COLLABORATIVE CARE MODEL
Reference Guide

About Behavioral Health Integrated Care

What is integrated care?

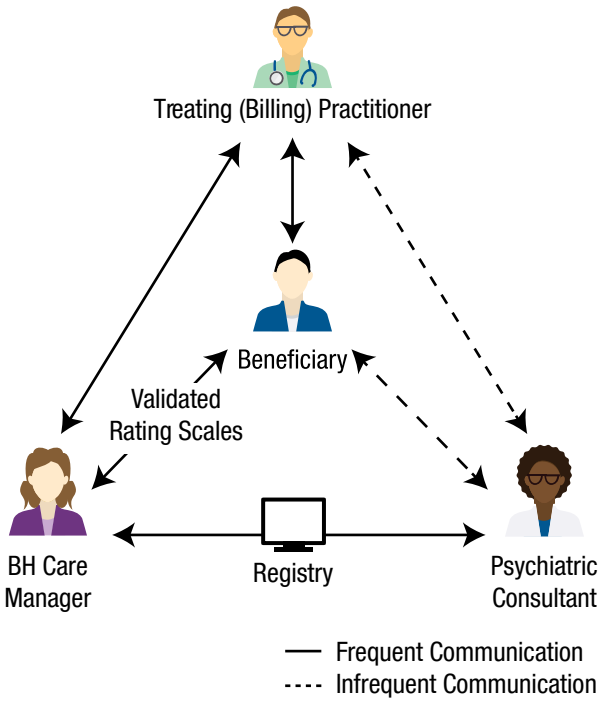
The integration of behavioral health and physical health care is essential for improving overall health, promoting adherence to treatment and reducing the cost of care. A comprehensive approach to integrated behavioral health care is achieved through close communication between health care professionals to combine primary care and behavioral health care. Integrating behavioral health (BH) and primary care is now widely considered an effective strategy for improving outcomes for patients with behavioral health conditions.

What is the Psychiatric Collaborative Care Model (CoCM)?

The Psychiatric Collaborative Care Model (CoCM) uses an interdisciplinary team-based approach to providing evidence-based treatment. The CoCM allows for a more inclusive team approach in treating common mental health conditions by incorporating behavioral health professionals into the team.

The collaborative care team is led by the primary medical provider (PMP) and includes psychiatrists, behavioral health care managers and other mental health professionals. The team implements a measurement-guided care plan based on evidenced-based practice guidelines and focuses particular attention on patients not meeting their clinical goals. This model differs from other attempts to integrate BH services because of the replicated evidence supporting its outcomes, it's steady reliance on consistent principles of chronic care delivery and attention to accountability and quality improvement (QI). There are five essential elements of the CoCM:

- ***Patient-Centered Care Team*** – Primary care and behavioral health providers collaborate using shared care plans that incorporate patient goals



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- ***Population-Based Care*** – Care team shares a defined group of patients tracked in a registry to ensure no one falls through the cracks
- ***Measurement-Based Treatment*** – Treatment plan clearly articulates personal goals; clinical outcomes are routinely measured by evidence-based tools like the Patient Health Questionnaire (PHQ)-9 depression scale; treatments are actively changed if patients are not showing improvement towards goals, until goals are achieved
- ***Evidenced-Based Care*** – Patients are offered evidenced-based services such as behavioral activation, motivational interviewing and problem-solving treatment
- ***Accountable Care*** – Providers are accountable and reimbursed for quality of care and clinical outcomes (not just volume of care provided)

Why should a PMP implement the CoCM into their practice?

There are many benefits of integrating behavioral and physical health care using the CoCM for patients and healthcare professionals.

Lower overall health care costs

- Comorbid mental and medical illnesses have been shown to more than double the cost of care in patients, primarily in the form of:
  - Increased emergency department (ED) visits and hospitalizations
  - Longer lengths of stay
  - Higher 30-day readmission rates[1]
- 22 studies over the past 30 years have addressed the economics of collaborative care, showing:
  - CoCM is at least cost neutral, with most studies indicating cost savings
  - Although the cost for both CoCM and usual care increased initially, the treatment costs for CoCM clinics were three-fourths of that of usual care clinics
  - Patients who were seen in the CoCM programs were 54% less likely to use the ED
  - Most health care economists believe the health savings from CoCM are significantly underestimated.[2]

Better clinical outcomes

- Mental health conditions in patients with medical illness result in greater treatment resistance in their medical illness as well as more medical complications.[3]
- The addition of a collaborating psychiatrist and a care manager specifically focused on mental health conditions for the primary care team has been shown to improve both physical and mental health outcomes, including:
  - Improved medication compliance
  - Decreased hypertension
  - Improved hemoglobin A1c
  - Increase in the number of depression-free days[4]

Increased access to care

- Using the CoCM, the established treatment relationship between patients and their PMP can be leveraged to decrease barriers to accessing treatment for behavioral health concerns in their primary care office.

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[1]National Library of Medicine. "Bridging the Mental-Physical Divide in Health Care www.ncbi.nlm.nih.gov/pmc/articles/PMC6606411/#:~:text=Patients%20with%20comorbid%20medical%20and,with%20those%20without%20medical%20comorbidity

[2]AIMS Center (Advancing Integrated Mental Health Solutions. "Evidence Base for Collaborative Care, Financing and Payment Models, Including Cost-Effectiveness" https://aims.uw.edu/sites/default/files/3%20Evidence%20Base_Financing.pdf

[3]National Library of Medicine. "Collaborative Mental Health Care: A Narrative Review" www.ncbi.nlm.nih.gov/pmc/articles/PMC9803502/#:~:text=If%20implemented%20with%20these%20core,care%20by%20improving%20clinical%20outcomes

[4]National Library of Medicine. "Mental Health Collaborative Care and Its Role in Primary Care Settings" www.ncbi.nlm.nih.gov/pmc/articles/PMC3759986/

Patient satisfaction and quality of life

- Patients treated in the CoCM report greater patient satisfaction, improved quality of life, and improved physical function more than usual care.[5]

Quality of care

- CoCM provides improved quality of care through ongoing communication and collaboration to understand patients' unique needs and ensure they are receiving appropriate treatment to manage their health conditions.

CareSource Support for the CoCM

No Prior Authorization

There are no prior authorization requirements for CoCM services.

CoCM Reimbursement

CoCM is delivered monthly for an episode of care that ends when treatment goals are met (graduation) or there is failure to meet the targeted treatment goals (discharge).

Reimbursement is available to PMPs for integrating the CoCM into their practice by using the codes below.

Code	Definition	BH Care Manager or Clinical Staff Threshold Time	Billing Practitioner Time
CoCM First Month (CPT Code 99492)	Initial psychiatric collaborative care management	First 70 minutes in the first calendar month	30 minutes
CoCM Subsequent Months (CPT code 99493)	Subsequent psychiatric collaborative care management	First 60 minutes in a subsequent month of behavioral health care manager activities	26 minutes
Add-On CoCM (Any month) (CPT code 99494)	Initial or subsequent psychiatric collaborative care management	Each additional 30 minutes in a calendar month	13 minutes
Initial or subsequent psychiatric collaborative care management (HCPCS code G2214)		First 30 minutes in a month of BH care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional	Usual work for the visit code

[5]AIMS Center (Advancing Integrated Mental Health Solutions). "Collaborative Care" https://aims.uw.edu/collaborative-care#:~:text=Collaborative%20Care%20Outcomes&text=It%20leads%20to%20significantly%20better,and%20reduces%20health%20care%20costs

Billing these codes does not guarantee payment. Providers should refer to billing guidance from Centers for Medicare & Medicaid Services (CMS) prior to claims submission.

*For questions related to billing, please contact CareSource's Provider Services at **1-844-607-2831** Monday through Friday, 8 a.m. to 8 p.m. Eastern Time. Providers can also email questions or interest in participating in the CoCM directly to the Behavioral Health clinical mailbox at Indiana_BH@CareSource.com.*

Tools & Resources

CareSource provides resources to promote mental health and well-being through free digital evidenced-based self-care tools.

BeMe Health

The BeMe Health behavioral health platform is a teen-centric 'tech' and 'touch' solution, aimed at meeting adolescents where they are, when support is needed most. The tech component consists of a highly personalized user experience, complete with regular check-ins and personalized digital resources. Human support is provided through a stepped care model—ranging from highly trained coaches to adolescent-focused clinicians practicing measurement-based care, to ever-present crisis management support. BeMe Health supports teens through the ups and downs of being a teenager, including helping teens build health habits, develop communication skills, cope with stress, manage depression or anger and more. BeMe Health is available to Hoosier Healthwise (HHW) teens ages 13 through 18 at no cost. CareSource teens and parents can visit www.beme.com/CareSource to sign up and learn more about BeMe Health.

MyStrength Self-Management Tool

The myStrength self-management tool offers tracking, education, inspirations, articles, and activities to foster a member's overall health on a computer, tablet or smartphone. Some examples of topics include stress management, anxiety, depression, chronic pain, substance use recovery, insomnia, and mindfulness. myStrength is available to members ages 13 and older. CareSource members can visit www.mystrength.com/r/caresource to sign up. Please encourage your patients with behavioral health needs to take part in this no-cost service.

Behavioral Health Member Profile

The Behavioral Health Member Profile promotes coordination of care between physical and behavioral health providers. Information contained in the Behavioral Health Member Profile can lead to a more efficient and accurate path to diagnosis and treatment. Patient-specific quality metrics may also help identify preventative tests your patients' needs. For patients with chronic conditions, the Member Profile can play a significant role in supporting your ongoing care. The Behavioral Health Member Profile can also drive appropriate ED use. We encourage providers to take advantage of this tool to increase care coordination and to better serve our members. Visit our secure online Provider Portal at https://providerportal.caresource.com/IN/User/Login.aspx?ReturnUrl=%2fIN and follow the instructions to login to see how the Behavioral Health Member Profile can help improve patient outcomes.

Care Management

CareSource can provide a Care Manager through our Integrated Care Management program. A Care Manager can assist your patients in finding the resources needed to stay healthy.

Providers can refer patients to Care Management or patients may request a Care Manager by calling Member Services at 1-844-607-2829 (TTY: 1-800-743-3333 or 711). Providers may also make referrals by email or online:

- Email: INCaseManagement@CareSource.com
- Website: https://providerportal.caresource.com/IN/User/Login
  - Expand the "Providers" option in the menu on the left-hand side of the portal, select "Care Management Referral," complete the form and submit your request

Learn More

You can use the following resources to find out more about integrated care:

- Collaborative Care Model
  Collaborative Care | University of Washington AIMS Center (uw.edu)
- Behavioral Health Integration Services
  www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegrationPrint-Friendly.pdf
- Institute for Healthcare Improvement
  www.ihi.org/resources/Pages/Publications/IntegratingBehavioralHealthPrimaryCare.aspx
- Agency for Healthcare Research and Quality
  https://integrationacademy.ahrq.gov/

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