Best Practices for Reimbursing the Collaborative Care Model in Medicaid

AMERICAN PSYCHIATRIC ASSOCIATION

State Medicaid Agencies Reimbursing Psychiatric Collaborative Care Management Services

Arizona, Illinois, Iowa, Kentucky, Michigan, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Utah, Vermont, and Washington

BACKGROUND

Overview of the Collaborative Care Model
Over the past decade, the integration of behavioral health and general medical services has been shown to improve patient outcomes, save money, and reduce stigma related to mental health and substance use disorders. Significant research spanning three decades has identified one model in particular — the Collaborative Care Model — as being effective and efficient in delivering integrated care.

The Collaborative Care team is led by a primary care provider (PCP) and includes behavioral health care managers, psychiatrists and frequently other mental health professionals all empowered to work at the top of their license. The team implements a measurement-guided care plan based on evidence-based practice guidelines and focuses particular attention on patients not meeting their clinical goals.

The Collaborative Care Model differs from other attempts to integrate behavioral health services because of the replicated evidence supporting its outcomes, its steady reliance on consistent principles of chronic care delivery, and attention to accountability and quality improvement (QI).

History of Reimbursement for the Collaborative Care Model
In 2017, Medicare began paying for behavioral health integration services, which includes collaborative care services. The following year, 2018, Medicare introduced the Psychiatric Collaborative Care Management CPT® codes and CMS also expanded coverage to include services provided in FQHCs and RHCs, through the use of two G-codes. To date, many private payers and state Medicaid agencies around the country are also reimbursing the Psychiatric Collaborative Care Management CPT® codes, however, insurance coverage for services differs between insurance providers, individual plans, and state Medicaid agencies.

The American Psychiatric Association has compiled an interim list of payers who have either indicated they have approved coverage for psychiatric collaborative care management (CoCM) codes (CPT® codes 99492-99494) or for whom we have confirmation that a paid claim(s) has occurred. It is a dynamic list so it is important to confirm coverage on a payer-by-payer basis. CLICK HERE to access the list.

Overview of the Psychiatric Collaborative Care Management Codes
The Psychiatric Collaborative Care Model (CoCM) CPT® codes are billed by the treating practitioner to account for their work, and the work of the psychiatric consultant and the behavioral health care manager. The codes include required elements based on the evidence-based CoCM — patient engagement and assessment, tracking progress and treating to target goals, consultation with psychiatric consultant, and management of an individual patient as part of a population of patients. Billing of the services are based on the work performed and the total number of minutes spent by a behavioral health care manager over the course of a month.

CPT® CODE	CoCM CODE INFO	BEHAVIORAL HEALTH CARE MANAGER OR CLINICAL STAFF TIME [1]
99492	CoCM First Month	70 minutes per calendar month; billable at 36 minutes
99493	CoCM Subsequent Months	60 Minutes per calendar month; billable at 31 minutes
99494	Add-On CoCM (any month)	Each additional 30 minutes per calendar month; billable at 16 minutes beyond total time (86 minutes for the first month; 76 minutes for subsequent months)
Rural Health Centers/Federally Qualified Health Centers		
G0512	CoCM (all months)	60 minutes or more of clinical staff time
G0511	General care management and BHI services	20 minutes or more

1. CoCM codes (99492 – 99494) follow the CPT® Time Rule which allows for the billing of the service at 50% plus 1 minute of time based on the times listed in the CPT® manual. For example, the 99242, which notes 70 minutes of clinical activities in the description, can be billed once you reach the 36th minute, which is 1 minute past the midpoint of 35 minutes. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) have DIFFERENT billing codes and time requirements for billing purposes. There is one Healthcare Common Procedure Coding System (HCPCS) code that describes the work of the Collaborative Care Model – G0512, and there is one HCPCS code that describes the work of general behavioral integration – G0511. The full allocation of minutes (70 minutes for the initial month and 60 minutes for the subsequent month) must be met prior to billing for CoCM in an FQHC or RHC. And there is no mechanism to account for additional time spent over the course of the month for these settings.

Recommendations Based on Best Practices for Implementing the Codes

1. Allow paraprofessionals with formal education (BA level or higher) or specialized training to serve as care managers
2. Keep options for diagnosis open and not limited to a specific condition
3. Waive cost sharing, when possible
4. Prior authorization should not be required
5. Set reimbursement rates at Medicare or above for all settings including FQHCs and other primary care clinics
6. Allow specialists (i.e. cardiology, oncology) to bill the codes if they have an established Collaborative Care program

The chart below includes current Medicare guidance. Some state Medicaid agencies have enhanced or cut back on certain policies.

Component Assessed	Medicare Guidance	Rationale/Recommendation
Attestation Required for clinic or PCP doing CoCM to fidelity	None required (retrospective audits occur in cases where fraudulent billing occurs)	Consider attestation to ensure fidelity to the model
Behavioral Health Care Manager Credentials	Licensed or paraprofessional with "some formal education or specialized behavioral health training"	Allows a range of individuals to serve in the role which is especially helpful in rural areas with limited numbers of licensed professionals.
Behavioral Health Conditions Covered	No diagnostic exclusions	All mental health and SUD disorders included; referral to CoCM is possible even if diagnosis is suspected but not yet confirmed.

Cost Sharing/Co-Pays	Required	CMS has signaled support for removing cost sharing requirements which will take an act of Congress.
Length of Episode of Care	No limitations	Research shows a typical episode of care is 6-9 months with some episodes as short as 3-6 months or as long as 12 or more months.
Prior Authorization	None required	Implementation of prior authorization creates an unnecessary barrier to care.
Reimbursement	99492 $157 99493 $126 99494 $64 FQHC/RHC Codes: G0512 $142 G0511 $67	Set rates at Medicare or above (i.e., Montana - 99492 $176, 99493 $141, 99494 $73).
Required Metrics Reporting	None required	Consider reporting quality measures (such as NQF 1884 and 1885 and NQF 710 and 711)
Treating/billing physician	Any physician with the exception of psychiatrists who are paid as part of the bundled service	Recognizes that the model can be adopted in a range of settings.

Link to Medicare Fact Sheet on CoCM Coverage
Medicare MLN Booklet – Behavioral Health Integration Services (May 2019)

Example of State Medicaid CoCM Coverage
Michigan Medical Services Administration Bulletin (July 1, 2020)

How to Advocate for Legislation or a Draft Waiver Amendment for the Adoption of the CoCM Codes in Your State

With your existing contacts, we recommend you start a discussion with either members of your state legislature or Medicaid office on the best way to advance the use of the Collaborative Care Model. Links are provided below to draft legislation and draft waiver amendment language that you may use to start a discussion with your state legislation or state Medicaid office to advocate for the Collaborative Care codes.

- Collaborative Care Legislation Draft for the States – The legislation drafted for each state focuses on commercial coverage however some states have included coverage under Medicaid as well – see New Jersey, Section 11 as an example.
- DRAFT Information – State Plan Amendment for 1115 Waiver