**MEMORANDUM**

**TO:** Kelly Cunningham, Medicaid Administrator, Illinois Department of Healthcare and Family Services

**FROM:**

Illinois Academy of Family Physicians
Illinois Chapter, American Academy of Pediatrics
Illinois Health and Hospital Association
Illinois Psychiatric Society
Illinois Primary Health Care Association
Illinois State Medical Society
The Kennedy Forum

**RE:** Collaborative Care Model Implementation Feedback

**Date:** March 10, 2022

---

Public Act 101-0574 amended the Public Aid Code and Insurance Code to create targeted reimbursement for the Mental Health Collaborative Care Model (CoCM). As more collaborative care models are established pursuant to the Public Act, we reiterate the importance this implementation has for both patients and primary care providers as these codes:

- are clinically significant and cost-efficient, as they reduce productivity loss and health care utilization;
- Improve patients' quality-adjusted life years; and
- reduce barriers to access, improves service quality and lower healthcare expenditures.

At your request, below is our collective response to the Department's questions:

1. What are the recommended qualifications for the Behavioral health manager and allowable employment relationship (CPT code says this person is supervised by the PCP)? Please provide any justification.

   *Care Managers must be licensed mental health professionals with training in mental health/substance use conditions. BA level (RN) or master's level clinicians can serve in this role. "4-letter" licensed clinicians ( LSCWs and LCPCs) or PsyD clinicians can also serve in the Care Manager role, but these advanced degrees/licenses are not a requirement. It is beneficial for the Care Manager to have basic training in evidence-based techniques proven to work in the primary care setting, such as Motivational Interviewing, Behavioral Activation and Problem-Solving Treatment.*
   ***Justification**: These requirements are analogous to CMS guidance and CPT requirements.*

2. What are the qualifications for the psychiatric consultant (CPT book says they have to be able to prescribe full range of medication)? Please provide any justification.
   *The psych consultant role can be filled by a medical professional who is trained in psychiatry. This can be a psychiatrist, nurse practitioner, with psychiatry experience, or physician assistant, with psychiatry experience. NOTE: NP's have an additional education track to receive PMHNP (Psychiatric Mental Health Nurse Practitioner) distinction, but this certification is not necessarily a requirement to serve as a psych consultant for CoCM.) Nevertheless, in the absence of a psychiatrist, a PMHNP is preferable to a nurse or PA with experience, as NPs who have enough experience to serve well in this role would be the exception to the rule.*
   ***Justification**: While the psychiatric consultant does not directly prescribe in this model, since this is done by the PCP, they must have the knowledge to offer detailed recommendations that outline how they would prescribe if they were seeing patients directly.*

3. What are the requirements for a registry (HFS assumes less than a shared EMR, but some digital platform accessible to all members of the team so that care plans and other clinical information can be shared)?

*The registry can be as simple as a spreadsheet and is used to track the Care Manager's defined group of patients and their progress over time (ex: sequential PHQ-9 score tracked over time, number of weeks in treatment, etc...) The Care Manager is the main team member who uses the registry as a tool to allow the care manger to track progress and to review it with the psychiatric consultant. The psychiatric consultant can also review the registry on a weekly basis prior to meeting with the Care Manager. The PCP can have access to the registry but will likely not use the registry on a regular basis. Care plans and other clinical information would be shared within the EMR rather than in the registry, which is intended to be a minimal data set for tracking patients and their progress.*

A. Should there be a requirement that Psychiatric consultant be Medicaid enrolled? In other words, all consultants must have in-state licensure and be enrolled in the Medicaid program to participate. HFS' current belief is that federal regulations require this.

*No. This is **not** a requirement by **any payer**, including Medicare. We would discourage including this. In fact, requiring a Psychiatric consultant to enroll in Medicaid could limit the universe of potential partners when there are already limited psychiatrists available. The CPT code should reimburse the primary care provider. CMS clearly states this in the FAQs for BHI which can be found here: Behavioral Health Integration FAQs.*

B. For frequency of billing, current thought is that these codes can only be billed once a month per patient for time spent in the previous month. Is that frequency appropriate, too often, or too infrequent? Why?

*The CoCM codes are based on the number of minutes the Care Mangers spends working with the patient each month. Some Care Managers will bill the codes as soon as they hit the minute threshold (once the time requirement is met). Others will bill the codes after the month has ended or the very beginning of the month (Ex: During the first week of March, Care Manager will total up the minutes spent with patient during February and bill the appropriate codes.)*

C. How should HFS indicate the NPI of the psychiatric consultant on the claim form?

*The psychiatrist's NPI is not needed. The CoCM codes are billed through the PCP. The psych consultant typically receives an hourly pay rate to work as part of the CoCM team. The psych consultant makes treatment recommendations, but the PCP makes the final decision as to how to proceed and is considered the treating physician/physician of record. The PCP is the only treating provider on the claim form. The only time (minutes) that is reported is that of the behavioral health care manager. See Item A above.*

D. What process should HFS put in place to ensure the components of the model are in place (i.e., a behavioral health manager, contract with psychiatric consultant)? The process must, at a minimum: outline how the PCP will reimburse psychiatric consultant, and ensure a registry is in place.

*HFS will ensure the following items are in place: a patient registry, evidence of contract for a BHM, evidence of contract for a psychiatric consultant, and documentation in patient medical record of the collaborative process. Some states will ask for an attestation form to document the members of the CoCM team. If Medicare felt CoCM claims were fraudulent, they could conduct an audit. The UW AIMS Center provides a Sample Psych Consultant Job Description; as well as a, Sample Contract for Psychiatric Consultative Services.*

*The use of a registry is often part of the attestation that a practice would make to show that they have the required members of the team. We are not aware of an attestation that requires outlining the specific contractual arrangement between the psychiatric consultant and the practice but are aware of one that asked if that role was filled by staff or contracted. The contract referenced here is between a practice and a BH Agency but could be modified for an individual consultant in private practice.*

**Please Provide Feedback on the Following HFS Positions/Issues:** HFS research includes many states, however, the agency believe that the Michigan program has very good policies and they also like how New York does the billing. If you have looked at CoCM implementation in other states, please provide feedback on any preferences.

*The staff at UW AIMS Center have worked with numerous CoCM programs across the country and a great deal of feedback on CoCM implementation in other states. Washington state was the first to implement CoCM codes with their Medicaid program, and UW AIMS provided input on those regulations. They advocated for close alignment with CMS Medicare guidance, and for the most part Washington did that. However, they elected to put more specific requirements in some cases. For example, the BH Care Manager must be licensed in the state with one of the authorized BH licensures, which includes an "associate" license; individuals doing supervised work and direct supervision to gain an independent license. Washington also requests an attestation prior to billing, which is the case in multiple other states. Some states choose to pay the General BHI codes (99484 and G0511), but others do not for budgetary reasons. For reference, APA has a comprehensive guide.*