Improving Behavioral Health Care for Youth Through Collaborative Care Expansion

FINAL REPORT

November 2022

MEADOWS MENTAL HEALTH POLICY INSTITUTE

The Commonwealth Fund

Contents

Acknowledgements

The Meadows Mental Health Policy Institute would like to thank The Commonwealth Fund for its financial support and intellectual collaboration on this report, the many individuals that contributed to this report, including representatives from Medicaid offices across the country, the California Health Care Foundation, and Mass General for providing information specific to their state Medicaid collaborative care benefits. We would also like to extend a special thanks to Collaborative Care Consulting, American Psychiatric Association, Shatterproof, and Concert Health for sharing their knowledge about the overall landscape of collaborative care.

Abstract

Issue: Mental health systems in the United States are not set up to detect and treat mental illness early in disease onset, thus failing to meet demands of the mental health crisis facing adolescents and transition-age youth (TAY). While the collaborative care model (CoCM) is an evidenced-based solution that can scale early detection and treatment, its uptake among health systems and primary care providers has been slow. Medicaid plays a key role in the adoption of CoCM for youth, yet its availability across the nation is uneven.

Goal: Conduct a national scan of Medicaid programs to understand which states cover CoCM and how.

Methods: We reviewed state Medicaid fee schedules, policies, and bulletins and conducted interviews with state Medicaid representatives.

Key Findings: Only 22 states have CoCM as a covered Medicaid benefit. Many states' benefit coverage is inconsistent with Medicare, reimbursement rates are often low, and very few states provide incentives or technical assistance for implementing the model.

Policy Recommendations: Congress, the Centers for Medicare & Medicaid Services, and state Medicaid authorities can act to implement the CoCM Medicaid benefit, ensure reimbursement rates allow the model to be financially viable for providers, and provide funding for implementation costs and technical assistance.

Introduction

Even before the COVID-19 pandemic, mental illness among America's youth was at a crisis point; since then, the crisis has only escalated.[1] Nearly half of teenagers in the U.S. report they struggle with persistent feelings of sadness and hopelessness.[2] Youth are also reporting serious thoughts of suicide at disturbing rates: 20% of high school students and 11% of youth ages 18-25,[3] with the rate of suicide for black youth growing at alarming rates.[4] Simultaneously, severe shortages in the overall behavioral health workforce will make it hard to meet the current need,[5] particularly in underserved communities,[6] exacerbating pronounced inequities across communities of color.[7,8,9,10]

While 75% of mental health (MH) conditions present by the age of twenty-five, and 50% before the age of 14,[11] most mental illnesses are not detected until eight to ten years after symptoms emerge, a major factor contributing to the MH crisis.[12] Moreover, interventions work best at an early stage when symptoms are less severe, *before* they reach a crisis point.[13,14] To get ahead of this trajectory, we need more expansive and readily accessible screening and treatment for MH conditions, especially for children and youth when most mental illnesses begin.

Table 1: Average Age of Onset for Mental Health Conditions[15]

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

The collaborative care model (CoCM) exemplifies and has the most evidence for this needed transformation:

- CoCM is the integrated behavioral health model with the largest evidence base; over 90 randomized controlled trials have demonstrated its efficacy in diverse settings, diagnoses, and populations.[16]
- CoCM treats MH conditions the same as other health care diseases, by screening and treating them early, helping to circumvent the stigma and difficulty often found in navigating specialty care.
- By serving people with mild to moderate MH conditions in pediatric and primary care and facilitating referral to specialty care for more severe conditions, CoCM allows our limited specialty care workforce to focus on people with more severe and complex needs.[17]

Medicaid plays a critical role in the adoption of CoCM for children, adolescents (age 13-18) and Transition-age youth (TAY, defined here as 19-25). Medicaid is the single largest payer and insures almost half of all children in the U.S. Even for transition age youth (TAY, ages 19-25) who may transition out of Medicaid benefits, Medicaid plays an important role for early intervention before this transition occurs. Moreover, Medicaid rates play a vital role in the financial sustainability of CoCM for pediatric and primary care practices with a significant number of Medicaid patients.[18,19] Adequate reimbursement is critical for making CoCM accessible to and equitable for our country's diverse population of youth.

Medicare and many commercial plans already reimburse for CoCM codes,[20] yet many state Medicaid programs do not yet cover the codes. Given Medicaid's essential role in making CoCM accessible for youth in pediatric and primary care settings, this paper provides a national scan of CoCM coverage in Medicaid programs.

Background: The Collaborative Care Model & Its Billing Codes

In CoCM, a team supports the patient using a patient registry to track and follow patient progress (see Table 2). The treatment plan for each patient may include medication recommendations the primary care provider (PCP) prescribes, brief therapeutic interventions the behavioral health care manager (BHCM) delivers, or both. The team refers patients who are not improving to specialty behavioral health services.[21]

Table 2: Collaborative Care Model Team Member Interactions[22]

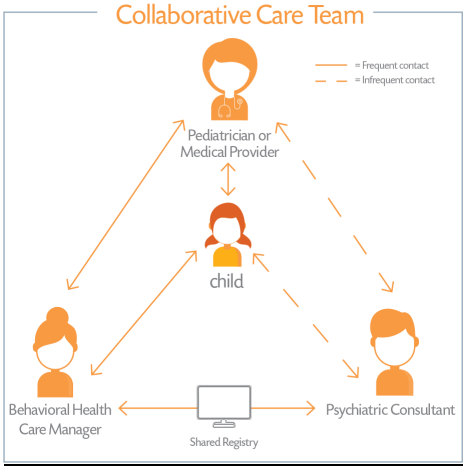
Member	Role	Member Contact Interactions
Patient	CoCM is a person-centered model, supporting the patient with several care team members.	
PCP	Explains the model and garners verbal consent to enroll the patient.	
BHCM	Delivers brief therapeutic interventions and tracks patient progress using common patient reported outcome instruments, collaborates with psychiatric consultant on case reviews, and communicates information back to the PCP/pediatrician.	
Psychiatric Consultant	Collaborates with the BHCM to develop a treatment plan and communicates with the PCP/pediatrician as needed.	

Image source: HopeSparks Family Services

In 2017, the Centers for Medicare & Medicaid Services (CMS) activated three new billing codes for CoCM reimbursement in Medicare, now Current Procedural Terminology (CPT) codes 99492, 99493, and 99494.[23] Shortly after, CMS created a special code for federally qualified health centers (FQHCs) and rural health centers (RHCs) to be consistent with the existing FQHC/RHC payment system (G0512). In 2021, CMS added the G2214 code to ensure providers could bill for services that did not meet the time thresholds of the other codes. See Appendix 1 for details on what each code covers.

As Table 4 outlines, collaborative care is transformative, offering solutions to several mental health challenges.

Table 4: How CoCM Provides Solutions to Multiple Mental Health Challenges for Youth

Mental Health Challenge	CoCM-Driven Solution
Limited early MH screening and delayed interventions: 50% of MH conditions are present by the age 14 and 75% by the age 25, including severe MH illness.[24] Yet, our pediatric primary care systems separate medical and MH issues screening, treatment, and interventions.	CoCM brings MH care to the primary care/pediatric setting and acts as an entry point to MH care. CoCM emphasizes universal screening and tracks patients using a treatment registry so patients with MH problems are identified, routinely followed up with, and treated.

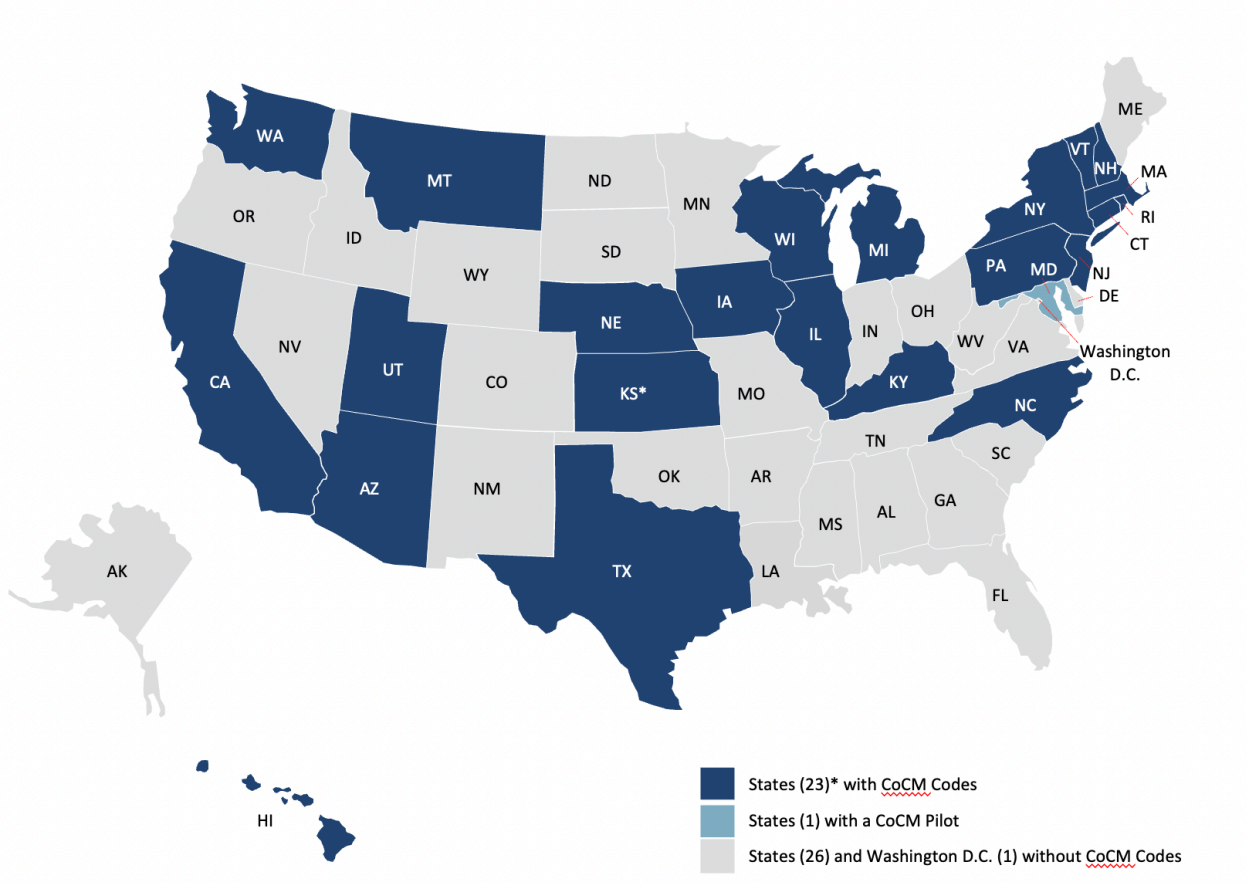
Mental Health Challenge	CoCM-Driven Solution
Appropriate level of care: Only about 20% of children with mental, emotional, or behavioral disorders receive care from a specialized MH care provider.[25]	Patients screened for mild to moderate MH conditions can receive evidenced based treatment through CoCM while patients with more serious MH conditions are connected to specialized care.
MH provider access: There is a severe shortage of child and adolescent psychiatrists. On average, there are 11 child and adolescent psychiatrists per 100,000 children in the U.S.[26]	Treating patients with mild to moderate MH problems in the primary care setting instead of referring them to overwhelmed and understaffed specialty care systems addresses workforce shortage issues. CoCM leverages psychiatrist time over 3.5 times.
Access to care disparities: Youth of color, youth living in rural areas, and youth with lower incomes have worse outcomes and inadequate access to MH care.[27] Twenty-one percent of all children in Medicaid are African American, 17.5% are multi-racial, and 36% are Hispanic.[28]	Implementation of CoCM has been shown to reduce disparities in MH outcomes for people of color.[29] It has also been shown to be more effective than treatment as usual in FQHCs and RHCs.[30,31]
Continuity of care challenges: Because many youth struggle with care continuity when they turn 19 and age out of pediatric care and, for many, Medicaid coverage, this is a time when many youth fall through the cracks. As it is also the age where most first episode psychosis presents,[32] we often miss the opportunity to connect youth to proper treatment.	For youth transitioning out of pediatric care and/or aging out of Medicaid eligibility, the BHCM can support their transition out of pediatric care and, if needed, connect them to other sources of mental and physical health care as part of a follow-up plan.
Primary care providers untrained in MH issues: Mental health problems require substantial time and coordination for proper diagnosis and effective treatment. As the youth MH crisis grows, MH needs may take up significant time for pediatricians and other physicians who are already short on time and experiencing burnout.[33]	CoCM enables PCPs to deliver higher-quality MH treatment by supplementing existing services with a designated team.
Late interventions: Too many of our nation's youth first receive MH care in the juvenile justice system. Up to 70% of youth in the juvenile justice system suffer from MH disorders.[34]	By extending the reach of screening and treatment, CoCM has the potential to provide earlier intervention for youth with MH needs.

Key Findings

States Covering Codes

Since CMS activated the CoCM billing codes in 2017, twenty-two states (22) have adopted CoCM CPT codes for all Medicaid beneficiaries. Additionally, Kansas has adopted the codes for dually eligible members (i.e., members who have both Medicare and Medicaid coverage). Since 2021, when CMS adopted the CoCM HCPCS G2214 code to help providers better capture all services for CoCM, only ten states have adopted the code for Medicaid. Other states Medicaid Managed Care plans may also cover CoCM even if the state has not activated the codes.

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



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

Federally Qualified Health Center & Rural Health Center Billing

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) deliver primary health care to one in three people living in poverty and one in five rural residents which makes their participation in CoCM vitally important for transforming mental health in Medicaid.[35] Five

state Medicaid programs have adopted the FQHC/RHC G0512 code; Arizona utilizes G0512 to reimburse only for dually eligible patients. Some state Medicaid representatives we interviewed noted their state had inadvertently overlooked the activation of the FQHC/RHC code, while others allow FQHCs/RHCs to bill the legacy CoCM CPT codes and deem them eligible for a prospective payment system (PPS) encounter rate.

Medicaid Rates & Billing

As is typically seen in Medicaid, most state Medicaid CoCM rates are lower than Medicare rates, though the degree to which varies significantly.[36] Montana's Medicaid reimbursement rate, for example, is higher than the Medicare rates (see Table 5). Hawaii has the lowest rate; notably, their Medicaid program reported that physicians are not using the codes. As with other benefits, Medicaid's low reimbursement rates create barriers to quality care with stark impacts on underserved communities, especially people of color.[37] (See Appendix 2 for a detailed rates table.)

Table 5: Comparison of Select State Medicaid benefit rates for Code 99492 to the Medicare National Payment Amount ($153.65)[38]

State	Medicaid (Non-Facility Rate)	Percent of Medicare Rate
Hawaii	$55.54	36%
Michigan	$87.96	57%
Utah	$113.46	74%
North Carolina	$130.64	85%
Washington	$142.84	93%
Montana	$184.98	120%

State Medicaid Rules & Restrictions Differ from Medicare

States that have implemented CoCM codes have done so with varying guidelines and restrictions. We have outlined these differences in Table 6.

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

Topic	Medicare Policy	State Medicaid Policies that Differ from Medicare
Differences for Pediatrics	N/A	NY: only allows ages 12+ TX: higher reimbursement for ages 0-20
Diagnoses Restrictions	No restrictions	MI: prohibits use for medication-assisted treatment of opioid disorder NY: anxiety and depression only

Topic	Medicare Policy	State Medicaid Policies that Differ from Medicare
Behavioral Health Care Manager Credentials	Formal education or specialized training in behavioral health, including social work, nursing, or psychology	MI: Licensed masters or doctoral level clinician or individual with specialized training in behavioral health, such as a licensed social worker, registered nurse, or licensed psychologist IL: BA or MA in related field or BA in any field + 2 years relevant experience TX: BA required WI: BA in human service-related field + 1 year of experience
Psychiatric Consultant Credentials	A medical professional trained in psychiatry and qualified to prescribe the full range of medications. This includes nurse practitioners (NP) and physician assistants (PA).	IL: Allows licensed clinical psychologists NY: Must be a physician (MD or DO) or NP; cannot be a PA MI: Must be a physician (MD or DO); cannot be an NP or PA
Billing Provider	Any provider qualified to use evaluation and management codes, except psychiatrists	MI: Does not allow specialists to be the billing provider
Prior Authorization	None	MI: 6 months or 6-month lapse in care NY: 12 months TX: 6 months WA: 6 and 12 months
Attestation Required*	None	IL, NY, TX, and WA all require a form of attestation
G2214 Code	Used when there are insufficient minutes to bill other codes	IA, MI, MT, NH, NJ, NC, TX, UT, WA currently use G2214 code. AZ uses G2214 for Medicare crossover claims only.
FQHCs/RHCs	Reimbursed via G0512 code	IL, MA, MI, NE, WA currently use G0512. AZ, KY, NY, and UT allow CoCM CPT codes to be eligible for a PPS encounter rate.
School-based health clinics	N/A	IL allows for school-based clinics to reimburse for CPT codes (99492-4)

**Signed document stating provider is providing key elements of CoCM that some states require before approval to use the CoCM benefit.*

Source: Information collected in interviews with state Medicaid representatives or other individuals supporting collaborative care, fee schedules, medical policies, and Medicaid bulletins. There may be additional variations in CoCM benefit policies that were not identified.

Implementation Costs, Technical Assistance, & Incentives

CoCM requires changes in practice workflow, new team members, and unique billing processes that require financial investment in system transformation. Without support for implementation costs and technical assistance, the development of CoCM programs may seem daunting to practices.[39] A small number of state Medicaid authorities provide support in these areas:

- **Massachusetts** developed a Roadmap for Behavioral Health Reform. In the first phase, the state passed new integrated behavioral health codes, including the CoCM Medicaid codes. Through an 1115 demonstration extension waiver, the second phase will include increased and value-based payments for primary care practices that participate in the state's Medicaid accountable care organizations to deliver integrated MH and addiction services in primary care.[40]
- **New York** provides ongoing training and technical assistance to CoCM providers, including one-to-one coaching calls and billing support. With the goal of ensuring fidelity to the model, it requires practices to demonstrate the required components of the model are in place as part of an application process.
- Beginning in 2022, **North Carolina** is working to increase CoCM adoption by investing in training and technical assistance through the North Carolina Area Health Educator Centers and by establishing a registry that will be free to practices. It is exploring the feasibility of providing funding for implementation costs and/or financial incentives for implementing CoCM.
- **Texas:** With philanthropic funding from the Lyda Hill Foundation and others, the Meadows Mental Health Policy Institute (Institute) is facilitating CoCM implementation through free technical assistance for nearly 40 health systems. Together with the state, the Institute is also utilizing American Rescue Plan Act (ARPA) funds to support implementation of CoCM for children and adolescents in 18 health systems with no-cost technical assistance. Additionally, through ARPA, implementation funds are available to physician practices to assist in covering the costs of practice transformation.

Policy Recommendations

Policy Recommendation 1: All 51 Medicaid programs should cover CoCM reimbursement codes and state Medicaid guidelines should align with Medicare rules and reimburse at rates at or above Medicare. Consistency in medical policy and reimbursement rates increases provider adoption of new protocols. Matching current Medicare guidelines will simplify the process for providers and will allow CoCM to be more financially viable for providers, thus increasing adoption and leading to better MH outcomes for youth.[41]

Table 7: Recommended Actions for Collaborative Care Reimbursement & Guidelines

Agency	Recommended Actions
CMS	**Include CoCM as a mandated benefit in Medicaid, consistent with Medicare.** CoCM is billed as a physician service, which are mandatory services in Medicaid. Mandatory services in Medicaid are typically defined consistently with Medicare because of the comparability across aid categories and the need for each service to be sufficient in coverage, and so that all members receive at least the coverage dual eligible members receive.[42, 43] CMS recognizing CoCM as a mandated benefit would require all states to cover it, leading to its rapid adoption.
	Issue a CoCM Medicaid policy guidance through a State Medicaid Director Letter similar to the one it issued on CoCM Medicare policy guidance through its Medicare Learning Network.[44] On August 18, 2022, CMS issued an informational bulletin encouraging states and Medicaid managed care plans to adopt integrated care models like CoCM.[45] However, a State Medicaid Director Letter that specifically provides CoCM implementation guidance like the Medicare Learning Network guidance provides, would give much needed guidance on how states should cover the benefit. The guidance should include covering the full range of diagnoses, mirroring the BHCM and psychiatric consultant eligibility requirements, and ensuring providers in different specialties are eligible for reimbursement.
State Medicaid Authorities	**Cover CoCM as a Medicaid benefit and align CoCM benefit coverage and policies with Medicare**.
	Adopt FFS rates on par with Medicare rates (at a minimum) and make adjustments to managed care contracts and capitation rates to provide financial incentives to Medicaid managed care plans who offer CoCM providers financially viable rates to help ensure financial sustainability in both Medicaid fee for service (FFS) and managed care delivery systems.
	Be cognizant of what payment strategy is the most operationally and financially feasible for FQHCs/RHCs. Rather than automatically adopting the G0512 code that Medicare requires FQHCs/RHCs to use, each state should carefully consider the best billing strategy for their FQHCs/RHCs in both Medicaid FFS and managed care payment delivery systems.

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

Table 8: Recommended Actions for Collaborative Care Implementation Funds & Technical Assistance

Agency	Recommended Actions
Congress	**Congressional leaders should support legislation to advance large-scale efforts to build integrated care infrastructure and widescale adoption of models such as CoCM, such as** The Collaborate in an Orderly and Cohesive Manner Act (as incorporated in H.R. 7666), which would provide funding and technical assistance to primary care providers to implement integrated behavioral health and primary care models. A 2021 RAND Corporation report, suggested federally funded technical assistance for CoCM is necessary for widescale adoption.
CMS	**Develop a national initiative modeled after the Transforming Clinical Practices Initiatives** (TCPI) to provide technical assistance, implementation tools, and a learning collaborative to support providers in the implementation of CoCM, as also recommended by RAND in 2021.[46] CMS should ensure that pediatric practices, FQHCs, and RHCs participate, and that technical assistance is tailored to their needs. As in TCPI, CMS should extend the initiative over at least a five-year period and encourage monitoring and evaluation to track health outcomes and return on investment. [47]
	Offer financial incentives, through planning grants and/or an enhanced Federal Medicaid Assistance Percentage (FMAP), to states that cover CoCM in Medicaid. Funds could be used to provide technical assistance and training to primary care providers that choose to offer CoCM.
	Through the Center for Medicare and Medicaid Innovation (CMMI), create a Medicaid demonstration project targeted specifically on the testing, designing and implementation of different payment models for reimbursement of Collaborative Care Model of care with a focus on lowering costs and improving quality of care.
State Governors/ State Legislatures	**Utilize ARPA funds to finance CoCM implementation and technical assistance costs.** Texas, for example, is using ARPA funds to aid the implementation of CoCM in pediatric centers in 18 health systems.
State Medicaid Authorities	**Leverage the Affordable Care Act Health Home provision (Section 2703) to pay for CoCM.** Medicaid health homes are optional Medicaid State plan benefits in which states can receive a 90% FMAP for Medicaid patients with two or more chronic conditions. This enhanced FMAP can provide partial coverage of implementation training and infrastructure costs.[48,49]

Conclusion

The mental health crisis facing our country's youth is well-known and needs a rapid response. Congress, CMS, and states can act today to increase access to care for the 50% of youth who received mental healthcare through Medicaid by advancing policy for national Medicaid coverage for CoCM.

Future Considerations for Transition Age Youth

Transition Age Youth (TAY), defined here as 19-25, face challenges as they exit the pediatric health care system and enter the adult health care system. This transition also has implications for continuity in care treatment for TAY with mental health conditions.[1] Moreover, as the eligibility criteria for adult beneficiaries is more limited in some states,[1] TAY may lose Medicaid benefits and access to mental health treatment at this critical time in their development. The CoCM BHCM can support the transition from pediatric care to other sources of mental and physical health care as part of a follow-up plan. CoCM may be especially beneficial for TAY transitioning to the adult system and/or encountering changes in insurance status and benefits. Additionally, the loss in coverage often experienced by this age group makes viability of FQHCs and RHCs, who provide services to people without insurance, particularly important. States should carefully assess what payment strategy is most operationally and financially feasible for the FQHCs and RHCs in their state.

There may be additional mechanisms for states to incentivize focused transition planning to support TAY, including adopting CPT codes to cover elements of transition planning or create value-based payment mechanisms for pediatric and adult primary care practices.[1] Furthermore, state leaders should also consider the challenges created by a gap in insurance coverage for TAY when aging out of Medicaid coverage[1]

Methodology

To begin our analysis, we utilized the American Psychiatric Association's compiled list of payors who are covering the CoCM codes and the California Health Care Foundation's 2020 analysis of CoCM Medicaid codes to identify specific requirements of different Medicaid programs.

We compiled benefit reimbursement rates from Medicaid program physician fee schedules. Where available, we reviewed Medicaid medical policies, procedure manuals, or bulletins to discern specific requirements surrounding CoCM codes. Finally, we contacted state Medicaid programs, asking each state about their CoCM benefit, special requirements and, when possible, incentivization and uptake. Some states preferred to answer by email and while other states engaged in 20 to 30-minute phone calls. In a few states, we spoke with organizations working in collaborative care, including the California Health Care Foundation, Mass General, Montana Healthcare Foundation, and the Montana Primary Care Organization. We engaged all states with CoCM codes except New Jersey and Nebraska. If coverage policy details were not available, we assumed the policies aligned with Medicare coverage. Finally, to support our findings, we spoke with national leaders in CoCM implementation, including Concert Health, Shatterproof, American Psychiatric Association, and Collaborative Care Consulting.

Appendix 1: Collaborative Care & General Behavioral Health Billing Codes[50]

CoCM/BHI Codes	BHCM or Clinical Staff Threshold Time
99492 – CoCM First Month	First 70 minutes in the first calendar month of BHCM activities for a patient. Can bill at 36+ minutes.
99493 – CoCM Subsequent Months	First 60 minutes in any subsequent month of BHCM activities. Can bill at 31+ minutes.
99494 – Additional Time (any month)	Each additional 30 minutes in a calendar month of BHCM activities. Used in conjunction with 99492 and 99493. Max two add-on codes per month. Cannot use until full amount of time required to meet 99492 (70 mins) or 99434 (60 mins) has been completed.
G2214	First 30 minutes in any month for BHCM activities. Used when there are not enough minutes to bill the 99492 or 99493 codes. Generally used in first and last month of care.
G0512 – FQHC/RHC CoCM Billing Code	Accrue at least 70 minutes of care delivered by BHCM (in collaboration with the psychiatric consultant) for each patient over each calendar month. Only minutes of time spent by the BHCM count (and minutes cannot be counted twice).

Appendix 2: Facility and Non-Facility Medicaid CoCM Reimbursement Rates

State	CoCM CPT Billing Codes					
	99492		99493		99494	
	Facility	Non-facility/ Outpatient	Facility	Non-facility/ Outpatient	Facility	Non-facility/ Outpatient
Arizona	$83.66	$135.63	$91.27	$135.95	$36.44	$51.97
California	$141.26	$141.26	$112.14	$112.14	$57.88	$57.88
Connecticut*	--	--	--	--	--	--
Hawaii	$55.54	$55.54	$50.25	$50.25	$26.81	$26.81
Illinois	$69.45	$69.45	$76.30	$76.30	$31.10	$31.10
Iowa	$142.16	$80.44	$113.77	$72.72	$58.88	$38.83
Kentucky	$70.08	$121.51	$63.35	$97.56	$33.79	$50.50
Maryland (pilot-only)	-	-	$100.95	$153.59	$40.15	$58.65
Massachusetts	$67.79	$121.41	$61.05	$97.28	$32.54	$49.06
Michigan	$53.88	$87.96	$59.23	$85.18	$24.17	$36.45
Montana	$112.53	$184.98	$123.00	$184.98	$48.96	$70.74
Nebraska	-	$124.32	-	$97.68	-	$48.84
New Hampshire	$58.19	$58.19	$52.40	$52.40	$28.05	$28.05
New Jersey**	$67.96	$67.96	$67.71	$67.71	$25.84	$25.84
New York***	$112.50	-	$112.50	-	$0.00	-
North Carolina	$73.86	$130.64	$66.78	$104.54	$35.63	$54.08
Pennsylvania	$71.18	$71.18	$64.36	$64.36	$34.58	$34.58
Rhode Island	$92.47	$92.47	-	-	$38.18	$38.18
Texas (Age 0-20)	$75.50	$124.06	$82.52	$124.06	$32.84	$47.43
Texas (Age 21+)	$71.91	$118.15	$78.59	$118.15	$31.27	$45.17
Utah	$113.46	$113.46	$110.34	$110.34	$47.09	$47.09
Vermont	$76.30	$125.43	$83.88	$121.31	$34.21	$51.93
Washington	$142.84	$142.84	$126.33	$126.33	$66.04	$66.04
Wisconsin	$146.05	$89.98	$141.61	$98.90	$60.51	$40.30

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

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

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

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

Endnotes

[1] The U.S. Surgeon General's Advisory. (2021). *Protecting youth mental health.* https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf

[2] House, T. W. (2022, July 29). *FACT SHEET: Biden-Harris Administration Announces Two New Actions to Address Youth Mental Health Crisis*. The White House. https://www.whitehouse.gov/briefing-room/statements-releases/2022/07/29/fact-sheet-biden-harris-administration-announces-two-new-actions-to-address-youth-mental-health-crisis/

[3] *What You Need to Know About Youth Suicide | NAMI: National Alliance on Mental Illness*. (n.d.). Retrieved September 9, 2022, from https://www.nami.org/Your-Journey/Kids-Teens-and-Young-Adults/What-You-Need-to-Know-About-Youth-Suicide

[4] AACAP. (n.d.). *AACAP Policy Statement on Increased Suicide Among Black Youth in the U.S.* Retrieved September 9, 2022, from https://www.aacap.org/aacap/Policy_Statements/2022/AACAP_Policy_Statement_Increased_Suicide_Among_Black_Youth_US.aspx

[5] Health Resources and Services Administration/National Center for Health Workforce Analysis; Substance Abuse and Mental Health Services Administration/Office of Policy, Planning, and Innovation. (2015). *National projections of supply and demand for behavioral health practitioners: 2013-2025.* https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/behavioral-health-2013-2025.pdf

[6] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. (2020). *Using HRSA's health workforce simulation model to estimate the rural and non-rural health workforce.* https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/hwsm-rural-urban-methodology.pdf

[7] Ramchand, R., Gordon, J. A., & Pearson, J. L. (2021). Trends in suicide rates by race and ethnicity in the United States. *JAMA Network Open*, *4*(5), e2111563. https://doi.org/10.1001/jamanetworkopen.2021.11563

[8] Panchal, N., Kamal, R., Cox, C., & Garfield, R. (2021, February 10). *The implications of COVID-19 for mental health and substance use.* Kaiser Family Foundation.

[9] Kuchment, A., Hacker, H.K, Solis, D. (2020, December 19). *COVID's 'untold story': Texas Blacks and Latinos are dying in the prime of their lives*. The Dallas Morning News. https://www.dallasnews.com/news/2020/12/19/covids-untold-story-texas-blacks-and-latinos-are-dying-in-the-prime-of-their-lives/

[10] Hillis, S. D., Blenkinsop, A., Villaveces, A., Annor, F. B., Liburd, L., Massetti, G. M., Demissie, Z., Mercy, J. A., Nelson III, C. A., Cluver, L., Flaxman, S., Sherr, L., Donnelly, C. A., Ratmann, O., & Unwin, H. J. T. (2021). COVID-19–associated orphanhood and caregiver death in the United States. *Pediatrics*, *148*(6), e2021053760. https://doi.org/10.1542/peds.2021-053760

[11] Kessler, R. C., Angermeyer, M., Anthony, J. C., DE Graaf, R., Demyttenaere, K., Gasquet, I., DE Girolamo, G., Gluzman, S., Gureje, O., Haro, J. M., Kawakami, N., Karam, A., Levinson, D., Medina Mora, M. E., Oakley Browne, M. A., Posada-Villa, J., Stein, D. J., Adley Tsang, C. H., Aguilar-Gaxiola, S., … Ustün, T. B. (2007). Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, *6*(3), 168–176.

[12] American Academy of Child & Adolescent Psychiatry. (2012). Best Principles for Integration of Child Psychiatry into the Pediatric Health Home.

[13] Membride, H. (2016). Mental health: Early intervention and prevention in children and young people. *British Journal of Nursing*, *25*(10), 552–557. https://doi.org/10.12968/bjon.2016.25.10.552

[14] Kane, J. M., et al. (2015). Comprehensive versus usual community care for first episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry, AJP in Advance*, 1–11.

[15] The Meadows Mental Health Policy Institute for Texas. (2016). Estimates of Prevalence of Mental Health Conditions among Children and Adolescents in Texas.

[16] Archer, Janine, Peter Bower, Simon Gilbody, Karina Lovell, David Richards, Linda Gask, Chris Dickens, and Peter Coventry. "Collaborative Care for Depression and Anxiety Problems." Edited by Cochrane Common Mental Disorders Group. *Cochrane Database of Systematic Reviews*, October 17, 2012. https://doi.org/10.1002/14651858.CD006525.pub2.

[17] Wolk CB, Last BS, Livesey C, Oquendo MA, Press MJ, Mandell DS, Ingram E, Futterer AC, Kinkler GP, Oslin DW. Addressing Common Challenges in the Implementation of Collaborative Care for Mental Health: The Penn Integrated Care Program. Ann Fam Med. 2021 Mar-Apr;19(2):148-156. doi: 10.1370/afm.2651.
[18] Carlo, Andrew D., Jürgen Unützer, Anna D. H. Ratzliff, and Joseph M. Cerimele. "Financing for Collaborative Care—a Narrative Review." *Current Treatment Options in Psychiatry* 5, no. 3 (September 2018): 334–44. https://doi.org/10.1007/s40501-018-0150-4.
[19] Carlo, Andrew D., Andrea Corage Baden, Rachelle L. McCarty, and Anna D. H. Ratzliff. "Early Health System Experiences with Collaborative Care (CoCM) Billing Codes: A Qualitative Study of Leadership and Support Staff." *Journal of General Internal Medicine* 34, no. 10 (October 2019): 2150–58. https://doi.org/10.1007/s11606-019-05195-0.
[20] *Coverage for Psychiatric Collaborate Care Management (CoCM) Codes*. (2021). American Psychiatric Association.
[21] *Behavioral Health Integration Services* (No. MLN909432). (2022). CMS, Medicare Learning Network. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf..
[22] *Team Structure | University of Washington AIMS Center*. (n.d.). Retrieved September 9, 2022, from https://aims.uw.edu/collaborative-care/team-structure
[23] *Behavioral Health Integration Services* (No. MLN909432). (2022). CMS, Medicare Learning Network. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
[24] Kessler, R. C., Angermeyer, M., Anthony, J. C., DE Graaf, R., Demyttenaere, K., Gasquet, I., DE Girolamo, G., Gluzman, S., Gureje, O., Haro, J. M., Kawakami, N., Karam, A., Levinson, D., Medina Mora, M. E., Oakley Browne, M. A., Posada-Villa, J., Stein, D. J., Adley Tsang, C. H., Aguilar-Gaxiola, S., … Ustün, T. B. (2007). Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, *6*(3), 168–176.
[25] AACAP. (n.d.). *Severe Shortage of Child and Adolescent Psychiatrists Illustrated in AAACP Workforce maps*. Retrieved September 9, 2022, from https://www.aacap.org/AACAP/Press/Press_Releases/2018/Severe_Shortage_of_Child_and_Adolescent_Psychiatrists_Illustrated_in_AAACP_Workforce_maps.aspx
[26] AACAP. (n.d.). *Severe Shortage of Child and Adolescent Psychiatrists Illustrated in AAACP Workforce maps*. Retrieved September 9, 2022, from https://www.aacap.org/AACAP/Press/Press_Releases/2018/Severe_Shortage_of_Child_and_Adolescent_Psychiatrists_Illustrated_in_AAACP_Workforce_maps.aspx
[27] *Child and Adolescent Mental and Behavioral Health Resolution*. (n.d.). Https://Www.Apa.Org. Retrieved September 9, 2022, from https://www.apa.org/about/policy/child-adolescent-mental-behavioral-health
[28] Brooks, T., & Gardner, A. (2020). *Snapshot of Children with Medicaid by Race and Ethnicity, 2018*. Georgetown University Health Policy Institute, Children & Families. https://ccf.georgetown.edu/wp-content/uploads/2020/07/Snapshot-Medicaid-kids-race-ethnicity-v4.pdf
[29] Angstman, K. B., Phelan, S., Myszkowski, M. R., Schak, K. M., DeJesus, R. S., Lineberry, T. W., & van Ryn, M. (2015). Minority Primary Care Patients With Depression: Outcome Disparities Improve With Collaborative Care Management. *Medical Care*, *53*(1), 32–37. https://doi.org/10.1097/MLR.0000000000000280
[30] Powers, D. M., Bowen, D. J., Arao, R. F., Vredevoogd, M., Russo, J., Grover, T., & Unützer, J. (2020). Rural clinics implementing collaborative care for low-income patients can achieve comparable or better depression outcomes. *Families, Systems, & Health*, *38*(3), 242–254. https://doi.org/10.1037/fsh0000522
[31] Cooper, L. A., Ghods Dinoso, B. K., Ford, D. E., Roter, D. L., Primm, A. B., Larson, S. M., Gill, J. M., Noronha, G. J., Shaya, E. K., & Wang, N.-Y. (2013). Comparative Effectiveness of Standard versus Patient-Centered Collaborative Care Interventions for Depression among African Americans in Primary Care Settings: The BRIDGE Study. *Health Services Research*, *48*(1), 150–174. https://doi.org/10.1111/j.1475-6773.2012.01435.x
[32] Chan, V. (2017). Schizophrenia and Psychosis. *Child and Adolescent Psychiatric Clinics of North America*, *26*(2), 341–366. https://doi.org/10.1016/j.chc.2016.12.014
[33] 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. https://doi.org/10.1001/jamapsychiatry.2020.3216
[34] AACAP. (n.d.). *Severe Shortage of Child and Adolescent Psychiatrists Illustrated in AAACP Workforce maps*. Retrieved September 9, 2022, from

https://www.aacap.org/AACAP/Press/Press_Releases/2018/Severe_Shortage_of_Child_and_Adolescent_Psychiatrists_Illustrated_in_AAACP_Workforce_maps.aspx

[35] *Health Center Program: Impact and Growth | Bureau of Primary Health Care*. (2022). https://bphc.hrsa.gov/about-health-centers/health-center-program-impact-growth

[36] Medicaid-to-Medicare Fee Index. (2017, July 12). *KFF*. https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/

[37] Ford, T. N., & Michener, J. (2022). Medicaid Reimbursement Rates Are a Racial Justice Issue. *Commonwealth Fund*. https://www.commonwealthfund.org/blog/2022/medicaid-reimbursement-rates-are-racial-justice-issue

[38] https://www.cms.gov/medicare/physician-fee-schedule/search?Y=0&T=4&HT=0&CT=0&H1=99492&M=5

[39] *Physician Fee Schedule Look-Up Tool | CMS*. (n.d.). Retrieved September 9, 2022, from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup

[40] Kraft, A. C. (2021, July). *MassHealth: Physician Bulleting 103: Integrated Behavioral Health Service Code, Description, and Billing Requirements*. https://www.mass.gov/doc/physician-bulletin-103-integrated-behavioral-health-service-code-description-and-billing-requirements-0/download

[41] Carlo, Andrew D., Jürgen Unützer, Anna D. H. Ratzliff, and Joseph M. Cerimele. "Financing for Collaborative Care—a Narrative Review." *Current Treatment Options in Psychiatry* 5, no. 3 (September 2018): 334–44. https://doi.org/10.1007/s40501-018-0150-4.

[42] *42 CFR 440.50—Physicians' services and medical and surgical services of a dentist.* (n.d.). Retrieved September 9, 2022, from https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A/section-440.50

[43] *Ibid.*

[44] *Behavioral Health Integration Services* (No. MLN909432). (2022). Previously cited.

[45] Daniel Tsai. (2022, August 18). CMCS Informational Bulletin: Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth. https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf

[46] McBain, R. K., Eberhart, N. K., Breslau, J., Frank, L., Burnam, M. A., Kareddy, V., & Simmons, M. M. (2021). How to transform the U.S. mental health system: Evidence-based recommendations. RAND Corporation. https://www.rand.org/pubs/research_reports/RRA889-1.html

[47] *Ibid.*

[48] "Medicaid & Collaborative Care for Substance Use Disorder and Mental Health White Paper." White Paper. Shatter Proof and Path Forward, n.d.

[49] Unützer, J., Harbin, H., Schoenbaum, M., & Druss, B. (2013, May). The collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes. Health Home Information Resource Center. http://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf

[50] *Behavioral Health Integration Services* (No. MLN909432). (2022). Previously cited.