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

Executive Summary

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

Figure 1. **The CoCM Roadmap**

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

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

Context and Introduction

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

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

Overview of the Collaborative Care Model

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

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

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

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

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

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

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

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

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

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

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

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

Early Adoption – and Challenges – for CoCM in North Carolina

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

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

Case Study: University of North Carolina Health (UNC)

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

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

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

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

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

Capacity Building for CoCM in NC: The Collaborative Care Consortium

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

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

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

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

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

The Roadmap

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

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

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

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

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

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

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

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

Step 1: Aligning Reimbursement Across Payors

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

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

Strategy 1a: Ensure Coverage of the Same CoCM Codes

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

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

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

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

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

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

Strategy 1b: Align Requirements to Bill

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

Strategy 1c: Make Reimbursement Sustainable

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

Case Study: One Health and C3/MindHealthy

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

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

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

Strategy 1d: Remove Beneficiary Copays

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

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

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

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

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

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

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

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

Strategy 2b: Establish Psychiatry Connections

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

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

Strategy 2c: Customize and Fund a Statewide Registry

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

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

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

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

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

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

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

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

Case Study: Dayspring Family Medicine

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

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

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

Success Factors

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

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

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

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

Monitoring Evolving Efforts

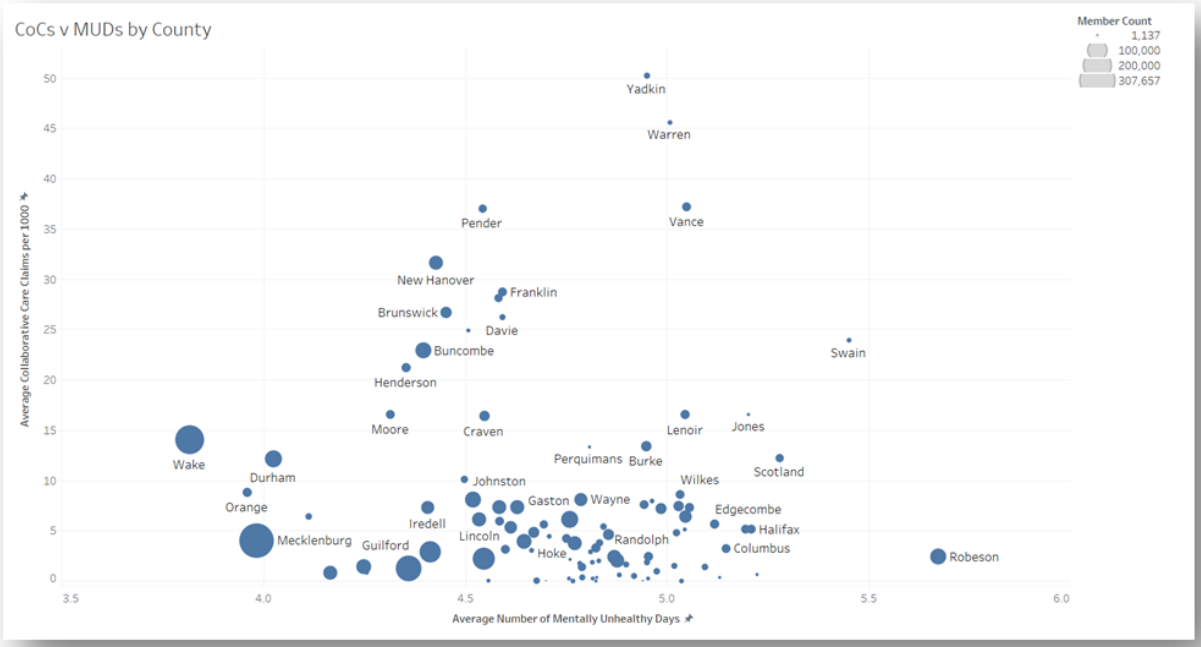
The Consortium has stayed nimble as new challenges emerge, with one ongoing challenge around how to monitor the Consortium's efforts – how widely CoCM has been deployed throughout the state, the impact of the practice supports and outcomes from the model – given that the data are spread among stakeholders.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

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

The Data Dashboard in Action

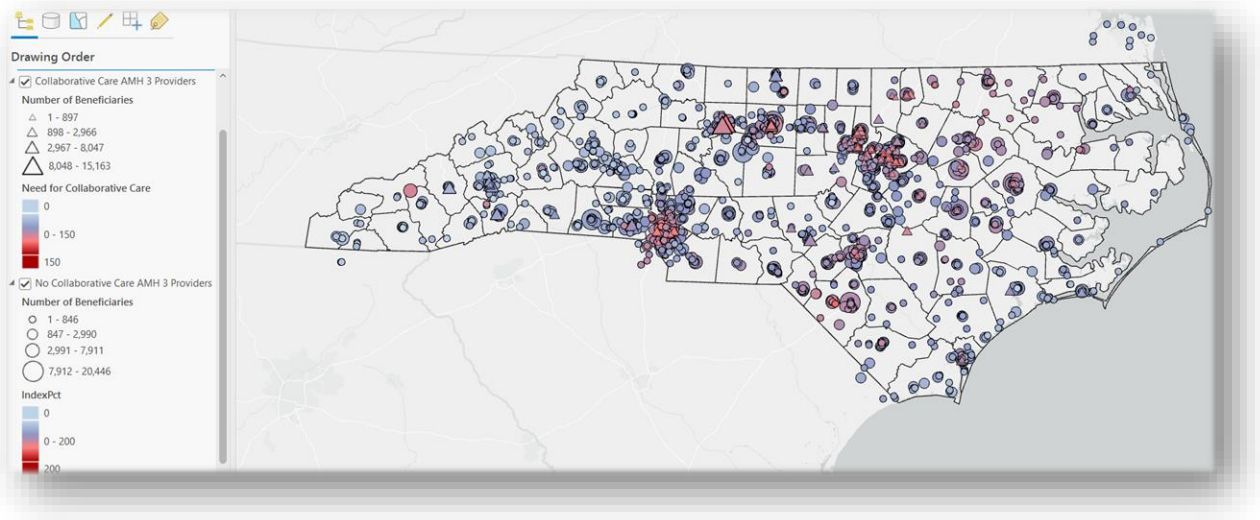
In *Figure 6,* NC Medicaid examined Medicaid claims in conjunction with non-Medicaid data sources, in this case the average number of mentally unwell days from the Behavioral Risk Factor Surveillance System. Counties in the lower righthand corner, like Robeson County, could be candidates for targeted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

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



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

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



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

Future Opportunities

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

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

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

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

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

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

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

Focus 3: Peer-to-peer opportunities

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

Interview with a BHCM: Key Themes and Opportunities

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

Focus 4: Engaging larger health systems

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

Appendix A: Collaborative Care Consortium

Steering Committee Participants

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

Appendix B: Payor Alignment in North Carolina

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

Appendix C: Psychiatric Consultant Matching Survey

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

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

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

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

Please tell us about you:

Respondent's Name

Respondent's Position/Title:

Phone Number:

Email:

Next, tell us about your practice:

Practice Name:

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

Which county is your practice in?
(None)

Practice Phone Number:

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12. Ibid.

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