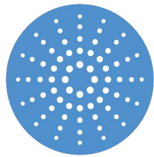
# Behavioral Health Integration Community Design Studio Summary and Learnings Document



Connecting for Better Health

Advancing data sharing to improve the health of all Californians

California Quality Collaborative

# Agenda

| No. | Items |
| --- | --- |
| 1 | Design Studio Overview |
| 2 | Key Learnings & Recommendations |
| 3 | Guidance Documents Available |
| 4 | Stay Connected |

# The Problem

The Collaborative Care Model (CoCM) is a highly effective, evidence-based approach to integrating behavioral health within primary care, but widespread adoption is limited by implementation barriers including fragmented documentation workflows and payer inconsistency with claims adjudication.

## Payer Barriers

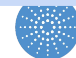
- **CoCM claims are medical benefits:** due to a behavioral health diagnosis, CoCM claims are often misunderstood as behavioral health benefits, when they are medical benefits
- **Payer misalignment:** CoCM reimbursement is challenging in California because carve-outs that separate behavioral health from medical care (through MBHOs or DOFR-based contracts, sometimes both at once) cause claims to be misclassified as behavioral health benefits rather than medical benefits
- **Limited claims transparency:** CoCM claims face additional challenges compared to standard medical claims (e.g. due to BH carve-outs) leading to denial reasons being less transparent to the practice

## Data Barriers

- **EHR gaps:** CoCM workflows are not natively built into EHRs, requiring manual workarounds and increased administrative overhead
- **Data infrastructure gaps:** Limited access to actionable data (e.g. CoCM ROI, payer-level performance, denial reasons) constraints a practices' ability to monitor performance, refine workflows, and confidently expand CoCM

## Operational Barriers

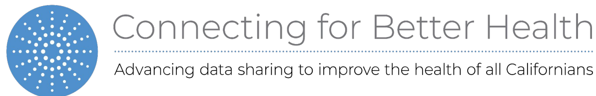
- **Low uptake:** Adoption is limited in CA compared to other states: many practices do not fully implement or sustain CoCM billing due to operational and financial barriers
- **Billing complexity:** high provider documentation and workflow burden
- **High denial rates:** In a study done of 2018 CoCM Medicare claims, ~20% of claims were denied as compared with 8% denial rate for overall Medicare-Advantage claims



# What We Did

The Design Studio translated frontline provider and health plan experience into concrete billing guidance for CoCM giving practices and health plans a shared roadmap to reduce denials, cut administrative burden, and make CoCM financially viable.

**Participants**

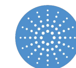


# Our Shared Vision

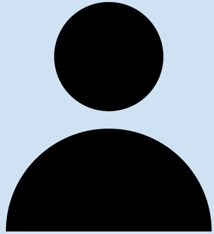
*How might we improve billing and reimbursement for CoCM services so that more practices will embrace and be able to sustain the model, helping make integrated behavioral health the default in primary care rather than the exception?*

# Design Studio Persona: Ariana Davis

- **Age:** 26
- **Health Concerns:** mild depression and anxiety, type 2 diabetes
- **Social Needs:** struggling to connect with her family due to substance abuse issues within the family
- **Location:** Rural Northern California (tribal-adjacent community)
- **Occupation:** Retail Worker
- **Insurance:** Commercial Health Plan
- **Pronouns:** She/Her



# List of Entities Involved in CoCM

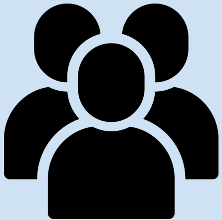


## Patient

*Receives CoCM care*

## Health Plan

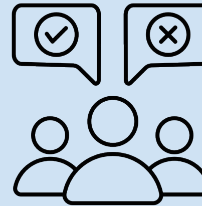
*Payer of CoCM services*



## Practice

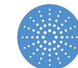
*Provides CoCM care*

Includes: Behavioral Health Care Manager, Psychiatric Consultant, and Primary Care Provider

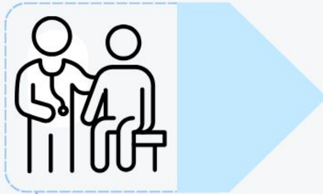


## Behavioral Health Service Administrator

*Manages BH claims on behalf of the health plan, does not pay for CoCM claims*



# User Journey Diagram

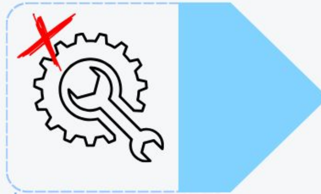


**Ariana starts receiving CoCM services**

Ariana meets with the CoCM team about her anxiety and depression and is prescribed medication; her Behavioral Health Care Manager (BHCM) checks in with her throughout the month and documents notes in the EHR which are linked to a monthly Episode of Care.

**First month billing for CoCM**

At the end of the first month, the Practice's billing team adds up the total minutes the BHCM spent on CoCM services for Ariana and creates a claim using appropriate billing codes, behavioral health diagnosis, and billing and rendering providers. The billing team submits the claim to the health plan.



**Claim denial and intervention**

The health plan incorrectly routes the claim to their Behavioral Health Services Administrator due to the behavioral health diagnosis, who denies it. The Practice works with their Health Plan Provider Relationship Manager to intervene and get the claim correctly processed and paid. *

**Ariana continues CoCM services**

The next month, Ariana's symptoms do not change and her CoCM team decides to increase her medication dosage. All provider notes are entered into the EHR and linked to the monthly Episode of Care.

**Second month billing & documentation request**

At the end of the month, the Practice's billing team adds up the total minutes the BHCM spent on CoCM services for Ariana, enters the correct billing codes and other information, and submits the claim to the health plan. The health plan requests additional documentation, and the billing team provides all notes linked to the Episode of Care in question. After review, the health plan approves and pays the claim.

| ***Claim #1 Submitted*** | ***Claim #1 Rejected, Reconcilled, and Paid*** | ***Claim #2 Submitted*** | ***Claim #2 Rejected, Resubmitted, and Paid*** |
| --- | --- | --- | --- |

****This step is not an ideal workflow; rather, it is included as an illustration of a common, incorrect CoCM denial.***

# Key Learnings

Higher than normal denial rates for CoCM claims are due to carve-out payment structures, lack of plan alignment, and the non-standard nature of claims structure

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A lack of built-in EHR workflows and errors in payer systems causes manual work and is error-prone

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**Large administrative burden and less financial viability for providers to adopt and sustain CoCM programs**

*The design studio highlighted documentation and education best practices (e.g. claims coding, data entry) to reduce claim denials and strengthen the financial viability of CoCM programs. Future opportunities shift CoCM claim management from a practice burden to a system-level responsibility by embedding CoCM logic directly into payer and EHR systems.*

# Key Insight: Improper Denials

| Key Insight | Impact | Recommendation |
|---|---|---|
| **Claim Incorrectly routed to BH Partner**: CoCM claims (CPT 99492–99494) are often incorrectly sent to the Health Plan's Behavioral Health Partner since they often include a behavioral health diagnosis, but are actually medical claims. The claims are then denied by the BH partner because they do not meet the BH billing criteria. For example, billing provider on the claim is not a contracted BH provider and the CPT codes are not valid for a BH claim. | Reimbursement is delayed and administrative burden increases which create financial barriers and may discourage adoption of CoCM. | • Health plans to have more internal education particularly about CoCM codes. Because of how they are named ("Psychiatric Care Management"), they are assumed to be Behavioral Health claims although they are a medical benefit.<br>• Support internal health plan provider liaisons who understand the nuances of integrated Behavioral Health and related claims to improve processes related to billing and reimbursement and provide support to provider partners for troubleshooting issues. |
| **CoCM service may be incorrectly flagged as a duplicate:** When a patient receives individual psychiatric or behavioral health treatment outside of the CoCM model, claims reviewers may see these services as duplicative with CoCM when, in fact, CoCM allows patients to receive more intensive BH services alongside receiving CoCM. | Reimbursement is delayed and administrative burden increases which create financial barriers and may discourage adoption of CoCM. | • Better education for practices and health plans about what constitutes a duplicate service and what is legitimate; embed automatic logic into claims systems to flag true duplicates versus allowable CoCM + BH combinations. For example, if a psychiatrist meets directly with a CoCM client, the visit can be billed as an individual claim (vs. a CoCM claim). Similarly, if a BHCM provides 40 minutes of psychotherapy and 10 minutes of case management, they would bill one individual claim and apply the case management time to the monthly CoCM claim. |
| **Patient cost-sharing may be incorrect**: When claims are incorrectly denied, patients may receive more of their cost-sharing than they should pay. | Patients may stop attending appointments leading to poorer outcomes. | • Practices to align benefits design and cost-sharing logic across medical and BH systems for CoCM services.<br>• Practices to provide real-time eligibility and cost-sharing transparency to patients at point of service. |

# Key Insight: Coding Best Practice

| Key Insight | Impact | Recommendation |
|---|---|---|
| **Claim must include PCP's place of service**: If the place of service is not listed as the PCP's credentialing location, the CoCM claim will be denied. | Reimbursement is delayed and administrative burden increases which create financial barriers and may discourage adoption of CoCM. | ● EHRs should include the PCP's location in an accessible location.<br>● If not readily available in EHR, practices can place the PCP's location in the Patient Registry where it is easy to find and use. |
| **Each note should include length of time for service**: When the BHCM enters visit notes into the EHR, it is important that the total time is documented since it will be added up at the end of the month so appropriate CoCM CPT code(s) can be used. | Undercounting time results in underbilling and lost revenue and overcounting creates compliance risk. | ● Practices can partner with EHR vendors to standardize CoCM templates (e.g. time tracking, place of service, provider fields)<br>● Some EHRs ask for Beginning Time and Ending Time, or, for example, Epic has a SmartPhrase that will automatically track time from note creation to closure. However, administrative time is not equivalent to time spent delivering the service; CoCM is looking for service delivery time as the billable time. |
| **Correct entry for billing and rendering provider**: Since CoCM is "incident to" billing, PCPs must be listed as the billing provider. Also, the BHCM must be listed as the rendering provider. Not having this information correct will lead to claim denial. | Reimbursement is delayed and administrative burden increases which create financial barriers and may discourage adoption of CoCM. | ● Practices should ensure the revenue cycle management (RCM) system include rules that will flag claims that are not coded correctly. For instance, if a BH provider (like the BHCM) is listed as the Billing Provider, the claim can be flagged because BH providers are not credentialed to provide medical services. |
| **Extra administrative staff needed for CoCM**: Some health systems have hired full-time employees to manage patient eligibility checks and other administrative tasks associated with CoCM. | Hiring full-time employees adds significant overhead costs that could impact the financial sustainability of CoCM programs and disproportionately effect smaller health systems. | ● Quantify the cost of additional administrative overhead caused by inappropriate claims denial and missing EHR functionality.<br>● Prioritize investments that eliminate repeat manual steps (e.g. eligibility checks, claims routing, and documentation checks). |

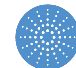
# Key Insights: Other

| Key Insight | Impact | Recommendation |
|---|---|---|
| **CoCM CPT codes have specific rules on how they can be used**: 99494 requires a parent code (99492 or 99493) as well; 99492 can only be used for 1st month billing, etc. | Failure to code claims correctly leads to automatic claim denials. Providers may lose reimbursement for additional care management. | • RCM systems can be setup to catch that an add on code, like 99494, needs to have a parent code and that 99492 can not be used in a subsequent month.<br>• Billing rules should be audited regularly for ongoing accuracy. Workflow changes can lead to billing changes which can then interfere with claims processing. |
| **CoCM workflow isn't built into EHRs**: Many practices utilize other workflows such as Episodes of Care, non-billable CPT codes and manual reconciliation of encounter notes which creates additional administrative burden. | Without robust EHR configuration, providers may face manual, error-prone workflows that increase the risk of claim denials. | • Educate EHR vendors on how they can update current workflows to better match CoCM in order to improve adoption and reduce administrative burden. |
| California legislative requirements, including **SB 1320** (2024) requires commercial health plans to establish a **process** to review, but not necessarily **accept**, CoCM claims. | Without a mandate for health plans to actually reimburse CoCM services, SB 1320 does not guarantee claim reimbursement. | • Additional regulatory definitions would strengthen the bill language and provide greater strength to the bill's viability such as: clarifying expectations for coverage, not just review, through regulatory or contractual mechanisms; monitor implementation and publish payer performance on CoCM claims approval rates.<br>• Publish additional education materials (e.g. standardize payer adjudication rules for CoCM CPT codes across plans, clear and standard billing guidance for providers). |

# Guidance Documents Available

*Additional education and implementation resources are available for your organization to help improve CoCM documentation and claims workflows.*

| Deliverable | Description | How it Can Be Used |
|---|---|---|
| Behavioral Health Integration Systems Improvement Blueprint | Detailed user journey of Ariana's CoCM journey, demonstrating CoCM billing best practices. | A step-by-step reference guide for practices implementing CoCM. The user journey walks clinical and administrative teams through real-world billing scenarios, human and system interactions, and documentation of best practices. |
| **System Interaction Diagrams (live in the Blueprint)** | System Diagrams to demonstrate how data flows through personas and systems to facilitate CoCM care and billing. | Use to train clinical and operational staff on how data flows between EHR, RCM, and health plan during CoCM billing process. |
| Health Plan Guidance Document | CoCM Guidance for Commercial Health Plans to provide overview of billing rules, best practices, and potential scenarios. | Use to educate health plan staff and claim reviewers on the correct adjudication of CoCM claims. Provides clear guidance on billing and rendering provider requirements, CPT code rules, prior authorization, and common denial scenarios to reduce improper claim routing and rejections. |



# Stay Connected

July 9 (11-12PM PT) Connecting for Better Health Coalition Meeting: BHI Design Studio Readout
*Register here*

September 16-17: BHI Health Care Leadership Summit
*Register here*

***Opportunities for Future Engagement***

- EHR vendor engagement
- Moving from faxing workflows to electronic exchange
- Administrative cost quantification

## Resources

**For providers looking to implement BHI:**

- BHI Compendium (American Medical Association)
- Behavioral Health Integration Improvement Collaborative Curriculum (California Quality Collaborative)
- Building Blocks of Behavioral Health Integration (University of Colorado)
- Directory: Collaborative Care Service Organizations (Mental Health Treatment and Research Institute)

**CQC's BHI Payer Workgroup documents are available for other plans and partners to adapt and adopt, including:**

- BHI Health Plan Policy & FAQ – provides health plans, and their managed behavioral health organization partners or internal behavioral health departments, with operational responsibilities to facilitate behavioral health integration in primary care, covering credentialing, billing and claims, medical/behavioral health collaboration, data analytics, enterprise strategy.
- Behavioral Health Integration into Primary Care: Provider Implementation Guide – a resource plans can share with providers to support implementation of BHI (either Collaborative Care or Primary Care Behavioral Health)
- BHI Data Request – template to analyze claims data to understand Collaborative Care codes in network