Improving Behavioral Health Care for Youth Through Collaborative Care Expansion

FINAL REPORT

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MEADOWS MENTAL HEALTH POLICY INSTITUTE

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Contents

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Executive Summary

Mental health systems in the United States are not set up to detect and treat mental illness early in disease onset, thus failing to meet demands of the mental health crisis facing adolescents and youth. Integrated behavioral health - a model of mental health care delivered in primary care - allows for the early screening and treatment needed to help alleviate the youth mental health crisis.[1] In particular, the collaborative care model (CoCM) is the integrated behavioral health model with the strongest evidence-base to effectively address the needs of our mental health care system, especially for children and adolescents.[2,3,4,5] Yet, its uptake among health systems and primary care providers has been slow, especially in pediatric practices.

As for any health care service, sustainable reimbursement is critical to provide adoption of new services and models. Since Medicaid insures almost half of all children in the U.S., it plays an essential role in making CoCM accessible for children and youth in pediatric and primary care settings. While Medicare and many commercial plans already reimburse for CoCM,[6] previous research shows that less than half of states (22) reimburse for the CoCM. Even in states that include CoCM as a mandated benefit in Medicaid, rates are often low and many states' benefit coverage is inconsistent with Medicare.

While Medicaid payment is critical for adoption of CoCM throughout the country, payment alone has not been enough to catalyze adoption. In this report**,** we review research on implementation barriers and facilitators for CoCM adoption in New York, North Carolina, Texas, and Washington once Medicaid CoCM codes are in place. Based on key informant interviews, we identify solutions to common implementation barriers and highlight exemplary and innovative strategies used by each of the states. We identify key recommendations and discuss the barriers and state solutions within these recommendations:

Recommendation 1: Make Reimbursement Requirements Consistent and Payment Sustainable in All States

Barriers addressed: Underscoring findings in our previous report (see Appendix 1), clear, consistent reimbursement requirements, and sustainable payment rates are critical to provider adoption. Inconsistent reimbursement guidelines between payers makes CoCM administration more cumbersome. In particular, inconsistent reimbursement requirements are especially confusing for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). [7] Furthermore, most state Medicaid reimbursement rates for CoCM are lower than Medicare and commercial rates (20 out of 22 states in our research), though to what degree varies significantly (See Appendix 1, Table 5 for more detail).[8]

Exemplary state solution: To create **consistency in reimbursement requirements and sustainable payment**, North Carolina removed more stringent licensure restrictions on key CoCM staff, adopted G0512 code that Medicare created for FQHCs/RHCs to use, and increased its reimbursement of CoCM to 120% of the Medicare rate.

Recommendation 2: Support Health System Practice Transformation

2A: Invest in and Disseminate Implementation Tools, Training, and Technical Assistance with a Focus on Pediatrics

Barriers addressed: CoCM requires changes in practice workflow, addition of new team members, and unique billing processes that require specialized expertise and investment in system transformation. These changes require training and technical assistance that may seem dauting to practices.

Exemplary state solutions: Several states have stepped in to assist in the provision of health system training and technical assistance. The New York State Office of Mental Health provides free, tailored technical assistance, and implementation support at no cost to participating Medicaid primary care providers, including billing support, one-on-one coaching, and workflow development. North Carolina has a directory of psychiatric consultants interested in contracting with primary care practices to implement CoCM.

2B: Offset Costs Associated with Practice Transformation

Barriers addressed: CoCM implementation requires start-up funds to cover the initial costs, which include engaging health systems, establishing registries, hiring staff, as well as workflow changes, training, and technical assistance discussed as part of Recommendation 2A. The inability or perceived risk of taking on these startup costs prevents practices from implementing CoCM.

Exemplary state solutions: New York, North Carolina, and Washington have all partnered with the AIMS Center at the University of Washington to supply health systems a registry option for little or no cost to alleviate the burden of startup and implementation costs. In Texas, health systems have been successful offsetting startup and implementation costs by leveraging federal and philanthropic grant funding through the support of the Meadows Institute.

Finally, in future considerations, transition age youth (TAY, ages 19-25) face unique challenges accessing care as they age out of pediatric care and, in some states, Medicaid benefits. States can further increase mental health access by supporting CoCM adoption in places where TAY are most likely to seek care, such as student health settings and FQHCs and RHCs.

The mental health crisis faced by our country's youth is well-known and a rapid response is needed. As our findings suggest, Congress, CMS, states, and others can act today to increase access to care for the nearly 50% of youth who received mental health care through Medicaid by advancing policy for national Medicaid coverage for Collaborative Care.

Introduction

Even before the COVID-19 pandemic, mental illness among America's youth was at a crisis point; since then, the crisis has only escalated.[9] Nearly half of teenagers in the U.S. report they struggle with persistent feelings of sadness and hopelessness.[10] Youth are also reporting serious thoughts of suicide at disturbing rates: 20% of high school students and 11% of youth ages 18-25,[11] with the rate of suicide for black youth growing at alarming rates.[12] Simultaneously, severe shortages in the overall behavioral health workforce will make it hard to meet the current need,[13] particularly in underserved communities,[14] exacerbating pronounced inequities across communities of color.[15,16,17,18]

While 75% of mental health (MH) conditions present by the age of twenty-five, and 50% before the age of 14,[19] most mental illnesses are not detected until eight to ten years after symptoms emerge which is a major factor contributing to the MH crisis.[20] This demonstrates that we are missing an opportunity to intervene at a time when services can have the most impact. Interventions work best at an early stage when symptoms are less severe and *before* they reach a crisis point.[21,22] To get ahead of this trajectory, we need more expansive and readily accessible screening and treatment for MH conditions, especially for children and youth when most mental illnesses begin.

Table 1: Average Age of Onset for Mental Health Conditions[23]

Mental Health Conditions with Average Age Onset			
Mental Health Condition	**Age**	**Mental Health Condition**	**Age**
Anxiety Disorders	11	Bipolar Disorder	25
Attention Deficit	7	Schizophrenia	22
Post-Traumatic Stress	23	Substance Use Disorders	19

Integrated behavioral health is a model of mental health care service delivery that embeds mental health care service delivery into primary care. In primary care, the doctor provides ongoing routine care for the patient and is the front line for health care delivery and the place where families are most likely to receive care. Integrated behavioral health helps address stigma tied to accessing mental health treatment and allows for the early screening and intervention needed to help alleviate the youth mental health crisis.[24]

The collaborative care model (CoCM) is the integrated behavioral health model with the strongest evidence base to effectively address the needs of our mental health care system, especially for youth and children.[25,26,27,28] Over 90 randomized controlled trials have demonstrated its efficacy in diverse settings, diagnoses, and populations.[29] By serving people with mild to moderate MH conditions in pediatric and primary care and facilitating referral to specialty care for more severe conditions, CoCM allows our limited specialty care workforce to focus on people with more severe and complex needs.[30]

Sample Evidence for CoCM in Specific Populations

CoCM was found to be efficacious in:

- Rural settings (on par with in urban settings); [31]
- Specific medical populations, such as those with recent cardiac events; [32]
- Patients with co-morbid diabetes, such as heart disease, obesity, cancer, HIV; [33] [34] [35] [36]
- Patient Centered Medical Homes,[37] FQHCs and other under-resourced settings; [38]
- Telehealth; [39]
- Trauma survivors and patients with Post-Traumatic Stress Disorder (PTSD);[40] [41] and
- Patients with alcohol and opiate use disorders. [42] [43]

Additionally, CoCM has consistently show to:

- Mitigate treatment disparities for persons of color, including Black, Hispanic/Latino, Asian, Native American, Alaska Native patients.[44]

Despite its strong evidence base and proven impact, health systems have been slow to adopt CoCM, especially in pediatric practices. There are many reasons for this, including:

(1) First, as for any health care service, sustainable and clear reimbursement is critical to provider adoption. While Medicare and many commercial plans already reimburse for CoCM,[45] twenty-eight state Medicaid programs still do not cover the CoCM reimbursement codes. Given Medicaid insures almost half of all children in the U.S., Medicaid plays an essential role in making CoCM accessible for youth in pediatric and primary care settings.

(2) Second, CoCM requires changes in practice workflow, addition of new team members, and unique billing processes that require financial investment in system transformation. These changes require training and technical assistance.

(3) Finally, these changes to workflow and the necessary training and technical assistance, in addition to hiring new staff, require initial start-up funding. Without support for implementation costs and technical assistance, the development of CoCM programs may seem daunting to practices.[46]

Building off of our previously published national scan of Medicaid codes (included here as Appendix 1,) this brief explores major impediments to CoCM adoption and potential solutions. We provide an analysis of key barriers and facilitators to the implementation of CoCM based on key informant interviews in four states that include CoCM as a mandated benefit in Medicaid: New York, North Carolina, Texas, and Washington.

All four states selected include CoCM as a mandated benefit in Medicaid and have innovative state Medicaid programs or technical assistance centers focused on improving CoCM uptake within Medicaid primary care practices. These state programs were selected to include

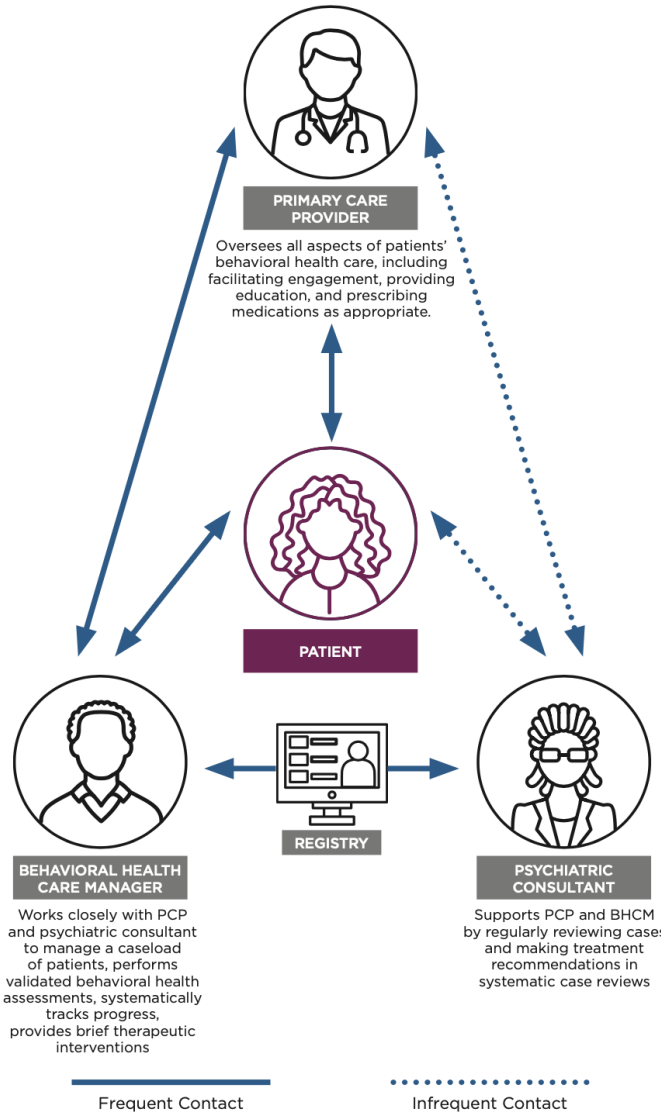
geographic and political differences that could potentially influence strategies for increasing adoption.

Within these recommendations, we discuss barriers, solutions to support CoCM expansion, and highlight exemplary and innovative examples of implementation solutions found in each state, including the needs and innovations for implementing CoCM with transition-age youth. We provide policy recommendations to advance state and national CoCM implementation best practices and consider unique opportunities to accelerate mental health access for adolescents and transition-age youth.

Background: The Collaborative Care Model

The collaborative care model (CoCM) brings together physical and mental health care treatment within a primary care provider's office. In this integrated care approach, a primary care provider (PCP), a psychiatric consultant, and behavioral health care manager (BHCM) support the patient using a patient registry to track and follow patient progress (see Figure 1). This CoCM team works together to detect and provide established treatments for common mental health problems, measure patients' progress toward treatment targets, and adjust a patient's treatment plan when appropriate. The treatment plan for each patient may include medication recommendations the PCP prescribes, brief therapeutic interventions the BHCM delivers, or both. The team refers patients who are not improving to specialty behavioral health services.[47]

Figure 1: Collaborative Care Model Team Member Interactions



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As Table 2 outlines, collaborative care is transformative, offering solutions to several mental health challenges.

Table 2: How CoCM Provides Solutions to Multiple Mental Health Challenges for Youth

Mental Health Challenge	CoCM-Driven Solution
Limited early MH screening and delayed interventions: 50% of MH conditions are present by the age 14 and 75% by the age 25, including severe MH illness.[48] Yet, our pediatric primary care systems separate medical and MH issues screening, treatment, and interventions.	CoCM brings MH care to the primary care/pediatric setting and acts as an entry point to MH care. CoCM emphasizes universal screening and tracks patients using a treatment registry so patients with MH problems are identified, routinely followed up with, and treated.
Appropriate level of care: Only about 20% of children with mental, emotional, or behavioral disorders receive care from a specialized MH care provider.[49]	Patients screened for mild to moderate MH conditions can receive evidenced-based treatment through CoCM while patients with more serious MH conditions are connected to specialized care.
MH provider access: There is a severe shortage of child and adolescent psychiatrists. On average, there are 11 child and adolescent psychiatrists per 100,000 children in the U.S.[50]	Treating patients with mild to moderate MH problems in the primary care setting, instead of referring them to overwhelmed and understaffed specialty care systems, addresses workforce shortage issues. CoCM leverages psychiatrist time over 3.5 times.
Access to care disparities: Youth of color, youth living in rural areas, and youth with lower incomes have worse outcomes and inadequate access to MH care.[51] Twenty-one percent of all children in Medicaid are African American, 17.5% are multi-racial, and 36% are Hispanic.[52]	Implementation of CoCM has been shown to reduce disparities in MH outcomes for people of color.[53] It has also been shown to be more effective than treatment as usual in federally qualified health centers (FQHCs) and rural health centers (RHCs).[54,55]
Continuity of care challenges: Many youth struggle with care continuity when they turn 19 and age out of pediatric care; this is a time when youth often fall through the cracks and may lose Medicaid coverage. As it is also the age when most first episode psychosis presents,[56] we often miss the opportunity to connect youth to proper treatment.	For youth transitioning out of pediatric care and/or aging out of Medicaid eligibility, the BHCM can support their transition out of pediatric care and, if needed, connect them to other sources of mental and physical health care as part of a follow-up plan.

Mental Health Challenge	CoCM-Driven Solution
Primary care providers lack training in MH issues: Mental health problems require substantial time and coordination for proper diagnosis and effective treatment. As the youth MH crisis grows, MH needs may take up significant time for pediatricians and other physicians who are already short on time and experiencing burnout.[57]	CoCM enables PCPs to deliver higher-quality MH treatment by supplementing existing services with a designated team.
Late interventions: Too many of our nation's youth first receive MH care in the juvenile justice system. Up to 70% of youth in the juvenile justice system suffer from MH disorders.[58]	By extending the reach of screening and treatment, CoCM has the potential to provide earlier intervention for youth with MH needs.

Key Barriers and Facilitators for Successful CoCM Implementation with Youth

Our analysis of key barriers and facilitators to implementation of CoCM based on key informant interviews in New York, North Carolina, Texas, and Washington resulted in two key recommendations to promote adoption of CoCM in Medicaid for adolescents and transition-age youth:

- Recommendation 1: Make Reimbursement Requirements Consistent and Payment Sustainable in all States, and
- Recommendation 2: Support Health System Transformation
  - 2A. Invest in and Disseminate Implementation Tools, Training, and Technical Assistance with a Focus on Pediatrics
  - 2B. Offset Costs Associated with Practice Transformation.

Within these recommendations, we discuss barriers, solutions to support CoCM expansion, and highlight exemplary and innovative examples of implementation solutions found in each state.

Recommendation 1: Make Reimbursement Requirements Consistent and Payment Sustainable

In 2017, Medicare adopted CoCM codes, set reimbursement requirements, and established rates which provided the guidelines for billing rules and allowed providers to determine financial sustainability.[59] However, as detailed in Appendix 1, CMS did not mandate that the benefit be covered in Medicaid or issue any guidance to state Medicaid programs, creating inconsistencies across state Medicaid programs as well as billing challenges for providers across payers.[60]

Barriers

Inconsistent Reimbursement Requirements are Cumbersome for Adoption

As highlighted in Appendix 1, state Medicaid programs and commercial insurers should reimburse CoCM codes. Even when adopted, states may implement some or all of the codes and modify requirements for reimbursement. Inconsistent coverage requirements and medical policies pose a CoCM implementation barrier. For example, states may have different stipulations around personnel licensure, prior authorization, diagnostic categories, and use of an attestation form. Such inconsistencies present challenges to CoCM implementation by exacerbating the time-consuming administrative and operational burden as detailed in Recommendation 2A.[61]

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are an invaluable resource for the delivery of health care to many of our nation's most at-risk residents.[62] Nearly half of FQHC & RHC patients are Medicaid beneficiaries, and Medicaid accounts for roughly 40% of FQHC & RHCs operational revenue, making them more reliant on Medicaid payments.[63] Thus, it is vitally important that state Medicaid programs reimburse for CoCM delivery in a way that is financially viable for FQHCs & RHCs. State Medicaid programs are required to pay FQHCs and RHCs differently than other Medicaid providers, and this has led to different interpretations of how Medicaid can reimburse for CoCM at FQHCs and RHCs.[64] [65] As a result, states adoption of codes for FQHCs and RHCs has been inconsistent and often unclear (see Appendix 1 for more detail). This variation may create uncertainty as to whether FQHCs can bill for delivering CoCM to patients with Medicaid and, if so, how.

Low Medicaid Rates Disincentivize Adoption

Because Medicaid insures almost half of the children in the U.S.,[66] Medicaid reimbursement rates play a vital role in the financial sustainability of CoCM, particularly for pediatric practices with large numbers of patients insured through Medicaid.[67,68] Adequate reimbursement is imperative to compensate practices for the cost of personnel required to deliver CoCM to fidelity. Most state Medicaid reimbursement rates for CoCM are lower than Medicare and commercial rates (20 out of 22 states in our research), though to what degree varies significantly (See Appendix 1, Table 5 for more detail).[69] Multiple studies have found CoCM to be cost-effective. [70] [71] One such study showed for every $1 spent on CoCM services, $6 are saved in other healthcare costs,[72] demonstrating the financial benefit of CoCM.

Solutions to Support CoCM Expansion

In addition to taking the initial step of adopting and reimbursing for CoCM codes, state Medicaid programs can facilitate adoption of CoCM by:

- Making state CoCM Medicaid benefit coverage requirements consistent with Medicare. Consistency in medical policy and reimbursement rates simplify and streamline CoCM

implementation for health systems that serve patient populations with diverse insurance coverage. Aligning state Medicaid guidelines to Medicare guidelines helps reduce inconsistencies.

- Increasing reimbursement rates for CoCM. Increased rates will support financial sustainability of the model and help encourage CoCM uptake among Medicaid providers. This in turn has benefits for ensuring equitable access to CoCM and cost savings to the overall healthcare system. In our research of states working to solve barriers, we found solutions in both North Carolina and Washington that address the barriers created by inconsistencies in benefit structure and rates.

Exemplary State Solutions

North Carolina Augments Medicaid Benefit Coverage to Accelerate CoCM Adoption

North Carolina Medicaid first implemented CoCM codes in 2018,[73] but CoCM still had minimal uptake. During the pandemic, health care leaders recognized the magnitude of the mental health crisis across the country and its impacts on communities. Building on established relationships and networks, state leaders came together to identify solutions to address mental health needs.

In 2021, they identified expanding and scaling CoCM across the state as a priority initiative. Led by the Chief Medical Officer of North Carolina (NC) Medicaid, NC Medicaid formed the Collaborative Care Consortium (Consortium) consisting of Medicaid, academic training centers, health systems, technical assistance groups, and medical associations. The Consortium's aim is to identify and solve barriers to CoCM implementation and drive uptake across the state.[74]

The Consortium identified a pressing need for all payers to cover CoCM and adopt consistent reimbursement requirements to reduce the administrative burden and complexity for providers. The Consortium approached the North Carolina Payers Council to reach private payers and, more importantly, recruited Blue Cross Blue Shield (BCBS) North Carolina — one of the state's biggest payers — into the conversation. BCBS North Carolina began covering CoCM codes in 2022. North Carolina has since aligned its coverage requirements, revised its BHCM licensure requirements, and added the G2114 and G0512 codes to align with Medicare.[75]

The Consortium maintained that sustainable rates were essential to the viability of CoCM and worked with state leadership to raise the Medicaid reimbursement rate. On December 15, 2022, NC Medicaid announced considerable increases to CoCM Medicaid managed care rates to "120% of Medicare rates to demonstrate the state's commitment to improving access to high-quality behavioral health services through Medicaid." Key informants in North Carolina expressed hopefulness that this rate increase would have the potential to catalyze rapid CoCM adoption for youth and transition-age youth.[76]

Washington Mental Health Integration Program Encourages FQHC Adoption of CoCM

In Washington, the Mental Health Integration Program (MHIP), which is supported and administered by a Medicaid managed care organization called the Community Health Plan of Washington (CHPW), has helped to incentivize the implementation of CoCM since 2007. Initially implemented in the Seattle

Metropolitan area, the program expanded state-wide in 2009. Around this time, MHIP added a pay-for-performance incentive based on key CoCM-specific metrics. Practices receive a per member per month case rate for anyone on the active caseload, which is intended to cover the cost of the BHCM. CoCM outcomes are tracked according to five quality metrics and there is an opportunity to earn up to 125% of the case rate for demonstrated high performance. MHIP has helped community practices throughout the state defray the costs of CoCM, many of which were FQHCs. Early research on the MHIP pay-for-performance program found that the introduction of quality measures improved patient outcomes in CoCM.[77] CHPW also contracts with the Advancing Integrated Mental Health Solutions (AIMS) Center to support health systems participating in the MHIP program as well as access to the Care Management Tracking System registry tool.

Recommendation 2. Support Health System Practice Transformation

CoCM implementation requires significant institutional and operational shifts. Health systems require CoCM implementation support through the use of tools, training, technical assistance, and start-up costs.

2A. Support Health System Practice Transformation through Investing in and Disseminating Tools, Training, and Technical Assistance

Training and technical assistance are typically required to learn this model, including evidence-based treatments, modified roles and workflows, caseload management through a patient registry, and unique billing procedures.

Barriers

Implementing CoCM Requires New Operational Tools and Workflows

Technical assistance on utilizing a registry, workflow planning, and billing optimization is typically needed for health systems to successfully implement CoCM. A key component of CoCM is a patient registry, which is a caseload management tool maintained by the BHCM that tracks enrolled patients. Patient registry options include a simple spreadsheet, a standalone registry application, or a registry integrated into an electronic health record (EHR). There are different challenges tied to these options that can include an additional cost to the health system and/or double documentation, with BHCMs required to document both patient outcomes and progress in an outside registry as well as within their EHR.

Workflow planning and billing optimization is a significant component of CoCM implementation, since CoCM codes require tracking minutes of service-delivery over a calendar month. This entails tracking multiple interactions, recording aggregate time of service delivery, and then determining which CoCM code to bill. Unless already implementing codes with similar thresholds, this process requires new workflows for the clinicians and billing personnel.

Implementing CoCM Requires Training and Technical Assistance

CoCM implementation requires specific training and education for all levels of staff. BHCMs, for example, are trained to deliver brief evidence-based interventions to patients, such as motivational interviewing and problem-solving therapy. Depending on the diagnostic scope of a clinic's CoCM program, there are additional training considerations when working with youth, such as training in suicidal ideation screening, risk assessment, substance use disorder evaluation, and safety planning. Furthermore, training and technical assistance can support PCPs' familiarity with the model, as well as changes in established practices that include obtaining and documenting patient consent, team-based care, and working with a psychiatric consultant. Ensuring dedicated time for training during start-up can be challenging for busy clinics and some practices cannot afford to close entirely to train providers and staff. Training often occurs in the clinic when staff are expected to multitask, which increases overall practices demand and provider burden.

Solutions to Support CoCM Expansion

While not all implementation challenges can be alleviated, states, managed care organizations (MCOs), health systems, and academic training centers can take advantage of various opportunities to provide necessary training and technical assistance:

- State Medicaid programs, Medicaid MCOs, and health systems can partner with academic training centers, technical assistance centers, and/or other third-party vendors to provide initial and ongoing training, technical assistance, staffing support, and/or a patient registry option to providers at no- or low-cost.
- Academic training centers can establish learning collaboratives so that BHCMs from different practices can learn best practices from their peers and troubleshoot challenges, which further increases their confidence in implementing this model.
- State Medicaid programs, Medicaid MCOs, and academic training centers can also provide free registries to practices serving Medicaid beneficiaries and technical assistance in using the registry.

Exemplary State Solutions

In New York and North Carolina, state Medicaid programs directly provide or fund technical assistance:

New York Medicaid Supports CoCM Through Its Technical Assistance Program

Primary care providers participating in the New York State Collaborative Care Medicaid Program (CCMP) can access free technical assistance and implementation support at no cost, including billing support, one-on-one coaching, and workflow development. The New York State Office of Mental Health (NYS OMH) tailors its technical assistance to each provider by giving them an informal needs assessment and addressing their unique needs to support CoCM implementation. In partnership with the AIMS Center at the University of Washington, NYSOMH offers additional discounted training opportunities for the CoCM team, including self-paced introduction training modules, Problem Solving Treatment certification, and Behavioral Activation training. NYS OMH collects quarterly metrics that have been defined around outcomes to improve fidelity to the model and quality care for patients.

North Carolina Partners to Provide Technical Assistance Across the State

The North Carolina CoCM consortium (described above) found that providers, especially independent primary care practices and FQHCs/RHCs, do not possess the bandwidth to learn and implement the CoCM model on their own. This led the North Carolina Department of Health and Human Services to contract with North Carolina Area Health Education Centers (NC AHEC), an organization that provides education and technical assistance and is trusted to provide practice support, education, and technical assistance at no cost to practices. NC AHEC provides a broad range of training, including:

- Direct practice support coaching to primary care practices that accept Medicaid patients on how to implement CoCM. Education is provided to primary care providers, behavioral health staff, and practice managers. Topics include clinical and administrative workflows, data registry implementation, billing/coding, proforma analysis, EHR optimization, telehealth, and scheduling best practices.
- Educational programs on CoCM and related clinical topics in partnership with the North Carolina Department of Health and Human Services. Courses are provided at no cost and include educational credits for participants.
- Peer learning collaboratives, beginning with BHCMs.
- Education on CoCM through presentations at professional society meetings.

Additionally, matching psychiatrists with practices is an important part of CoCM implementation by NC AHEC. The North Carolina Psychiatry Association has established a directory of adult and pediatric psychiatry consultants interested in contracting directly with practices, including those NC AHEC supports. NC AHEC also ensures practices are aware of and coordinates with the NC Psychiatry Access Line (NCPAL) for no cost pediatric psychiatric consultants.

NC Department of Health and Human Services covers the cost of the NCPAL and AHEC courses and practice support coaching for CoCM.

CoCM Training and Technical Assistance Tools in Texas

Through philanthropic funding, the Meadows Institute and Dell Medical School at the University of Texas are developing foundational technical assistance tools to support primary care practice teams with CoCM implementation and model adherence fidelity. These tools will guide workflow discussions and support health systems with necessary operations adjustments when implementing CoCM. The Meadows Institute and Dell Medical School will also train providers on CoCM outcomes, fidelity, and operational processes.

2B. Offset Costs Associated with Practice Transformation

CoCM implementation requires start-up funds to cover initial costs, which include a multitude of tasks ranging from engaging health systems to establishing registries. Additionally, staff time away from normal duties and delayed reimbursement make implementation of CoCM an additional expense for practices.

Barriers

Initial Start-Up Costs Slow Adoption of CoCM

There are a number of costs associated with initial start-up of CoCM, including those associated with recruiting, hiring, and contracting new staff, training new and existing staff, developing patient-centered workflows, and creating or buying a patient registry. Although sparse data exist detailing real-world CoCM start-up costs, a recent evaluation of 10 U.S. health systems conducted by the Meadows Institute estimates that average CoCM costs per clinic implemented were $220,000, ranging from $49,000 to $650,000. These costs were found to vary based on the extent of leadership involvement during implementation, the length of the implementation ramp-up period, the use of CoCM-specific vendors (or the lack thereof), decisions made surrounding IT infrastructure, the number of clinics included in the CoCM program, and geographic location, among others.[78] This initial investment can be burdensome for health systems interested in implementing CoCM.

Delayed Reimbursement Exacerbates Startup Costs

During the initial implementation stages, staff cannot immediately bill for CoCM services. Staff need to be trained and onboarded before official program launch and patients must be identified and enrolled in the program. As one key stakeholder in Texas reported, it can take six to eight weeks for new BHCMs to become fully trained and have a full caseload. For many primary care practices, preexisting narrow margins make it difficult to absorb these expenses and thus are often unwilling – or unable - to accept such risk. Furthermore, as CoCM billing is based on a calendar month, practices need to provide care until a calendar month concludes before they can bill, which further delays the amount of time before they can obtain compensation for their initial investment.

Solutions to Support CoCM Expansion

In addition to training and technical assistance, private and public funders can support health systems offset startup implementation costs in a variety of ways.

- As previously described, states and Medicaid MCOs can cover a portion of initial implementation costs for Medicaid providers by supplying free or low-cost access to technical assistance, training, and education, as well as supplying a registry.
- States can help ease the burden of finding and contracting with psychiatric consultants by providing template contracts and liaising between practices and available psychiatric consultants.
- Private and public funders can support clinical practices by providing them one-time grants to offset startup costs, providing practices the flexibility to conduct planning, hiring, and workflow development that is necessary before a practice can begin earning consistent revenue. Both states and health systems can help facilitate these public and private partnerships.

Exemplary State Solutions

Offsetting Cost with AIMS Registry Tool Options

The AIMS Center at the University of Washington is an important facilitator for CoCM implementation. The AIMS Center has facilitated CoCM implementation locally, nationally, and internationally by providing coaching, training, technical assistance, resources, and implementation guides to providers.

The AIMS Center also supports health systems by providing patient registry options. AIMS Caseload Tracker is a secure web-based registry for managing behavioral health caseloads in integrated care settings. An enhanced version of this tool uses an integration engine to read real-time clinical data from health systems' EHR and displays it within the AIMS Caseload Tracker user interface. This eliminates the double-documentation burden for clinical staff and ensures accurate and up-to-date information is available across the care team. AIMS also offers a Care Management Tracking System (CMTS) customizable registry option. This option is most ideal for providing a registry option that spans multiple healthcare organizations using various EHRs who may have specific tracking and reporting needs. North Carolina, New York, and Washington have all partnered with the AIMS Center to supply health systems within their respective states a registry option.

The North Carolina Department of Health and Human Services provided funding to Community Care North Carolina (CCNC) to develop an AIMS Caseload Tracker registry which is available to 100 primary care practices at no cost as of December 2022. CCNC contracted with the AIMS Center and developed this customized registry that includes screens for depression, anxiety, attention-deficit/hyperactivity disorder for children and adolescents, and post-traumatic stress disorder for adults. NC AHEC has been working closely with CCNC and has provided training and supports to the practices that utilize the registry.

In 2013, New York State (NYS) Office of Mental Health (NYSOMH) commissioned the AIMS Center to build a customized version of the Care Management Tracking System (CMTS). This CMTS registry contains custom reports for quarterly data submission by clinics and aids in Medicaid billing. NYS OMH

provides initial access to the registry for interested health systems joining the CCMP. With approval from NYSOMH, access to this version of CMTS is free for the first year and about $1,000 for each year after that (for up to 50 users).

In Washington, the Mental Health Integration Program (MHIP), which is supported and administered by a Medicaid managed care organization called the Community Health Plan of Washington, has CoCM teams in safety-net primary care settings who serve diverse Medicaid and uninsured populations. MHIP uses the AIMS Center CMTS patient registry to track and measure patient goals and clinical outcomes, as well as facilitate treatment adjustment if a patient is not improving as expected. Health systems participating in MHIP have access to this registry for free.

Texas Healthcare Systems Leverage Public and Private Resources

Texas has been successful in offsetting startup costs for clinical practices interested in CoCM by leveraging public and private funding streams and developing a coordinated implementation strategy led by the Meadows Institute. The Meadows Institute has utilized a range of philanthropic grant funding and American Rescue Plan Act (ARPA) resources in partnership with the state to provide technical assistance and training on CoCM implementation in primary care and pediatric health systems throughout the state of Texas. Specifically, the Meadows Institute, in partnership with various Texas-based medical schools, has provided technical assistance and implementation support on the specifics of delivering the CoCM model, such as necessary operational workflow adjustments and billing processes. University of Texas Southwestern Medical Center's Center for Depression Research and Clinical Care (UTSW CDRC) is developing and maintaining a data repository used by all participating health systems to tracks program metrics. The public and private resources have also been utilized to support the financial start-up burden associated with CoCM implementation that health systems incur and often serve as a barrier to implementation as described above. These programs will continue to launch by stages across the state with an ambitious goal of reaching 10 million individuals.

Future Considerations for Transition Age Youth

Transition-age youth are at risk of losing needed services as they progress from youth to adult mental health services. Depending on the state, Medicaid coverage may end at age 19. Even when coverage continues, adolescents and transition-age youth need to engage in a medical transition from pediatric to adult care.[79] CoCM has an additional inherent benefit for adolescents and transition-age youth since BHCMs are responsible for supporting the overall health and well-being of their patients over time, including modifying treatment plans for patients as changes arise and facilitating referrals to new providers.

States can further increase mental health access for adolescents and transition-age youth by supporting CoCM adoption in student health settings on college campuses. The majority of college and university undergraduate students have health insurance, allowing them to access these services. As of 2021, 91% of undergraduate students nationally have health insurance; 17% of these undergraduate students access their health insurance through Medicaid or government assistance.[80] College and university students may be covered through a student health plan that colleges and universities make available to their enrolled students, a private or public insurance plan, or through dependent coverage, which allows young adults to remain on their parents' insurance until they are 26.

Seventeen percent of undergraduate students in the U.S. are insured through Medicaid or government assistance

Barriers

Traditional college-aged students (18 to 25 years old) represent a critical stage of development where growth and maturation occur in physical, psychological, and social arenas. Mental health concerns may also surface during this critical stage of development, as 75% of mental health issues present by the age of 25.[81] Moreover, there is a strong negative correlation between acuity of depressive symptoms and cognitive performance, potentially influencing academic performance, retention, and graduation rates.[82,83]

Solutions to Support CoCM Expansion

The pronounced escalation of college-enrolled TAY struggling with mental health issues provides a unique opportunity to implement scalable services through CoCM. University Health Centers should implement evidence-based CoCM to better support large numbers of students. CoCM provided through student health centers could serve to support this transition to adult mental health services for transition-age youth while also ensuring there is no gap in service provision. Similar to youth and adult populations, CoCM may offer opportunities for more consistent positive mental health outcomes for transition-age youth enrolled in college.[84]

There may be additional mechanisms for states to incentivize focused transition planning to support transition-age youth, including adopting CPT codes to cover elements of transition planning or create value-based payment mechanisms for pediatric and adult primary care practices.[85] Furthermore, state leaders should also consider the challenges created by a gap in insurance coverage for transition-age youth when aging out of Medicaid coverage.[86]

Exemplary State Solutions

Texas A&M University, University Health Services

The Meadows Institute has partnered with Texas A&M University Health Services to support implementation of CoCM programming for its student population. Through this partnership, the Meadows Institute is developing tailored workflows and implementation tools, as well as providing technical assistance and implementation support to Texas A&M. Moreover, the Meadows Institute is assisting across various operational aspects of their CoCM programming, including roles, responsibilities, billing procedures, measurement-based care inventory, patient registry, and CoCM service array.

Ithaca College and Cayuga Health System (New York)

Starting in fall 2022, Ithaca College (IC) partnered with Cayuga Health System (CHS) to provide a continuum of behavioral health services at its on-campus student health center. Service offerings include Collaborative Care Model (CoCM) and Primary Care Behavioral Health (PCBH) services, which students can access as needs arise. Medical providers connect students same-day with in-office behaviorists for any primary care need. Virtual telehealth CoCM services offer students highly-effective, focused treatment for depression and anxiety. The integrated team includes two onsite behavioral health consultants, one remote behavioral health care manager, and one remote consulting psychiatrist. The health center conducts universal screenings at all student appointments to proactively identify needs and direct care.

The college's integrated team coordinates with other campus partners such as Counseling and Psychological Services (CAPS), the Office of Case Management (ICare), and Student Disability Services (SDS). These collaborations help the university to offer a spectrum of services differing by care entry point, modality, and population target to best meet the needs of a diverse university population.

Austin Community College Launches CoCM to Expand Reach of Mental Health Services

The University of Texas at Austin Dell Medical School's Center for Youth Mental Health and the Austin Community College partnered to create the Amplify Center, a clinic modeled after the Australian *headspace* program, designed as an early intervention in mental health challenges that develop during adolescence and young adulthood. [87] The Amplify Center launched in 2022 at the Austin Community College Eastview Campus, providing mental health services, personalized support, and guidance to students ages 18-29. This clinic is currently adding primary care services through the use of a Nurse Practitioner, with the ultimate goal of implementing CoCM to meet the psychiatric needs of youth attending Austin Community College.

Policy Recommendations

Federal and state policy makers and regulators, Medicaid authorities, philanthropists, academic training centers, technical assistance centers, and college campuses can all act to further the adoption of CoCM and alleviate the nation's youth mental health crisis.

Below are policy recommendations tied to Recommendation 1:Make Reimbursement Requirements Consistent and Payment Sustainable, and Recommendation 2: Support Health System Transformation through technical assistance and startup funds.

Recommendation 1: Make Reimbursement Requirements Consistent and Payment Sustainable

Policy Recommendation 1: All 51 Medicaid programs should cover CoCM reimbursement codes and state Medicaid guidelines should align with Medicare rules and reimburse at rates at or above Medicare. Consistency in medical policy and reimbursement rates increases provider adoption of new protocols. Matching current Medicare guidelines will simplify the process for providers and allow CoCM to be more financially viable for providers, thus increasing adoption and leading to better mental health outcomes for youth.[88]

Table 3: Recommended Actions for Collaborative Care Reimbursement and Guidelines

Agency	Recommended Actions
Congress	**Congressional leaders should require CMS** to develop and implement a clear plan to increase access to collaborative care and boost adoption of collaborative care codes, with particular attention to providing explicit guidance and technical assistance on the use of CPT and G codes.
CMS	**Include CoCM as a mandated benefit in Medicaid, consistent with Medicare.** CoCM is billed as a physician service, which are mandatory services in Medicaid. Mandatory services in Medicaid are typically defined consistently with Medicare because of the comparability across aid categories and the need for each service to be sufficient in coverage, and so that all members receive at least the coverage dual eligible members receive.[89,] CMS recognizing CoCM as a mandated benefit would require all states to cover it, leading to its rapid adoption.
	Issue a CoCM Medicaid policy guidance through a State Medicaid Director Letter similar to the one it issued on CoCM Medicare policy guidance through its Medicare Learning Network.[90] On August 18, 2022, CMS issued an informational bulletin encouraging states and Medicaid managed care plans to adopt integrated care models like CoCM.[91] However, a State Medicaid Director Letter that specifically provides CoCM implementation guidance like the Medicare Learning Network guidance provides, would give much needed guidance on how states should cover the benefit. The guidance should include covering the full range of diagnoses, mirroring

Agency	Recommended Actions
	the BHCM and psychiatric consultant eligibility requirements, and ensuring providers in different specialties are eligible for reimbursement.
State Medicaid Authorities	**Cover CoCM as a Medicaid benefit and align CoCM benefit coverage and policies with Medicare**.
	Adopt fee-for-service (FFS) rates on par with Medicare rates (at a minimum) and make adjustments to managed care contracts and capitation rates to provide financial incentives to Medicaid managed care plans who offer CoCM providers financially viable rates to help ensure financial sustainability in both Medicaid FFS and managed care delivery systems.
	Be cognizant of what payment strategy is the most operationally and financially feasible for FQHCs/RHCs. Rather than automatically adopting the G0512 code that Medicare requires FQHCs/RHCs to use, each state should carefully consider the best billing strategy for its FQHCs/RHCs in both Medicaid FFS and managed care payment delivery systems.
	To advance health equity, collect higher quality and more complete patient data on CoCM utilization and clinical outcomes based on race, ethnicity, languages spoken, gender, and geography to mitigate access barriers and evaluate performance.

Recommendation 2: Support Health System Transformation through Tools, Training, Technical Assistance, and Offset Costs Associated with Practice Transformation

Policy Recommendation 2: Increase availability of implementation funds and technical assistance to incentivize the uptake of CoCM, with a focus on pediatrics. Because CoCM requires system change, including changes across various departments and levels of staff, technical assistance plays a critical role in its adoption. To successfully implement CoCM, thoughtful and localized technical assistance that considers the uniqueness of not only the health care system, but also the payer makeup in that region, is needed. Technical assistance includes working directly with executive leaders, clinical leaders, information technology departments, and billing staff to ensure buy-in across staff. Through tailored technical assistance, health systems meet identified barriers with actionable solutions.

Table 4: Recommended Actions for Collaborative Care Implementation Funds & Technical Assistance

Agency	Recommended Actions
Congress	**Congressional leaders should fully fund the Primary and Behavioral Health Care Integration Grant Program**, which will provide funding and technical assistance to primary care providers to implement integrated behavioral health and primary care models. Congress should also greatly expand the amount of funding available through the integration grant program, as one of

Agency	Recommended Actions
	the most cost-effective potential expenditures to address workforce concerns and increase access to behavioral health care services. A 2021 RAND Corporation report suggested federally funded technical assistance for CoCM would facilitate program growth and widescale adoption.
	As detailed by the U.S. Senate Finance Committee's Bipartisan Mental Health Care Integration taskforce, Congress should **increase Medicare payment rates for behavioral health integration services for a set period of time to help defray a portion of the startup costs** that providers incur when they begin delivering care through integrated care models such as CoCM. Congress should also designate behavioral health integration as one of the types of opportunities that the CMS Center for Medicare and Medicaid Innovation must consider when developing new demonstration models or revising existing models.
CMS	**Develop a national initiative modeled after the Transforming Clinical Practices Initiatives** (TCPI) to provide technical assistance, implementation tools, and a learning collaborative to support providers in the implementation of CoCM, as also recommended by RAND in 2021.[92] CMS should ensure that pediatric practices, FQHCs, and RHCs participate, and that technical assistance is tailored to their needs. As in TCPI, CMS should extend the initiative over at least a five-year period and encourage monitoring and evaluation to track health outcomes and return on investment. [93]
	Offer financial incentives, through planning grants and/or an enhanced Federal Medicaid Assistance Percentage (FMAP), to states that cover CoCM in Medicaid. Funds could be used to provide technical assistance and training to primary care providers that choose to offer CoCM.
	Through the Center for Medicare and Medicaid Innovation (CMMI), create a Medicaid demonstration project targeted specifically on the testing, designing, and implementation of different payment models for reimbursement of Collaborative Care Model of care with a focus on lowering costs and improving quality of care.
State Governors/ State Legislatures	**Utilize ARPA funds to finance CoCM implementation and technical assistance costs.** Texas, for example, is using ARPA funds to aid the implementation of CoCM in pediatric centers in 18 health systems.

Conclusion

The mental health crisis faced by our country's youth is well-known and a rapid response is needed. Congress, CMS, and states can act today to increase access to care for the nearly 40% of youth who received mental health care through Medicaid by advancing policy for national Medicaid coverage for CoCM.

Methodology

We conducted 60-minute virtual interviews with representatives from Medicaid offices, health systems, payers, and technical assistance providers from New York, North Carolina, Texas, and Washington. We reviewed interview notes and transcriptions for common themes to identify common barriers, facilitators, and state solutions to implementing CoCM.

Appendix 1: National Scan of Medicaid Benefit Coverage of CoCM

Importance of Medicaid Coverage for CoCM Expansion in Youth Population

Medicaid plays a critical role in the adoption of CoCM for children, adolescents (age 13-18), and transition-age youth (ages 19-25). Medicaid is the single largest payer and insures almost half of all children in the U.S. Even for transition-age youth (ages 19-25), who may transition out of Medicaid benefits, Medicaid plays a critical role in providing early identification and intervention before this transition occurs. Moreover, Medicaid rates support the financial sustainability of CoCM for pediatric and primary care practices for a significant number of Medicaid patients.[94,95] Adequate reimbursement is a necessary first step for making CoCM accessible to and equitable for our country's diverse population of youth. While Medicare and many commercial plans already reimburse for CoCM codes,[96] many state Medicaid programs do not yet cover the codes.

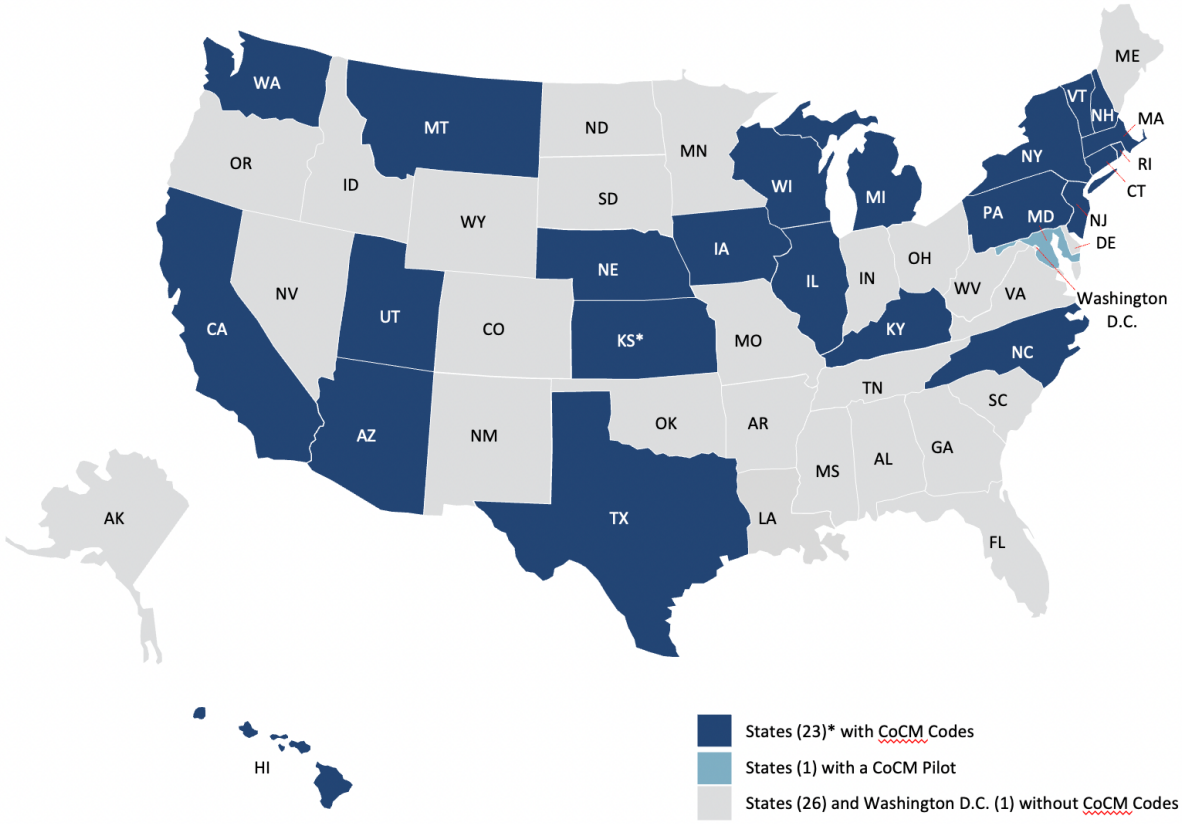
History of CoCM Billing Codes

In 2017, the Centers for Medicare & Medicaid Services (CMS) activated three new billing codes for CoCM reimbursement in Medicare, now Current Procedural Terminology (CPT) codes 99492, 99493, and 99494.[97] Shortly after, CMS created a special code for federally qualified health centers (FQHCs) and rural health centers (RHCs) to be consistent with the existing FQHC/RHC payment system (G0512). In 2021, CMS added the G2214 code to ensure providers could bill for services that did not meet the time thresholds of the other codes. See Appendix 1A for details on what each code covers.

Less than Half of All State Medicaid Programs Cover CoCM Codes

After Medicare implements codes, commercial payers and state Medicaid programs often follow their lead. However, because individual state Medicaid programs are not mandated adopt CoCM Medicare coverage benefits in part or in full, not all states do. Despite the strong evidence base for CoCM, less than half of states (22) have fully adopted CoCM CPT codes for all Medicaid beneficiaries since CMS activated the CoCM billing codes in 2017. Kansas has adopted the codes only for dually eligible members (i.e., members who have both Medicare and Medicaid coverage) and in some states the Medicaid Managed Care plans may reimburse for CoCM even if the state has not activated the codes. Since 2021, when CMS implemented the G2214 code to help providers better capture all time spent delivering CoCM services, only ten state Medicaid programs have adopted the code.

Figure 1: States (including Washington, D.C.) with Medicaid Collaborative Care Model Codes and Pilots



**Kansas activated the codes only for individuals who are dually enrolled in Medicare and Medicaid.*

Unclear Reimbursement Policies May Impede CoCM Uptake by FQHCs and RHCs

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are an invaluable resource for the delivery of health care to many of our nation's most at-risk residents. These clinics deliver primary health care to one in three people living in poverty and are required to care for all patients including those without insurance.[98] Nearly half of FQHC & RHC patients are Medicaid beneficiaries, and Medicaid accounts for roughly 40% of FQHC & RHCs operational revenue, making them more reliant on Medicaid payments.[99] State Medicaid programs are required to pay FQHCs and RHCs differently than other Medicaid providers either through a prospective payment system or an alternative payment methodology.[100] [101] Since FQHCs and RHCs are paid differently and because of their reliance on Medicaid payments, it is vitally important that state Medicaid programs reimburse for CoCM delivery in a way that is financially viable for FQHCs & RHCs.

To reimburse for CoCM in FQHCs, five state Medicaid programs have adopted the G0512 code; of note, Arizona utilizes G0512 to reimburse only for dually eligible patients. Some state Medicaid representatives we interviewed noted their state had inadvertently overlooked the activation of the G0512 code, while others allow FQHCs and RHCs to bill using CoCM CPT codes (99492-99494). Still other states allow FQHCs and RHCs to bill through the typical FQHCs/RHC billing system (i.e. the prospective payment system (PPS) encounter rate) or allow them to choose their billing method. This variation may create uncertainty as to whether FQHCs could bill for delivering CoCM to patients with Medicaid and, if so, how.

Time thresholds for G0512 are much more limiting than the CoCM CPT codes for non-FQHC providers. Stricter time thresholds prevent FQHCs and RHCs from billing for time spent with a patient if it is under or over specific thresholds. Ultimately, this creates financial viability of the model more challenging and may impede adoption.

Low Medicaid Reimbursement Rates May Impede CoCM Uptake

As is typically seen in Medicaid, most state Medicaid CoCM rates are lower than Medicare rates.[102] North Carolina, which recently increased its reimbursement rates for CoCM, now has the highest CoCM reimbursement rate for CoCM alongside of Montana. Both are higher than the Medicare rates (see Table 5). Hawaii has the lowest rate; notably, its Medicaid program reported that physicians are not using the codes. As with other benefits, Medicaid's low reimbursement rates create barriers to quality care with stark impacts on underserved communities, especially people of color.[103] (See Appendix 1B for a detailed rates table.)

Table 5: Comparison of State Medicaid benefit rates to the Geographic-based Medicare Rates for Code 99492 (non-facility)*

State	Medicare Geographic Rate (2022)	Medicaid (Non-Facility Rate)	Percent of Medicare Rate
Hawaii	$165.19	$55.54	34%
Texas (Dallas)	$155.62	$75.50	49%
New York (Manhattan)	$178.43	$112.50	63%
Washington (Seattle)	$171.59	$142.84	83%
North Carolina (Prior to December 2022)	$146.86	$130.64	89%
Montana	$153.56	$176.23	115%
North Carolina (December 2022 - present)	$146.86	$176.23	120%

** State Medicaid rates are based on state Medicaid Physician Fee Schedules pulled June-August 2022 (with the exception of the revised North Carolina rate implemented December 2022). Medicare geographic-based rates were*

identified using the Medicare Physician Fee Schedule search tool, selecting "2022" under "Year", selecting "Specific Locality" under the "MAC Option," and entering "99492" under "HCPCS Code."

Varying State Medicaid Rules and Restrictions Complicate Implementation

Aligning with Medicare billing codes and rules helps simplify the process and expense of reimbursement and allows for CoCM to be financially viable for providers.[104] When payers are consistent in medical policy and reimbursement, providers have an easier time with adoption and financial sustainability. For full financial benefit, it is important that state Medicaid programs cover the full range of diagnoses like Medicare does and mirror Medicare policies for credential requirements for the behavioral health care manager (BHCM) and psychiatric consultant.[105] States that have implemented CoCM codes have done so with varying guidelines and restrictions which may or may not be in alignment with Medicare. We have outlined these differences in Table 6.

Table 6: State Variations in CoCM Benefit Policy as Compared to Medicare Policy

Topic	Medicare Policy	State Medicaid Policies that Differ from Medicare**
Differences for Pediatrics	N/A	NY: only allows ages 12+ TX: higher reimbursement for ages 0-20
Diagnoses Restrictions	No restrictions	MI: prohibits use for medication-assisted treatment of opioid disorder NY: anxiety and depression only
Behavioral Health Care Manager Credentials	Formal education or specialized training in behavioral health, including social work, nursing, or psychology	MI: licensed masters or doctoral level clinician or individual with specialized training in behavioral health, such as a licensed social worker, registered nurse, or licensed psychologist IL: BA or MA in related field or BA in any field + 2 years relevant experience TX: BA required WI: BA in human service-related field + 1 year of experience
Psychiatric Consultant Credentials	A medical professional trained in psychiatry and qualified to prescribe the full range of medications. This includes nurse practitioners (NP) and physician assistants (PA).	IL: allows licensed clinical psychologists NY: must be a physician (MD or DO) or NP; cannot be a PA MI: must be a physician (MD or DO); cannot be an NP or PA

Topic	Medicare Policy	State Medicaid Policies that Differ from Medicare**
Billing Provider	Any provider qualified to use evaluation and management codes, except psychiatrists	MI: does not allow specialists to be the billing provider
Prior Authorization	None	MI: 6 months or 6-month lapse in care NY: 12 months TX: 6 months WA: 6 and 12 months
Attestation Required*	None	IL, NY, TX, and WA all require a form of attestation.
G2214 Code	Used when there are insufficient minutes to bill other codes	IA, MI, MT, NH, NJ, NC, TX, UT, WA currently use G2214 code. AZ uses G2214 for Medicare crossover claims only.
FQHCs/RHCs	Reimbursed via G0512 code	IL, MA, MI, NC, NE, WA currently use G0512. AZ, KY, NY, and UT allow CoCM CPT codes to be eligible for a PPS encounter rate.
School-based health clinics	N/A	IL allows for school-based clinics to reimburse for CPT codes (99492-4).

**Signed document stating provider is providing key elements of CoCM required by some states.*
***Source: Information collected in interviews, fee schedules, medical policies, and Medicaid bulletins. If a state is not listed, no variation was identified or the state does not have CoCM codes.*

Methodology

We began our nationwide scan of Medicaid coverage by utilizing the American Psychiatric Association's compiled list of payors who are covering the CoCM codes and the California Health Care Foundation's 2020 analysis of CoCM Medicaid codes to identify specific requirements of different Medicaid programs.

We compiled benefit reimbursement rates from Medicaid program physician fee schedules. Where available, we reviewed Medicaid medical policies, procedure manuals, and bulletins to discern specific requirements surrounding CoCM codes. Finally, we contacted state Medicaid programs, asking each state about its CoCM benefit policy, special requirements, and when possible, incentivization and uptake. Some states preferred to answer by email, while others engaged in brief interviews. In a few states, we spoke with organizations working in collaborative care, including the California Health Care Foundation, Mass General, Montana Healthcare Foundation, and the Montana Primary Care Organization. We engaged all states with CoCM codes except New Jersey and Nebraska. If coverage policy details were not available, we assumed the policies aligned with Medicare coverage. Finally, to support our

findings, we spoke with national leaders in CoCM implementation, including Concert Health, Shatterproof, American Psychiatric Association, and Collaborative Care Consulting.

Appendix 1A: Collaborative Care and General Behavioral Health Billing Codes[106]

CoCM/BHI Codes	BHCM or Clinical Staff Threshold Time
99492 – CoCM First Month	First 70 minutes in the first calendar month of BHCM activities for a patient. Can bill at 36+ minutes.
99493 – CoCM Subsequent Months	First 60 minutes in any subsequent month of BHCM activities. Can bill at 31+ minutes.
99494 – Additional Time (any month)	Each additional 30 minutes in a calendar month of BHCM activities. Used in conjunction with 99492 and 99493. Max two add-on codes per month. Cannot use until full amount of time required to meet 99492 (70 mins) or 99434 (60 mins) has been completed. Can bill at 16+ minutes.
G2214	First 30 minutes in any month for BHCM activities. Used when there are not enough minutes to bill the 99492 or 99493 codes. Generally used in first and last month of care.
G0512 – FQHC/RHC CoCM Billing Code	Must accrue at least 70 minutes of BHCM activities (in collaboration with the psychiatric consultant) in the initial calendar month of service and 60 minutes in subsequent calendar months. Cannot bill if less than 70/60 minutes. No additional codes can be used with this code. Only minutes of time spent by the BHCM count (and minutes cannot be counted twice).

Appendix 1B: Facility and Non-Facility Medicaid CoCM Reimbursement Rates

State	CoCM CPT Billing Codes					
	99492		99493		99494	
	Facility	Non-facility/ Outpatient	Facility	Non-facility/ Outpatient	Facility	Non-facility/ Outpatient
Arizona	$83.66	$135.63	$91.27	$135.95	$36.44	$51.97
California	$141.26	$141.26	$112.14	$112.14	$57.88	$57.88
Connecticut*	--	--	--	--	--	--
Hawaii	$55.54	$55.54	$50.25	$50.25	$26.81	$26.81
Illinois	$69.45	$69.45	$76.30	$76.30	$31.10	$31.10
Iowa	$142.16	$80.44	$113.77	$72.72	$58.88	$38.83
Kentucky	$70.08	$121.51	$63.35	$97.56	$33.79	$50.50
Maryland (pilot-only)	-	-	$100.95	$153.59	$40.15	$58.65
Massachusetts	$67.79	$121.41	$61.05	$97.28	$32.54	$49.06
Michigan	$53.88	$87.96	$59.23	$85.18	$24.17	$36.45
Montana	$112.53	$184.98	$123.00	$184.98	$48.96	$70.74
Nebraska	-	$124.32	-	$97.68	-	$48.84
New Hampshire	$58.19	$58.19	$52.40	$52.40	$28.05	$28.05
New Jersey**	$67.96	$67.96	$67.71	$67.71	$25.84	$25.84
New York***	$112.50	-	$112.50	-	$0.00	-
North Carolina^	$109.94	$176.23	$120.82	$171.30	$49.24	$73.14
Pennsylvania	$71.18	$71.18	$64.36	$64.36	$34.58	$34.58
Rhode Island	$92.47	$92.47	-	-	$38.18	$38.18
Texas (Age 0-20)	$75.50	$124.06	$82.52	$124.06	$32.84	$47.43
Texas (Age 21+)	$71.91	$118.15	$78.59	$118.15	$31.27	$45.17
Utah	$113.46	$113.46	$110.34	$110.34	$47.09	$47.09
Vermont	$76.30	$125.43	$83.88	$121.31	$34.21	$51.93
Washington	$142.84	$142.84	$126.33	$126.33	$66.04	$66.04
Wisconsin	$146.05	$89.98	$141.61	$98.90	$60.51	$40.30

^ Reflects new rates in effect on December 1, 2022.

** Connecticut recently passed the codes, which are anticipated to go into effect in 2023.*

***New Jersey has separate rates for specialists and non-specialists. The table shows the non-specialist rate.*

****New York reimburses $112.50 per month for first year and $75 for per month in the second year. The 99494 code is only used for tracking purposes. Practices may also use the T2022, which New York created before CMS implemented codes for CoCM.*

Note: Kansas activated the codes, but only for individuals who are dually enrolled in Medicare and Medicaid and therefore are omitted from this chart.

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