Expanding the Collaborative Care Model in Michigan: Overcoming Barriers and Enhancing Sustainability

FINAL REPORT

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Contents

Introduction

The Collaborative Care Model (CoCM) is a financially sustainable integrated behavioral health model with the strongest evidence-base to effectively address the shortcomings of our current mental health care system.[1,2,3,4] CoCM enables a primary care provider or specialty physical medicine provider (PCP), psychiatric consultant, and behavioral health care manager (BHCM) to collaboratively support the patient and their family in the primary care setting by using a patient registry to track and follow the patient's progress. Through an integrated care approach and under the clinical direction of the PCP, the CoCM team works together to identify mental health needs early and provide evidence-based interventions as well as measure the patient's progress toward treatment targets and adjust the patient's treatment plan when appropriate.[5]

To improve access to evidence-based care for Michiganders, the Michigan Department of Health & Human Services (MDHHS), Blue Cross Blue Shield of Michigan (BCBSM), and philanthropic foundations including the Michigan Health Endowment Fund (The Health Fund), are invested in expanding the model's adoption across the state. For years, they have championed the model's expansion through strategic initiatives such as enhanced reimbursement rates, grants to offset initial implementation costs, and comprehensive technical assistance. After five years of investment and expanded adoption of the model across the state, the Health Fund partnered with Meadows Mental Health Policy Institute (Meadows Institute) to complete both an assessment of the investments' impact and an exploration of additional opportunities to sustain and expand adoption.

Methodology and Approach

Qualitative Analysis

To simultaneously assess the impact of CoCM investments and explore expansion opportunities, the Meadows Institute conducted semi-structured interviews (SSIs) to capture firsthand experiences from health systems and key informant interviews (KIIs) to gather expert insights from stakeholders. Throughout our engagement efforts, we sought to identify

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[1] The United States Senate Committee on Finance. (n.d.). *Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration*. Retrieved October 30, 2024, from https://www.finance.senate.gov/hearings/behavioral-health-care-when-americans-need-it-ensuring-parity-and-care-integration

[2] Covino, N. A. (2019). Developing the Behavioral Health Workforce: Lessons from the States. *Administration and Policy in Mental Health and Mental Health Services Research, 46*(6), 689–695. https://doi.org/10.1007/s10488-019-00963-w

[3] Lauerer, J. A., Marenakos, K. G., Gaffney, K., Ketron, C., & Huncik, K. (2018). Integrating behavioral health in the pediatric medical home. *Journal of Child and Adolescent Psychiatric Nursing, 31*(1), 39–42. https://doi.org/10.1111/jcap.12195

[4] Kepley, H.O., & Streeter, R. A. (2018). Closing behavioral health workforce gaps: A HRSA program expanding direct mental health service access in underserved areas. *American Journal of Preventive Medicine, 54*(6), S190–S191. https://doi.org/10.1016/j.amepre.2018.03.006

[5] For more on the Collaborative Care Model, please see Appendix Four.

facilitators of successful CoCM adoption, barriers to scaling CoCM in Michigan, why a health system may have opted out of implementing CoCM, and key stakeholders' experiences with The Health Fund grant opportunities. Additionally, we sought an enhanced understanding of the current and future landscape of behavioral health integration in Michigan, with a particular focus on the expansion and sustainability of CoCM statewide. Supported by warm introductions from The Health Fund, our team engaged both health systems and other key stakeholders, initiating discussions on their experience with implementing (or choosing not to implement) CoCM. The conversations, as outlined below, occurred between December 6, 2024, and December 19, 2024 and represented varied engagement with the model (Table 2).

Table 1. Key Informant and Semi-structured Interviews

Organization	Contact	Format	Date
Health Systems			
Henry Ford Health System (Henry Ford)	Doree Ann Espiritu, MD, Medical Director of Adult and Pediatric Outpatient	SSI	12/6/2024
Michigan State University (MSU)	Andrea Wittenborn, PhD, Chair of Human Development and Child Studies	SSI	12/6/2024
Pine Rest Christian Mental Health Services (Pine Rest)	Amy VanDenTorn, LMSW, Appointed Regional Director of Outpatient & Recovery Services Tom Worm, LMSW, MPA, C-TAGME, Lead Behavioral Healthcare Manager	SSI	12/10/2024
Other Stakeholders			
Blue Cross Blue Shield of Michigan (BCBSM)	David Bye, Manager of Clinical Program Development Julia Isaacs, LMSW, Director of Behavioral Health Strategy and Planning	KII	12/19/2024
Michigan Center of Clinical Systems Improvement (Mi-CCSI)	Sue Vos, Program Director Thomas Dahlborg, Executive Director	KII	12/5/2024
Michigan Department of Health & Human Services (MDHHS)	Lisa Dilernia, Medicaid Policy Specialist Sam Rushman, Assistant Policy Specialist Janell Troutman, MSN, RN, Maternal and Infant Health Policy Specialist for Medicaid	KII	12/12/2024
PRISM, Department of Psychiatry, Michigan Medicine	Gregory Dalak, MD, Chair of the Department of Psychiatry and Program Director Debbra Snyder-Sclater, LLP, Project Manager Sarah Bernes, MPH, LMSW, MBA, Lead Clinical Training and Implementation Specialist Paul Pfeiffer, MD, Co-Director	KII	12/9/2024

Table 2. Stakeholder Involvement with CoCM Implementation

Organization	Description	Grant Returned?	CoCM Active?
Health Systems			
Henry Ford	Received a Health Fund grant in 2019 for CoCM.	No	Yes
MSU	Received a Health Fund grant in 2019 to train six family medicine clinics in a perinatal CoCM.	No	Yes*
Pine Rest	Has not received a Health Fund grant but has received other CoCM grants.	N/A	Yes
Other Stakeholders			
BCBSM	Health insurance company that reimburses for CoCM delivery and provides CoCM training for providers.	No	N/A
Mi-CCSI	Initially provided CoCM training for one independent practice. Received subsequent funding from BCBSM to scale CoCM training.	No	No
MDHHS	Received a Health Fund grant in 2019 to implement CoCM reimbursement codes for patients with Medicaid.	No	N/A
PRISM	Received a Health Fund grant in 2019 to scale CoCM in 3 FQHCs and a prior grant in 2017 with a similar focus.	Yes	No

*Contact has only been maintained with two out of four practices over the past year, and they are actively continuing CoCM work. For the other two practices, changes in clinic workflows, including shifts in EHR access and state consultation, suggest they may still be using CoCM, although this is not confirmed.

Quantitative Analysis

Our quantitative analysis examined trends in CoCM uptake in Michigan over time. Specifically,

1. The number of unduplicated patients served in CoCM and average length of treatment;
2. Longitudinal trends in CoCM service use by payor, including individuals insured by Medicare, Medicaid, and commercial plans;[6,7] and,
3. Geographical variation in CoCM use.

[6] Data for this analysis was sourced from Milliman, Inc., based on their 2025 report of CoCM utilization trends. The Milliman report included national claims data from approximately 221 million insured Americans between 2018 and 2023. Additional information on the Milliman data and methodology is provided in the Data Appendix.
[7] Trends were examined from 2018 to 2022 for Medicare and Medicaid beneficiaries, and from 2018 to 2023 for commercially insured individuals, based on the years of data supplied by Milliman for analysis.

All data for this analysis were abstracted by Milliman, Inc. between March and May 2025.[8] We derived CoCM utilization from healthcare claims submitted for approximately 7.8 million insured individuals in the state of Michigan. [9,10] Please see Appendix 1 for more details.

Findings and Recommendations

Utilization Highlights

We identified growth in CoCM services and patients served across Michigan among all payor groups, with commercially insured patients receiving the greatest increase in CoCM service provision and patients served over time.[11] The MSAs receiving startup funding from the Health Fund, such as Ann Arbor, Grand Rapids, Jackson, and Lansing, demonstrated higher utilization of CoCM billing codes, suggesting a correlation between initial investment and adoption. Conversely, Medicaid patients experienced the slowest rates of growth in service provision and patients served over time.

Growth was not uniformly distributed across the state. Among all payor types, the highest rates of growth were observed in the Flint and Warren-Troy-Farmington Hills metropolitan statistical areas (MSAs). Commercially insured patients saw growth in CoCM services across the state, with strong growth across nearly all regions, including Battle Creek, Jackson, and Bay City MSAs. CoCM service growth was more geographically concentrated among Medicaid beneficiaries, where most growth was observed in Grand Rapids-Kentwood MSA.[12]

Patients utilizing Medicare received an average of 5.4 services per patient, compared to 4.8 services per patient for those covered by Medicaid and 4.1 services per patient for those with commercial insurance. On average, patients with Medicare received the longest duration of care at 3.7 months, followed by patients utilizing Medicaid (3.5 months of service billed) and patients using commercial insurance (2.8 months). These data jointly suggest that patients covered by Medicare received, on average, one additional month of care compared to patients using commercial insurance.

[8] Davenport, S., Mager, M., Darby, B. (2025, May). *Trends in adoption of the Collaborative Care Mode: Analysis of variation by payer and region, 2018-2023*. http://www.mmhpi.org/wp-content/uploads/2025/05/Milliman-Collaborative-Care-report-2025-05-13.pdf.
[9] CoCM services were identified using Current Procedural Terminology (CPT) codes 99492, 99493, 99494, and G2214.
[10] Davenport, S., Mager, M., Darby, B. (2025, May). *Trends in adoption of the Collaborative Care Mode: Analysis of variation by payer and region, 2018-2023*. http://www.mmhpi.org/wp-content/uploads/2025/05/Milliman-Collaborative-Care-report-2025-05-13.pdf.
[11] These conclusions are adjusted for the variable years of data supplied by Milliman by payer type.
[12] More detail about the rates of growth in CoCM services and patients by payor type is available in Appendix One.

Recommendations

Leveraging both quantitative and qualitative data, the Meadows Institute mapped the current state of CoCM in Michigan across several key areas, including Medicaid coverage, workforce considerations, financial sustainability, statewide partnerships, the grant process, and grant timelines. We then developed associated, targeted recommendations to strengthen and enhance the delivery of CoCM across the state.

Medicaid Coverage
Current State
Michigan Medicaid program adopted CoCM codes 99492, 99493, 99494, G2214, and G0512 in 2020. For Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) specifically, Michigan Medicaid reimburses for CoCM through the use of code G0512. This code requires meeting the full 60-minutes threshold with no additional payment for time that exceeds it, creating a significant barrier to financial sustainability for many providers. In addition, Michigan Medicaid's low reimbursement rates, prior authorization requirements, requirement of the BHCM's initial assessment to be in-person or via dual audio-visual telemedicine, and frequent claim denials add administrative burden and discourage broader adoption of the model. As seen in Appendix 1, the quantitative analysis, shows that Michigan Medicaid uptake of CoCM services has been significantly lower than that of Medicare and commercial insurance in Michigan (see Appendix 1).
Recommendations
1. CMS has proposed eliminating the G0512 code allowing FQHCs and RHCs to bill CoCM services using the parent codes 99492, 99493, and 99494 starting January 1, 2026, a change that should be strongly supported by state Medicaid programs. This proposal would provide a stronger foundation for sustainable CoCM reimbursement and expand access. 2. Currently, Michigan Medicaid reimburses CoCM codes below Medicare rates, creating a barrier to financial sustainability. To support broader adoption and long-term viability, Michigan Medicaid should increase reimbursement to match, or ideally exceed, Medicare. North Carolina may be a strong model to follow, having increased their Medicaid reimbursement rate from 70% to 120% of the Medicare rate.[13,14] See Appendix 5 for additional details on the steps North Carolina took to ease implementation of CoCM. 3. Michigan's Medicaid should eliminate prior authorization requirements for CoCM codes to streamline billing and reduce administrative complexity. Medicare does not require prior

[13] North Carolina Department of Health and Human Services. (2023, December 8). *Collaborative Care Model in North Carolina: Policy Paper*

[14] Following the increase in reimbursement in January 2022, North Carolina Medicaid experienced a 15% increase in CoCM services compared to the previous year. Davenport, S., Mager, M., Darby, B. (2025, May). *Trends in adoption of the Collaborative Care Mode: Analysis of variation by payer and region, 2018-2023*. http://www.mmhpi.org/wp-content/uploads/2025/05/Milliman-Collaborative-Care-report-2025-05-13.pdf.

authorization for these services, and Michigan Medicaid's continued use of this requirement remains a barrier to financial sustainability and broader adoption of the model.

Workforce Considerations

Current State

The success of CoCM relies heavily on strong community relationships and reliable staffing. While national and statewide workforce shortages have created significant challenges across healthcare fields, CoCM team shortages are further exacerbated by several factors. Staff attrition within CoCM teams disrupts the development of lasting patient relationships, and behavioral health care managers (BHCMs) often manage substantial caseloads alongside other responsibilities, leading to burnout and turnover. In addition, there is a lack of education about integrated behavioral health and CoCM in high school, undergraduate, and graduate programs which leaves many potential BHCM candidates unaware of these career opportunities. Limited access to psychiatric consultants has also been a persistent challenge, and those who do participate often require training and support to transition from autonomous practice to the integrated, team-based approach CoCM demands.

Recommendations

1. Michigan should collaborate with organizations across the state, including universities, community colleges, health systems, and professional associations to increase awareness of and education around the benefits of integrated behavioral health and CoCM. Expanding awareness of this field will help attract more people to BHCM roles and strengthen the overall workforce pipeline. Introducing CoCM earlier in educational programs can ensure that students are aware of these career pathways.
2. Create a statewide matching program to connect trained psychiatric consultants with CoCM programs in need. This initiative would optimize existing resources, help distribute consultant capacity more effectively, and improve access to care, particularly in areas where CoCM teams struggle to recruit or retain psychiatric consultants. By facilitating these connections, Michigan can ease CoCM implementation, reduce gaps in psychiatric support, and enhance the overall sustainability of integrated behavioral health services. A similar program is already in place through the North Carolina Psychiatric Association, which maintains a registry to match trained psychiatric providers with practices implementing CoCM.[15]
3. Establish a statewide learning collaborative for CoCM programs to share knowledge, best practices, and lessons learned. This initiative would allow programs to learn from each other's successes and challenges, fostering continuous improvement and building on the momentum of existing effective programs. In addition, publish case studies that highlight successful CoCM implementations and outcomes. Showcasing real-world examples of what works helps inspire

[15] North Carolina Psychiatric Association. "Collaborative Care Model (CoCM)." https://www.ncpsychiatry.org/cocm. Accessed July 30, 2025.

new programs, provides practical guidance, and encourages broader adoption and innovation across the state.

4. Ensure that grant initiatives incorporate provisions specifically aimed at supporting BHCMs, recognizing their essential role in long-term sustainability. This could include offering training and resources to strengthen their skill sets, implementing mentorship programs to promote retention and growth, or establishing a feedback mechanism to drive continuous improvement.
5. Require grant initiatives to prioritize centering the PCP as well as relationship-building between PCPs and BHCMs to create a more seamless, interconnected patient experience. This could include compensation and additional training for PCP champions, dedicated time and funding for team-building activities or regular feedback loops to support open communication. A strong, trusting relationship between the PCP and the psychiatric consultant is also essential. Although their interactions may be less frequent, building trust across all team members supports more effective collaboration and can lead to increased referrals into the program. Highlighting the crucial work of the PCPs within the model and strengthening collaboration between team members will foster better communication, more coordinated care, and ultimately, improved outcomes for patients served through CoCM.

Financial Sustainability

Current State

While financial sustainability is essential to the long-term success of CoCM, stakeholders have identified several challenges that impact its economic viability. Many practices do not experience immediate profitability. Maintaining realistic expectations for return on investment is important for sustaining commitment, with sustainability typically achievable within two years based on financial modeling developed by Meadows Institute. Rejected CoCM claims add further strain by complicating billing processes and wasting staff time and resources. These rejections are often caused by the complex nature of CoCM billing procedures and can be discouraging for teams working to sustain the model. In Michigan, FQHCs and RHCs face especially complicated Medicaid reimbursement protocols, making CoCM implementation difficult or, in some cases, unfeasible in these settings.

Recommendations

1. Provide robust billing technical assistance that includes the creation of a financial proforma to set realistic expectations for breakeven and profitability, along with initial billing training for CoCM codes. This support should also include follow-up assistance for denied claims and ongoing analysis to identify opportunities to optimize financial sustainability. By equipping practices with stronger financial planning tools and targeted billing guidance, Michigan can reduce claim rejections, strengthen confidence in CoCM implementation, and help more practices achieve long-term viability.
2. The state should financially subsidize a CoCM registry where CoCM team members can record outcome measures from validated behavioral health assessments and track each patient's progress over time. This centralized registry would consolidate all CoCM data within a single

technological platform, streamlining data tracking and billing processes. By reducing administrative burden, improving accuracy in documentation, and providing a shared infrastructure, the registry would support financial sustainability, reduce claim rejections, and make CoCM implementation more feasible, especially for FQHCs and rural clinics. An example of a similar model was created in North Carolina. North Carolina Medicaid provides free access to the customized state registry for up to three years.[16]

3. Continue providing startup funding to support the implementation and expansion of CoCM programs, as this financial support is essential for health systems to successfully launch and sustain these services. Quantitative analysis shows a correlation between MSAs that received startup funding from the Health Fund and increased use of CoCM billing codes; in MSAs where the Health Fund invested in implementation, such as Ann Arbor, Grand Rapids, Jackson, and Lansing, there was notably higher utilization of CoCM billing. See Appendix 1 for more details.

Statewide Partners

Current State

Michigan has already achieved significant progress in advancing CoCM by building strong relationships with key stakeholders such as the Michigan Department of Health and Human Services (MDHHS), Blue Cross Blue Shield of Michigan (BCBSM), and several philanthropic organizations. These partnerships have been instrumental in supporting CoCM implementation and expansion, as well as providing resources, guidance, and financial support that have helped programs grow and succeed across the state.

Recommendations

1. Continue fostering access to MDHHS, BCBSM, and other philanthropic organizations that are leading efforts in CoCM implementation and expansion. These relationships have been foundational to the growth and success of CoCM across Michigan. Quantitative analysis reflects broad adoption of CoCM throughout Michigan, and we believe these organizations and their collaborative efforts have played a meaningful role in that progress (see Appendix 1).

Grant Process

Current State

Through the qualitative analysis, previous applicants for the Health Fund's grants expressed they did not receive clear feedback when their CoCM proposals were declined, limiting their ability to strengthen future submissions. Some health systems expressed interest in using grant funds for activities that complement, rather than strictly adhere to, full-fidelity CoCM.

Recommendations

[16] North Carolina Department of Health and Human Services. (2023, December 8). *Collaborative Care Model in North Carolina: Policy Paper*

1. Ensure that clear feedback is provided when proposals are declined so grantees can understand areas for improvement and strengthen future submissions.
2. Utilize flexible grant frameworks to encourage the development of new ideas and innovative adaptations that respond to the specific needs of each health system.
3. Encourage health systems to appoint a CoCM champion, an internal leader dedicated to driving the growth and evolution of CoCM programs and ensuring that integrated care remains a strategic priority within the organization. Health systems that appoint an internal CoCM champion who actively advocates for integrated care consistently achieve stronger outcomes. These champions help maintain focus, guide implementation, and adapt the model to fit local needs, even during periods of staff turnover or shifting priorities. Without this leadership, programs are more likely to lose momentum and experience disruptions.

Grant Timeline

Current State

Circumstantial challenges hindered the broader adoption of CoCM in Michigan, particularly during the Health Fund's most recent funding cycle. The COVID-19 pandemic forced many health systems to redirect resources and prioritize immediate pandemic-related needs, delaying or disrupting their CoCM implementation efforts. In addition, some health systems had originally designed their CoCM programs for in-person delivery, which became impossible during periods of restricted access and safety precautions. These difficulties were further compounded by the grant's limited timeline, leaving health systems without sufficient time to adjust their implementation plans.

Recommendations

1. In circumstances where extensions are necessary, provide a one-year extension rather than a six-month option. A longer extension gives health systems adequate time to recover from unexpected disruptions, adapt their CoCM programs to evolving conditions, and ensure more successful and sustainable implementation.

Provider Spotlights

The Meadows Institute also gleaned insight from systems with sustained successful CoCM practices. We identified two programs as standout initiatives, both of which expressed high praise regarding the model's effectiveness and impact.

Henry Ford Health System

At Henry Ford, patient engagement has been effective, particularly with the inclusion of a community health worker. There are many metrics Henry Ford tracks, including number of screenings conducted, the number of patients seen, wait times, remission rates, reductions in PHQ-9 and GAD-7 scores, and

no-show rates. Their health system is also the birthplace for the zero-suicide approach, which they integrated into CoCM. [17]

Notably, they stated that their depression remission rates have been impressive; CoCM extends the clinical impact of prescribing behavioral health clinicians to as many as eight times the number of patients that they could serve individually.[18]

"We have saved lives," they stated, as evidenced by patient testimonies from those who have contemplated ending their lives.

Michigan State University

MSU considers its CoCM integration a success, having successfully trained 128 physicians, behavioral health professionals, and other CoCM staff. Their implementations demonstrated strong fidelity, with impressive screening rates: 96% of pregnant and postpartum individuals were screened post-implementation, and 70% of those identified as at risk were connected with behavioral health services—an increase from just 16% previously. This achievement is particularly notable given their programs were happening during the COVID-19 pandemic. MSU helped support their clinics by structuring workflow changes, enhancing electronic medical records for better tracking, providing workshops and refresher training for providers, and organizing psychiatric consultation meetings to support the clinics.

MSU staff said they faced discouragement at first but remained focused on the positive impact of their work, which paid off with high rates of both screenings and referrals to behavioral health services.

Next Steps

The Collaborative Care Model (CoCM) has become increasingly prevalent in primary care settings across Michigan. Through this assessment, the Meadows Institute identified several facilitators that have supported its adoption, including strong backing from the Michigan Department of Health and Human Services, Blue Cross Blue Shield of Michigan, and philanthropic organizations such as the Michigan Health Endowment Fund. Strategic grant funding and well-defined implementation structures have also played a critical role in establishing a solid foundation for CoCM statewide.

Despite successes, policymakers, healthcare providers, CoCM experts, and funders should continue working collaboratively to impact CoCM implementation strategies, enhance its long-

[17] CoCM is often not used for high acuity cases. When asked about this, Henry Ford stated there is an escalation point for patients who are suicidal and there is an "access point" with a nurse practitioner and a physician available to see these patients immediately, prescribe medications, and provide two visits while they await to get a connection with behavioral health services, which typically have an eight-week wait. Henry Ford pointed to having an almost immediate access to care through CoCM as filling a gap in their previous system.

[18] Carlo, A. D., McNutt, C., & Talebi, H. (2024). Extending the Clinical Impact of Behavioral Health Prescribing Clinicians Using the Collaborative Care Model (CoCM). *Journal of General Internal Medicine*, *39*(8), 1525–1527. https://doi.org/10.1007/s11606-024-08649-2

term sustainability, and ultimately improve access to high-quality mental health care for patients across the state. Significant barriers remain, particularly for federally qualified health centers (FQHCs) and rural health centers (RHCs). In Michigan, these health centers annually serve more than 700,000 people[19] and addressing Medicaid reimbursement rates is a critical first step toward expanding adoption in these settings. Without more viable financial pathways, many providers struggle to sustain CoCM, despite its clinical value.

To broaden sustainable implementation efforts, consider engaging CoCM technical assistance experts to provide targeted, tailored support aligned with the needs identified through this assessment. For example, the Meadows Institute regularly assists with billing and financial sustainability. The technical assistance team works with health systems to develop customized financial proformas that outline expected costs, reimbursement timelines, and break-even projections. These tools help practices plan strategically and allocate resources effectively. The team also offers billing training on CoCM codes, follow-up support for denied claims, and troubleshooting assistance. The team reviews billing data to identify patterns and highlight opportunities for process improvement. This type of practice specific support helps reduce administrative burden and builds confidence among health systems as they implement and sustain CoCM.

Based on our analysis, the systems that would benefit most from this level of technical assistance include new systems just getting started that need support in building a strong foundation, FQHCs due to complex billing processes, and lower-performing systems that may need help identifying barriers to achieving a sustainable caseload. Additionally, establishing a statewide learning collaborative would be an effective way to share knowledge, amplify best practices, and build on the momentum already underway.

Investing in these supports will not only accelerate CoCM adoption but also reinforce the long-term viability of integrated behavioral health services across Michigan. By fostering shared learning and offering tailored guidance, Michigan can build on its existing investment in CoCM and ensure more practices benefit from the groundwork laid by these dedicated organizations.

[19] Michigan Primary Care Association. (n.d.). *Michigan Health Centers*. Retrieved July 30, 2025, from Michigan Primary Care Association website: https://www.mpca.net/about/michigan-health-centers/

Appendices

Appendix One. Michigan Trends in Collaborative Care Model Utilization 2018 - 2023

Summary

The Collaborative Care Model (CoCM) is an evidence-based care delivery model that integrates behavioral health care into primary care settings. Following the widespread adoption of CoCM billing options by the Centers for Medicare & Medicaid Services (CMS) in 2018, uptake of CoCM has grown substantially in practices nationwide.[20]

This analysis examined trends in CoCM uptake in Michigan over time. Specifically,

1. The number of unduplicated patients served in CoCM and average length of treatment;
2. Longitudinal trends in CoCM service use by payer, including individuals insured by Medicare, Medicaid, and commercial plans;[21,22] and,
3. Geographical variation in CoCM use.

Results identified growth in CoCM services and patients served across Michigan among all payer groups, with commercially insured patients receiving the greatest increase in CoCM service provision and patients served over time.[23] Conversely, Medicaid patients experienced the slowest growth in rates of service provision and patients served over time.

Growth was not uniformly distributed statewide. Across all payer types, the highest rates of growth were observed in the Flint and Warren-Troy-Farmington Hills MSAs. Growth in CoCM services and patients served was most geographically dispersed for those who were commercially insured, spanning Battle Creek, Jackson, and Bay City (among other) MSAs. Dispersion of growth geographically was less pronounced among Medicaid beneficiaries, where most growth was observed in the populous Grand Rapids-Kentwood MSA.

Medicare patients received an average of 5.4 services per patient, compared to 4.8 services per patient for those covered by Medicaid and 4.1 services per patient for those with commercial insurance. On average, Medicare patients received the longest duration of care at 3.7 months, followed by Medicaid patients (3.5 months of service billed) and commercially insured patients

[20] Davenport, S., Mager, M., Darby, B. (2025, May). *Trends in adoption of the Collaborative Care Mode: Analysis of variation by payer and region, 2018-2023*. http://www.mmhpi.org/wp-content/uploads/2025/05/Milliman-Collaborative-Care-report-2025-05-13.pdf.

[21] Data for this analysis was sourced from Milliman, Inc., based on their 2025 report of CoCM utilization trends. The Milliman report included national claims data from approximately 221 million insured Americans between 2018 and 2023. Additional information on the Milliman data and methodology is provided in the Data Appendix.

[22] Trends were examined from 2018 to 2022 for Medicare and Medicaid beneficiaries, and from 2018 to 2023 for commercially insured individuals, based on the years of data supplied by Milliman for analysis.

[23] These conclusions are adjusted for the variable years of data supplied by Milliman by payer type.

(2.8 months). These data jointly suggest that Medicare patients received, on average, one additional month of care compared to commercial patients.

Data Sources and Methodology

All data for this analysis were abstracted by Milliman, Inc. between March and May 2025.[24] CoCM utilization was derived from healthcare claims submitted for approximately 7.8 million insured individuals in the state of Michigan. [25,26] Except where explicitly stated, the data here are reported as rates to normalize for changes in the insured population.

Results

Statewide CoCM Use in Michigan

Growth of CoCM services in Michigan since 2018 has been substantial. In 2018, an estimated 550 patients received CoCM treatment across commercial, Medicare, or Medicaid insurance plans.[27] By 2022, that number had grown to an estimated 10,000 individuals statewide.

CoCM Services Rendered

Figure 1 shows the growth in CoCM services used by payer. CoCM service use in the State of Michigan grew substantially:

- 3,000% among commercially insured individuals,
- 1,800% among Medicare beneficiaries,[28] and
- 390% among Medicaid beneficiaries. [29,30,31,32]

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[24] Davenport, S., Mager, M., Darby, B. (2025, May). *Trends in adoption of the Collaborative Care Mode: Analysis of variation by payer and region, 2018-2023*. http://www.mmhpi.org/wp-content/uploads/2025/05/Milliman-Collaborative-Care-report-2025-05-13.pdf.

[25] CoCM services were identified using Current Procedural Terminology (CPT) codes 99492, 99493, 99494, and G2214.

[26] Davenport, S., Mager, M., Darby, B. (2025, May). *Trends in adoption of the Collaborative Care Mode: Analysis of variation by payer and region, 2018-2023*. http://www.mmhpi.org/wp-content/uploads/2025/05/Milliman-Collaborative-Care-report-2025-05-13.pdf.

[27] This estimate represents an absolute number of patients, not a population adjusted rate. The data relied upon for this analysis includes 100% of Medicare and Medicaid claims, and approximately 53% of commercially insured lives in 2018. Counts of Medicaid patients were deflated by 15% to account for dual enrollment with Medicare. The total number of commercially insured lives was estimated by grossing up the number of individuals treated in the sample to account for 100% of commercially insured lives. Source: Kaiser Family Foundation (2025). *State health facts: Health insurance coverage of the total population [2018].* https://www.kff.org/other/state-indicator/total-population/

[28] The time frame for this increase was 2018 to 2022 given the available data.

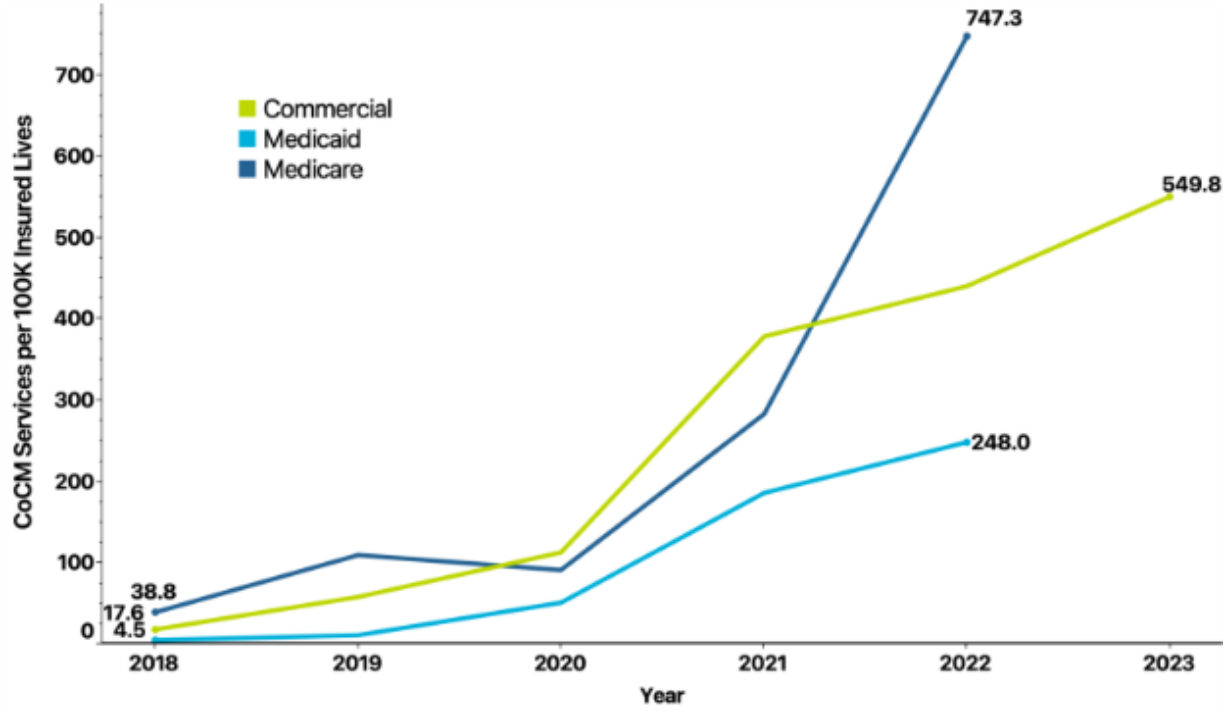
[29] The time frame for this increase was 2020 to 2022 given the available data.

[30] Services are defined as the total number of units billed for any of the following codes: 99492, 99493, 99494, or G2214.

[31] Commercial claims data are available from 2018 through 2023, Medicare and Medicaid claims data are available from 2018 to 2022.

[32] Michigan Medicaid began reimbursing for CoCM services in August 2020.

Figure 1: Michigan Statewide Growth of CoCM Service Use by Payer, 2018–2023[33]



In 2022, Medicare beneficiaries received 70% more CoCM services than commercially insured individuals (747 vs. 440 services per 100,000 insured lives, respectively), and more than three times the number of services provided to Medicaid beneficiaries (248 services per 100,000 insured lives). Initial CoCM adoption was highest among Medicare and commercially insured individuals, as Michigan Medicaid began reimbursing providers for CoCM services in August 2020.[34]

Unduplicated Patients Served

The growth in unduplicated patients receiving CoCM services followed a similar pattern. The number of patients who received at least one CoCM service increased by 1,800% among

[33] Michigan Medicaid began reimbursing providers for CoCM services in August 2020. Therefore, service provision before August 2020 was expectedly low.

[34] Michigan Department of Health & Human Services. (2020, July) *Medical Services Administration Policy Bulletin MSA 20-38.* https://michigan.gov/-/media/Project/Websites/mdhhs/Folder4/Folder21/Folder3, from /Folder121/Folder2/Folder221/Folder1/Folder321/MSA_20-38-CoCM.pdf

commercially insured individuals, 1,100% among Medicare beneficiaries,[35] and 240% among Medicaid beneficiaries. [36,37]

Below, we examine trends in CoCM service use by payer type and geography.

Commercially Insured Population

This section presents an overview of CoCM service utilization and patient counts among commercially insured individuals in Michigan, highlighting geographic variation and growth trends from 2018 to 2023.

CoCM Services Rendered

Table 1 shows the growth of CoCM services provided in the commercial insurance market by metropolitan statistical area (MSA) in Michigan between 2018 and 2023. The Battle Creek and Flint MSAs experienced the largest growth between 2020 and 2023 (10,340% and 3,293%, respectively).

Table 1: Collaborative Care Model (CoCM) Services per 100,000 Commercially-Insured Individuals by Metropolitan Statistical Area (MSA), 2018–2023[38]

MSA	2018	2019	2020	2021	2022	2023	Percent Growth Since 2020
Ann Arbor	127	603	610	2,275	2,332	2,326	281%
Battle Creek	0	0	10	1,093	1,182	1,044	10,340%
Bay City	0	0	17	214	312	460	2,606%
Detroit-Dearborn-Livonia	35	143	214	557	568	601	181%
Flint	5	15	15	221	304	509	3,293%
Grand Rapids-Kentwood	0	0	6	238	292	363	N/A
Jackson	2	34	92	238	320	1,027	1,016%
Kalamazoo-Portage	0	8	0	363	618	747	N/A
Lansing-East Lansing	2	5	14	91	163	207	1,379%
Midland	238	25	16	78	256	177	1,006%
Monroe	113	210	337	469	477	523	55%
Muskegon	0	0	30	58	120	160	433%

[35] The time frame for this increase was 2018 to 2022 given the available data.
[36] The time frame for this increase was 2020 to 2022 given that Michigan began reimbursing CoCM services in August 2020.
[37] Patients are defined as unique, unduplicated beneficiaries who received at least one billed service for any of the following CPT codes: 99492, 99493, 99494, or G2214.
[38] Percent growth rates are not reported for MSAs with fewer than 10 CoCM services per 100,000 insured individuals in 2020 due to low baseline volume.

Niles	0	0	0	9	6	26	N/A
Non-MSA Area	3	14	41	139	194	225	449%
Saginaw	2	0	18	142	293	263	1,361%
Warren-Troy-Farmington Hills	7	27	135	379	434	639	373%
Michigan, Statewide Average	**18**	**58**	**112**	**378**	**439**	**550**	**391%**

Commercial CoCM Patients Served

Commercial CoCM patient density was highest in the Ann Arbor MSA and other southeastern areas of the state, as detailed in Table 2. In 2023, 351 patients per 100,000 commercially insured individuals received CoCM services in the Ann Arbor MSA, followed by Jackson (271 patients per 100,000) and Battle Creek (172 patients per 100,000).

Table 2: Collaborative Care Model (CoCM) Patients per 100,000 Commercially-Insured Individuals by Metropolitan Statistical Area, 2018–2023[39]

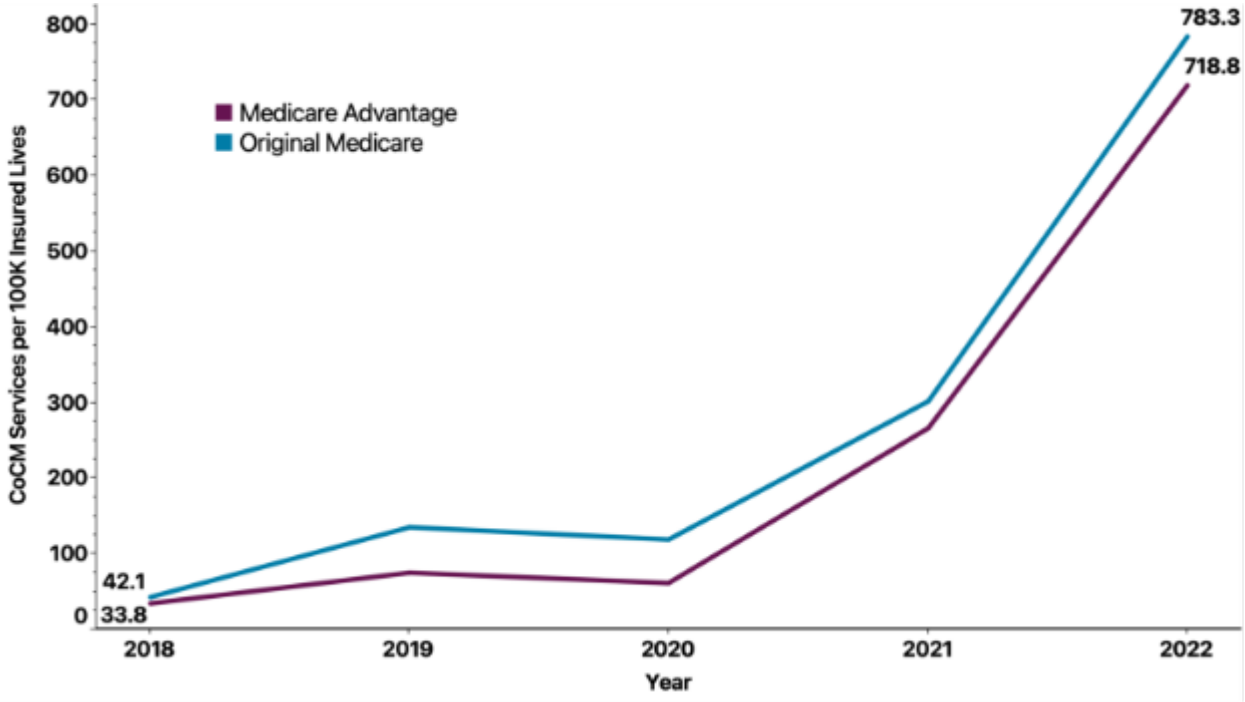
MSA	2018	2019	2020	2021	2022	2023	Percent Growth Since 2020
Ann Arbor	41	178	169	368	394	351	108%
Battle Creek	0	0	8	152	167	172	2,050%
Bay City	0	0	7	42	77	93	1,229%
Detroit-Dearborn-Livonia	15	45	52	138	169	170	226%
Flint	2	6	5	50	73	89	1,680%
Grand Rapids-Kentwood	0	0	3	51	60	71	N/A
Jackson	2	16	14	57	100	271	1,836%
Kalamazoo-Portage	0	6	0	61	121	139	N/A
Lansing-East Lansing	1	2	3	22	37	43	N/A
Midland	28	14	12	29	45	49	308%
Monroe	30	57	72	103	122	121	67%
Muskegon	0	0	3	11	38	48	N/A
Niles	0	0	0	3	3	3	N/A
Non-MSA Area	2	4	11	30	38	40	264%
Saginaw	2	0	4	23	51	71	N/A
Warren-Troy-Farmington Hills	4	13	31	98	122	145	368%

[39] For MSAs where the 2020 patient utilization rate was less than 5 per 100,000, percent growth rates are not reported.

Medicare Population

This section reviews the growth and geographic distribution of Collaborative Care Model (CoCM) services and patient counts among Michigan's Original Medicare and Medicare Advantage beneficiaries between 2018 and 2022. Unless otherwise specified, all analyses of the Medicare insurance segment represent the combined data for both Original Medicare and Medicare Advantage, given the convergent patterns observed in services provided across Medicare and Medicare Advantage beneficiaries (Figure 2).

Figure 2: Growth of Collaborative Care Model (CoCM) Services Among Original Medicare vs. Medicare Advantage Recipients in Michigan, 2018–2022



Medicare CoCM Services Rendered

Table 3 shows the growth of CoCM services used within the Medicare population by MSA between 2018 and 2022. Among MSAs with 2020 service volume, the most substantial growth in services rendered was observed in Warren-Troy-Farmington Hills (+8,000%), Flint (+1,365%), and Midland (+655%).

Despite rendering no services in 2020, the Jackson MSA experienced the largest growth in the state by 2022, from zero in 2020 to 5,502 CoCM services per 100,000 Medicare insured lives in 2022. Notably, the Ann Arbor MSA was an early adopter of CoCM uptake, with services

provided during (or pre-) 2018. Despite the established practice of CoCM in the MSA, the rate of services provided doubled (+101%) between 2020 and 2022.

Table 3: Collaborative Care Model (CoCM) Services per 100,000 Medicare Insured Individuals by Metropolitan Statistical Area (MSA), 2018–2022[40]

MSA	2018	2019	2020	2021	2022	Percent Growth Since 2020
Ann Arbor	638	2,376	1,827	3,506	3,676	101%
Battle Creek	0	0	3	176	6	N/A
Bay City	0	0	0	4	7	N/A
Detroit-Dearborn-Livonia	45	187	167	117	232	39%
Flint	0	1	23	202	337	1,365%
Grand Rapids-Kentwood	0	0	1	310	484	N/A
Jackson	0	0	0	2,944	5,502	N/A
Kalamazoo-Portage	0	4	0	180	119	N/A
Lansing-East Lansing	0	0	1	2	74	N/A
Midland	0	0	11	11	83	655%
Monroe	0	3	60	205	245	308%
Muskegon	0	3	38	0	99	161%
Niles	0	0	0	0	0	N/A
Non-MSA Area	0	0	4	58	71	N/A
Saginaw	0	0	0	1,186	1,135	N/A
Warren-Troy-Farmington Hills	11	41	19	101	1590	8,268%
Michigan, Statewide Average	**39**	**109**	**91**	**283**	**747**	**721%**

Medicare CoCM Patients Served

Table 4 shows the growth of Medicare patients served in CoCM by MSA between 2018 and 2022. Among MSAs with patients served in 2020, the most substantial growth in patients receiving CoCM was observed in Warren-Troy-Farmington Hills (+2,411%), followed by Flint (+165%). Very few Medicare patients received CoCM treatment in northern Michigan, particularly the Upper Peninsula.

[40] Percent growth rates are not reported for MSAs with fewer than 10 CoCM services per 100,000 insured individuals in 2020 due to low baseline volume.

Table 4: Collaborative Care Model (CoCM) Patients Served per 100,000 Medicare Insured Individuals by Metropolitan Statistical Area, 2018–2022[41]

MSA	2018	2019	2020	2021	2022	Percent Growth Since 2020
Ann Arbor	166	560	413	604	647	57%
Battle Creek	0	0	3	6	6	N/A
Bay City	0	0	0	4	7	N/A
Detroit-Dearborn-Livonia	18	67	82	65	102	24%
Flint	0	1	23	49	61	165%
Grand Rapids-Kentwood	0	0	1	78	130	N/A
Jackson	0	0	0	549	1,223	N/A
Kalamazoo-Portage	0	4	0	32	31	N/A
Lansing-East Lansing	0	0	1	2	2	N/A
Midland	227	0	11	11	10	-9%
Monroe	0	3	3	59	58	N/A
Muskegon	0	3	3	0	2	N/A
Niles	0	0	0	0	0	N/A
Non-MSA Area	0	0	0	10	17	N/A
Saginaw	0	0	0	239	313	N/A
Warren-Troy-Farmington Hills	5	24	9	35	226	2,411%

Medicaid Population

This section presents trends in CoCM services and patient density among individuals covered by Michigan Medicaid between 2020 and 2022. As with other payer types, the data below are organized by service utilization and unduplicated patient counts.

Medicaid CoCM Services Rendered

Since Michigan Medicaid began reimbursing for CoCM services in August 2020, service utilization has increased five-fold statewide. As shown in Table 5 by MSA, Grand Rapids–Kentwood experienced the largest percentage increase in CoCM utilization, growing by nearly 4,000% between 2020 and 2022. Among MSAs with measurable service rates in 2020, substantial growth was also evident in Flint (+673%) and Warren-Troy-Farmington Hills (+543%).

[41] For MSAs where the 2020 patient utilization rate was less than 5 per 100,000, percent growth rates are not reported.

Table 5: Collaborative Care Model (CoCM) Services per 100,000 Medicaid Insured Individuals by Metropolitan Statistical Area, 2018–2022[42]

MSA	2018	2019	2020	2021	2022	Percent Growth Since 2020
Ann Arbor	0	0	601	2,292	2,282	280%
Battle Creek	0	0	3	101	197	N/A
Bay City	0	0	85	113	44	-48%
Detroit-Dearborn-Livonia	0	0	60	169	166	177%
Flint	0	0	22	109	170	673%
Grand Rapids-Kentwood	0	0	12	217	485	3,942%
Jackson	0	0	2	109	362	N/A
Kalamazoo-Portage	0	0	2	2	198	N/A
Lansing-East Lansing	0	0	34	95	128	276%
Midland	0	0	6	136	269	N/A
Monroe	0	0	121	491	499	312%
Muskegon	0	0	2	2	115	N/A
Niles	0	0	0	2	2	N/A
Non-MSA Area	0	0	36	98	148	311%
Saginaw	0	0	2	28	92	N/A
Warren-Troy-Farmington Hills	0	0	37	159	238	543%
Michigan, Statewide Average	**5**	**11**[43]	**51**	**186**	**248**	**386%**

Medicaid CoCM Patients Served

Geographic trends in unduplicated Medicaid patients served largely mirror service trends. As shown in Table 6 by MSA, Grand Rapids–Kentwood experienced the largest percentage increase in unduplicated patients receiving CoCM, with an increase of 1,171% between 2020 and 2022. Among MSAs with measurable service rates in 2020, substantial growth was also evident in Warren-Troy-Farmington Hills (+445%).

[42] Percent growth rates are not reported for MSAs with fewer than 10 CoCM services per 100,000 insured individuals in 2020 due to low baseline volume.

[43] Dually eligible beneficiaries could have received some CoCM services prior to 2020 and had it reimbursed under their Medicare benefit. This analysis includes patients who received the service billed, regardless of if the service was paid for by insurance.

Table 6: Collaborative Care Model (CoCM) Patients per 100,000 Medicaid Insured Individuals by Metropolitan Statistical Area, 2018–2022[44]

MSA	2018	2019	2020	2021	2022	Percent Growth Since 2020
Ann Arbor	0	0	197	442	421	114%
Battle Creek	0	0	3	2	47	N/A
Bay City	0	0	4	4	3	N/A
Detroit-Dearborn-Livonia	0	0	18	36	35	94%
Flint	0	0	1	23	40	N/A
Grand Rapids-Kentwood	0	0	7	57	89	1,171%
Jackson	0	0	2	2	86	N/A
Kalamazoo-Portage	0	0	2	2	35	N/A
Lansing-East Lansing	0	0	13	23	26	100%
Midland	0	0	6	5	6	0%
Monroe	0	0	4	102	125	N/A
Muskegon	0	0	2	2	27	N/A
Niles	0	0	0	2	2	N/A
Non-MSA Area	0	0	9	22	30	233%
Saginaw	0	0	2	1	25	N/A
Warren-Troy-Farmington Hills	0	0	11	36	60	445%

Treatment Duration and Services Rendered per Unduplicated CoCM Patient

This section examines the duration of patient engagement in CoCM treatment by payer. Two measures are used to assess this:

1. the average length of treatment per patient, measured in months of CoCM services; and,
2. the average number of services rendered per patient in 2022.

[44] For MSAs where the 2020 patient utilization rate was less than 5 per 100,000, percent growth rates are not reported.

Average Length of Treatment

Since providers can only bill one service per month of treatment provided, the average number of services billed serves as a proxy for the average length of treatment.[45] Table 7, below, shows the average length of CoCM services by payer and MSA in 2022.

In 2022, Medicare patients received CoCM for **one month longer** than commercially insured patients, on average

On average, Medicare patients received the longest duration of care at 3.7 months, followed by Medicaid patients (3.5 months of service billed) and commercially insured patients (2.8 months). This indicates that Medicare patients received, on average, one additional month of care compared to commercial patients.

Table 7: Average Length (in Months) of Collaborative Care Model (CoCM) Treatment Provided per Patient by Payer and Metropolitan Statistical Area, 2022[46]

MSA	Commercial	Medicaid	Medicare
Ann Arbor	3.7	4.0	4.2
Battle Creek	3.7	3.0	-
Bay City	2.3	-	-
Detroit-Dearborn-Livonia	2.5	3.6	2.1
Flint	3.4	3.1	4.1
Grand Rapids-Kentwood	2.9	3.8	2.7
Jackson	2.4	3.1	3.1
Kalamazoo-Portage	3.8	4.2	2.9
Lansing-East Lansing	3.3	3.7	-
Midland	2.5	-	-
Monroe	2.8	2.9	3.5
Muskegon	2.2	3.0	-
Non-MSA Area	3.3	3.6	3.2
Niles	-	-	-
Saginaw	3.3	2.8	2.7

[45] The average number of CoCM services per patient was calculated using total billed units for codes 99492, 99493, and G2214, divided by the number of unique patients. Our analysis has a few important limitations. First, months in which a patient's services do not meet the minimum time requirements are not included, as those services typically go unbilled. In such cases, providers often bill using code 99484 instead. Second, the total number of billed service months may not align with the full episode length of care, as any months without billed services during an episode are not counted in our analysis.

[46] Average CoCM services per patient could not be calculated for some MSAs due to small sample sizes and cell suppression policies.

Warren-Troy-Farmington Hills	2.4	3.0	4.6
Michigan Statewide Average	**2.8**	**3.5**	**3.7**

Average Number of Services Rendered per Patient

Table 8 presents the average number of services rendered per patient by payer and MSA in 2022. Medicare patients received an average of 5.4 services per patient, 32% more than commercially insured patients (4.1 services per patient), and 13% more services than Medicaid patients (4.8 services per patient). The Ann Arbor MSA, a consistent leader in CoCM delivery, reported above-average service delivery rates across all three payers.

Table 8: Average Number of Collaborative Care Model (CoCM) Services Rendered per Patient by Payer and Metropolitan Statistical Area, 2022[47]

MSA	Commercial	Medicaid	Medicare
Ann Arbor	5.9	5.4	5.7
Battle Creek	7.1	4.3	-
Bay City	4.0	-	-
Detroit-Dearborn-Livonia	3.4	4.8	2.3
Flint	4.2	4.2	5.5
Grand Rapids-Kentwood	4.9	5.5	3.7
Jackson	3.2	4.2	4.5
Kalamazoo-Portage	5.1	5.8	3.8
Lansing-East Lansing	4.5	5.0	-
Midland	5.6	-	-
Monroe	3.9	4.0	4.2
Muskegon	3.1	4.3	-
Niles	-	-	-
Non-MSA Area	5.1	4.9	4.3
Saginaw	5.7	3.8	3.6
Warren-Troy-Farmington Hills	3.6	4.0	7.0
Michigan Statewide Average	**4.1**	**4.8**	**5.4**

[47] Average CoCM services per patient could not be calculated for some MSAs due to small sample sizes and cell suppression policies.

Supplemental Data

Data Description and Measurement of CoCM Uptake

All data reported in this summary were received from Milliman between March and May 2025. More information about these data is available in the published report from Milliman, Inc., commissioned by the Meadows Mental Health Policy Institute (Meadows Institute).[48]

CoCM patients and services in this report reflect the usage of the following Current Procedural Terminology (CPT) codes: 99492, 99493, 99494, and Healthcare Common Procedure Coding System (HCPCS) code G2214.[49] Descriptions of these services are available below.[50]

Codes	Description
99492	Initial psychiatric collaborative care management, first calendar month, first 70 minutes
99493	Follow-up psychiatric collaborative care management, subsequent calendar month, first 60 minutes
99494	Psychiatric collaborative care management per calendar month, each additional 30 minutes
G2214[51]	Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care provider

Suppression

The data used for this analysis was suppressed in accordance with Centers for Medicare & Medicaid Services (CMS) standards by Milliman, Inc. In accordance with CMS policy, research datasets require that any metrics that reflect the experience of fewer than 11 beneficiaries be suppressed to protect patient privacy. To prevent these values from being inferred, Milliman Inc. suppressed values between 1 and 12 and rounded all other values to the nearest 5. When data suppression was required, actual values were reported as "<8.7 patients per 100,000 population". These suppression rules did not apply to commercial market data.

[48] Davenport, S., Mager, M., Darby, B. (2025, May). *Trends in adoption of the Collaborative Care Mode: Analysis of variation by payer and region, 2018-2023*. http://www.mmhpi.org/wp-content/uploads/2025/05/Milliman-Collaborative-Care-report-2025-05-13.pdf.

[49] This HCPCS code was added by the Centers for Medicare & Medicaid Services in 2021.

[50] Centers for Medicare & Medicaid Services. (2024). *Medicare physician fee schedule 2023.* Department of Health and Human Services. https://www.cms.gov/medicare/payment/fee-schedules/physician

[51] CMS introduced a Healthcare Common Procedure Coding System (HCPCS) code (G2214) in 2021 to allow practices more flexibility in billing for CoCM.

Supplementary Figures

Figure S-1: Collaborative Care Model (CoCM) Patients per 100,000 Medicare Insured Individuals by County, 2022

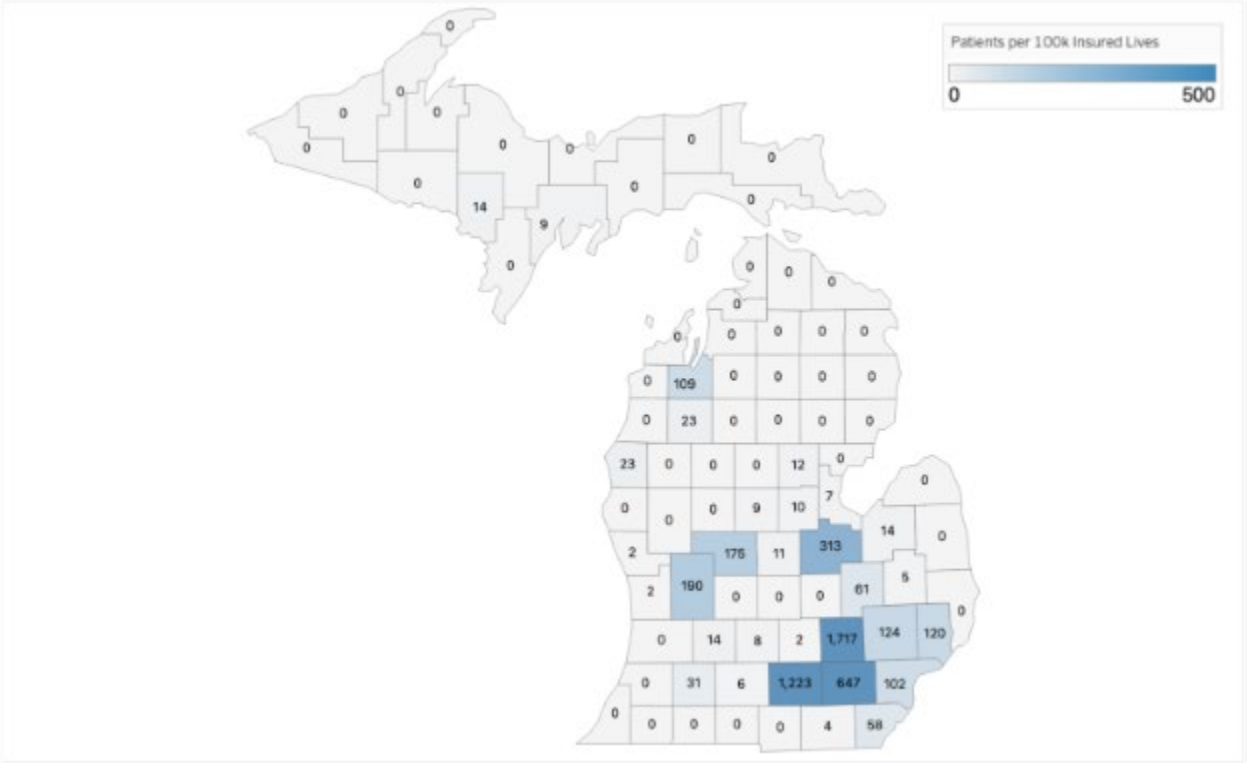
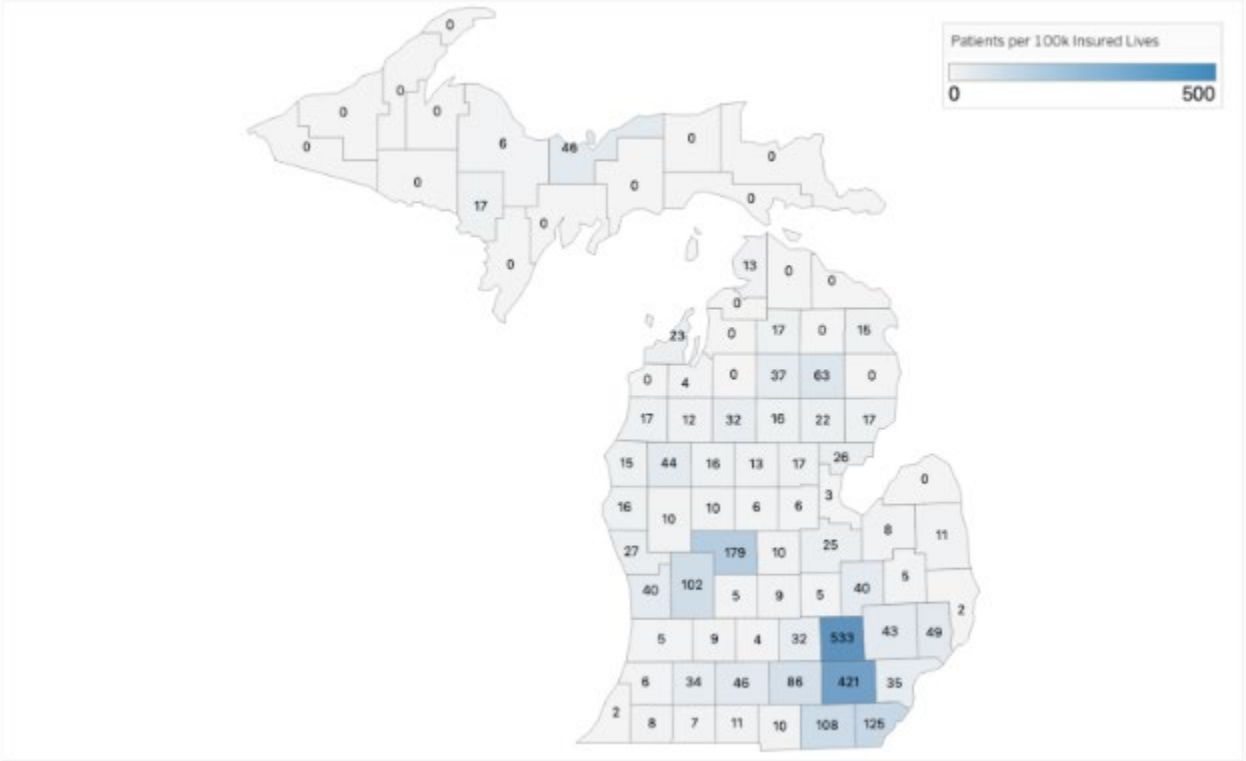


Figure S-2: Collaborative Care Model (CoCM) Patients per 100,000 Medicaid Insured Individuals by County, 2022



Appendix Two. Interview Questions

Questions for Semi Structured Interviews with Health Systems re: Health Systems

Introduction:

1. Were you familiar with the Collaborative Care model before learning about the grant?

2. What goals did you have when you applied for the CoCM grant?

3. What was your understanding of the specific objectives the grant aimed to achieve in terms of Collaborative Care?

4. What changes or improvements were made to your existing workflows to implement the Collaborative Care model?

5. How were the grant funds allocated across different aspects of the Collaborative Care model? Please give rough estimates out of 100%.
   a. Staffing
   b. Technology
   c. Training
   d. Patient education
   e. Other

6. Were there any unexpected costs and/or needs that arose during the implementation process?

Success of CoCM Implementation:

7. Would you define your CoCM integration as a success?

8. Is CoCM still a part of your health system?

9. What outcomes or metrics were established to measure the success of your CoCM implementation?
10. What feedback have you received from BHCMs and PCPs about the Collaborative Care model?

11. What feedback have you received from patients about the Collaborative Care model?

12. What key lessons have you learned from the implementation of the Collaborative Care model?

Barriers:

13. What were the biggest challenges in implementing the Collaborative Care model?

14. Were there any difficulties related to technology adoption or integration into existing systems?

15. How did you address challenges related to staff or patient buy-in to CoCM model?

Staff:

16. What challenges, if any, did you encounter in coordinating care across multiple providers?

17. Did you hire a BHCM from outside the organization, or were they a member of your existing team? Did they deliver services on-site or virtually?

18. Did you hire a psychiatric consultant from outside, or were they a member of your existing team? Was it on-site or virtual?

19. Did you need to hire new staff to take on the CoCM implementation?

20. Did you understand the time and resources a CoCM implementation would take?

Prior Behavioral Health Experience:

21. Did your health system have a history of behavioral health integration prior to the CoCM grant?

If yes,

a. What are the current and/or previous strategies (models) for behavioral health intervention that your health system has undertaken?
b. What successes have you had?
c. What barriers have you encountered?

If no,

d. Why not?

22. Do your clinics currently have universal behavioral health screenings (e.g., GAD-7, PHQ-9)?

e. If yes, and you do not have integrated behavioral health, how do your patients with BH needs receive BH care?

Feedback and Recommendations

23. How could the grant be structured differently to make it more effective?

24. What recommendations would you offer to other health systems looking to implement CoCM?

25. If you could go back and change any aspect of the implementation process, what would you do differently?

Appendix Three. Grant Fund Return Reasons

PRISM's Reasons for Returning Grant Funds

1. **Lack of Support**: The school-based project struggled to garner the necessary support to implement their plans effectively. There were difficulties in engaging and enrolling participants.
2. **Competing Funding**: A tragic event led to an influx of funding for school-based clinics, which redirected resources away from PRISM's proposed solutions, as clinics opted to use those funds for alternative initiatives.
3. **Specific Requirements**: The project faced barriers related to the types of school-based clinics needed for rollout. They could not gain interest and buy-in from the specific types required (e.g., needing 8 clinics with at least 2 each from urban, rural, and suburban areas). A less specific requirement would have made it easier to find suitable partners.
4. **Timing and Expertise**: There was a mismatch between the right experts and the wrong timing for the project, making it challenging to execute as planned.
5. **Political Environment**: The general political climate surrounding school-based health clinics added to the challenges, with some groups aiming to limit what could be done in these settings.
6. **Appreciation for MHEF**: They expressed gratitude for MHEF's focus in this area and showed interest in future projects, noting that the problem lay not with the grant itself, but with the project's requirements.

Appendix Four. In Depth Review of CoCM

The Collaborative Care Model (CoCM), which is predicated on the adult chronic care model, empowers a specially trained Behavioral Health Care Manager (BHCM) to practice in concert with PCPs and systematically evaluate patients' behavioral health care needs using common patient-reported outcome instruments (e.g., the 9-Item Patient Health Questionnaire for depression), all while receiving regular input and supervision from a designated psychiatric consultant.[52] In CoCM, a caseload approach and other population health methods are leveraged to treat common behavioral health concerns, such as depression or anxiety. A defined subgroup of patients within the primary care practice is identified and tracked through a registry. CoCM incorporates MBC and a treatment registry to help the team identify and measure key behavioral health symptoms over time. The Psychiatric Consultant provides treatment recommendations including medication, when indicated, for the PCP to consider and carry out. The BHCM delivers brief therapeutic interventions (e.g., motivational interviewing, behavioral activation) to help patients with their BH symptoms.

CoCM is extensively evidence based, with its efficacy being demonstrated by more than 90 randomized controlled trials (RCTs) and several meta-analyses across diverse diagnoses (e.g., depression, anxiety, bipolar disorder), patient populations (e.g., older adults, patients with chronic medical problems) and treatment settings (e.g., Federally Qualified Healthcare Centers, the Veterans Health Administration).[53] Additionally, CoCM has been shown to reduce racial and ethnic treatment outcome disparities[54] and is effective when implemented in rural[55] and underserved urban[56] treatment settings. Finally, CoCM has designated billing codes that are reimbursed by Medicare, most commercial payers, and a growing number of state Medicaid plans, leading the model to be financially sustainable.[57]

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[52] Carlo, A. D., Barnett, B. S., & Unützer, J. (2021). Harnessing Collaborative Care to Meet Mental Health Demands in the Era of COVID-19. *JAMA Psychiatry*, *78*(4), 355–356. https://doi.org/10.1001/jamapsychiatry.2020.3216

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[54] Hu, J., Wu, T., Damodaran, S., Tabb, K. M., Bauer, A., & Huang, H. (2020). The Effectiveness of Collaborative Care on Depression Outcomes for Racial/Ethnic Minority Populations in Primary Care: A Systematic Review. *Psychosomatics*, *61*(6), 632–644. https://doi.org/10.1016/j.psym.2020.03.007

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[56] Blackmore, M. A., Patel, U. B., Stein, D., Carleton, K. E., Ricketts, S. M., Ansari, A. M., & Chung, H. (2022). Collaborative Care for Low-Income Patients From Racial-Ethnic Minority Groups in Primary Care: Engagement and Clinical Outcomes. *Psychiatric Services*, *73*(8), 842–848. https://doi.org/10.1176/appi.ps.202000924

[57] Carlo, A. D., Corage Baden, A., McCarty, R. L., & Ratzliff, A. D. H. (2019). Early Health System Experiences with Collaborative Care (CoCM) Billing Codes: A Qualitative Study of Leadership and Support Staff. *Journal of General Internal Medicine*, *34*(10), 2150–2158. https://doi.org/10.1007/s11606-019-05195-0

Evidence-based Principles

CoCM has five primary evidence-based principles or pillars.

Patient-centered Team Care

CoCM is patient-centered, meaning that all care delivered through the model is done, to the greatest extent possible, with the patient's interests, preferences, and schedule in mind. All three core members of the CoCM team work together to achieve this goal.

Population-based Care

CoCM leverages a care team to screen an entire patient population and influence the care of far more patients than they would be able to see working on their own, allowing a whole population of patients to be carefully managed and enter treatment more quickly and preventing patients from falling through the cracks.

Measurement-based Treatment to Target

When outcomes are tracked in the CoCM treatment registry, the CoCM treatment team is responsible for ensuring that patients' outcome scores improve according to evidence-based metrics, such as response or remission.

Evidence-based Care

CoCM is itself evidence-based, and additionally, the model incorporates other evidence-based treatments, including medication prescribing guidelines (that may include the use of treatment algorithms) and brief interventions such as cognitive behavioral therapy, problem solving therapy, or motivational interviewing.

Accountable Care

In CoCM, the clinical team is incentivized to provide high-value care, as opposed to high-volume care. The team may regularly be presented with data on their patients' treatment progress, providing the opportunity for clinicians to continuously improve their treatment strategies.

Collaborative Care Model Clinical Workflow

CoCM presents an innovative approach to integrating behavioral health services within pediatric care settings, aiming to improve early identification of behavioral health needs and

access to youth mental health care. A broad-based overview of a pediatric CoCM program clinical workflow is as follows.

After adopting universal behavioral health screening, a pediatric practice must define the target population and diagnostic scope for its CoCM program. For example, a practice may define its target population as pediatric patients between the ages of four and 21, and its diagnostic scope as depression, anxiety, and ADHD. Patients in the target population who screen positive for conditions within the diagnostic scope or display concerning signs/symptoms are considered for referral to the CoCM program.

Typically, the pediatrician will inform the patient and their guardian of the program and offer them enrollment. For billing purposes, the pediatrician informs the patient and guardian that, depending on their health insurance, they may receive a monthly bill for CoCM services (i.e., cost sharing). This discussion between the pediatrician, patient (as developmentally appropriate), and guardian is considered the "consent process." Verbal consent must be documented in the medical record. Uninsured patients and their guardian(s) should also be informed that they may receive a bill for CoCM services (though they may not be required to pay the bill due to sliding scale payment arrangements). If the patient is ultimately enrolled in CoCM, the pediatrician will connect them with the program's BHCM.

The BHCM connects with the patient and guardian via warm handoff in person, by telephone, or through secure messaging to schedule an intake visit. During this visit, the BHCM conducts a full behavioral health evaluation that explores current symptoms in addition to a comprehensive history of diagnoses, treatments (including medication and psychotherapy), higher acuity care, and comorbid medical problems. In this evaluation, the BHCM also administers evidence-based assessments, such as the Patient Health Questionnaire-9 Modified for Adolescents (PHQ-A) and the Generalized Anxiety Disorder-7 (GAD-7). The BHCM may, with guardian permission, speak with a school representative to obtain BH assessment teacher reports (e.g., Vanderbilt Assessment Scale) or other relevant collateral information. The BHCM writes a draft report of the findings from the intake evaluation and enters demographic data, visit data, and assessment results into the patient registry.

During weekly case reviews with the psychiatric consultant, the BHCM reviews the treatment registry broadly, with each patient considered for detailed discussion. The BHCM and psychiatric consultant typically discuss new patients and those with acute events; patients who are not responding to treatment or following up as scheduled with the BHCM are also prioritized. The BHCM, with help from the psychiatric consultant, develops a personalized treatment plan, which may include parent training, interaction with school-based care, medication recommendations, brief psychotherapy, and/or psychosocial interventions for new patients. This plan is then described in the BHCM's report, which is preliminarily discussed with

the patient and guardian and sent to the pediatrician. The pediatrician then reviews the patient's treatment plan with recommendations from the rest of the CoCM team.

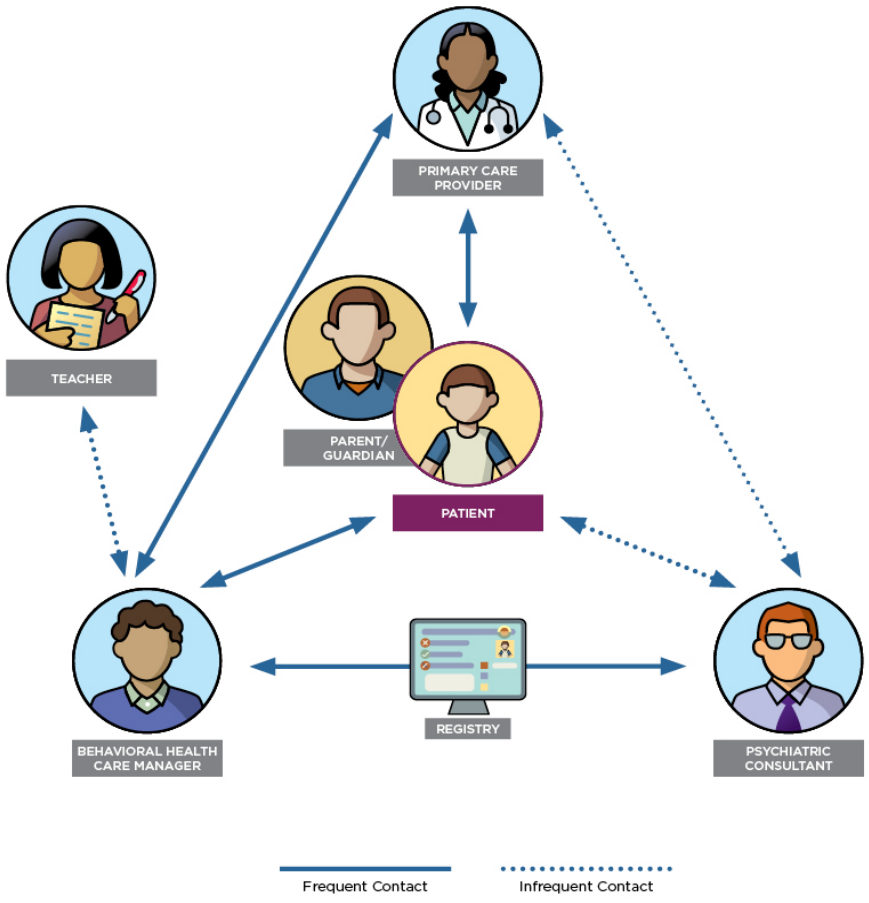
If the psychiatric consultant recommends medications and the pediatrician agrees, the pediatrician will write prescriptions and schedule a visit with the patient and guardian to discuss the recommended medications further. The pediatrician is always welcome to ask follow-up questions of the CoCM team. Due to this bidirectional collaboration, CoCM provides valuable real-time education opportunities for pediatricians, rendering them more knowledgeable about relevant psychopharmacology during future patient encounters. When the CoCM team recommends specific psychotherapy, these services are typically delivered by the BHCM directly. The BHCM most commonly provides brief behavioral health interventions, such as motivational interviewing or behavioral activation, though other modalities or psychosocial interventions may be used as indicated. In some cases, patients can be referred to community providers (while still being followed in CoCM) if they require more extensive therapy, long-term therapy, or additional interventions for which the BHCM is not adequately trained.

After the CoCM intake visit and initial recommendations, patients are followed closely by the BHCM. Typically, patients interact with the BHCM and potentially their guardians, a minimum of two times per month while in active treatment. During each interaction between the patient, guardian, and BHCM, the BHCM administers evidence-based assessments, and adds follow-up results to the treatment registry. The goal for each target symptom is remission, which is defined differently for each instrument. With the PHQ-A, for example, remission is defined as a score of less than five. Patient treatment response is also tracked, which is typically defined as a reduction from the baseline score of 50% or more with the PHQ-A. Of note, the choice of instruments is discretionary for each CoCM program. The BHCM and psychiatric consultant update treatment plans for existing CoCM patients during case review sessions based on clinical progress. All treatment plan updates, including updated medication recommendations, are sent to the pediatrician. Each patient is considered for review weekly in case review sessions with the psychiatric consultant (and is reviewed at least monthly). The BHCM also remains in close contact with the patient's guardian to discuss treatment recommendations and proposed changes. Additionally, the BHCM may remain in ongoing communication with school representatives or teachers, if indicated and permissible. On Average, patients remain in the active treatment phase of the program for three to six months.

A patient moves from active treatment into the relapse prevention phase of the CoCM program when they achieve symptom response or remission. At this point, the patient's frequency of interaction with the BHCM typically decreases to approximately once per month, and the clinical focus shifts to creating a plan to mitigate future worsening of symptoms. This relapse prevention plan integrates the patient's goals, medication recommendations (if applicable), and

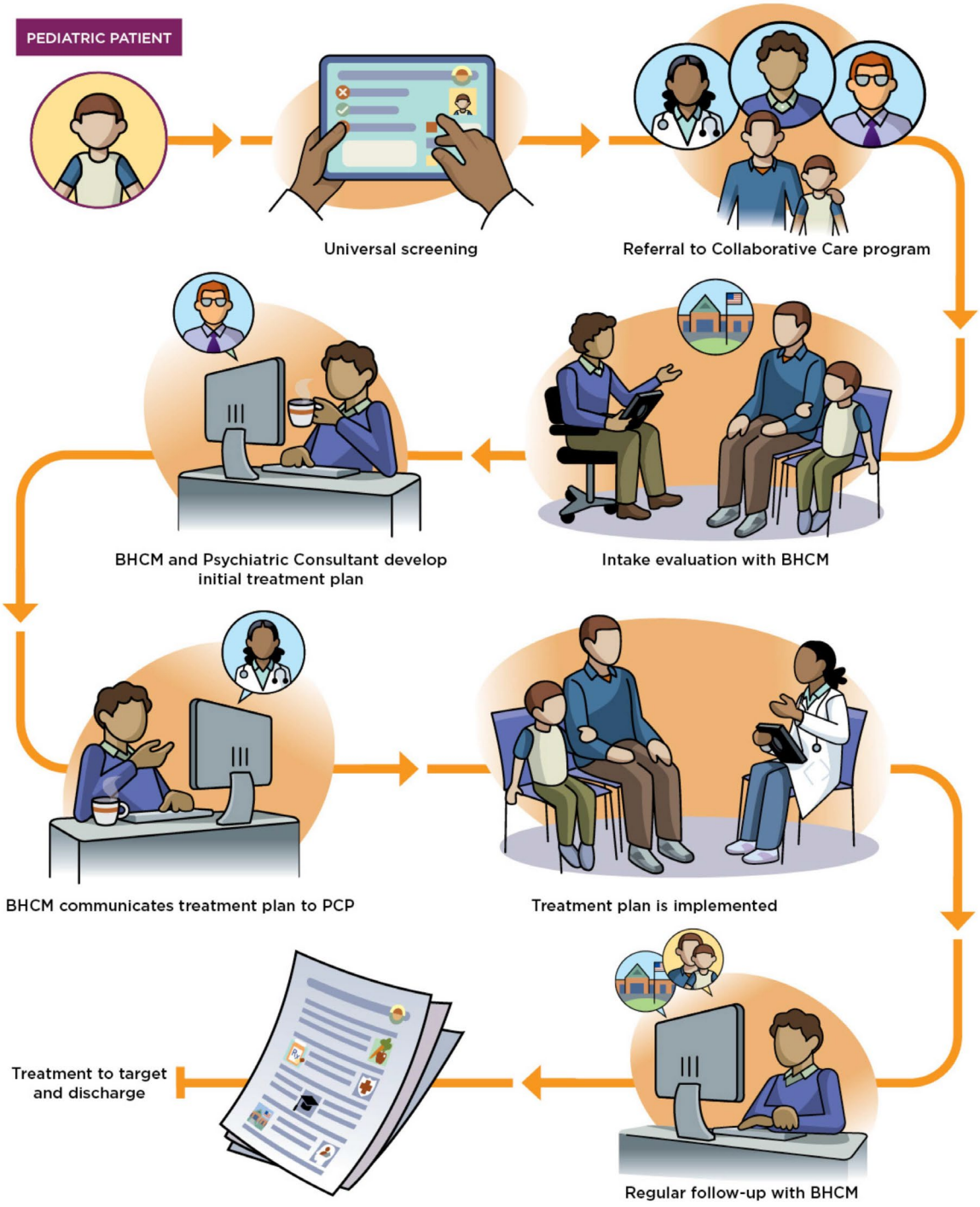
guidance on the use of key therapy skills interventions. After successful maintenance in relapse prevention for two to three months, patients are typically discharged from CoCM and back to the care by their pediatrician entirely. Patients are able to re-enroll in CoCM if clinically necessary.

Figure H1: Pediatric Collaborative Care Model



Primary care providers participating in the CCMP can access free CoCM technical assistance and implementation support at no cost, including billing support, one-on-one coaching, and workflow development. The New York State OMH tailors its technical assistance to each provider by administering an informal needs assessment and addressing their unique needs to support CoCM implementation. And yet, despite the efficacy demonstrated through CoCM, and the many accolades the state has received for piloting and implementing CoCM in New York, the model remains underutilized in the state and region. Funded through a managed care carve-out arrangement, state level policy and program decisions have created administrative hurdles further complicating the implementation of CoCM and making the process challenging for many providers.

Figure H2: Pediatric Collaborative Care Model Clinical Workflow



Appendix Five. North Carolina' Roadmap for Adoption of Collaborative Care

(See next page)

The Collaborative Care Model in North Carolina:
A Roadmap for Statewide Capacity Building to Integrate Physical and Behavioral Health Care

Executive Summary

In January of 2022, North Carolina Medicaid (NC Medicaid) launched a Collaborative Care Model Consortium ("the Consortium"), which included leaders representing the primary care and psychiatric provider communities, payers, and other community organizations. The goal of the Consortium was to expand the availability of integrated mental and primary care services in primary care clinics across the state, using the widely tested and clinically proven *collaborative care model* (CoCM). The Consortium focused on seven strategies that addressed the major barriers to adoption of the model in the primary care setting: financial sustainability and practice operations/change management.

Figure 1. **The CoCM Roadmap**

Steps	Strategies	Actions
Step 1: Aligning Reimbursement Across Payors **Goal:** Align coverage, requirements and payment across payors to validate that CoCM is an endorsed model worth adopting and reduce administrative burden for providers.	Ensure Coverage of the Same CoCM Codes	• NC Medicaid added coverage of additional CoCM codes to align with Medicare coverage.
		• The Consortium confirmed and promoted widespread commercial adoption of CoCM codes.
	Align Requirements to Bill	• NC Medicaid and other insurers aligned with Medicare requirements on who can serve as the behavioral health care manager.
	Make Reimbursement Sustainable	• NC Medicaid increased reimbursement for CoCM codes from 70% to 120% of Medicare.
	Remove Beneficiary Copays	• NC Medicaid and other insurers removed beneficiary copays for CoCM services.
Step 2: Promoting Streamlined Operations for Adoption and Ensuring Fidelity **Goal:** Encourage uptake by providing primary care practices with practice resources to make adopting CoCM as easy as possible and ensure that CoCM is implemented with fidelity.	Provide and Fund 1:1 Training for Providers	• NC Medicaid contracted with a Consortium member to provide 1:1 technical assistance and develop education modules focused on different CoCM issues (e.g., best practices in pediatric care, billing codes, brief therapeutic interventions).
		• Consortium members created learning opportunities for their members (e.g., working sessions at annual meetings, peer-to-peer "solutions" sessions for practice managers).
	Establish Psychiatry Connections	• The Consortium identified 20+ psychiatrists willing to act as psychiatric consultants.
		• The Consortium developed a model contract for psychiatrists and primary care providers to use.
	Customize and Fund a Statewide Registry	• The Consortium developed a customized registry with a set of assessments for adults, children and adolescents.
		• NC Medicaid contracted with a Consortium member to provide Medicaid enrolled providers with free access to the customized state registry ($4K-$7.4K per practice per year) for up to three 3 years.

Over the course of 18 months, the Collaborative met to advance this roadmap, assigning Consortium members leadership roles to drive individual tasks under a work group model. Use of collaborative care services has grown since the launch of the Consortium and the implementation of the capacity building supports developed by the Consortium, with total Medicaid CoCM encounters increasing between 2021 and 2022. With the foundational work now complete, the Consortium is turning its focus on additional capacity building strategies to help practices offset model costs and create a more seamless experience implementing the model in the clinical practice setting.

Context and Introduction

As a result of the leadership of NC Medicaid and the work of a consortium of partners representing payers, providers, and other community groups, the number of North Carolinians with access to integrated behavioral health services in primary care settings is growing. Formed in 2022, the Consortium developed and is now implementing a roadmap for expanding capacity for primary care practices to implement the CoCM, which embeds behavioral health services into the primary care model in a seamless and integrated manner. At its core, the roadmap focused on two primary areas: enhanced financial support via aligned reimbursement across government and private payers, and operational supports and tools to enable practices to launch and manage collaborative care services.

The roadmap, while specific to the North Carolina health care landscape, offers important insights for other states considering their own strategies to promote adoption of CoCM and other primary care based clinical delivery innovations. This report summarizes the key elements of the CoCM model, the strategic roadmap developed by the state to support its adoption, and key success factors from the implementation of the roadmap that others should consider in their own approaches.

Overview of the Collaborative Care Model

The national crisis in behavioral and mental health care continues to worsen, driven by a confluence of factors that include increased prevalence of mental and behavioral health conditions in adults and children, critical access challenges driven by shortages of licensed behavioral and mental health care providers, insurance coverage gaps and low reimbursement rates, and continued societal stigma surrounding many behavioral and mental health disorders. In response, health care providers have been testing innovative ways to bring behavioral and mental health services to children and adults in need.

One approach that providers have tested is the integration of certain behavioral and mental health services into the primary care setting, services that were historically delivered separately. The evidence base indicates that these models deliver better outcomes for patients and families, as well as efficiencies in terms of cost and other factors to the broader health care system.[1]

Several models for integrated behavioral and mental health and primary care services exist. *Figure 2* (page 4) lists selected integration models ranging in intensity of integration of services, providers and the patient experience.

Figure 2. **Continuum of Physical and Behavioral Health Care Integration**[2,3]

	Level of Integration					
	Least					Most
	Coordinated		Co-located		Integrated	
	Screening	**Consultation**	**Care management/ navigation**	**Co-location**	**Health homes**	**System-level integration**
Definition	PCPs identify patients with behavioral health needs and refer them	Consultants work with patients to meet care goals established by PCPs	Behavioral health care managers monitor care plans and treatment programs and coordinate care with patients and PCPs	PCPs and behavioral health providers provide services and collaborate from the same facility	Ongoing care management and coordination, referrals, and support for individuals with complex needs	PCPs and behavioral health providers from the same facility coordinate and collaborate under one management system
Example	Screening, Brief Intervention and Referral to Treatment (SBIRT)	Vermont's Hub and Spoke Model	Collaborative Care Model	Common in FQHCs	Medicaid health homes	Intermountain Healthcare

Note: PCP refers to primary care providers; FQHCs refers to Federally Qualified Health Centers.

CoCM is an example of co-located services, where patients can access behavioral and mental health services in their primary care clinic. CoCM was developed by the University of Washington in the 1990s and is geared toward patients with mild-to-moderate behavioral health conditions. The Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington defines five "core principles" of CoCM:[4]

1. **Patient-Centered Team Care**, in which providers collaborate to engage patients and provide care;
2. **Population-Based Care**, in which the patient population and outcomes are tracked by practices via a registry;
3. **Measurement-Based Treatment to Target**, in which the patient's treatment plan includes measurable goals and outcomes that treatment is responsive to;
4. **Evidence-Based Care**, in which treatment has a strong foundation of evidence to support it; and
5. **Accountable Care**, in which reimbursement is contingent on the quality of provided care.

The team-based structure of CoCM involves three provider types: the billing practitioner, the behavioral health care manager (BHCM) and the psychiatric consultant.

- The **billing practitioner** is generally a primary care provider (PCP) who uses the expertise of the BHCM and psychiatric consultant to treat a patient's behavioral health problems alongside their physical health concerns.
- The **BHCM** is a professional (e.g., clinical social worker, nurse) who executes care management activities in alignment with the patient's treatment plan. The AIMS Center recommends that this role be performed by a full-time, or nearly full-time, staff member.
- The **psychiatric consultant** is a professional in a support role, generally a psychiatric physician, who acts as a resource to the billing practitioner and the BHCM. The psychiatric consultant's job is to provide virtual consultation, rather than to see the patient.

The bottom line for patients and families is that they can access a coordinated set of services that treat both physical and mental/behavioral health needs in a common setting, with team members able to collaborate on care plans and ongoing management of a person's care in a holistic manner.

CoCM is considered to have one of the strongest evidence bases of any integrated behavioral health model, and more than 100 randomized clinical trials have demonstrated its effectiveness. The evidence shows that CoCM can be cost-effective and impactful for a multitude of settings and population groups.[5]

Early Adoption – and Challenges – for CoCM in North Carolina

The formation of the Consortium came at a time of enormous change in the health care landscape in NC, in large part a result of the State's transition to an integrated, whole-person managed care model for the Medicaid population. Prior to the adoption of managed care, physical and mental health care were bifurcated, making it difficult to integrate care in primary care settings. With the transition to managed care – through which physical and basic mental health services are provided by contracted commercial plans – primary care practices can more easily provide both physical and behavioral health care to Medicaid members with mild-to-moderate behavioral health needs. The development of the consortium also came on the heels of the height of the COVID-19 pandemic and its devastating impacts on physical and mental health in the state and on the provider communities that were on the front lines navigating the public health crisis.

Despite these challenges, the Consortium perceived an opportunity to promote adoption of the CoCM model. There were many examples of the model being adopted in primary care practices within the provider community already, in large part driven by integrated health systems across the state. Duke Health piloted the use of CoCM starting in 2017 and as of 2023 had implemented it in 40 clinics.[6] The University of North Carolina Health (UNC) spent years testing integrated care models and in 2018 launched an effort to implement CoCM that now spans seven primary care practices in urban and rural parts of the state (see "*Case Study: University of North Carolina Health*" for more information).

Case Study: University of North Carolina Health (UNC)

UNC's efforts to promote integrated care are long-standing. Its latest efforts to implement CoCM began in 2018, with a partnership between the Department of Psychiatry and the Department of Family Medicine. That partnership has since grown to encompass seven primary care practices, spanning urban and rural counties.

Startup Challenges and Solutions: While UNC has successfully grown its CoCM footprint, the 2018 landscape made it difficult to launch CoCM. Not all commercial payors were reimbursing for CoCM, so UNC limited enrollment to Medicaid and Medicare patients. UNC also experienced challenges covering the costs of employing a full-time BHCM and instead leveraged existing social workers who were supporting the Chronic Care Model deployed in the Department of Family Medicine's practice.

Expanding CoCM: In 2021, UNC decided to broaden the reach of CoCM and invested additional startup funds to expand the number of practices using CoCM. The startup funds were necessary to support practices in the implementation phase, given the ramp-up period needed to recoup investment and reach a financial break-even point. Practice expansion began in earnest in 2022, aligning with the coverage of CoCM by the majority of commercial insurers in North Carolina. Payor alignment, coupled with enhanced Medicaid reimbursement for CoCM, has made the expansion more financially viable. UNC is also seeing positive outcomes associated with the expansion – patients referred to the program due to depression and anxiety are seeing remission in line with the rates indicated in published research on CoCM.

The reimbursement landscape for CoCM had also been changing in a positive direction. The Centers for Medicare & Medicaid Services (CMS) began reimbursing CoCM in Medicare using three Current Procedural Terminology (CPT) codes in 2017, and NC Medicaid followed suit in 2018.[7]

However, despite the efforts of these large systems and the alignment of the government payor reimbursement for CoCM, there was still more limited adoption of the model particularly for the Medicaid population. Between October 2018 and December 2019, only 915 of North Carolina's more than 2 million Medicaid beneficiaries had at least one CoCM claim.[8] Several barriers were still in place. First, commercial insurance coverage of CoCM was not widespread at the time, making it difficult for practices with varied payor mixes to make the financial case for adopting the model and achieving sustainability. Second, the operational startup costs for practices, particularly independent practices with more limited resources, coupled with operational change management requirements, were a significant deterrent for many. The Consortium's efforts would focus on these two issues head on.

Capacity Building for CoCM in NC: The Collaborative Care Consortium

The CoCM Consortium was a natural evolution of successful relationship development and partnership among organizations across the state over recent years. As one example, when the COVID-19 pandemic hit in 2020, a cross-section of community partners came together to develop a "Navigating COVID-19 webinar series" to help providers across the state navigate the pandemic, covering topics such as how to apply for funding for personal protective equipment, improve the implementation of telehealth and more.[9] The series became a starting point for a collective effort to promote CoCM and the formation of the Consortium followed in January, 2022.

The Consortium is led by NC Medicaid and sponsored by NC Medicaid's Chief Medical Officer. It meets regularly and includes a Steering Committee, whose members (see *Appendix A*) led four subcommittees:

- **The Clinical Advisory Workgroup**, which aims to build connection between stakeholders and support best practices for implementation;
- **The Logistics Workgroup**, which aims to develop the CoCM registry and psychiatric consultation contracts;
- **The Alignment Workgroup**, which aims to coordinate and align payors in reimbursing for CoCM; and
- **The Communications and Training Workgroup**, which aims to build supports for practices to implement CoCM and develop trainings and enduring resource materials.

The Consortium worked through three phases to prepare, build and execute a plan to promote adoption of CoCM. The Steering Committee met initially on a monthly basis to report on the efforts of each subcommittee, which provided an opportunity to address challenges as they arose. On multiple occasions, the Consortium developed new and creative tools to address key challenges, such as a matchmaking service to help primary care practices connect with psychiatrists, and a data dashboard to monitor utilization and identify practices that might benefit from additional resources (more on these solutions in the next section, "The Roadmap").

Regular meetings fostered accountability among Consortium members, many of whom remarked in interviews that they wanted to be sure they had completed their "homework" before meetings. As the work progressed and meetings moved from monthly to quarterly, Consortium members continued to engage with each other and identify solutions to promote CoCM.

The Roadmap

There are several operational changes practices must undertake to implement the CoCM model:

- Hiring and training a BHCM;
- Training practice clinical staff – primary care physicians, physician assistants, nurses – on the model;
- Updating clinical and electronic health record (EHR) workflows;
- Implementing a registry to track member engagement, ideally one that integrates with the EHR; and
- Training practice management and billing staff on COCM codes and billing best practices.

Consortium members estimate that the startup cost for a practice to adopt CoCM is roughly $30,000 over the first three months of implementation when accounting for the costs of hiring a BHCM, staff training and contractual payments to the psychiatric consultant (*Figure 3*). These startup costs make the long-term financial sustainability of CoCM a critical factor in whether practices are willing to adopt the model.

Figure 3. **The Cost of Implementing CoCM[10]**

Activities in the First 3 Months of Implementing CoCM	Cost
Salary and Fringe Benefits for Behavioral Health Care Manager	$19,500
Psychiatric Consultation Time	$3,500
Primary Care Clinician Training and Implementation Time	$5,000
Staff Training	$2,500
Total	**$30,500**

In recognition of the resources required to adopt CoCM, the Consortium focused its initial efforts (The Roadmap) on two key steps:

- Step 1: Aligning reimbursement across payors; and
- Step 2: Promoting streamlined operations for practice adoption to ensure fidelity.

Within these two key steps, the Consortium employed a variety of strategies to make adopting CoCM as easy as possible while ensuring practices implemented it with fidelity.

Step 1: Aligning Reimbursement Across Payors

From the beginning, the Consortium recognized that aligning reimbursement across payors, to the extent possible, would send a signal that CoCM was a model worth adopting. Alignment across payors would also streamline the requirements providers and practices must comply with in order to bill for CoCM services provided.

To promote alignment across payors, the Consortium made sure that all payors were covering the same set of CoCM codes, requirements to bill were aligned, reimbursement was sustainable across payors and beneficiary copays were removed.

Strategy 1a: Ensure Coverage of the Same CoCM Codes

The Consortium first compiled information on what codes were covered across different in-state payors and Medicare, to understand gaps in coverage that might discourage providers from implementing CoCM. Without broad alignment in coverage for CoCM, practices working with a variety of payors did not have a strong incentive to adopt the model.

An initial gap was coverage of CoCM codes by Blue Cross and Blue Shield (BCBS) of North Carolina, one of the largest commercial payors in the state. Beginning July 1, 2022, BCBS of North Carolina began covering CoCM codes for its members, and by midway through 2022 the Consortium confirmed that virtually all major commercial and individual marketplace payors covered CoCM (see *Appendix B* for the full list of payors the Consortium confirmed covered CoCM). Commercial coverage, coupled with existing Medicare and Medicaid coverage, meant that any insured individual in North Carolina would have CoCM services covered if offered by their primary care provider.

In addition to general coverage of CoCM across payors, NC Medicaid also adopted two new codes – G2214 and G0512 – over the course of 2022 to match the set of CoCM codes covered by Medicare. Prior

to the addition of these codes, NC Medicaid covered procedure codes 99492, 99493 and 99494 (see *Figure 4*).[11]

Figure 4. **North Carolina Medicaid Covered Procedure Codes and Rates[12]**

Procedure Code	Procedure Code Description	Facility Rate	Non-Facility Rate
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month	$109.94	$176.23
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities	$120.82	$171.30
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month	$49.24	$73.14
G2214	Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.	$32.70	$50.93
G0512	Rural health clinic (RHC) or federally qualified health center (FQHC) only, psychiatric collaborative care model, (psychiatric COCM) 60 minutes or more of clinical staff time for psychiatric CoCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month	$124.53	$124.53

Strategy 1b: Align Requirements to Bill

Beyond coverage of CoCM codes, the Consortium identified discord in billing requirements across payors in its early review of payor alignment. A key area of difference was who could serve as the BHCM. In its initial coverage of CoCM codes, NC Medicaid did not allow nurses or unlicensed, but trained, behavioral health staff to fulfill the BHCM role. Excluding these providers from fulfilling the BHCM role diverged from Medicare requirements, meaning that practices using a nurse to fill the BHCM role could bill Medicare for CoCM services but not Medicaid. Beginning in March 2022, however, NC Medicaid modified its definition of who could serve as a BHCM to align with Medicare, making it easier for practices to comply with billing requirements across payors.

Strategy 1c: Make Reimbursement Sustainable

The Consortium also recognized that in order to make CoCM viable for practices to adopt, payors would need to reimburse CoCM codes at a rate that would be financially sustainable. In December 2022, NC Medicaid increased its reimbursement of CoCM codes from 70% to 120% of Medicare, increasing the incentive for providers to adopt CoCM in their practices.[13] Practices have already credited the reimbursement increase with making the adoption of CoCM more feasible in the state (see "*Case Study: One Health and C3/MindHealthy*").

Case Study: One Health and C3/MindHealthy

In 2022, One Health – a group of primary care practices in and around Charlotte – and MindHealthy PC – a company focused on helping primary care providers adopt CoCM – partnered to implement CoCM across One Health's primary care practices. As of June 2023, the partnership had embedded CoCM in five One Health practices, with the goal of having all 29 practices using CoCM by the end of 2023. One Health shared that the decision by NC Medicaid to increase CoCM reimbursement and broaden payor alignment has made the adoption of the model more financially sustainable.

The Partnership: One Health had attempted, without luck, to implement CoCM in the years leading up to its partnership with MindHealthy. Through the partnership, MindHealthy provides One Health with virtual behavioral health care managers, psychiatric consultants and case management technology for registry management and time-based code tracking. MindHealthy is also now integrated into One Health's EHR and handles the CoCM registry.

Measuring Success: While practice implementation is still underway, One Health and MindHealthy plan to track numerous metrics, such as enrollment, screening (e.g., GAD-7, PHQ-9), retention, readmissions and average reimbursement. They are also surveying patients and providers to understand satisfaction with the model. As of June 2023, approximately 60% of One Health patients referred to CoCM were enrolled in the model.

Strategy 1d: Remove Beneficiary Copays

Another key strategy employed by the Consortium was to encourage payors to remove copays for CoCM services. Under the CoCM billing structure, providers can bill for services provided even when a patient is not directly engaged. If a payor requires a copay for all CoCM services, however, patients may be charged a copay without ever interfacing with their providers, which can lead to confusion and potential payment noncompliance. NC Medicaid and other commercial insurers opted to remove copays for CoCM services, streamlining payment requirements for beneficiaries.

Step 2: Promoting Streamlined Operations for Practice Adoption to Ensure Fidelity

In addition to promoting payor alignment, the Consortium recognized that practices would need additional supports to make it easier to adopt the new model with fidelity. These practical supports included practice-specific technical assistance, opportunities to establish a connection with a psychiatric consultant and initial funding to enable participation in a customized statewide registry.

Strategy 2a: Provide and Fund 1:1 Training for Providers

To ensure practices interested in CoCM had easy access to information, NC Medicaid contracted with the North Carolina Area Health Education Centers (NC AHEC) to provide technical assistance and coaching. As of July 2023, NC AHEC had engaged in 850 one-on-one encounters with practices on a variety of topics (see "*Most Common Topics Covered in CoCM Technical Assistance Discussions*"). NC AHEC has also developed 10 on-demand, online education modules focused on different CoCM issues (e.g., best practices in pediatric care, billing codes, brief therapeutic interventions) that 680 participants had completed for continuing education credit. Beginning in 2024, NC AHEC is also planning to develop peer-to-peer sessions for individuals serving as BHCMs.

In addition to the formal practice supports funded by NC Medicaid, Consortium members have created learning opportunities for their members. For example, the North Carolina Pediatric Society featured CoCM topics at in-person meetings, including sessions for practice managers and staff, and many Consortium members have hosted sessions on CoCM at their annual meetings.

Most Common Topics Covered in CoCM Technical Assistances (TA) Discussions

- Providing an overview of the CoCM model
- Determining the appropriate patients on their panel
- Analyzing the economic feasibility of the program and how long it will take to achieve break-even status
- Providing guidance on the appropriate type of person for the BHCM role and the duties expected and sharing best practices for recruitment
- Recruiting a psychiatric consultant
- Implementing a data registry, including the Medicaid-funded opportunity
- Training on billing/coding
- Using telehealth versus on-site care
- Discussing clinical and administrative workflow redesign and calibration
- Helping PCPs and BHCMs understand and align with expected roles, duties and referrals

Strategy 2b: Establish Psychiatry Connections

A key component of the CoCM model is establishing a relationship with a psychiatric consultant. While some providers in North Carolina have existing relationships with psychiatrists who could fulfill this role, the North Carolina Psychiatric Association (NCPA) distributed a survey to its members trained in CoCM by the American Psychiatric Association to see which psychiatrists would be willing to serve as a psychiatric consultant. Through the survey, NCPA identified more than 20 psychiatrists across the state willing to serve as consultants to a primary care practice and created a "matching" survey for practices to complete if they were interested in connecting with a potential psychiatric consultant. The survey asked for information on the practice size, type, patient population and more (see *Appendix C*). NCPA and the North Carolina Academy of Family Physicians (NCAFP) also developed a streamlined model contract for primary care practices and psychiatric consultants to use to formalize their relationship with minimal administrative burden for practices. Taken together, the goal was to make identifying and establishing a relationship with a psychiatric consultant as easy as possible.

While few matches have been created thus far, Consortium members indicated that practices adopting CoCM have been able to tap into other existing resources, such as relationships with individuals who participate in the North Carolina-Psychiatry Access Line (NC-PAL), to source psychiatric consultants.

Strategy 2c: Customize and Fund a Statewide Registry

Adopting CoCM also requires practice to develop a registry to track patient outcomes and engagement. Creating a registry that can integrate with existing practice EHRs requires significant resources, however, and has historically been a barrier to adopting CoCM. To address this issue, Consortium members decided to explore implementing a centralized, statewide registry to ease this burden on practices. After considering different options, the Consortium settled on using a customized version of the AIMS

registry. The customized registry includes a set of assessment tools covering three age groups and four conditions (see *Figure 5*).

Figure 5. **Assessment Tools in Statewide Registry by Age Group**

Age Group	Condition			
	Depression	Anxiety	ADHD	PTSD
Children	✓	✓	✓	X
Adolescents	✓	✓	✓	X
Adults	✓	✓	X	✓

The following tools are embedded in the customized registry, by age group:

- **Children:** Short Mood and Feelings Questionnaire (SMFQ) for Parent and Child, Screen for Child Anxiety Related Emotional Disorders (SCARED) for Parent and Child, and the National Institute for Children's Health Quality (NICHQ) Vanderbilt Assessment Scale for Parent and Teacher.
- **Adolescents:** Patient Health Questionnaire (PHQ-9) modified for adolescents, SCARED for Parent and Child, and the NICHQ Vanderbilt Assessment Scale for Parent and Teacher.
- **Adults:** PHQ-9, General Anxiety Disorder-7 (GAD-7) and the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5).

NC Medicaid contracted with Community Care of North Carolina (CCNC), a long-standing medical home system with a history of supporting primary care practices, to provide Medicaid-enrolled providers with free access to the customized state registry (equivalent to approximately $4,000-$7,400 per practice per year) for up to three years. Practices that first engaged with NC AHEC and were interested in participating in the statewide registry were referred to CCNC to set up registry access (see "*Case Study: Dayspring Family Medicine*" for an example of one practice that worked with both CCNC and NC AHEC to adopt CoCM).

As of June 2023, nine practices are using the statewide registry. All practices using the registry have agreed to allow NC Medicaid to access information in the registry, and in the future the Consortium plans to aggregate findings on outcomes and engagement to track CoCM rollout.

Case Study: Dayspring Family Medicine

In November 2022, Dayspring Family Medicine in Eden, North Carolina, began working with NC AHEC to adopt CoCM in an effort to expand access to mental health services to its residents. Mental health care in the area has historically been located far from the populations Dayspring serves. In March 2023, the practice officially launched the model when a former nurse who had been with Dayspring for over two decades, became the office's first BHCM. Since implementing CoCM, Dayspring's caseload has grown to include over 60 patients, with demand continuing to increase for CoCM services.

CoCM Implementation: Dayspring employs a virtual psychiatric consultant with whom the BHCM meets once a week. Their meetings leverage the AIMS caseload tracker, which CCNC supported Dayspring in setting up, to identify patients who require treatment adjustments.

Startup Challenges and Solutions: The primary issues that Dayspring has faced in its CoCM implementation are capacity and startup billing issues with insurance companies. With only one BHCM on staff, the demand for CoCM is beginning to outpace the BHCM's capacity (a recommended 65-70 patients per BHCM). Additionally, entities paying Dayspring experienced system issues with tracking CoCM codes, resulting in slowed reimbursement. NC AHEC's CoCM coaches continue to work with Dayspring's practice manager to rectify CoCM billing problems and other challenges as they appear.

Success Factors

Besides the tactical steps taken by the Consortium to align reimbursement across payors and create tools and resources for practices to use to streamline CoCM adoption, several other factors contributed both to the success of the Consortium and to the uptake in adoption of CoCM utilizing the resources organized by the Consortium. Those included:

1. North Carolina's CoCM built on consensus among major stakeholders.
    - ✓ NC's collaborative brought major stakeholders to the table to ensure all parties were on board with decisions.
    - ✓ The process was iterative, and all decisions were documented.
    - ✓ The Consortium leveraged long-standing, existing relationships that had tackled prior behavioral health care integration initiatives.
2. Statewide leaders representing different stakeholder groups championed the idea of promoting CoCM, and NC Medicaid leadership helped drive the work forward.
    - ✓ Several statewide leaders, who became consortium members, brought the idea of promoting CoCM to NC Medicaid. They also served as CoCM champions within their broader networks, ensuring prioritization of CoCM and expanding the reach of the Consortium's efforts.
    - ✓ Stakeholders noted that having a central champion in a significant leadership position, in this case NC Medicaid's Chief Medical Officer, was essential. Having a leader who prioritized and regularly promoted the initiative was a major reason for its success and helped justify resources spent on the initiative.
3. The timing was right.

- ✓ The state implemented NC Medicaid Managed Care Standard Plans in July 2021, which removed a barrier between physical and mental health by enrolling individuals in integrated, whole-person managed care plans that covered both physical and basic behavioral health services.
- ✓ The structure of managed care assigned mild-to-moderate behavioral health patients to the Standard Plans, which empowered primary care practices to leverage innovative approaches to implement whole-person care.
- ✓ The COVID-19 pandemic, although it magnified behavioral health concerns in the state, also brought these conditions to the forefront.

4. Medicaid aligned its collaborative care policies with those of Medicare and provided funding.
   - ✓ NC Medicaid ensured its policies aligned with those of Medicare, so providers would not have to worry about noncompliance.
   - ✓ The state agreed to reimburse 120% of Medicare rates for the model and contracted with stakeholders to cover the cost of other practice supports.
5. North Carolina provided practical supports that aimed to streamline implementation for providers as much as possible.
   - ✓ Consortium members developed learning opportunities for members.
   - ✓ NCPA created a consulting psychiatrist match program.
   - ✓ NCAFP and NCPA developed a baseline model contract that all consulting psychiatrists and PCPs implementing the model could use.
   - ✓ The Consortium developed a customized registry and provided Medicaid-enrolled providers free access for up to three years.
6. CoCM implementation allowed flexibility across policies where possible, allowing implementation to be responsive to capacity issues across the state.
   - ✓ North Carolina allowed multiple professionals to fill the role of BHCM.
   - ✓ Medicaid did not require the consulting psychiatrist to be enrolled in Medicaid as a condition for reimbursement.
7. The Consortium use focused efforts to promote the model.
   - ✓ Consortium members convened opportunities for their members interested in the model to connect.
   - ✓ NC AHEC provided 1:1 training and technical assistance for providers to implement CoCM.

Monitoring Evolving Efforts

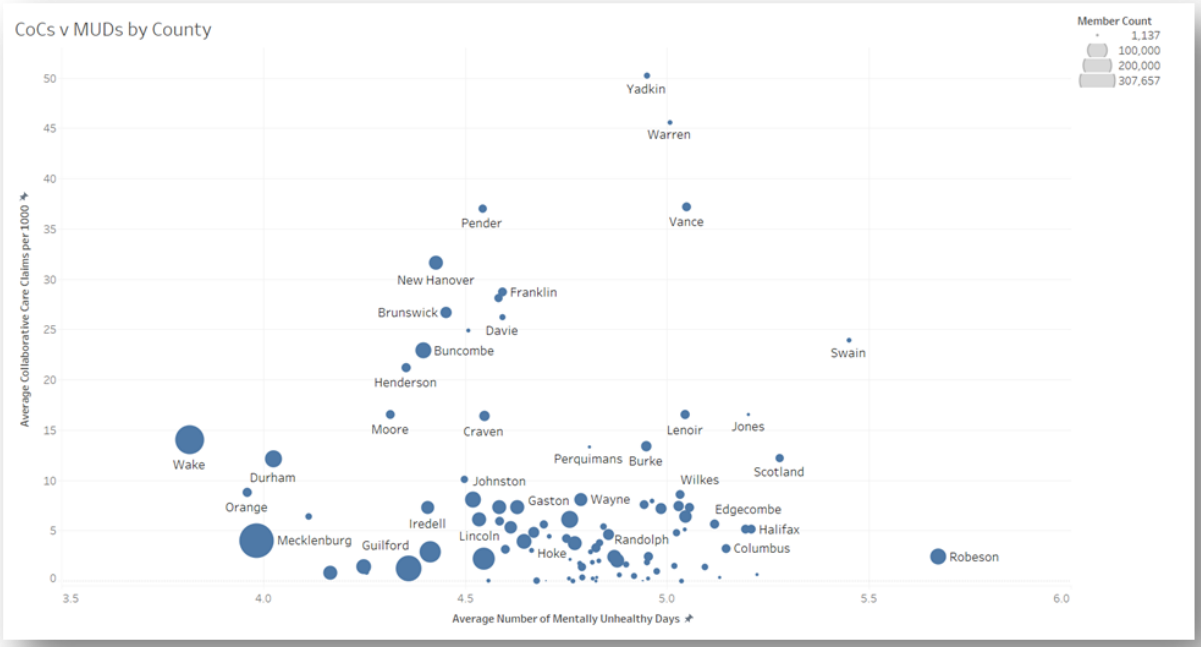
The Consortium has stayed nimble as new challenges emerge, with one ongoing challenge around how to monitor the Consortium's efforts – how widely CoCM has been deployed throughout the state, the impact of the practice supports and outcomes from the model – given that the data are spread among stakeholders. CoCM is only one model among a spectrum to promote integrated behavioral and physical health care, and some providers across the state have employed other models (e.g., co-location), making it difficult to track the full scope of integrated care efforts across the state. Further, Consortium members indicated that not all providers are billing CoCM codes, which could lead to an undercount of services provided in analyses of Medicaid utilization.

To address these challenges and track progress, NC Medicaid developed an integrated, interactive care dashboard to track CoCM Medicaid encounters across the state, including by geography, race, ethnicity, age, Medicaid program (fee for service versus managed care) and provider type (e.g., independent providers, hospital-affiliated providers, FQHC). The Consortium is leveraging the dashboard to identify parts of North Carolina that would benefit from targeted efforts to promote CoCM (see *"The Data Dashboard in Action"* for examples of dashboard figures).

The Data Dashboard in Action

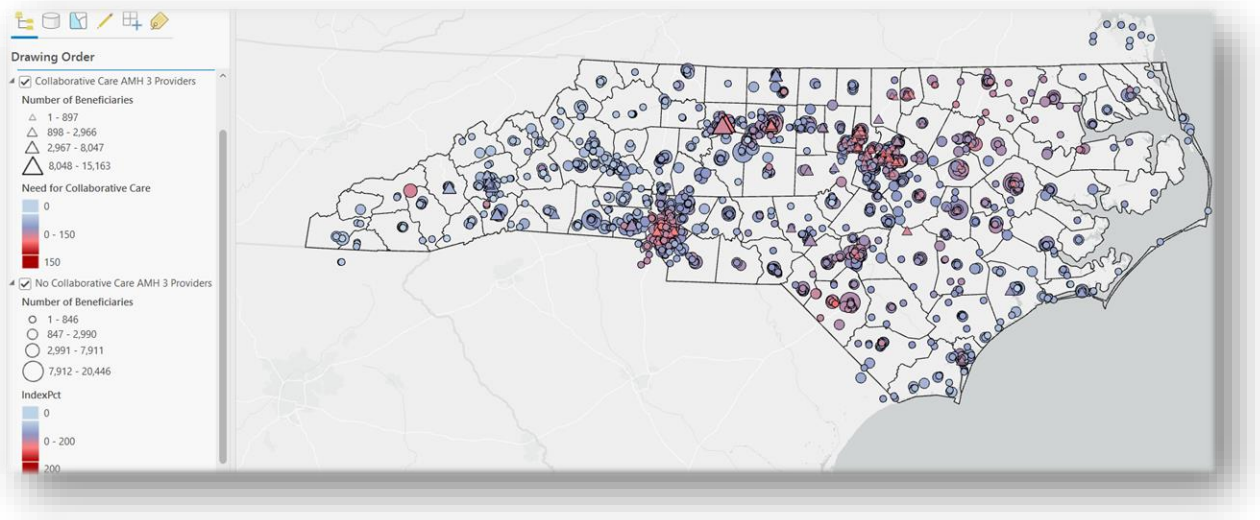
In *Figure 6,* NC Medicaid examined Medicaid claims in conjunction with non-Medicaid data sources, in this case the average number of mentally unwell days from the Behavioral Risk Factor Surveillance System. Counties in the lower righthand corner, like Robeson County, could be candidates for targeted efforts to promote CoCM given they are experiencing a higher average number mentally unwell days and fewer CoCM claims. *Figure 7*, a visual focused on a smaller geographic level, compares practice-level CoCM penetration to Medicaid member need. Practices indicated by red circles (i.e., practices not providing CoCM but with a higher patient need for behavioral health services) could be candidates for targeted efforts to promote CoCM. Both figures highlight the creative way NC is using claims data to deploy increasingly targeted practice supports.

Figure 6. **Average CoCM Claims by Average Number of Mentally Unhealthy Days[14]**



Note: Counties in the lower right are those that are in higher need of behavioral health care but experiencing lower access to CoCM. CoCM claims span Jan. 1, 2019, to May, 24, 2023.

Figure 7. **Practice-Level Penetration of CoCM Relative to Medicaid Member Need**



Note: "Need for Collaborative Care" is identified by: the percentage of a practice's beneficiaries that have given birth in the prior 12 months, have been diagnosed with anxiety or depression in the prior 12 months and/or are a member of a historically marginalized population.

Future Opportunities

While the Consortium has many successes to celebrate – and efforts outlined in The Roadmap have encouraged practices that had not previously adopted CoCM to do so – uptake of the model has not been as robust as initially hoped. As the Consortium and its members learn from the experiences of providers implementing the model and utilizing different resources, it is actively planning for the next phase of its work and focus. Several major opportunities have been identified, and planning will continue over the coming months and years.

Focus 1: Supporting practices in offsetting startup costs for the CoCM

Adopting CoCM has an estimated startup cost of roughly $30,000 per practice over the first few months (see *Figure 3*, page 8), largely driven by costs associated with the ramp-up of the BHCM and other staffing-related costs due to new clinical workflows.

North Carolina explored opportunities to cover these costs, including Medicaid capacity-building programs. Using its managed care authority, NC Medicaid could establish a capacity-building program that would allow the state to flow funding to providers and other entities that invest in CoCM implementation via their managed care contracts. Medicaid would set investment priorities for the program, such as hiring/contracting with a BHCM or contracting with a psychiatric consultant, and practices that fulfill the investment priorities would be eligible for funding to offset their investments. Given the numerous requirements to implement capacity-building programs, however, North Carolina ultimately decided not to pursue this approach.

In addition to capacity-building programs, North Carolina explored other opportunities to offset the startup costs of CoCM, including North Carolina's Medicaid expansion sign-on bonus, private funders/philanthropy, organized payor-funded capacity-building programs and federal grants. At the time of this publication, North Carolina had recently passed a budget with substantial investments in behavioral health, including $5 million earmarked for capacity building for primary care practices across the state to adopt CoCM.

Focus 2: Developing a pipeline for necessary workforce (e.g., BHCM)

One of the biggest barriers to implementation is hiring a BHCM, due to shortages of available providers. The Consortium is considering models that might increase both the capacity of the current BHCM workforce (i.e., utilization of virtual models across practices) and pipeline development programs, which could include new education/training programs, third-party vendors and other strategies.

Focus 3: Peer-to-peer opportunities

In interviews with primary care practice administerial and clinical staff, opportunities to connect to peers and share best practices and tools was noted as a major opportunity (see *"Interview with a BHCM: Key Themes and Opportunities"* (page 17) for more on this and other future opportunities from a current BHCM in North Carolina). The state is exploring ways to connect practice managers, BHCMs and other stakeholders to enable them to troubleshoot challenges and teach/learn from each other. These connections would also create forums to engage practices that have not adopted the model and encourage them to adopt.

Interview with a BHCM: Key Themes and Opportunities

1. **Be prepared for the demand for CoCM:** Dayspring did not anticipate how high the demand would be for CoCM once launched. Patients have been receptive to the model, given the quick and regular access to behavioral health services that it provides.
2. **Start with a part-time BHCM:** The BHCM started in their role as a part-time BHCM. The slow ramp-up allowed Dayspring to organize and be responsive to practice-specific issues not covered in AIMS Center trainings, such as adjusting to the North Carolina billing environment.
3. **Walk through challenge scenarios, and process questions with peers:** Dayspring's Insurance Department could have used better support before the model was adopted to anticipate the various scenarios it would encounter in billing for CoCM. Dayspring also found issues in preparing its EHR to have the necessary options to provide and track mental health services. The BHCM believes that certain hurdles could have been avoided had they known the types of questions to ask in the beginning and had other experienced entities to learn from.
4. **Leave room for a ramp-up period:** The BHCM noted that it is important for practices to have everything (e.g., the EHR system, the number of people to be added to the system) figured out prior to launch. Practices should give themselves time to troubleshoot issues, rather than attempting to implement at 100% capacity.

Focus 4: Engaging larger health systems

The Consortium has predominately engaged with independent practices so far, with engagement of larger health systems occurring on a more limited basis. This includes some of the early adopters of CoCM in North Carolina, such as UNC, Duke, and Novant Health. While the Consortium's technical assistance and financial supports are not limited to independent practices, the lack of engagement by larger systems highlights a need for varied approaches to encourage and understand CoCM efforts based on practice size, scope and ownership. The Consortium is currently exploring ways to foster connections with larger health systems and understand their existing efforts around CoCM in order to bring integrated services to more North Carolinians.

Appendix A: Collaborative Care Consortium

Steering Committee Participants

CoCM Consortium Member Affiliations	Member Job Titles
AmeriHealth Caritas	• Chief Medical Officer
Blue Cross and Blue Shield of North Carolina	• Medical Director • Medical Director of Behavioral Health Value Transformation
Carolina Complete Health	• Chief Medical Officer
Community Care of North Carolina (CCNC)	• President & CEO
Healthy Blue	• Chief Medical Officer
North Carolina's Division of Health Benefits (DHB)	• Chief Medical Officer for North Carolina Medicaid • Associate Medical Director for Behavioral Health • Chief Quality Officer for North Carolina Medicaid
North Carolina Area Health Education Centers (NC AHEC)	• Director
North Carolina Academy of Family Physicians (NC AFP)	• Executive Vice President & CEO
North Carolina's Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS)	• Deputy Chief Psychiatrist
North Carolina Division of State Operated Healthcare Facilities (DSOF)	• Chief Medical Officer for Behavioral Health and IDD
North Carolina Pediatric Society (NC Peds)	• Executive Director
North Carolina Psychiatric Association (NCPA)	• Executive Director
UnitedHealthcare Community Plan	• Chief Medical Officer
WellCare	• Chief Medical Officer

Appendix B: Payor Alignment in North Carolina

Payor Name	Covers CoCM Codes	Aligned with Medicaid/ Medicare on BHCM Definition
Medicaid Prepaid Health Plan		
AmeriHealth Caritas North Carolina	Yes	Yes
Blue Cross and Blue Shield of North Carolina	Yes	Yes
UnitedHealthcare of North Carolina	Yes	Yes
WellCare of North Carolina	Yes	Yes
Carolina Complete Health	Yes	Yes
Commercial		
Blue Cross and Blue Shield	Yes	Yes
UnitedHealthcare	Yes	Yes
Aetna	Yes	Yes
Cigna	Yes	Yes
Marketplace		
Ambetter of NC	Yes	Yes
WellCare of NC	Yes	Yes
AmeriHealth Caritas	Yes	Yes
UnitedHealthcare	Yes	Yes
Blue Cross and Blue Shield	Yes	Yes

Appendix C: Psychiatric Consultant Matching Survey

See below for snippets of the Psychiatric Consultant Matching Survey. The full survey can be accessed here: https://ncpsych.memberclicks.net/cocm-matching?servId=10829#!/

Are you looking for a psychiatric consultant trained in Collaborative Care?

The American Psychiatric Association trained ~4,000 psychiatrists and 400 primary care physicians around the country in the **Collaborative Care Model (CoCM)** and many of them are here in North Carolina!

These trained psychiatrists are ready to start working with you to implement the model in your practices!
Please complete the requested information below to begin the match making process.

Please tell us about you:

Respondent's Name

Respondent's Position/Title:

Phone Number:

Email:

Next, tell us about your practice:

Practice Name:

Where is your practice located?
Address, City, State, Zip

Which county is your practice in?
(None)

Practice Phone Number:

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