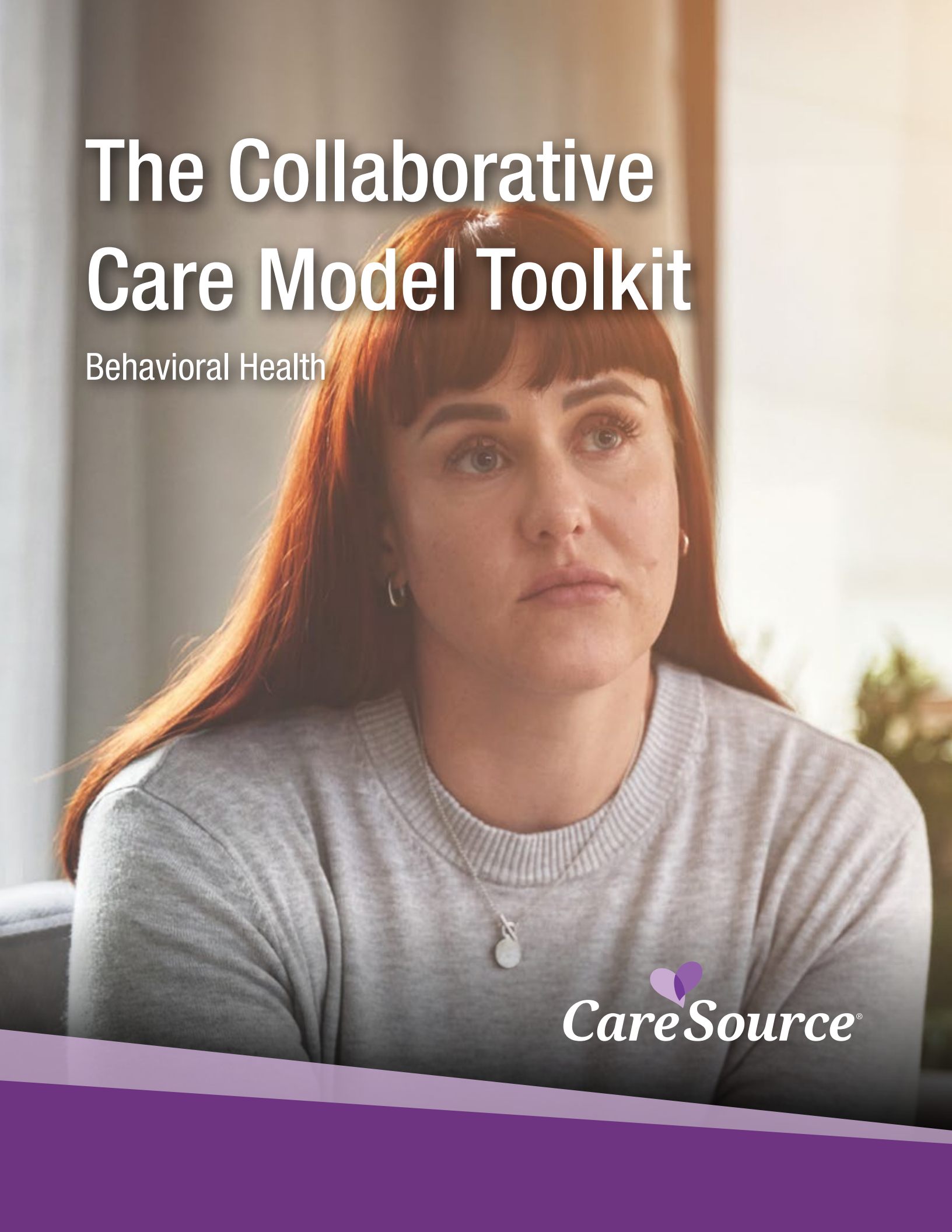


The Collaborative Care Model Toolkit

Behavioral Health

CareSource®

Toolkit Contents

1. Introduction

This toolkit was developed to deliver resources to providers who are implementing the Collaborative Care Model (CoCM) into their practices and are billing for services delivered in the model. The information contained in this toolkit includes evidence from a literature review:

- A brief overview of the Collaborative Care Model (CoCM)
- Practical information to consider in developing a collaborative care team
- Tools to assist with implementation of the processes necessary to implement the CoCM in the provider's practice

The materials contained in this toolkit are intended for primary medical providers (PMPs), specialists, care managers, therapists and psychiatrists. However, this toolkit may be appropriate for other health care providers who are treating individuals with behavioral health (BH) needs and to promote overall health and wellness.

2. Integrated Physical and Behavioral Health

CareSource understands the importance of integrating physical and behavioral health care for seamless coordination of care across the health care continuum. Integrated health care has the potential to help people to address their physical health and behavioral health needs in their primary care setting. People with serious mental illnesses die earlier than the general population, with the vast majority of these deaths due to chronic physical medical conditions (cardiovascular, respiratory, and infectious diseases, diabetes and hypertension).

Integration of physical and behavioral health care can be achieved in primary settings using the CoCM. CoCM empowers all providers to increase access to behavioral health care and address patients' mental health conditions in a primary care setting with support from behavioral health specialists. It promotes whole person care by addressing mental health needs where patients already receive care, leading to better treatment, health outcomes, and quality of life.

CareSource has developed this toolkit to empower both PMPs and BH providers in their everyday practices to address patients' unmet needs. It provides downloadable resources and practical tools you can use as you endeavor to provide mental health education, screening and treatment for your patients.

3. The Collaborative Care Model

The CoCM is an evidence-based integrated care model for behavioral health (BH). The model is a multi-disciplinary team-based, patient-centered approach to treating mental health conditions by integrating BH professionals into the care team. The team may includeprimary care providers, addiction specialists, mental health providers, allied health professionals, and other service providers. The model supports the physical health care clinicians who are providing treatment by improving their skills and confidence in the assessment and treatment of behavioral health conditions.

The CoCM helps the primary care system to identify their patients with BH needs, engage patients in care, and apply a team of professional to collaboratively manager their care until their symptoms are stabilized. Individuals who do achieve their treatment goals using this team-based approach are referred to more intensive services with BH specialty providers.

Principles of Collaborative Care

Patient-Centered Care Team – Primary care and behavioral health care providers collaborate in the treatment planning.

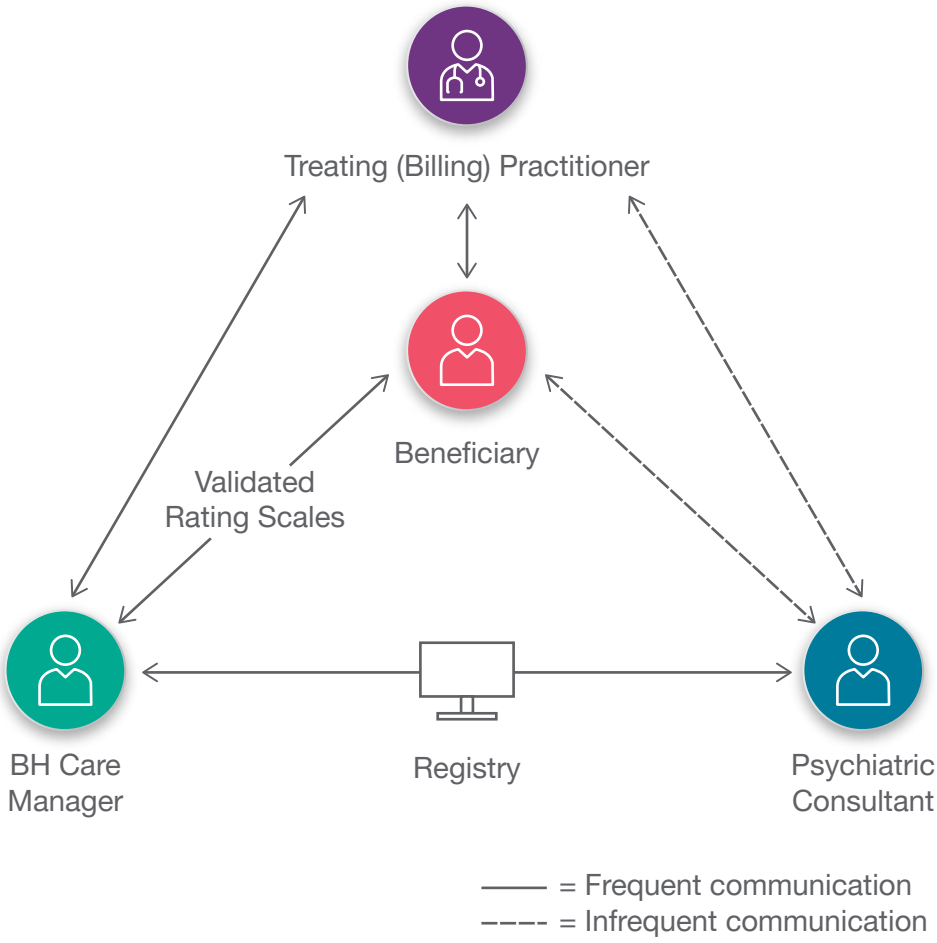
Population-Based Care – The care team shares a defined group of patients and follows them in a registry to ensure no person falls through the cracks. The care manager consults with a psychiatrist to determine appropriate changes to the care treatment plan to promote improved health outcomes.

Measurement-Based Treatment – An individualized care plan identifies the patient's personal goals and progress is monitored using evidence-based tools such as the PHQ-9 or GAD-7. Treatment planning is changed as needed if patients are not responding until the goal or expected outcome is achieved.

Evidence-Based Care – Treatments with credible evidence to support their efficacy in treating specific conditions are offered to patients in the primary care setting. Examples include: Problem Solving Therapy (PST), Behavioral Activation (BA), and Cognitive Behavioral Therapy (CBT).

Accountable Care – Providers who have integrated the CoCM into their practices are reimbursed for the quality of care they provide and for clinical outcomes, not by the volume of care provided.

CoCM Care Team Members



Treating (Billing) Practitioner – A physician and/or non-physician practitioner (physician assistance or nurse practitioner); typically primary care, but may be of another specialty (for example, cardiology or oncology)

Behavioral Health Care Manager (BH CM) – A designated individual with formal education or specialized training in behavioral health (including social work, nursing, or psychology) working under the oversight and direction of the billing practitioner

Psychiatric Consultant – A medical professional trained in psychiatry and qualified to diagnose mental health conditions and recommend treatment options, including medication management

Patient – The patient is a member of the care team

Collaborative Care Service Components	
Step 1	Initial identification and screening assessment is completed by the billing practitioner and BH CM results in a referral to CoCM.
Step 2	A comprehensive BH assessment is completed by the BH CM.
Step 3	An individualized care plan is developed by the CoCM care team, in tandem with the patient, in order to define treatment goals.
Step 4	Weekly case consultations are conducted by the BH CM, in tandem with the psychiatric consultant, in order to review progress. The CoCM team makes specific recommendations to modify the treatment plan to facilitate progress towards treatment goals.
Step 5	The BH CM performs proactive follow-up to assess treatment adherence and clinical response using the validated rating scales. The BH CM delivers brief evidence-based psychosocial interventions, including the use of Motivational Interviewing, or Behavioral Activation.
Step 6	The primary care team adjusts or maintains treatment, as indicated, based on recommendations from the CoCM team.

4. Reimbursement

Primary care practices that are providing collaborative care services can bill for those services using CPT codes for **Psychiatric Collaborative Care Management Services**, which include:

- **99492**
- **99493**
- **99494**
- **G2214**

The codes listed above are classified by The Centers for Medicare and Medicaid Services (CMS) as **Behavioral Health Integration Services**, which are detailed more thoroughly on CMS' care management web page. CMS has developed a fact sheet and FAQs that describe CoCM services and their associated billing requirements.

Psychiatric CoCM Coding

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

Reimbursement is available to PMPs who have integrated the CoCM into their practice by using the codes listed in the chart below. Four new codes were created by CMS to allow payment for health care providers for furnishing behavioral health integration services using the CoCM.

Billing Reference

Code	Definition	BH Care Manager or Clinical Staff Threshold Time	Billing Practitioner Time
CoCM First Month CPT 99492	Initial psychiatric collaborative care management	First 70 minutes in the first calendar month	30 minutes
CoCM Subsequent Months CPT 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 99494	Initial or subsequent psychiatric collaborative care management beyond 60 or 70 minutes	Each additional 30 minutes in a calendar month	13 minutes
Initial or Subsequent Psychiatric Collaborative Care Management HCPCS G2214	Initial or subsequent psychiatric CoCM (0-30 minutes)	First 30 minutes of behavioral health care manager time per calendar month	Usual work for the visit code

Note: These codes should be billed on a HCFA 1500 form and a claim which does not contain other services codes outside of these four codes.

Billing these codes does not guarantee payment. Providers should refer to billing guidance from CMS prior to submitting claims. Please reference CMS' FAQs about Billing Medicare for BH Integration Services.

5. Rationale

There are many benefits to implementing the CoCM into your practice and adopting an integrative approach to behavioral and physical health care:

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.

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.[1]

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.

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.[2]

The addition of a collaborating psychiatrist and a care manager specifically focused on mental health conditions to 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

---

[1]AIMS Center, "Collaborative Care"

https://aims.uw.edu/collaborative-care#:~:text=Collaborative%20Care%20Outcomes&text=It%20leads%20to%20significantly%20better,and%20reduces%20health%20care%20costs

[2]National Library of Medicine, "Collaborative Mental Health Care: A Narrative Review"

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9803502/#:~:text=If%20implemented%20with%20these%20core,care%20by%20improving%20clinical%20outcomes

Lower overall health care costs.

Comorbid mental and medical illness has been shown to more than double the costs of care in those patients, primarily in the form of:

- Increased ER visits and hospitalizations
- Longer lengths of stay
- Higher 30-day readmission rates[3]

Twenty-two studies over the past 30 years have addressed the economic of collaborative care.

- Most found that CoCM was at least cost neutral, with most studies indicating that there were cost savings.
- Although the cost for both CoCM and usual care increased initially, the costs for CoCM clinics were three-fourths of usual care clinics.
- Patients seen in CoCM programs were 54% less likely to use the ED.[4]

Note: Most health care economists believe the health savings from CoCM are significantly underestimated.

---

[3]National Library of Medicine, "Bridging the Mental-Physical Divide in Health Care"

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6606411/#:~:text=Patients%20with%20comorbid%20medical%20and,with%20those%20without%20medical%20comorbidity

[4]AIMS Center, "Evidence Base for Collaborative Care: Financing and Payment Models, including Cost-Effectiveness"

https://aims.uw.edu/sites/default/files/3%20Evidence%20Base_Financing.pdf

6. CareSource Resources

Care Management

CareSource can provide a care manager through our Integrated Care Management program. The Care Management team can support your patients in their efforts to quit using tobacco as well as assist patients in finding resources needed to be healthy.

Providers can refer patients to Care Management or patients can 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: IN Case Management@CareSource.com
- Website: **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 the request.

BeMe Health

The BeMe mental health and wellness app is a teen-centric "tech and touch" solution aimed at meeting adolescents where they are when support is needed the most. The tech components consist of a highly personalized user experience complete with regular/daily 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 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 aged 13 through 18, at no cost. CareSource teens and parents can visit the BeMe website to learn more about BeMe Health and to register.

myStrength℠

CareSource members can access the myStrength tool for personalized support to help improve mood and engage in online activities. This platform offers programs that patients can access for free. The platform also offers other activities, including:

- Learning about mental health conditions
- Using empowering self-help tools, like mood trackers and thought/feeling logs
- Accessing wellness resources such as mindfulness exercises, parenting tips, weight, and stress management
- Reviewing inspirational daily quotes

Your patients can visit the myStrength website and complete the registration process to create a personal profile and access the benefits of the tool.

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 patient may need. For patients you are treating who have chronic conditions, the Behavioral Health Member Profile can play a significant role in supporting your ongoing care. The Behavioral Health Member Profile can also drive appropriate emergency department use. We encourage providers to take advantage of this tool to increase care coordination and to better serve our members.

Visit our secured Provider Portal here. Follow the instructions to log in to see how the CareSource Behavioral Health Member Profile can help improve patient outcomes.

CareSource Informational Tools

CareSource has developed informational tools that help with coordination of care:

- Behavioral Health Co-Existing Conditions Flier
- Behavioral Health Referrals Flier
- Coordination of Care Exchange of Information Form

7. Professional Resources

There are a number of resources available on the Collaborative Care Model, as well as on the topic of integrated care.

AIMS Center (Advancing Integrated Mental Health Solutions)	Collaborative Care Checklist of Collaborative Care Principles and Components Step-by-Step Collaborative Care Implementation Guide Billing & Financial: Behavioral Health Integration and Collaborative Care
Centers for Medicare & Medicaid Services (CMS)	Behavioral Health Integration Services Behavioral Health Integration Services FAQs about Billing Medicare for Behavioral Health Integration Services
American Psychiatric Association (APA)	Collaborative & Integrated Care Collaborative Care Report: Dissemination of Evidence-Based Integrated Care The Practice and Billing Toolkit: Tools for Successful Implementation of the Collaborative Care Model
Substance Abuse and Mental Health Services Administration (SAMHSA)	Promoting Integration of Primary and Behavioral Health Care
Milliman	Potential Economic Impact of Integrated Medical-Behavioral Healthcare

IN-MED-P-2562400 | Issued Date: 1/31/24
OMPP Approved: 1/29/24