–100.
9. Gregory E. Simon et al., "Cost-Effectiveness of Systematic Depression Treatment Among People With Diabetes Mellitus," *Archives of General Psychiatry* 64, no. 1 (2007): 65–72, doi:10.1001/archpsyc.64.1.65.
10. Rebecca C. Rossom et al., "Impact of a National Collaborative Care Initiative for Patients with Depression and Diabetes or Cardiovascular Disease," *General Hospital Psychiatry* 44 (Jan.–Feb. 2017): 77–85, doi:10.1016/j.genhosppsych.2016.05.006.
11. Rossom et al., "Impact."
12. Henry Ireys et al., *Evaluating the HCIA - Behavioral Health/ Substance Abuse Awards: Third Annual Report* (PDF), Mathematica Policy Research, January 23, 2017.
13. Sanjay Basu et al., "Behavioral Health Integration into Primary Care: A Microsimulation of Financial Implications for Practices," *Journal of General Internal Medicine* 32 (2017): 1330–41, doi.org:10.1007/s11606-017-4177-9.
14. E. Dawn Creach, Mike Franz, and Janet Foliano, *Key Factors for Advancing Integrated Care in Central Oregon: Payer, Provider, Policy, and Technical Assistance* (PDF) (presented at the Collaborative Family Healthcare Assn. Annual Conference, Denver, Colorado, October 18, 2019).
15. *Collaboration Under Value-Based Payment: Lessons Learned* (PDF), National Partnership for the Health Care Safety Net, July 2017.
16. The Collaborative Care Model was initially evaluated for use in depression, but has since been shown to be effective for anxiety, PTSD, and substance use disorder as well as for behavioral health patients with comorbid medical conditions like cancer, diabetes, and heart disease.
17. **42 CFR §§ 405, 410, 414, 424, and 425 (2017)** (PDF).
18. This is different than what would be required for a BCM to bill Medicare independently.
19. The psychiatric consultant is not required to be a Medicare provider.
20. While PCP is used as an example, the codes can be billed by physicians and nonphysician practitioners whose scope of practice includes evaluation and management (E/M) services and who can independently report services to Medicare. This includes physicians of any specialty, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives.
21. The CCM code was designed to reimburse nurse care managers for providing care for patients having two or more chronic medical conditions. It requires at least 20 minutes of care management tasks (e.g., coordination with specialists, systematic assessment of needs, care plans, outreach and engagement, medication reconciliation, etc.) be provided per month.
22. As with the 99492–94 codes, BCMs qualified to bill traditional diagnostic, evaluation, and therapy codes for Medicare recipients are allowed to bill for those services in the same month as billing G0512. Time spent on those additional activities may not be included in the time applied to G0512. In the FQHC and RHC setting, the BCMs bill and receive the PPS/AIR rate for these services rather than the specific codes. FQHCs and RHCs are paid based on a system that was historically tied to their costs. As a result, each center has its own rate for every qualifying visit. For FQHCs, this is the Prospective Payment System (PPS) rate and for RCHs, the All Inclusive Rate (AIR). The median PPS/AIR rate in California may be higher than the monthly CoCM reimbursement for the G0512 code. For example, in Washington, FQHCs delivering CoCM have not used the CoCM codes but instead have billed under their traditional PPS rate, which is much higher than the G0512 reimbursement.

23. Dori A. Cross et al., "Use of Medicare's Behavioral Health Integration Service Codes in the First Two Years: An Observational Study," *Journal of General Internal Medicine* (published ahead of print, Dec. 16, 2019), doi:10.1007/s11606-019-05579-2.
24. The author reviewed online Physician Fee Schedules for all 50 states and DC, looked for any Medicaid provider bulletins for states that had codes listed in the Physician Fee Schedule, and conducted two key informant interviews in Washington and New York, the states with the longest implementation experience.
25. New York's implementation predates the CoCM codes. As a result, New York uses a proprietary code (T2022) that is billed at \$150 per month. However, there is a 25% quality and outcome withhold, resulting in more typical reimbursement of \$112.50 per month.
26. Pamela B. Pietruszewski et al., "Effects of Staffing Choices on Collaborative Care for Depression at Primary Care Clinics in Minnesota," *Psychiatric Services* 66, no. 1 (October 1, 2014): 101–3, doi:10.1176/appi.ps.201300552.
27. These rates were found in the Physician Fee Schedule published online by the individual state Medicaid authorities. Rates presented are for fee-for-service billing, but managed care entities may pay higher negotiated rates for the CoCM codes than fee-for-service.
28. Medicare has differential rates by geographic region.
29. Montana has allowed FQHCs to use the 99492–4 codes, but reimburses them at a lower rate (\$99/\$90/\$48).
30. Some practices use this code to help capture revenue for tasks and activities related to collaborative care that do not meet the requirements for billing the CoCM codes (e.g., when a patient is improving and does not need the full 60 minutes, or when the first contact is near the end of a calendar month). Medicare reimburses \$48 for 99484, and the Medicaid rate as a percentage of the Medicare rate for this code is similar to the CoCM codes.
31. Mary K. Morreale et al., "Supporting the Education of Nurse Practitioners and Physician Assistants in Meeting Shortages in Mental Health Care," *Academic Psychiatry* 44 (2020): 377–79, doi:10.1007/s40596-020-01256-3.
32. Katherine Sanchez, "Collaborative Care in Real-World Settings: Barriers and Opportunities for Sustainability," *Patient Preference and Adherence* 11 (Jan. 5, 2017): 71-74, doi:10.2147/PPA.S120070.
33. Basu et al., "Behavioral Health Integration"; and Cory Page et al., *Financing Behavioral Health Integration and Collaborative Care Models* (PDF), Univ. of Michigan Behavioral Health Workforce Research Center, December 2019.
34. Andrew D. Carlo et al., "Financing for Collaborative Care — a Narrative Review," *Current Treatment Options in Psychiatry* 5 (2018): 334–44, doi:10.1007/s40501-018-0150-4.
35. Watkins et al., "Collaborative Care."