The Psychiatric Collaborative Care Model in Primary Care
Catherine S. Hwang, MD, MSPH, Joshua M. Liao, MD, MSc, Ashok Reddy, MD, MSc, Andrew D. Carlo, MD, Leah M. Marcotte, MD

VSSL Briefs are a series of documents written and led by trainees and learners with the goal of providing background information about policies and programs related to Lab activities. Please see the bottom of this document for additional disclaimers.

Common mental health conditions, such as anxiety and depression, affect millions of individuals and are responsible for one-quarter of all health-related disability worldwide. A growing proportion of these patients are managed in primary care settings. Mental health conditions frequently co-occur in individuals with other chronic diseases, and these patients often demonstrate worse clinical outcomes compared to those without co-morbid mental health disorders.

Recognizing the importance of broadening access to mental health services in primary care and making these services financially sustainable, the Centers for Medicare and Medicaid Services (CMS) implemented novel fee-for-service Psychiatric Collaborative Care Model (CoCM) billing codes in 2017 to reimburse health care organizations for delivering services supporting behavioral health integration, especially in primary care settings.

What is the Psychiatric Collaborative Care Model?
CoCM is a specific care model within the broader umbrella of CMS’s Behavioral Health Integration reimbursement initiative. Other treatment models are also eligible for reimbursement using General Behavioral Health Integration billing codes. As a care model, CoCM can be used to treat patients with any behavioral health condition, although the majority of evidence supports its use for the treatment of depression. CoCM is frequently employed in primary care settings, although it can also be applied to other fields, such as oncology, cardiology, and obstetrics (perinatal health care).

CoCM Team Members
CoCM encompasses a structured approach to mental health care delivery that promotes systematic communication among team members during and outside of face-to-face patient encounters. Team members consist of the patient, treating provider (most commonly the primary care provider), psychiatric consultant, and behavioral health...
care manager. The psychiatric consultant must be trained in psychiatry and qualified to prescribe medications. The behavioral health care manager must have formal training in behavioral health. CMS does not specify a minimum education or licensing requirement, and formal training includes a range of disciplines, such as social work, nursing, and/or psychology. Patients who participate in CoCM are entered into a registry and participate in periodic validated mental health assessments. Behavioral health care managers meet weekly with the psychiatric consultant to evaluate patient progress, formulate treatment plans, and provide evidence-based brief interventions.

**CoCM Team Structure**

![CoCM Team Structure Diagram](image)

**CoCM Service Eligibility and Reimbursement**

In order to be reimbursed for CoCM services using Medicare fee-for-service billing codes, patients must provide verbal consent for the treating provider (most commonly the primary care provider) to consult with specialists and agree to assume responsibility for applicable cost-sharing during their initial visit. The consent must be documented in the medical record and must be obtained prior to the first visit with the care manager. CoCM billing codes are furnished by the treating provider – usually a primary care physician, physician assistant, or nurse practitioner – and are based on the amount of time a patient’s behavioral health care manager spends managing the patient’s care over the course of each calendar month.
## Closing Thoughts
Evidence shows that collaborative care is a strategy that can significantly improve mental health\(^{19-21}\) while resulting in cost-savings.\(^{22}\) More work is needed to understand barriers to CoCM implementation, encourage buy-in from organizational leadership, and develop strategies for financial sustainability.

\[\text{References}\]

Disclaimers: The content in this issue brief is provided “as is,” and VSSL and the issue brief authors disclaim any and all warranties, express or implied, including any warranties as to accuracy, comprehensiveness, or currency of the content of this work. This work is no substitute for individual patient assessment based upon healthcare professionals’ and health care organizations’ examination of each patient and consideration of, among other things, age, current or prior medical conditions, applicability for the policies discussed in this work, and other factors unique to the patient. VSSL does
not provide advice or guidance and this work is merely a reference tool. Healthcare professionals, and not VSSL, are solely responsible for the use of this work including all medical and policy judgments and for any resulting diagnosis and treatments. Given continuous, rapid advances in policy and health information, independent professional verification of medical diagnoses, policy and service indications, and treatment options should be made, and healthcare professionals should consult a variety of sources. When applying policies and services to patients, healthcare professionals are advised to consult policy documents directly to verify, among other things, conditions of use, particularly if the policies or services being applied to patients are new, infrequently used, and involve multiple requirements. To the maximum extent permitted under applicable law, no responsibility is assumed by VSSL or its authors for any injury and/or damage to persons or property, as a matter of products liability, negligence law or otherwise, or from any reference to or use by any person of this work.