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Strengthening the Integrated Care Workforce

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Bipartisan Policy Center

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HEALTH PROGRAM

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., the Bipartisan Policy Center's Health Program develops bipartisan policy recommendations that will improve health care, lower costs, and enhance coverage and delivery. The program focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

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DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of BPC's founders, its funders, or its board of directors.

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Executive Summary

A significant treatment gap exists for individuals living with mental health and substance use conditions. As of 2023, 55% of adults who experience some form of mental illness receive no treatment and 60% of youth with major depression go without help.^{1,2} Currently, and for the foreseeable future, the United States is experiencing a shortage of behavioral health providers to deliver needed services.³ One of the most effective ways to close the prevention and treatment gap in the mental health and substance use fields is through behavioral health integration (BHI). For the purposes of this report, the term BHI refers to the integration of mental health and substance use services into primary care settings in a manner that is agnostic to model and service design.

High quality, integrated primary care services provide continuous, person-centered behavioral health care that considers the needs and preferences of individuals. Vital to increasing the reach of integrated care models is a health care workforce that is adequately trained and supported in BHI delivery. Several evidence-based models—including the [Collaborative Care Model \(CoCM\)](#) and the [Primary Care Behavioral Health Model](#)—integrate behavioral health into primary care and are reimbursed by Medicare, some state Medicaid plans, and commercial payers.

Over the past year, the Bipartisan Policy Center undertook an extensive effort to develop evidence-based, federal policy recommendations to support and grow the workforce responsible for delivering integrated behavioral health and primary care services. BPC conducted a series of interviews and hosted two private roundtables with health care policy and workforce experts, providers, payers, and patient advocates to gain insight into the opportunities and barriers related to the integrated care workforce.

BPC's March 2021 Behavioral Health Integration Task Force [report](#) looked broadly at ways to achieve the integration of behavioral health and primary care.⁴ This report builds on those recommendations by focusing on ways to train, recruit, pay for, and flex the BHI workforce. Although our recommendations focus on Medicare and Medicaid beneficiaries, the workforce investments outlined here have broad implications for the entire health care delivery system.

Policy Recommendations:

A. Training and Recruitment

- The Health Resources & Services Administration (HRSA) should include language in notices of funding opportunity for programs that give preference to applicants or entities that demonstrate they have relevant BHI programs in place, as well as those that intend to use funding to support BHI activities. These should include the Title VII Sections 747 and 748 primary care training programs, Title VIII programs, and the Teaching Health Center program.
- To expand the available behavioral health workforce, Congress should direct HRSA to use existing sources of funding—such as the Substance Use Disorder Treatment and Recovery Loan Repayment Program and the Community Health Worker Training Program—to create a pipeline program that enables interested behavioral health support specialists to become licensed behavioral health professionals.

B. Payment and Administrative Strategies

- Congress should increase reimbursement for behavioral health integration codes, including for the Collaborative Care Model, for up to three years. Congress should evaluate doing the same for provider-to-provider interprofessional consultations with behavioral health specialists. For both, Congress and the Centers for Medicare & Medicaid Services (CMS) should evaluate the impact of and determine best practices that result from additional funding on the volume of integrated care services delivered, as well as the quality of care and patient outcomes.
- Congress should fund long-term, sustainable investments in state, regional, and tribal mental health e-consultation services—especially Pediatric Mental Health Care Access programs—that provide primary care providers with behavioral health expertise for treating mild to moderate conditions and symptoms.
- The Center for Medicaid and Children's Health Insurance Program (CHIP) Services should issue a State Medicaid Director or State Health Official letter on how states can implement best-practice BHI models leveraging permissible Medicaid authorities.
- The CMS Innovation Center should require applicants and participants in primary care or total cost of care-oriented models to articulate BHI plans, the degree of integration achieved, and report on associated outcomes.

C. Network Requirements and Flexibility

- Congress and the U.S. Department of Health and Human Services (HHS) should require BHI in behavioral health plan network adequacy standards.

- Congress should direct CMS to audit Medicare Advantage plans to ensure that they are providing accurate information on the availability of their in-network providers. Congress should also require that private health plans use independent auditors to assess the accuracies of their provider directories.
- Congress should direct the secretary of HHS to develop a set of limited circumstances under which health care providers can deliver telehealth services to patients located out of state. Congress could then allow licensure flexibility for the specific set of circumstances deemed appropriate by the secretary.



Background

Mental health and substance use conditions are prevalent in the United States for both adults and children, yet large gaps in treatment remain. As of 2023, about 20% of adults were experiencing some mental illness, and 55% received no treatment.⁵ Nearly 1 in 5 U.S. children has a diagnosed mental health disorder; in 2023 almost 60% of youth with major depression receive no treatment.^{6,7} Furthermore, as many as 19% of youth have symptoms of a mental health condition without meeting criteria for a diagnosis.⁸ For substance use disorder (SUD), over 20 million in the United States were diagnosed with the condition in 2019, with only about 10% of these people receiving treatment.⁹

This treatment gap disproportionately affects people of color. More than 50% of white Americans with a mental health condition received some type of care in 2021, compared with 39.4% of Black or African Americans, 36.1% of Hispanics, and 25.4% of Asians.¹⁰ Along with lower rates of treatment, minority populations are disproportionately impacted by drug overdose deaths. In 2020, overdose death rates among older Black men were almost seven times higher than among older white men, and rates among younger American Indian and Alaska Native women were nearly two times higher than white women.¹¹

One of the most promising ways to close the behavioral health treatment gap is by integrating behavioral health into the primary care setting. BPC's March 2021 Behavioral Health Integration Task Force [report](#) looked broadly at ways to achieve behavioral health and primary care integration in the United States. BPC's new report takes a deeper look at ways to train, pay for, and increase the flexibility of the workforce needed to deliver integrated primary care and behavioral health services.

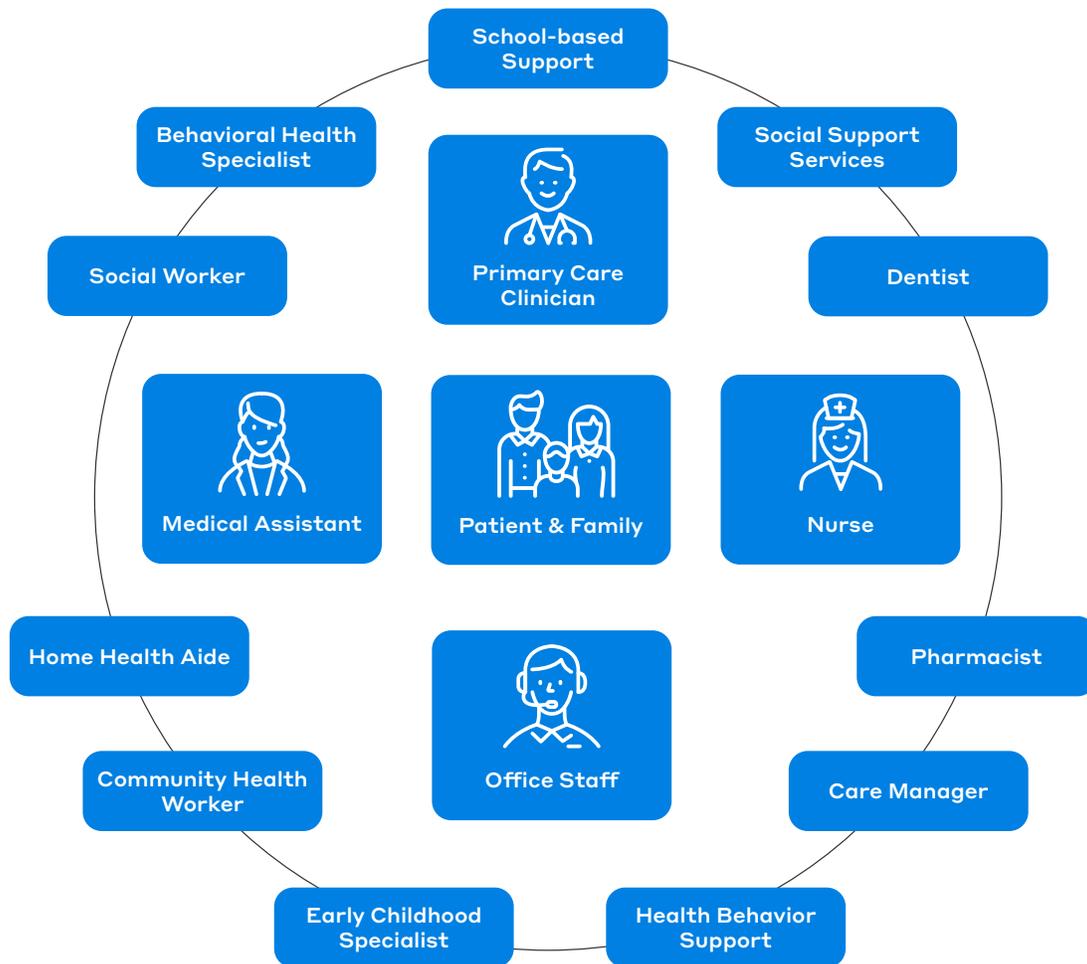
INTEGRATED CARE TEAMS

An extensive and growing body of evidence shows the benefits of delivering more behavioral health services through—and in collaboration with—primary care providers, including increasing patients’ access to services, improving health outcomes, and increasing cost-effectiveness of care.¹²

Interprofessional, integrated care teams can include many kinds of providers from both the licensed and the nonclinical workforce (see Figure 1). Members of the licensed medical workforce can include physicians, physician’s assistants, registered nurses, nurse practitioners, and advanced practice registered nurses. The licensed behavioral health workforce can include social workers, psychiatric providers, psychologists, mental health counselors, substance use counselors, and marriage and family therapists.¹³ Last, the nonclinical workforce can include health educators, care coordinators, care managers, depression care coordinators, community health workers, peer support and recovery specialists, and patient navigators.¹⁴

Integrated care teams can be structured or configured differently depending on multiple factors, including the availability of certain providers and the ability to reimburse them in a particular geographic area. Practices might deliver BHI within the criteria of one specific model, but might also use a blend of evidence-based approaches depending on the unique needs of patient populations and communities. This gives practices the flexibility and ability to tailor their care delivery within the confines of evidence-based methods. Practices can adopt the integrated care components most relevant to their needs and create their own customized delivery approach. See case studies on page 12 of Cherokee Health Systems and Southcentral Foundation as examples of two successful integrated models and how they blended approaches that do not rely on specific model criteria. Typically, integrated care teams have a core care team that is involved in the day-to-day care delivery of their patients, as well as an extended care team that augments the core team’s ability to deliver more complex care and address patient needs. The success of an integrated care team depends largely on the resources that a practice invests in transformation, as well as its ability to hire providers who exhibit the willingness to provide integrated care and to work on a team in a fast-paced environment.

Figure 1: Members of an Integrated Care Workforce¹⁵



Adapted from National Academies of Sciences, Engineering, and Medicine

INTEGRATED MODELS OF CARE

Many integrated care teams rely on existing evidence-based models proven to be effective in providing BHI services. Although this report’s recommendations aim to be model agnostic, it is important to acknowledge commonly used models that can be implemented in pediatric, adult, and family medicine settings.

Collaborative Care Model (CoCM): The foundation of CoCM is the use of a care team including a behavioral health care manager who works with the primary care provider and a psychiatric consultant, to effectively integrate behavioral health into primary care. The behavioral health care manager does not have to be independently licensed but does require specialized training in behavioral health. According to CMS, the manager is a designated provider with formal education or specialized training in behavioral health (including social work, nursing, or psychology) who

works under the oversight and direction of the billing practitioner.¹⁶ The team confers regularly with the psychiatric consultant (a psychiatrist or psychiatric nurse practitioner) to review a registry of patients, providing treatment recommendations to the behavioral health care manager. Treatment can include psychoeducation, talk therapies, and/or medication, and the team regularly monitors patient progress using validated assessments, which it enters into a patient registry.¹⁷ CoCM is most often used in adults for common mental health conditions such as depression or anxiety, as these disorders are persistent and treatment benefits from measurement-informed care and systematic follow-up.¹⁸ CoCM has been tested in over 90 randomized controlled trials and multiple meta-analyses, and the evidence suggests that among adults, it leads to better patient outcomes, patient and provider satisfaction, enhanced functioning, and reductions in health care costs.¹⁹ It is important to note, however, that patient advocates have raised concerns that the CoCM model does not facilitate much contact between patients and the psychiatric consultant. Additionally, pediatric providers experience difficulty implementing CoCM due to the model's reliance on a disease registry; many children may have behavioral health needs but do not receive a formal diagnosis.

Primary Care Behavioral Health Model: This model revolves around a behavioral health consultant who is a licensed behavioral health professional and acts as a core member of the primary care team. The consultant helps implement prevention, identification, and intervention strategies and offers treatment for patients with behavioral health conditions and symptoms.²⁰ In this model, the behavioral health consultant has scheduled visits with individual patients in addition to same-day “warm handoffs” or referrals from the primary care provider or other members of the care team.²¹ They are an embedded member of the care team and can assist the primary care provider by offering more immediate assistance to patients, which allows for patients to witness their care coordination in real time.

HealthySteps: HealthySteps is an interdisciplinary pediatric primary care model that promotes healthy development for babies and toddlers, with an emphasis on families living in low-income communities.²² The program focuses on early screening and intervention for young children ages zero to 3, and partners with pediatric primary care practices to integrate a child and development expert who brings knowledge in behavioral health promotion and prevention to the primary care team.^{23,24} The program's framework details the specific competencies these experts must have to understand dispositions, knowledge, and skills essential for the role.²⁵ For practices implementing the model, the program assists them with billing and coding, Continuous Quality Improvement, and research and evaluation.²⁶

In addition to the integrated care models outlined above, other care delivery components are important for BHI related to treating substance use disorder. People with SUD often experience co-occurring chronic physical health conditions, including chronic pain, cancer, or heart disease, which makes primary care a sensible setting for these patients to receive multiple care.^{27,28}

Screening Brief Intervention and Referral to Treatment (SBIRT): Developed to treat individuals with SUD and those at risk of developing the disorder, SBIRT is an integrated, public health approach to early intervention and treatment. SBIRT can take place in a range of settings, including primary care centers, emergency rooms, trauma centers, and community settings, as these sites allow early intervention before acute negative outcomes occur.²⁹ SBIRT's core elements include quick screenings to assess substance use severity and appropriate treatment; brief intervention to increase insight into and awareness of substance use and the person's motivation to change his or her behavior; and referral to treatment for those who would benefit from specialty care.³⁰ Medicare covers SBIRT when it is administered by a licensed/reimbursable provider as an early intervention, but the services are only reimbursable when they are provided in office-based and outpatient settings. Medicare patients receiving SBIRT could face financial barriers if the provider or level of care is not covered.³¹

Medication-Assisted Treatment (MAT): MAT is a biopsychosocial approach to substance use disorder treatment for opioid and alcohol use disorders. MAT provides pharmacotherapy through any of three FDA-approved medications (buprenorphine, methadone, and long-acting naltrexone) and combines it with behavioral health counseling, with the goal of creating a holistic program addressing the patient's comprehensive needs.^{32,33} MAT offers a range of care that includes both harm reduction approaches and integrated care, focusing on physical, psychological, and social variables.³⁴ MAT can be offered in a variety of primary care settings, allowing care teams to support patients. These teams include primary care providers, behavioral health providers, and peer support and recovery specialists.³⁵ MAT is an effective treatment that can reduce substance use, such as opioids and alcohol dependency, increase retention in treatment, and decrease overdose-related and all-cause mortality.³⁶

CHEROKEE HEALTH SYSTEMS

Cherokee Health Systems began as a small mental health provider and evolved into a Federally Qualified Health Center and a Community Mental Health Center jointly providing integrated behavioral health.³⁷ Cherokee operates 20 clinics in both urban and rural areas of Tennessee, as well as on-site and telehealth services in school systems.³⁸ It largely provides care to underserved populations, including the migrant farmworker population, patients with Opioid Use Disorder, and those who live in public housing.³⁹

In the Cherokee model, a behavioral health consultant, who is usually a Ph.D. or licensed clinical social worker, is embedded in the primary care team, so it is common for a patient to see *both* the primary care provider *and* a behavioral health consultant on the same day.⁴⁰ To increase the model's effectiveness, primary care providers are trained on the integrated clinical model, how and where to use the behavioral health consultant, referrals, and other facets of the model. Behavioral health consultants receive training in which they shadow primary care providers for up to four weeks, discuss assigned readings for the initial six to eight weeks with mentors, and align their schedules with primary care providers.⁴¹

At the start of an appointment, patients typically answers questions about their physical health concerns, as well as a few "behavioral health vitals," including screenings for depression and substance use.⁴² If the patient answers affirmatively to the behavioral health questions, the primary care provider brings in the behavioral health consultant to engage with the patient.⁴³ To support this model, the primary care provider and behavioral health consultant share an electronic health record (EHR).⁴⁴

Cherokee employs a range of staff, including nurses, psychiatrists, psychologists, community health workers, and pharmacists, who can help with the patient's care.⁴⁵ There are hurdles to this blended staffing approach. The work requires a unique skill set, so hiring the appropriate employees can be a challenge. Cherokee offers various educational opportunities relating to its work, such as a psychology internship and a practicum experience for master's and doctoral students. The practicum allows social work, clinical psychology, and counseling psychology students to work with and learn from Cherokee health care professionals.

The importance of payers allowing same-day billing of primary care and behavioral health services cannot be overstated. Seeing both primary care providers and behavioral health specialists is central to Cherokee's model.⁴⁶

SOUTHCENTRAL FOUNDATION

Southcentral Foundation is a nonprofit health care organization established under the tribal authority of Cook Inlet Region, Inc. It was created in 1982 in response to the fragmented care, poor patient satisfaction, and high staff turnover in the region. It considers itself customer-owned and built on the values of the Alaska Native people.⁴⁷

Customer-owners design all aspects of the care system, comprise the board of directors, and constitute 54% of the workforce. In addition, the organization conducts surveys and focus groups to seek feedback and incorporate it into the delivery of care.⁴⁸

Southcentral employs multidisciplinary, integrated care teams consisting of a primary care provider, a certified medical assistant, a nurse case manager, an administrative assistant providing care coordination support, behavioral health consultants, and others.⁴⁹ Teams can also incorporate tribal doctors or traditional healers.⁵⁰ Southcentral has its own integrated team playbook to help guide its team-based approach and to train staff on all components of implementing and sustaining integrated care teams.⁵¹

When bringing on new staff, Southcentral Foundation employs behavioral interviewing strategies and uses group interviews.⁵² All new employees are oriented to the Southcentral Foundation, with training focused on the customer-owner structure, Alaska Native culture, and quality improvement.⁵³ Front desk employees receive an additional two weeks of training before they take their position and six months of follow-up mentoring.

Staff within integrated care teams are trained to work to the full extent of their education and training, and Southcentral Foundation also takes steps to place new employees on teams that best align with their skill sets and preferences.⁵⁴

BARRIERS TO EXPANDING INTEGRATED CARE

While evidence supports the need for integrated care, barriers to integrating services are well documented. These barriers include shortages in the behavioral health provider workforce; entrenched workforce cultures; lack of education and training in integrated care; limited opportunities for cooperation and coordination across provider types; prohibitions by insurers for billing for medical and mental health services on the same day for the same patient; high practice costs for implementing BHI models; and lack of reimbursement for BHI services. Unfortunately, changing how individual providers practice

medicine, especially outside of large health systems, can be a slow, labor-intensive process.⁵⁵

Securing an adequately trained workforce with the competencies and skills needed to deliver integrated care is critical to implementation success.⁵⁶ Most primary care providers and behavioral health providers have historically received professional training in discipline-specific silos, in isolation from one another.⁵⁷ Therefore, many providers enter the workforce without the skills to function as part of an integrated care team. Technical assistance, the availability of interprofessional consultation, and on-the-job training opportunities are essential.

Provider payment is another significant barrier to the implementation of BHI. Across Medicare, Medicaid, and private health plans, providers report that they do not receive adequate payment commensurate with the time and effort required to care for patients with behavioral health conditions and symptoms. This reduces access to care, limits the participation of providers in insurance networks, and results in higher out-of-pocket costs for patients.

Nonclinical workers, such as peer support and recovery specialists and community health workers, also do not receive adequate training or reimbursement to deliver integrated care. Peer specialists are important members of an integrated care team, but they are unable to independently bill Medicare for services, and Medicaid has no standardized coverage. They also do not have uniform training opportunities to enhance their skills. Removing some of these barriers can help more successfully embed nonclinical workers in integrated care teams and help to relieve some of the burden on the licensed workforce.

Another barrier to BHI may be providers' lack of familiarity with the digital tools that can help integrated teams effectively document a patient's care in the EHR. Often these tools are underutilized because they are overly complex or lack standardization.⁵⁸ Providers might also feel uncomfortable using digital technology or do not know the extent of its usefulness in coordinating and providing care.

Incorporating BHI into pediatric care presents unique challenges. Pediatric providers should strongly focus on prevention and promotion and on including families and caregivers in the patient's care plan. Additionally, relying on diagnosis-based care is not as straightforward for children: About 1 in 5 children has symptoms of a mental health condition but do not meet the specific criteria for a diagnosis.⁵⁹ In adults, a patient's diagnosis often determines provider reimbursement, EHR documentation, and treatment. For children, providers must focus more on a patient's symptoms to determine treatment.

MOVING FORWARD

Integrated care promises to benefit patients and improve their access to critical behavioral health services, but multiple hurdles exist for providers desiring to participate in BHI. BPC's current work offers recommendations for Congress and the administration to strengthen the workforce that delivers integrated care services.

This report is divided into three key areas:

- efforts to support the workforce needed to deliver integrated behavioral health services through **training and recruitment**;
- recommendations to better **finance integrated models of care** to ensure continued uptake by providers and ample opportunities for providers to enhance their capabilities by working in integrated care settings; and
- recommendations that will **increase accountability and the flexibility** of the existing workforce to deliver integrated care, such as new policies regarding licensure.



Policy Recommendations

A. TRAINING AND RECRUITMENT

Ideally, health care providers become familiar with the principles of integrated care delivery in their respective training programs and then receive ongoing opportunities to deliver integrated care in settings in which they can practice and enhance those principles.

THE HEALTH RESOURCES & SERVICES ADMINISTRATION (HRSA) SHOULD INCLUDE LANGUAGE IN NOTICES OF FUNDING OPPORTUNITY FOR PROGRAMS THAT GIVE PREFERENCE TO APPLICANTS OR ENTITIES THAT DEMONSTRATE THEY HAVE RELEVANT BHI PROGRAMS IN PLACE, AS WELL AS THOSE THAT INTEND TO USE FUNDING TO SUPPORT BHI ACTIVITIES. THESE SHOULD INCLUDE THE TITLE VII SECTIONS 747 AND 748 PRIMARY CARE TRAINING PROGRAMS, TITLE VIII PROGRAMS, AND THE TEACHING HEALTH CENTER PROGRAM.

To develop health care providers who are familiar with, and incentivized to, practice in integrated models of care, it is essential to include these models in training curricula and clinical rotations. Preliminary results from a combined psychiatry and primary care clerkship, for instance, found that students reported greater benefits and understanding of how behavioral health and primary care intersect when they were allowed to practice in integrated care sites. In contrast, students in the clerkship who did not have direct exposure to such sites expressed more difficulty in appreciating connections between primary care and psychiatry.^{60,61}

Additionally, some studies of specialized rotation and hands-on training opportunities show that exposure increases the likelihood of providers practicing in such settings. For example, the Teaching Health Center program—which enables Federally Qualified Health Centers to serve as graduate medical center-sponsoring institutions and offers more in-depth exposure to practicing in high-need and rural settings—found that program graduates were significantly more likely than others to practice in rural locations to care for medically underserved populations.⁶²

Training programs that reach professionals who are likely to serve as members of integrated teams—psychiatrists, primary care providers, psychologists, nurse practitioners, social workers, and community health workers—should be a key area of focus.

BPC recommends that HRSA leverage the Title VII and VIII training programs and the Teaching Health Center program to augment real-world integrated care experiences for the future health care workforce. HRSA should include language in notices of funding opportunity for Title VII Sections 747 and 748 primary care training programs, Title VIII programs, and the Teaching Health Center program that give preference to applicants or entities that demonstrate they have BHI programs in place. Specifically, we recommend that HRSA provide points for applicants who demonstrate they operate BHI models suitable for training purposes. They will need to establish clear criteria for BHI programs to be considered, such as team-based staffing models, measurement-informed care, outcome-driven performance. HRSA could work with organizations in underserved communities to help enhance BHI training experiences for individuals who might be applying to loan forgiveness programs at those organizations.

The Title VII and VIII primary care education and training programs of the Public Health Service Act help shape the supply, diversity, and distribution of health professionals. These federal programs encompass a wide range of primary care workforce programs, nursing workforce development programs, and other initiatives such as public health and preventive medicine residency initiatives.⁶³

The Teaching Health Center program provides funding to community health centers to serve as residency training programs.⁶⁴ By prioritizing applicants who directly express a commitment to BHI programs, HRSA can increase understanding of BHI models among future providers and potentially motivate them to pursue workforce opportunities within these models.

In addition to the recommendations outlined in this section, BPC also suggests that HHS leverage its many distribution channels and programs to continue to train and educate the primary care workforce about BHI models and their associated billing mechanisms. For example, CMS has supported the Health Care Payment Learning & Action Network to provide guidance on adopting the value-based payment model.⁶⁵ Additionally, from 2015-2019, the CMS Innovation Center implemented the Transforming Clinical Practice Initiative, which sought to provide hands-on technical assistance to 140,000 clinicians to facilitate the shift to value-based payment arrangements.⁶⁶ These larger initiatives, as well as the Medicare Learning Network and the Medicaid and CHIP Learning Collaboratives, offer potential structures to offer training and resources on BHI models.^{67,68}

TO EXPAND THE AVAILABLE BEHAVIORAL HEALTH WORKFORCE, CONGRESS SHOULD DIRECT HRSA TO USE EXISTING SOURCES OF FUNDING—SUCH AS THE SUBSTANCE USE DISORDER TREATMENT AND RECOVERY PROGRAM AND THE COMMUNITY HEALTH WORKER TRAINING PROGRAM—TO CREATE A PIPELINE PROGRAM THAT ENABLES INTERESTED BEHAVIORAL HEALTH SUPPORT SPECIALISTS TO BECOME LICENSED BEHAVIORAL HEALTH PROFESSIONALS.

In January 2023, BPC released a comprehensive [report](#), *Filling the Gaps in the Behavioral Health Workforce*, which outlined ways to strengthen the role of behavioral health support specialists in delivering critical nonclinical behavioral health services. Behavioral health support specialists are defined as nonclinical behavioral health workers who contribute to teams that administer comprehensive patient care and who play important roles in delivering behavioral health services that support licensed professionals.⁶⁹ These individuals include peer specialists—also known as peer support and recovery specialists—as well as community health workers (CHWs) and paraprofessionals.

Behavioral health support specialists are an important piece of an integrated care team and play a large role in patients' access to primary care.⁷⁰ They have

the lived experience to help patients better understand their diagnoses, build self-management techniques and coping skills, and navigate the behavioral health care system.^{71,72} They also share life experience, trust, compassion, and alignment of culture and values with the communities where they live and serve.⁷³

Having more clinicians who share lived experiences with patients would help improve integrated care delivery. In addition to supporting the continued training and appropriate reimbursement of behavioral health support specialists in their current care team roles, BPC recommends expanding the workforce by helping interested behavioral health support specialists become licensed behavioral health professionals. Pipeline programs are especially critical for under-resourced communities and currently tend to target high school and college students rather than those who wish to undergo a career change.

Congress should direct HRSA to leverage existing funds to establish a pipeline program for interested behavioral health support specialists to become licensed behavioral health professionals within already existing provider types.⁷⁴ Allowing these professionals a pathway into the licensed workforce would create development opportunities for those interested, while establishing a sustainable approach to expanding the supply of licensed practitioners.

Currently, the pathway to licensure takes many years and requires trainees to assume some individual costs (e.g., tuition, time out of the labor force). In contrast, HRSA could establish a 32-week pipeline program to provide an accelerated educational curriculum to eligible entities that actively employ behavioral health support specialists. This could enable working behavioral health support specialists to leverage their years of experience to accelerate and satisfy any necessary prerequisites, including fulfilling the supervision requirements, to earn their licenses. By the end of the training, individuals could be eligible to begin fulfilling state supervision requirements as mandated by state licensing boards.⁷⁵ A condition of the award could include a two-year follow-up assessment to measure the program's success and track the number of individuals who obtained employment after licensure.

The pipeline program could utilize funds from existing HRSA programs but would need congressional authorization, especially if any new federal discretionary funding is required. One existing source of funding could come from the Substance Use Disorder Treatment and Recovery Loan Repayment Program, to which Congress appropriated \$28 million in fiscal year 2022. This program gives individual behavioral health providers up to \$250,000 to repay school loans in exchange for working full time for six years at an approved facility.⁷⁶ Funds from this program could go toward trainees' tuition, which could reduce a financial barrier to entering the pipeline program. Another possible funding source could be the Community Health Worker Training Program, which supports institutions that train community health workers.⁷⁷

Grantees of the pipeline program could use funding from this program to develop and update an accelerated curriculum every five years and to subsidize relevant training costs.

Both Congress and the Biden-Harris administration have recently taken action to bolster the nonclinical workforce. Sens. Tim Kaine (D-VA) and Mike Braun (R-IN) introduced the Providing Empathetic and Effective Recovery (PEER) Support Act ([S. 2733](#)) in September 2023. The bill takes steps to recognize peer specialists as a profession, to support and develop career pathways and professional development, and to promote more research into the profession. The Substance Abuse and Mental Health Service Administration's (SAMHSA) Office of Recovery released its [National Model Standards for Peer Support Certification](#) in June 2023.⁷⁸ These standards serve as a guidance for states, territories, tribes, and others to encourage alignment and reciprocity for peer support and recovery certifications that tend to vary greatly across state lines.⁷⁹

B. PAYMENT AND ADMINISTRATIVE STRATEGIES

Direct payments that reimburse providers for the delivery of BHI encourage more widespread adoption of BHI models and ensure increased opportunities for individuals to receive training and refine their clinical competencies within integrated care settings.

CMS sets Medicare fee-for-service payments that are often used by Medicare Advantage, Medicaid managed care organizations (MCOs), and commercial payers as a benchmark for payments in other contexts.⁸⁰ Within Medicare and Medicaid, several key options could increase uptake of BHI models. Opportunities exist for Congress and CMS to implement payment and administrative strategies to increase the adoption of BHI-related billing codes in Medicare and Medicaid, enabling and incentivizing a broader array of providers to participate in BHI models.

CONGRESS SHOULD INCREASE REIMBURSEMENT FOR BEHAVIORAL HEALTH INTEGRATION CODES, INCLUDING THE COLLABORATIVE CARE MODEL, FOR UP TO THREE YEARS. CONGRESS SHOULD EVALUATE DOING THE SAME FOR PROVIDER-TO-PROVIDER INTERPROFESSIONAL CONSULTATIONS WITH BEHAVIORAL HEALTH SPECIALISTS. FOR BOTH, CONGRESS AND CMS SHOULD EVALUATE THE IMPACT OF AND DETERMINE BEST PRACTICES THAT RESULT FROM ADDITIONAL FUNDING ON

THE VOLUME OF INTEGRATED CARE SERVICES DELIVERED AS WELL AS THE QUALITY OF CARE AND PATIENT OUTCOMES.

CMS pays for behavioral health integration services via several billing codes, which include those used for the Collaborative Care Model (see Appendix A for billing codes related to the delivery of integrated primary care and behavioral health services).⁸¹ Although Medicare and numerous commercial plans reimburse for CoCM, the adoption of CoCM and BHI codes has remained relatively low over time. Additionally, less than half of states reimburse for CoCM through Medicaid, and Medicaid already pays lower fees to providers than Medicare for the same services.^{82,83}

An early analysis of Medicare Part B billing codes related to the CoCM program and BHI indicated that while the number of claims and proportion of beneficiaries represented by those claims increased between 2017 and 2018, it still was less than 0.1% of the total number of Medicare claims.⁸⁴ It is important to note that these analyses occurred around the time that the CoCM codes were introduced, as they did not become G codes until 2017, and became CPT codes in 2018.⁸⁵

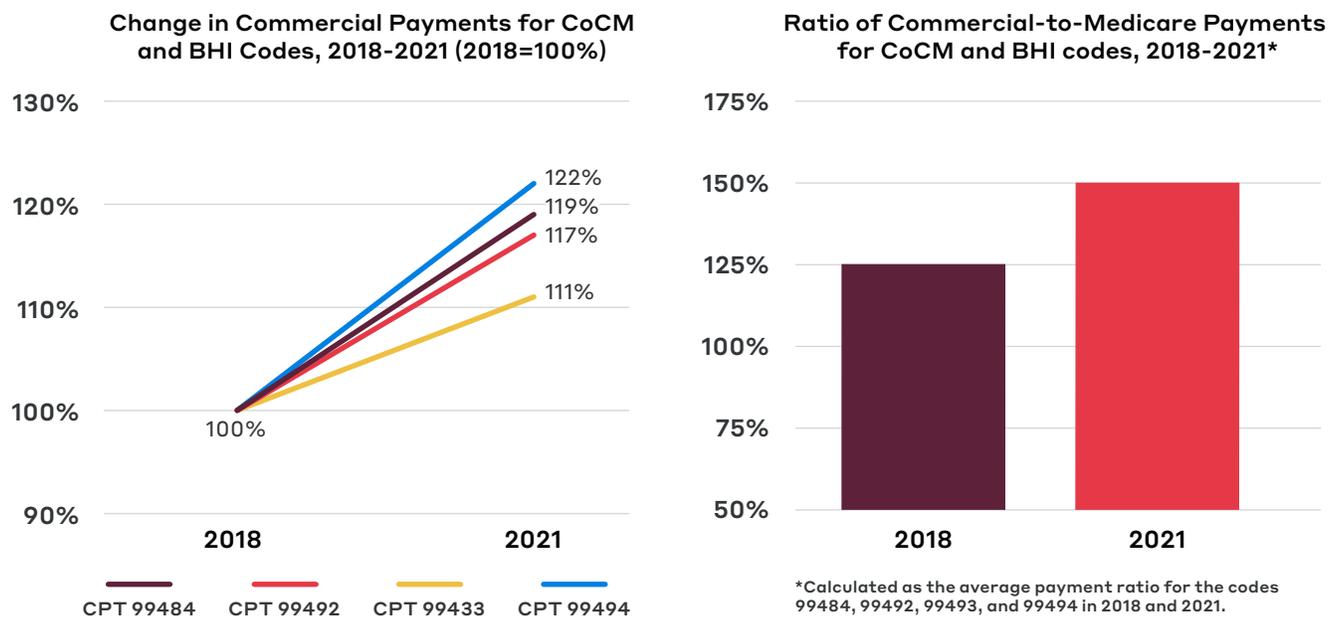
There are several potential reasons for the limited uptake. In the pediatric context, pediatricians and their related practices are often not considered mental health providers by payers or regulatory bodies. This limits the ability of pediatric practices to capitalize on CoCM codes, where they exist in Medicaid and commercial contexts. This limitation should be further explored at the state level to address and rectify. Additionally, as discussed previously, CoCM might not be the optimal model for younger populations in that it relies on individuals receiving a formal diagnosis and could entail cost sharing obligations.

Another likely reason for limited participation is that reimbursement rates do not adequately cover the high upfront and implementation costs of the model. One study of 10 health systems that implemented CoCM found that the median cost of implementation per clinic was \$160,000 for a period ranging from two to five years; these costs were driven primarily by leadership personnel involved directly in initiating CoCM.⁸⁶ Congress should increase reimbursement for behavioral health integration codes, including reimbursement for the Collaborative Care Model, for up to three years. BPC recommends increasing the Medicare payment for CoCM billing codes by 75% in the first year, 50% in the second year, and 25% in subsequent years. BPC's 2021 [report](#) included these payment rates and estimated that starting in 2022, the cost to the federal government would be \$152 million over 10 years.⁸⁷

Boosting reimbursement rates for behavioral health integration services would likely increase the adoption of CoCM and other integrated care models. For example, the increased reimbursement could allow health systems to offset startup and implementation costs and reduce barriers to entry. An analysis of CoCM and BHI codes in commercial claims saw increasing use of the codes from 2018-2021 (on average, codes were used 19 times more frequently in 2021 than previous years) as reimbursement rates increased over the same period (see Figure 2 below).⁸⁸ Similarly, the Affordable Care Act included a mandatory two-year increase in 2013 and 2014 for primary care services to Medicare levels for both Medicaid fee-for-service and managed care.⁸⁹

Figure 2: Commercial payments for collaborative care and behavioral health integration codes (2018-2021)⁹⁰

Commercial payments for the collaborative care and behavioral health codes in 2018 and 2021 were significantly higher than Medicare payments.



Congress recently took action to incentivize the uptake of CoCM and BHI codes. The bipartisan Connecting Our Medical Providers with Links to Expand Tailored and Effective Care (COMPLETE) Care Act, or [S. 1378](#), introduced by Sens. Catherine Cortez Masto (D-NV) and John Cornyn (R-TX), and the House companion bill, [H.R. 5819](#), introduced by a bipartisan [group](#) of six representatives would increase Medicare payment rates over three years (2025-2027) for billing codes related to BHI.⁹¹ The legislation proposes payment for BHI codes in 2025, 2026, and 2027 to be 175%, 150%, and 125% of the current rate, respectively, which aligns with BPC’s recommendation. The legislation also mandates the reporting of quality measures related to the use of these codes and allocates funding for technical assistance.⁹²

Another facet of supporting BHI models involves providing incentives to psychiatrists and psychologists to offer interprofessional electronic-consultation (e-consult) to those who engage directly with patients: primary care providers. Interprofessional e-consult codes were established in 2014 for a variety of specialists to serve in a consultative capacity to requesting providers.⁹³ In 2019, new codes were introduced that allow requesting providers to charge for their time spent reviewing advice from the consulting clinician, and the codes also introduced more flexible options to conduct electronic consultation and review EHRs.⁹⁴

In January 2023, CMS issued guidance to create an easier path for state Medicaid and CHIP programs to pay specialists directly when a beneficiary's primary care provider asks for advice. For example, if a pediatrician consulted with a specialty behavioral health provider about a patient's needs, both providers can be reimbursed for their care, even if the patient is not present.⁹⁵ This policy change aligned Medicaid and CHIP with the standards of practice in Medicare. The guidance also encouraged states to modify remaining same-day billing restrictions that do not allow providers to bill for both primary care and mental health services in the same facility on the same day. This change affects integrated care, and BPC [has advocated](#) for more states to amend their programs per this guidance. In Congress, the introduced bipartisan bill, Improving Coordination and Access to Resources Equitably (CARE) for Youth Act, [S. 2556](#), would ensure Medicaid coverage of primary care and mental health services furnished on the same day.⁹⁶

CMS and Congress should monitor the adoption of interprofessional e-consult codes, especially in light of recent modifications allowing psychologists to utilize them, and the increased use of digital modalities during the COVID-19 pandemic. Depending on uptake, Congress and CMS could include the same payment increases as described for CoCM for psychiatrists and psychologists using the relevant e-consult codes. Although such consultation may not mean that either the consulting or receiving providers are operating formal BHI models, it nonetheless increases workforce capacity, improves understanding of behavioral health needs in primary care settings, and enhances providers' confidence in treating behavioral health conditions and symptoms in primary care settings.

Congress and CMS should evaluate the impact of any additional funding for behavioral health integration codes on the volume of integrated care services delivered, as well as the quality of care and patient outcomes. Lastly, the Center for Medicaid and CHIP Services could provide additional assistance and support to state Medicaid agencies to help spur the adoption of e-consult programs, determining any barriers to adoption.

CONGRESS SHOULD FUND LONG-TERM, SUSTAINABLE INVESTMENTS IN STATE, REGIONAL, AND TRIBAL MENTAL HEALTH E-CONSULTATION SERVICES—ESPECIALLY PEDIATRIC MENTAL HEALTH CARE ACCESS PROGRAMS—THAT PROVIDE PRIMARY CARE PROVIDERS WITH BEHAVIORAL HEALTH EXPERTISE FOR TREATING MILD TO MODERATE CONDITIONS AND SYMPTOMS.

Mental health consultations are essential in providing primary care providers with the guidance they need to effectively manage some behavioral health conditions and symptoms. Consultations allow integrated care teams to access mental health care without necessitating an on-site mental health provider. These programs—funded through a range of resources, including federal appropriations, state budget line items, and, in a limited number of states, Medicaid payment, as well as private sources of funding—offer to primary care providers, specifically pediatricians, same-day consultations with child mental health professionals. These consultations help providers manage mental health symptoms and conditions, as well as provide them with bidirectional training.^{97,98,99}

Given the unique needs of children and the significant rise in mental health issues and substance use after the COVID-19 pandemic, Congress and the Biden-Harris administration directed new investments to state, regional, and tribal mental health teleconsultation models. In 2021, the American Rescue Plan provided \$80 million in funding, supporting 29 Pediatric Mental Health Care Access Program awards through 2025. In 2022, the Bipartisan Safer Communities Act allocated an additional \$80 million for Pediatric Mental Health Care Access Programs over four years.¹⁰⁰ This encompasses program expansions to hospital emergency departments and schools and provides technical assistance to funding recipients.¹⁰¹ Additionally, in September 2023, the administration allocated more than \$19 million to 25 states and territories to provide real-time teleconsultation for pediatricians seeking expert support from child mental health teams.¹⁰²

Some states have also taken steps to fund and sustain these programs. The Massachusetts Child Psychiatry Access Program, a system of children’s behavioral health consultation teams available to consult with primary care practices throughout the state, is funded by the Massachusetts Department of Health and several commercial payers.¹⁰³ A 2020 survey by the National Network of Child Psychiatry Access indicates that most of these programs are funded at the state level through a legislative line item.¹⁰⁴ The evidence base for the efficacy of these programs is widely accepted, given the significant prior federal, state, and private investments.

BPC calls for sustainable funding streams federally and within states to ensure the continuity and availability of these services. BPC's [March 2021 Behavioral Health Integration Task Force report](#) recommended that Congress appropriate money for HRSA grant-funded consultation services to make these services more widely available in all primary care settings.

THE CENTER FOR MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) SERVICES SHOULD ISSUE A STATE MEDICAID DIRECTOR OR STATE HEALTH OFFICIAL LETTER ON HOW STATES CAN IMPLEMENT BEST PRACTICE BHI MODELS LEVERAGING PERMISSIBLE MEDICAID AUTHORITIES.

As of 2022, only 22 states included the collaborative care model as a covered Medicaid benefit.¹⁰⁵ BPC encourages the Center for Medicaid and CHIP Services to issue a State Medicaid Director or State Health Official letter offering clarification on strategies for implementing integrated care models, including but not limited to CoCM.

This guidance could bring together content from prior guidance documents—for example, the state health official letter regarding coverage and payment of interprofessional consultation in Medicaid and CHIP, or the informational bulletin leveraging Medicaid, CHIP, and other federal programs in the delivery of behavioral health services for children and youth.^{106,107} Guidance could also offer additional input on strategies that states have used within Section 1115 waivers to create billing and quality parameters for CoCM in managed care or other funded co-location strategies.

Issuing federal guidance could help clarify how other states might implement or augment integrated behavioral health strategies. This guidance could also provide clarity on how existing billable codes, already accessible in many state Medicaid programs, can support different aspects of BHI models.

THE CMS INNOVATION CENTER SHOULD REQUIRE APPLICANTS AND PARTICIPANTS IN PRIMARY CARE OR TOTAL COST OF CARE-ORIENTED MODELS TO ARTICULATE BHI PLANS, THE DEGREE OF INTEGRATION ACHIEVED, AND REPORT ON ASSOCIATED OUTCOMES.

The Innovation Center focuses on testing and evaluating new health care payment and performance models. Although the center does not currently operate any initiatives with a sole focus on behavioral health, it has launched an array of primary care and accountable care programs that offer opportunities to incentivize and strengthen the BHI workforce. Additionally, integration is a stated overall goal of the Innovation Center; its 10-year strategic refresh underscores the significance of exploring greater integration between primary care and behavioral health.¹⁰⁸

Typically, Innovation Center models outline eligible entities that may participate, as well as outline specific provider network composition requirements (e.g., types of required or permissible participating providers and relationships to entities). However, beyond these requirements, the Innovation Center usually defers to applicants and participants to develop workforce training and development strategies unique to their implementation contexts.

To help support BHI workforce development, the Innovation Center should require applicants—for primary care and total cost-of-care initiatives—to articulate their specific strategies for promoting behavioral health and primary care integration in their responses to application requests and provide regular updates on their progress. Such reports should include specific information, such as the BHI model being used, the degree of integration, changes in services offered (specifically reporting on whether short-term therapy is provided in the practice) and staffing for BHI. Although we do not recommend that the Innovation Center be overly prescriptive in the type of BHI approach and how the integration operates, we do strongly urge the center to support the use of evidence-based BHI models and the compiling of reports indicating which models/components are being pursued.¹⁰⁹

Requiring these types of reports mirrors requirements in recent CMS Innovation Center efforts. For example, the Making Care Primary and ACO REACH requests for application note that applicants must develop a Health Equity Plan (drawing from the CMS Disparities Impact Statement) and report on it annually.¹¹⁰

For relevant initiatives that have closed requests for applications, the Innovation Center should require the development of BHI plans and monitoring in future performance years. The Innovation Center often offers technical assistance within models. Given the cross-cutting nature of BHI across models, as well as the higher success rate of programs that receive technical assistance, CMS should consider providing technical assistance to support the effort.¹¹¹ Such assistance could resemble efforts headed by SAMHSA to fund an external national training and technical assistance center for certified community behavioral health clinics across the country. Support could entail creating and maintaining a resource library of relevant topics, the development of group learning cohorts, the dissemination of evidence-based best practices, workflows, and materials related to BHI.

Investments in behavioral health care often result in savings on patients' physical health spending. This is critical for providers participating in accountable care or total cost of care models. When these providers make new investments in behavioral health services, the Innovation Center must ensure such investments are not counted against the provider's benchmark or spending targets.

C. NETWORK REQUIREMENTS AND FLEXIBILITY

To make better use of existing resources and expand patient access to the current behavioral health workforce, Congress and HHS can adjust behavioral health network adequacy standards and address barriers to state licensing requirements.

CONGRESS AND HHS SHOULD REQUIRE BHI IN BEHAVIORAL HEALTH PLAN NETWORK ADEQUACY STANDARDS.

Recent data underscores the fact that there is a dearth of mental health providers who accept insurance: Less than a quarter of psychiatrists are in-network with Medicare Advantage plans, and more than half of the U.S. counties with data had no psychiatrists who accepted insurance.¹¹² People covered by Medicaid struggle to find providers who accept their insurance, in part due to low reimbursement rates, despite Medicaid being the nation's largest payer of behavioral health services.¹¹³ Additionally, one reason individual patients are unable to get the treatment they need is the affordability factor. In 2021, about 25% of individuals who needed but did not receive SUD treatment indicated they could not afford it, and 42% of adults with an unmet need for mental health services indicated they could not afford the service.¹¹⁴

As part of efforts to implement mental health parity, HHS should require plans in Medicare Advantage, Medicaid managed care, and commercial contexts to evaluate and consider access to BHI models as part of their network adequacy assessments.

This recommendation follows a November 2021 [technical report](#) commissioned by HHS on behavioral health network adequacy that specifically calls for standards to include the unique structures of team-based care and integrated care. The report's authors note that such models can increase overall access versus simply basing standards on access to individual providers.¹¹⁵ BPC recognizes that plans will likely need to increase reimbursement, modify reimbursement practices, and/or institute technology-enabled matching

of providers and patients (e.g., based on patient preferences and provider experience and training) to meet such standards. This recommendation also aligns with the July 2023 [rule](#) from the Departments of Labor, Health and Human Services, and Treasury.^{116,117}

BPC [previously recommended](#) that CMS revise its November 2020 final [rule](#) to reinstate time and distance-to-provider standards for Medicaid managed care plans to demonstrate network adequacy, in addition to requiring two additional quantitative measures. Given that Medicaid MCOs are subject to parity requirements, a federal set of network adequacy requirements would promote national compliance. This would save an estimated \$105 million over 10 years.¹¹⁸

Recognizing the different pathways for requiring network parameters across Medicare, Medicaid, and commercial contexts, options to require BHI in behavioral health plan network adequacy standards include:

- requiring health plans to report on which in-network primary care providers offer BHI on-site as a part of procurements or network assessment processes (BHI would need to be defined and could include the implementation of CoCM, measurement-based care, e-consult with behavioral health providers, and other strategies);
- requiring a certain number or percent of providers delivering integrated primary care to meet network adequacy requirements;
- giving additional credit to health plans that include integrated care providers in their networks;
- issuing corrective action plans or financially penalizing health plans that fail to demonstrate availability of BHI within primary care providers in network; and
- rating health plans through standardized rating approaches on the delivery of BHI within primary care settings (for example, in the Oregon Medicaid Program, the Patient Centered Primary Care Program awards a 5-star designation to participating providers who meet a limited set of measures, including offering “integrated behavioral health services”).¹¹⁹

**CONGRESS SHOULD DIRECT CMS TO AUDIT
MEDICARE ADVANTAGE PLANS TO ENSURE THAT
THEY ARE PROVIDING ACCURATE INFORMATION
ON THE AVAILABILITY OF THEIR IN-NETWORK
PROVIDERS. CONGRESS SHOULD ALSO REQUIRE
THAT PRIVATE HEALTH PLANS USE INDEPENDENT
AUDITORS TO ASSESS THE ACCURACIES OF THEIR
PROVIDER DIRECTORIES.**

Accurate provider directories are crucial to ensuring that people seeking care can identify providers who are covered by their insurance. Provider directories are often a proxy for network adequacy.

A survey of privately insured individuals receiving mental health treatment found that more than half of those patients encountered inaccuracies when using a provider directory; this resulted in them being more likely to receive treatment from an out-of-network provider and four times more likely to receive a surprise, out-of-network bill.^{120,121} The term “ghost” or “phantom” network is often used to refer to a plan that seems to have many available providers but whose providers are no longer in practice or are not accepting patients. It is imperative that plans’ provider directories are accurate and include only those providers currently practicing.

People choose insurance plans for a variety of reasons, and the adequacy of the provider network is a common one. Someone could choose a particular plan based on the seemingly expansive provider directory, only to discover that they have a much narrower pool of providers to choose from.¹²² Plans are required by law to verify and update provider directory information, but this does not always ensure that the information is up to date and accurate.¹²³ Ghost networks could leave federal and state officials who are responsible for assessing a plan’s network adequacy with the impression that the plan is in compliance with the standards even when it is not.¹²⁴

To address the problem, Congress should direct CMS to audit health plans that provide Medicare Advantage coverage to ensure that they are providing accurate information on the availability of their in-network providers. Congress should also require private health plans to use independent auditors to assess the accuracy of their provider directories on a regular basis.

A May 2023 Senate Finance Committee brief found that CMS does not audit directories on a regular basis and that Medicare Advantage plan directories have not been audited since 2018.¹²⁵ Improving the accuracy of provider directories could allow people to make more informed choices and to receive more timely and cost-effective care.

CONGRESS SHOULD DIRECT THE SECRETARY OF HHS TO DEVELOP A SET OF LIMITED CIRCUMSTANCES UNDER WHICH HEALTH CARE PROVIDERS CAN DELIVER TELEHEALTH SERVICES TO PATIENTS LOCATED OUT OF STATE. CONGRESS COULD THEN ALLOW LICENSURE FLEXIBILITY FOR THE SPECIFIC SET OF CIRCUMSTANCES DEEMED APPROPRIATE BY THE SECRETARY.

Under current law, physicians and other types of health care providers can only offer telehealth across state lines if they are licensed separately in each state they practice. Interstate licensure compacts streamline the process for several types of health care providers seeking licensure to practice across state borders, but participation can carry significant costs and administrative burdens.¹²⁶

During the COVID-19 pandemic, almost every state and the federal government temporarily loosened licensure restrictions to allow health care providers greater flexibility to provide telehealth across state lines.¹²⁷ BPC's November 2021 [report](#), *What Eliminating Barriers to Interstate Telehealth Taught Us During the Pandemic*, outlined the rapid growth of interstate compacts across multiple professions, especially the Psychology Interjurisdictional Compact (PSYPACT) for psychologists. A study examining the reciprocity program in New Jersey found that over 7,000 temporary licenses were issued to mental health providers, allowing them to care for both existing and new patients.¹²⁸ Reciprocity programs also increased access to providers from diverse cultural and linguistic backgrounds, giving patients the opportunity to select providers who could better fulfill their needs.¹²⁹

These temporary licensing flexibilities have since expired, and more permanent solutions are needed.

Congress should pursue a limited set of circumstances in which providers can deliver telehealth services to out-of-state patients without the need for additional state licensure. Allowing providers to continue seeing patients who relocate or are temporarily out of state can be essential for continuity of care.¹³⁰ Discontinuities of care are a primary concern among college students, who move frequently between states for school breaks and internship opportunities.¹³¹ To guarantee proper adjudication of any provider misconduct claims, patients and providers engaged in care under these limited circumstances could be directed to adhere to the regulations of a provider's home state licensing board—ostensibly where the therapeutic relationship between the patient and the provider started.

Congress should direct the HHS secretary to develop a set of limited circumstances in which providers may be authorized to deliver telehealth services to out-of-state patients, provided the patients give informed consent. This should include care for patients who have an established patient-provider relationship. Following an assessment by CMS, Congress could then act to allow licensure flexibility for a specific set of circumstances deemed appropriate by the secretary.

Additionally, Congress should support the continued growth and utility of interstate licensure compacts for health care providers. Even with the limited authorizations for care delivery outlined above, interstate compacts would continue to be the predominant vehicle for care delivery across state lines.

While the number of states participating in compacts is vital, the involvement of providers is equally important. There is wide variation in provider participation across states. For example, BPC's analysis using psychologists' licensure data in December of 2022 showed that the participation of licensed psychologists in PSYPACT member states that have been active in the compact since at least October 2020 varied from 11% of psychologists in Oklahoma to 23% of psychologists in Delaware.^{132,133} If providers are not opting to participate in compacts, the promise of increased access to telehealth services, especially for rural and underserved areas, cannot be fully realized.

Conclusion

Behavioral health conditions are increasingly prevalent and costly, yet patients are not receiving the treatment they require. Integrating behavioral health and primary care is essential to bridging the treatment gap, but its adoption among providers remains low due to various barriers. It is crucial to expand the pool of trained and adequately compensated providers who can deliver integrated care services.

In this report, BPC outlines targeted recommendations aimed at bolstering the integrated care workforce by improving training, supplying sufficient financing, and removing practical barriers. It is imperative that policymakers come together to implement bipartisan solutions that will foster the adoption of behavioral health integration across the country.

Appendix A: Billing codes related to the delivery of integrated primary care and behavioral health services ^{134,135,136,137}

Code	Description	Model
CPT codes 99446-99449 and 99451	<ul style="list-style-type: none"> Interprofessional consultation codes provided by consulting providers to requesting providers (<i>these codes are broader than primary care and behavioral health; they can be used with any specialty provider</i>) 	Model agnostic
CPT code 99452	<ul style="list-style-type: none"> Enables requesting providers to bill for their time spent preparing for a referral and/or preparing to communicate with the consulting provider 	Model agnostic
CPT code 99484	<ul style="list-style-type: none"> Care management services for behavioral health conditions At least 20 minutes of clinical staff time per calendar month 	Model agnostic
HCPCS code G0323	<ul style="list-style-type: none"> Care management services for behavioral health conditions At least 20 minutes of clinical psychologist or clinical social worker time, per calendar month 	Model agnostic
CPT code 99492 – CoCM first month	<ul style="list-style-type: none"> Initial psychiatric collaborative care management First 70 minutes in the first calendar month of behavioral health care management services 	Collaborative Care Model
CPT code 99493 – CoCM subsequent months	<ul style="list-style-type: none"> Follow-up psychiatric collaborative care management First 60 minutes in a following month of behavioral health care manager activities 	Collaborative Care Model
HCPCS code G2214	<ul style="list-style-type: none"> Initial or subsequent psychiatric collaborative care management First 30 minutes in any month; used when there are not enough minutes to bill the 99492 or 99493 codes Generally used in the first and last month of care 	Collaborative Care Model
CPT code 99494 – CoCM add-on (any month)	<ul style="list-style-type: none"> Initial or subsequent psychiatric collaborative care management Each additional 30 minutes in a calendar month of behavioral health care manager activities 	Collaborative Care Mode

Glossary of Acronyms

BHI	Behavioral Health Integration	HRSA	Health Resources & Services Administration
CHIP	Children’s Health Insurance Program	MAT	Medication Assisted Treatment
CMS	Centers for Medicare & Medicaid Services	SAMHSA	Substance Abuse and Mental Health Services Administration
CoCM	Collaborative Care Model	SBIRT	Screening Brief Intervention and Referral to Treatment
EHR	Electronic Health Record	SUD	Substance Use Disorder
HHS	U.S. Department of Health and Human Services		

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