Department of Health Care Policy and Financing

Funding Request for the FY 2025-26 Budget Cycle

Request Title

R-12 Integrated Care Benefit

Dept. Approval By: _____ ____ **Supplemental FY 2024-25**

OSPB Approval By: _____ ____ **Budget Amendment FY 2025-26**

X **Change Request FY 2025-26**

Summary Information	Fund	FY 2024-25 Initial Appropriation	FY 2024-25 Supplemental Request	FY 2025-26 Base Request	FY 2025-26 Change Request	FY 2026-27 Continuation
Total of All Line Items Impacted by Change Request	**Total**	**$12,959,956,622**	**$0**	**$13,041,814,110**	**$1,575,367**	**$1,575,367**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,846,827,346	$0	$3,835,995,601	$368,170	$368,170
	CF	$1,400,470,683	$0	$1,391,139,734	$117,691	$117,691
	RF	$120,304,766	$0	$120,304,766	$0	$0
	FF	$7,592,353,827	$0	$7,694,374,009	$1,089,506	$1,089,506

Line Item Information	Fund	FY 2024-25 Initial Appropriation	FY 2024-25 Supplemental Request	FY 2025-26 Base Request	FY 2025-26 Change Request	FY 2026-27 Continuation
02. Medical Services Premiums, (A) Medical Services Premiums, (1) Medical Services Premiums - Medical Services Premiums	**Total**	**$11,931,356,051**	**$0**	**$12,009,671,603**	**($7,717,826)**	**($7,717,826)**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$3,573,779,779	$0	$3,561,445,916	($1,803,688)	($1,803,688)
	CF	$1,321,506,284	$0	$1,312,107,528	($576,581)	($576,581)
	RF	$120,304,766	$0	$120,304,766	$0	$0
	FF	$6,915,765,222	$0	$7,015,813,393	($5,337,557)	($5,337,557)
03. Behavioral Health Community Programs, (A) Behavioral Health Community Programs, (1) Behavioral Health Community Programs - Behavioral Health Capitation Payments	**Total**	**$1,028,600,571**	**$0**	**$1,032,142,507**	**$9,293,193**	**$9,293,193**
	FTE	0.0	0.0	0.0	0.0	0.0
	GF	$273,047,567	$0	$274,549,685	$2,171,858	$2,171,858
	CF	$78,964,399	$0	$79,032,206	$694,272	$694,272
	RF	$0	$0	$0	$0	$0
	FF	$676,588,605	$0	$678,560,616	$6,427,063	$6,427,063

Auxiliary Data

Requires Legislation?	NO		
Type of Request?	Health Care Policy and Financing Prioritized Request	**Interagency Approval or Related Schedule 13s:**	No Other Agency Impact

Governor Jared Polis
FY 2025-26 Funding Request

Kim Bimestefer, Executive Director
Department of Health Care Policy & Financing
November 1, 2024

Department Priority: R-12
Integrated Care Benefit Expansion

Summary of Funding Change for FY 2025-26

Fund Type	FY 2025-26 Base Request	FY 2025-26 Incremental Request	FY 2026-27 Incremental Request
Total Funds	$13,041,814,110	$1,575,367	$1,575,367
General Fund	$3,835,995,601	$368,170	$368,170
Cash Funds	$1,391,139,734	$117,691	$117,691
Reappropriated Funds	$120,304,766	$0	$0
Federal Funds	$7,592,353,827	$1,089,506	$1,089,506
FTE	0.0	0.0	0.0

Summary of Request

Problem and Opportunity: Through stakeholder engagement through HB 22-1302, the Department has identified existing problems and potential opportunities for better integrated care between behavioral health and primary care settings. Providers have identified that billing practices are too complicated for short term behavioral health services leading to administrative burden; current billing codes do not offer primary care providers options to do shorter assessments and interventions; and the Department has an opportunity to allow providers to bill for new collaborative services that can achieve savings and better outcomes.

Proposed Solution: The Department requests to move the first 6 short-term behavioral health from the Department's fee-for-service benefit to the behavioral health capitation program, implement new Health and Behavioral Assessment and Intervention (HBAI) codes and implement the Collaborative Care Model (CoCM) under the Department's fee for service benefit for primary care doctors to utilize. The Department's request aims to increase access to integrated care for patients with behavioral health disorders, reduce administrative burden for providers by simplifying billing practices and empower primary care providers to work more seamlessly with behavioral health specialists. This request promotes equitable outcomes by expanding access to care for underserved populations including those in rural areas.

Fiscal Impact of Proposed Solution: The Department requests $1.5 million in total funds including $0.4 in General Fund in FY 2025-26 ongoing. The Department requests this funding ongoing because the funding is intended to be a permanent change to the services and billing practices the Department has for the integrated health benefit.

Requires Legislation	Equity Impacts	Revenue Impacts	Impacts Another Department?	Statutory Authority
No	Positive	No	No	25.5-5-103 4, C.R.S.

Background and Opportunity

Integrated care is a form of practice that connects patients to behavioral health in a primary care setting, which is the place where many members receive their care. Integrated Care occurs in the primary care setting and utilizes various assessments and interventions to address physical health concerns by addressing behavioral health conditions. [1] Integrated Care services are associated with prevention of escalation of behavioral health conditions that could lead to severe disorders, as well as reduced transportation costs and decreased reliance on emergency departments.[2,3]

House Bill 22-1302 "Integrated Behavioral Health Grant Program" passed with the goal of supporting, improving and expanding integrated behavioral health services in Colorado. The Department received American Rescue Plan Act grant funding to be used for several initiatives, including: developing infrastructure for behavioral health in primary care; addressing the shortage of behavioral health care workforce; developing and implementing alternative payment models; developing infrastructure for primary care, pediatric, and behavioral health professionals to better serve individuals with behavioral health needs in outpatient health care settings; and expanding early intervention tactics that reduce escalation and exacerbation of behavioral health conditions. [4] The Department is engaging with providers through public forums, webinars, and meetings to build relationships and collaborate with health care providers. The Department is working with various providers and stakeholders including primary care physicians, school based health centers, and community-based organizations. The Department and stakeholders agree on the need to focus on whole-person care; implement meaningful changes in reimbursement models, including value-based care and the potential introduction of new payment methodologies; and engaging providers in data collection and reporting. Through this work the Department has collected and received feedback on how the Department can improve Integrated care.

---

[1] "Health and Behavior Assessment/Intervention – Medical Policy Article." CMS.Gov Centers for Medicare & Medicaid Services, www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=52434. Accessed 3 July 2024.

[2] Williams, Jessixa N, et al. "The Impact of an Integrated Care Management Program on Acute Care Use and Outpatient Appointment Attendance Among High-Risk Patients With Lupus." American College of Rhematology, 18 Jan. 2022, onlinelibrary.wiley.com/doi/full/10.1002/acr2.11343.

[3] Rybak TM, Herbst RB, Stark LJ, Samaan ZM, Zion C, Bryant A, McClure JM, Maki A, Bishop E, Mack A, Ammerman RT. Provider Perspectives on an Integrated Behavioral Health Prevention Approach in Pediatric Primary Care. J Clin Psychol Med Settings. 2023 Dec;30(4):741-752. doi: 10.1007/s10880-023-09947-3. Epub 2023 Feb 25. PMID: 36828991; PMCID: PMC9957689.

[4] HB 22. 1302 Fact Sheet, Department of Health Care Policy and Financing, hcpf.colorado.gov/sites/hcpf/files/HB 22. 1302 Fact Sheet.pdf. Accessed 3 July 2024.

The Department received specific feedback that the practices were unable to sustain their progress without an updated billing model to include the use of Health Behavioral Assessment and Intervention (HBAI) services, updating the existing Short-Term Behavioral Health Benefit, and implementing a Collaborative Care Model (CoCM). The Department has the opportunity to simplify billing practices and reduce the administrative burden on providers by migrating the existing first 6 visits of psychotherapy under the STBH benefit from fee for service to the behavioral health capitation program; expanding access to integrated care by offering service delivery options that allow for shorter less expensive behavioral health assessments; and providing members access to psychiatric consultation in the primary care setting. Providing expanded coverage would reassure providers involved in training, grant initiatives, and other capacity-building activities that their current efforts will be both recognized and compensated through Medicaid in the future.

Health and Behavioral Assessment and Intervention (HBAI) Services

HBAI services are provided by licensed behavioral health clinician and are used to help assess and intervene in the psychological and behavioral factors directly affecting a patient's psychical function. HBAI services can be used to help members with chronic conditions address behavioral factors to better manage their conditions. HBAI services were opened up by Medicare in 2002 and revised in 2020. [5] By 2022, HBAI services have been adopted by 21 state Medicaid programs and are increasingly recognized as a strategy to address integrated health care in the primary care setting.[6]

HBAI services allow shorter assessment and intervention services to occur, which is essential in a primary care setting. Many primary care providers do not have the time to complete a 60-minute psychotherapy service. HBAI services can take 15 minutes to complete and bridge the gap between the time available for providers to assist members and the services that members would benefit from utilizing in a primary care setting. By being able to connect members quicker to treatment for behavioral health conditions, the Department can avoid escalations of behavioral health conditions into severe disorders. In addition, since HBAI services are often shorter in nature than psychotherapy, they are on average less expensive than billing for psychotherapy services.

Short Term Behavioral Health (STBH) Services

Starting July 1, 2018, the Department increased access to short-term behavioral health (mental health and substance use disorder) services within the primary care setting. Health First Colorado members have been able to receive short-term behavioral health services (STBHS) provided by a licensed behavioral health clinician working as part of a member's Primary Care Medical Provider (PCMP). The intent of this change was to provide additional access to behavioral health services for short-term episodes of care of low-acuity conditions. This may include grief and adjustment conditions, as well as medical conditions where behavioral

[5] "Coding and Billing for Therapy and Rehab." 2020 Health and Behavioral Assessment and Intervention, American Psychological Association, cdn.ymaws.com/www.ipta.org/resource/resmgr/2014_ce_ads/coding_billing_ss_2014.pdf. Accessed 3 July 2024.

[6] "Medicaid Behavioral Health Services: Health Behavior Assessment and Intervention (HBAI) Services." KFF, www.kff.org/other/state-indicator/medicaid-behavioral-health-services-health-behavior-assessment-and-intervention-hbai-services/. Accessed 3 July 2024.

interventions can support treatment adherence and wellness (such as obesity and diabetes). By supporting the delivery of early interventions in a convenient location for members, the Department seeks to prevent the exacerbation of both medical and behavioral conditions and treat them in the most efficient manner. The Department currently offers the first 6 short term behavioral health visits in the primary care setting through the Department's fee for service benefit and the following behavioral health visits are covered through the behavioral health capitated benefit administered by the Regional Accountable Entities (RAEs).

Stakeholders have provided feedback that the Short-Term Behavioral Health (STBH) Benefit is not meeting the needs of primary care practices. Stakeholders indicate that while the STBH Benefit was a step in the right direction, the current set of codes offered are too restrictive for primary care due to psychotherapy services being too lengthy for a primary care setting. Additionally, stakeholders have indicated that billing practices are complicated since the first 6 visits must be billed fee for service and any service after the first 6 must be billed through the Regional Accountable Entities as a part of the behavioral health capitated program.

Collaborative Care Model (CoCM) Services

CoCM is an effective, evidence-based form of integrated mental health care that improves patient outcomes, team collaboration and provider satisfaction. CoCM is a team-based model of care that allows primary care providers to connect with psychiatrists and a Behavioral Health Care Manager in order to develop a treatment plan for members and ensure that members are receiving the appropriate treatment for their conditions and conduct medication management. This allows patients to receive treatment in Primary Care, where they already have a relationship with a provider, rather than being referred to an outside psychiatrist.[7] Providing this care in the primary care setting is not only more cost effective, it makes efficient use of scarce psychiatric availability in the state. CoCM services help improve members' health while reducing costs in inpatient psychiatric services and emergency departments.

Proposed Solution and Anticipated Outcomes

Health and Behavioral Assessment and Intervention (HBAI) Services

The Department requests $4,456,546 million total funds, including $1,041,513 million General Fund in FY 2025-26 ongoing, to expand coverage to include Health and Behavioral Assessment and Intervention (HBAI) services in order to better meet the needs of primary care providers with limited time, expand access to integrated care, and provide members with care that is associated with better health outcomes. The Department proposes opening up the HBAI codes and aligning the rates with the current Medicare rates for the services.

The Department anticipates that opening these services will lead to more members gaining access to behavioral health care in a primary care setting, which will lead to improved behavioral health outcomes. The Department also anticipates a shift in utilization from existing short term behavioral health benefit to HBAI services. leading to an overall reduction in the total cost between the two service categories. The Department anticipates that over time, these services will lead to better health outcomes for members, which will lead to overall lower costs of care. The Department anticipates that opening up HBAI Codes will address

[7] Medicine (Baltimore). 2022 Dec 30; 101(52): e32554.
Published online 2022 Dec 30. doi: 10.1097/MD.0000000000032554
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9803502/

providers' concerns about the time constraints associated with the STBH codes. The Department's proposal, alongside the Short-Term Behavioral Health Services proposal, helps the state achieve its Wildly Important Goal (WIG) of Improving Medicaid Efficiency by substituting existing higher cost services that do not meet providers' needs for lower cost services that address providers time constraints in the primary care setting.[8,9,10]

Short Term Behavioral Health (STBH) Services

The Department requests a reduction of $5,820,653 million total funds, including $1,360,310 million General Fund in FY 2025-26 ongoing, in order to move the short-term behavioral health benefit from the fee for service benefit to the behavioral health capitation program to simplify billing practices and reduce the administrative burden of providers. The Department proposes that all psychotherapy services with a covered behavioral health diagnosis, whether rendered in a primary care setting or a behavioral health setting, are billed through the RAEs.

The Department anticipates a reduction in costs as existing services billed as short-term behavioral health are expected to shift to HBAI services. Additionally, the Department anticipates this substitution will occur as claims under the behavioral capitation benefit are required to have a covered behavioral health diagnosis code. The Department anticipates that changing billing practices will reduce providers' administrative burden by removing the complexity behind billing for the same service in different manners depending on how many times a member has utilized STBH in a year.

Collaborative Care Model (CoCM) Services

The Department requests $2,939,474 total funds, including $686,967 General Fund in FY 2025-26 ongoing, to expand coverage to include Collaborative Care Management (CoCM) services in order to expand patient access to psychiatric care in a primary care setting. The Department proposes opening CoCM codes and aligning the rates with the current Medicare rates for the services.

The Department anticipates that by covering these services, members will have better health outcomes and will utilize less inpatient psychiatric and emergency department services. The Department's proposal helps the state achieve its Wildly Important Goal (WIG) of Increasing Medicaid Efficiency by Reducing Medicaid spending with value-based health care. This request both improves member's health and decreases the utilization of high cost services like inpatient psychiatric care and emergency department services.

The Department's proposed request is a significant step forward in sustaining integrated care. It addresses providers concerns by simplifying the billing process, expands the ability for providers to provide integrated care services in a primary care setting, and expands access for members to other behavioral health services in a primary care setting. The Department will

---

[8] Butler, M. (n.d.). Results. Integration of Mental Health/Substance Abuse and Primary Care. https://www.ncbi.nlm.nih.gov/books/NBK38628/#B151260

[9] Miller CJ, Griffith KN, Stolzmann K, Kim B, Connolly SL, Bauer MS. An Economic Analysis of the Implementation of Team-based Collaborative Care in Outpatient General Mental Health Clinics. Med Care. 2020 Oct;58(10):874-880. doi: 10.1097/MLR.0000000000001372. PMID: 32732780; PMCID: PMC8177737.

[10]The Collaborative Care Model: An Approach for integrating ... (n.d.). https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf

evaluate the efficacy of these services through the changes in utilization of inpatient psychiatric care, emergency department utilization, and psychiatric care utilization.

Supporting Evidence and Evidence Designation

Evidence Summary

Program Objective	The program's objective is to provide increased access to sustainable, integrated care in the primary care setting in order to improve members physical health outcomes through addressing behavioral health barriers.
Outputs being measured	Number of members utilizing HBAI Services, STBH services, and CoCM services.
Outcomes being measured	Decreased unnecessary use of Emergency Departments, Inpatient Psychiatric Services, and Inpatient Hospital services.
Evidence Designation with Brief Justification	The Department believes that integrated care has been "proven" as a way to improve health and is "promising" as a way to decrease costs associated with emergency department and inpatient care. Integrated Care has been demonstrated to improve health care through multiple randomized control studies. There is promising evidence through comparison group studies that Integrated Care reduces cost through reduced utilization of hospitalization.

Integrated Behavioral Health Care has been evaluated significantly with a wealth of promising evidence on improving health and reducing costs. Integrated Care has been proven to improve health through a series of randomized control trials that indicate Integrated Care improves depression. A meta-analysis of 37 randomized controlled trials compared the use that collaborative care had a statistically significant benefit to patients compared to primary care alone. [11] Additionally, a demonstration project, Sustaining Healthcare Across Integrated Primary Care Efforts (SHAPE), was conducted in Colorado and used a comparison group to evaluate the effects of integrated care on costs. The study found that there was a downstream impact on costs through reduced utilization of hospitalization.[12]

The Department's proposed policy is to continue efforts to improve integrated health by expanding access to integrated health services such as Health and Behavioral Assessment and Intervention (HBAI) services and Collaborative Care Model (CoCM) Services. The Department's proposal to add HBAI services aims to address provider concerns and expand access and availability of Integrated Care services. HBAI Services are a form of Integrated Care and can be directly related to Integrated Care research. The Department's proposal of adding CoCM services also expands access to integrated care through a model that has been separately

[11] Gilbody S, Bower P, Fletcher J, Richards D, Sutton AJ. Collaborative Care for Depression: A Cumulative Meta-analysis and Review of Longer-term Outcomes. *Arch Intern Med.* 2006;166(21):2314–2321. doi:10.1001/archinte.166.21.2314

[12] Ross KM, Gilchrist EC, Melek SP, Gordon PD, Ruland SL, Miller BF. Cost savings associated with an alternative payment model for integrating behavioral health in primary care. Transl Behav Med. 2019 Mar 1;9(2):274-281. doi: 10.1093/tbm/iby054. PMID: 29796605.

analyzed and found to be a way to achieve long term savings through reduced health care utilization and improved treatment compliance through several randomized controlled trials.[13]

Additional comparative analysis studies have been conducted finding that collaborative care was associated with additional cost savings in an outpatient hospital setting and better health outcomes compared to a normal co-located integrated care setting. [14][15]

The Department plans to further analyze the efficacy of Integrated Care by evaluating the impacts expanding Integrated care has on inpatient hospitalization, unnecessary emergency department visits, and inpatient psychiatric care utilization.

Promoting Equitable Outcomes

The proposal to support an integrated care payment model directly promotes equitable outcomes by expanding access to care for underserved populations, specifically those in rural areas. Eligibility criteria for the payment model encompasses individuals in need of early preventative behavioral health care, those with low acuity behavioral health needs, and those requiring primary care alongside mental health or substance use disorder (SUD) treatment services. Integrated care specifically can be used to help members with chronic conditions who are having difficulty managing their conditions due to behavioral health barriers. The Department anticipates that this request will have a positive impact on health disparities in Colorado.

Assumptions and Calculations

Health and Behavioral Assessment and Intervention (HBAI) Services

The Department estimates the cost of HABI Services based on the number of people expected to utilize the services, the estimated average annual cost of services, and the quantity of new providers who will be able to provide these services in a primary care setting in tables 3.1 and 3.3 of Appendix A.

The Department projects that new members and existing short term behavioral health utilizers will receive HABI services. The Department estimates that 38.2% of existing short term behavioral health utilizers will shift over to utilizing HBAI services based on a survey from providers that indicated STBH utilization would shift over to HBAI if services were covered by Medicaid. The Department also assumes that additional members will utilize HBAI services. The Department estimated the new population who would likely benefit for these services based on the number of members who are visiting a primary clinic, have a chronic condition, and have emergency department utilization. Members who are not already connected to their primary care clinic are not likely to utilize these services since they are rendered in the primary care

[13] Medicine (Baltimore). 2022 Dec 30; 101(52): e32554.
Published online 2022 Dec 30. doi: 10.1097/MD.0000000000032554
[14] Miller CJ, Griffith KN, Stolzmann K, Kim B, Connolly SL, Bauer MS. An Economic Analysis of the Implementation of Team-based Collaborative Care in Outpatient General Mental Health Clinics. Med Care. 2020 Oct;58(10):874-880. doi: 10.1097/MLR.0000000000001372. PMID: 32732780; PMCID: PMC8177737.
[15] Chung, Henry, et al. "Medicaid Costs and Utilization of Collaborative versus Colocation Care for Patients with Depression." Psychiatric Services, 24 May 2023, ps.psychiatryonline.org/doi/10.1176/appi.ps.20220604.

setting. Additionally, these services are targeted to members who are having difficulty managing physical health conditions due to a behavioral health barrier. The Department estimates that of the members identified, 88% of patients would begin to utilize these services based on a study finding that 59-88% of non-urgent patients in a participating integrated care practice participated in HBAI assessments. [16] The Department estimates that 32.75% of primary care providers will provide HBAI services based on the current percentage of primary care clinics that utilize the STBH codes.

The Department estimated the average cost per utilizer based on the current Medicare rates assuming an average of one assessment per individual, and that 83% of members who were accessed would have a follow up face to face consultation. The Department also distributed the costs between the estimated distribution of providers paid on the fee schedule and the Federally Qualified Health Centers (FQHCs). FQHC's provide a large proportion of the current STBH services and are paid based on an encounter rate. The Department did not estimate any change in the encounter rate billed for FQHCs due to the inclusion of HBAI services being an allowed cost. The Department anticipates that over time, the encounter rate for FQHCs could decrease as the average rate of reimbursement for HBAI services is lower than the average rate of STBH services.

The Department assumes that the utilization of HBAI services will lead to a substitution of STBH services as providers cannot bill for both services at the same time. [17] The Department did not assume immediate changes in utilization in other services, however the Department anticipates that in the long term that providing integrated care could provide between 5%-10% cost savings.[18]

Short-Term Behavioral Health (STBH) Services

The Department requests to move the current STBH services from fee for service to under the behavioral health capitation benefit in Table 4.1 in Appendix A. As a result, the Department anticipates seeing savings under the Medicaid fee for service benefit and a rise in costs under the behavioral health capitation. The Department estimates that not all of the existing costs for STBH will materialize at the same level within the behavioral health capitation as providers switch to utilizing the HABI services in place of the STBH services to some extent. The Department estimated that 38.2% of the costs associated with STBH will shift over to HABI based on the provider survey results shown in table 3.2 in Appendix A. The Department anticipates the shift in utilization as providers cannot bill for both services at the same time and that services billed under the behavioral health capitation are required to have a covered behavioral health diagnosis.[7]

---

[16] Rodriguez HP, Glenn BA, Olmos TT, Krist AH, Shimada SL, Kessler R, Heurtin-Roberts S, Bastani R. Real-world implementation and outcomes of health behavior and mental health assessment. J Am Board Fam Med. 2014 May-Jun;27(3):356-66. doi: 10.3122/jabfm.2014.03.130264. PMID: 24808114; PMCID: PMC4237013.

[17] "Health Behavior Assessment and Intervention Services." https://www.Apaservices.Org, www.apaservices.org/practice/reimbursement/health-codes/health-behavior. Accessed 3 July 2024.

[18] Melek, Stephen P, et al. Potential Economic Impact of Integrated Medical, Millliman, Inc, www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/Milliman-Report-Economic-Impact-Integrated-Implications-Psychiatry.pdf. Accessed 3 July 2024.

Collaborative Care Model (CoCM) Services

The Department estimates the cost of CoCM services and the resulting savings to other services in Table 5.1 through 5.3 in Appendix A. The Department estimated the cost by evaluating the number of members that would likely utilize services, the average annual cost of CoCM services, the estimated uptake in provider capacity, and the related savings to Inpatient Psychiatry services and Emergency Department Services for members with Psychiatric Care.

The Department assumes that members with multiple behavioral health medications who are actively seeing a primary care clinic would be likely beneficiaries of CoCM. The Department does not assume that members who do not actively use their primary care clinic would utilize these services since they take place in the primary care setting. The Department estimates that 56% of the members who could benefit from CoCM services would utilize services if offered by a provider based on a study of CoCM engagement amongst low income patients. [19] The Department estimates that 19.85% of primary care clinics would offer CoCM services based on the existing percentage of providers who could provide these services currently if they were reimbursed and the percentages of providers who indicated they would like to build capacity through the HB 22-1302 grant. In a 2017 qualitative study on Medicare utilization, it was found that only 4.5% of eligible primary care providers billed for CoCM services in the first 15 months of reimbursement.[20]

The Department estimated savings to inpatient psychiatric care and emergency department care based on the current cost of members who have multiple behavioral health medication and participate in primary care and projected corresponding savings based on a Health Blue Louisiana study on CoCM. The study was focused on the impact of integrated care and found that implementing these models are associated with a 17% reduction in emergency department visits and an 8% reduction in inpatient visits. [21] Some studies indicate further savings per person in outpatient health costs for members with poorly controlled diabetes and/or coronary heart disease. [22] The Department assumes additional savings could be seen from substitution of members utilizing CoCM services instead of psychiatric services as members who gain access to psychiatric consultations through CoCM would not need to have independent psychiatric services provided. The Department did not estimate savings for these members due to difficulties identifying how much funding is spent on psychiatric services for members who visit a primary care clinic and have multiple behavioral health medications.

---

[19] Blackmore, Michelle A., et al. "Collaborative Care for Low-Income Patients from Racial-Ethnic Minority Groups in Primary Care: Engagement and Clinical Outcomes." Psychiatric Services, 10 Feb. 2022, ps.psychiatryonline.org/doi/10.1176/appi.ps.202000924.

[20] Rodriguez HP, Glenn BA, Olmos TT, Krist AH, Shimada SL, Kessler R, Heurtin-Roberts S, Bastani R. Real-world implementation and outcomes of health behavior and mental health assessment. J Am Board Fam Med. 2014 May-Jun;27(3):356-66. doi: 10.3122/jabfm.2014.03.130264. PMID: 24808114; PMCID: PMC4237013.

[21] NCQA Innovation Awards, www.ncqa.org/wp-content/uploads/2023/01/2022-NCQA-INNOVATION-AWARDS_COMPENDIUM.pdf. Accessed 3 July 2024.

[22] Katon W, Russo J, Lin EH, Schmittdiel J, Ciechanowski P, Ludman E, Peterson D, Young B, Von Korff M. Cost-effectiveness of a multicondition collaborative care intervention: a randomized controlled trial. Arch Gen Psychiatry. 2012 May;69(5):506-14. doi: 10.1001/archgenpsychiatry.2011.1548. PMID: 22566583; PMCID: PMC3840955.

Table 1.1
Summary by Line Item
FY 2025-26

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(2) Medical Services Premiums; Medical Services Premiums	($7,717,826)	0.0	($1,803,688)	($576,581)	$0	($5,337,557)	N/A	Table 2.1 Row A + Row B + Row E
B	(3) Behavioral Health Community Programs; Behavioral Health Capitation	$9,293,193	0.0	$2,171,858	$694,272	$0	$6,427,063	N/A	Table 2.1 Row C + Row F
C	**Total Request**	**$1,575,367**	**0.0**	**$368,170**	**$117,691**	**$0**	**$1,089,506**	**N/A**	Sum of Rows A through K

Table 1.2
Summary by Line Item
FY 2026-27

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(2) Medical Services Premiums; Medical Services Premiums	($7,717,826)	0.0	($1,803,688)	($576,581)	$0	($5,337,557)	N/A	Table 2.2 Row A + Row B + Row E
B	(3) Behavioral Health Community Programs; Behavioral Health Capitation	$9,293,193	0.0	$2,171,858	$694,272	$0	$6,427,063	N/A	Table 2.2 Row C + Row F
C	**Total Request**	**$1,575,367**	**0.0**	**$368,170**	**$117,691**	**$0**	**$1,089,506**	**N/A**	Sum of Rows A through K

Table 1.3
Summary by Line Item
FY 2027-28 and Ongoing

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(2) Medical Services Premiums; Medical Services Premiums	($7,717,826)	0.0	($1,803,688)	($576,581)	$0	($5,337,557)	N/A	Table 2.3 Row A + Row B + Row E
B	(3) Behavioral Health Community Programs; Behavioral Health Capitation	$9,293,193	0.0	$2,171,858	$694,272	$0	$6,427,063	N/A	Table 2.3 Row C + Row F
C	**Total Request**	**$1,575,367**	**0.0**	**$368,170**	**$117,691**	**$0**	**$1,089,506**	**N/A**	Sum of Rows A through K

Table 2.1
Summary by Initiative
FY 2025-26

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Expanding New Health and Behavioral Assessment and Intevention (HBAI) Services									
A	Total New HBAI Service Costs	$4,456,546	0.0	$1,041,513	$332,938	$0	$3,082,095		Table 3.1 Row J
Moving Short-Term BH/ Psychotherapy Codes to the Behavioral Health Capitation									
B	Current Cost Moving from Fee For Service	($15,277,304)	0.0	($3,570,369)	($1,141,331)	$0	($10,565,604)		Table 4.1 Row D
C	Projected Cost Added to the Behavioral Health Capitation	$9,456,651	0.0	$2,210,059	$706,483	$0	$6,540,109		Table 4.1 Row C
D	Total Cost of Moving Short Term BH Codes to the Behavioral Health Capitation	($5,820,653)	0.0	($1,360,310)	($434,848)	$0	($4,025,495)		Row D + Row E
Adding Collaborative Care Management (CoCM) Services									
E	Total New CoCM Service Costs	$3,102,932	0.0	$725,168	$231,812	$0	$2,145,952		Table 5.1 Row A
F	Projected Savings	($163,458)	0.0	($38,201)	($12,211)	$0	($113,046)		Table 5.1 Row B
G	Total Cost of Adding CoCM Services	$2,939,474	0.0	$686,967	$219,601	$0	$2,032,906		Row E + Row F
H	**Total Request**	**$1,575,367**	**0.0**	**$368,170**	**$117,691**	**$0**	**$1,089,506**		**Row A + Row D + Row G**

Table 2.2
Summary by Initiative
FY 2026-27

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Expanding New Health and Behavioral Assessment and Intevention (HBAI) Services									
A	Total New HBAI Service Costs	$4,456,546	0.0	$1,041,513	$332,938	$0	$3,082,095		Table 3.1 Row J
Moving Short-Term BH/ Psychotherapy Codes to the Behavioral Health Capitation									
B	Current Cost Moving from Fee For Service	($15,277,304)	0.0	($3,570,369)	($1,141,331)	$0	($10,565,604)		Table 4.1 Row D
C	Projected Cost Added to the Behavioral Health Capitation	$9,456,651	0.0	$2,210,059	$706,483	$0	$6,540,109		Table 4.1 Row C
D	Total Cost of Moving Short Term BH Codes to the Behavioral Health Capitation	($5,820,653)	0.0	($1,360,310)	($434,848)	$0	($4,025,495)		Row D + Row E
Adding Collaborative Care Management (CoCM) Services									
E	Total New CoCM Service Costs	$3,102,932	0.0	$725,168	$231,812	$0	$2,145,952		Table 5.1 Row A
F	Projected Savings	($163,458)	0.0	($38,201)	($12,211)	$0	($113,046)		Table 5.1 Row B
G	Total Cost of Adding CoCM Services	$2,939,474	0.0	$686,967	$219,601	$0	$2,032,906		Row E + Row F
H	**Total Request**	**$1,575,367**	**0.0**	**$368,170**	**$117,691**	**$0**	**$1,089,506**		**Row A + Row D + Row G**

Table 2.3
Summary by Initiative
FY 2027-28 and Ongoing

Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Expanding New Health and Behavioral Assessment and Intevention (HBAI) Services									
A	Total New HBAI Service Costs	$4,456,546	0.0	$1,041,513	$332,938	$0	$3,082,095		Table 3.1 Row J
Moving Short-Term BH/ Psychotherapy Codes to the Behavioral Health Capitation									
B	Current Cost Moving from Fee For Service	($15,277,304)	0.0	($3,570,369)	($1,141,331)	$0	($10,565,604)		Table 4.1 Row D
C	Projected Cost Added to the Behavioral Health Capitation	$9,456,651	0.0	$2,210,059	$706,483	$0	$6,540,109		Table 4.1 Row C
D	Total Cost of Moving Short Term BH Codes to the Behavioral Health Capitation	($5,820,653)	0.0	($1,360,310)	($434,848)	$0	($4,025,495)		Row D + Row E
Adding Collaborative Care Management (CoCM) Services									
E	Total New CoCM Service Costs	$3,102,932	0.0	$725,168	$231,812	$0	$2,145,952		Table 5.1 Row A
F	Projected Savings	($163,458)	0.0	($38,201)	($12,211)	$0	($113,046)		Table 5.1 Row B
G	Total Cost of Adding CoCM Services	$2,939,474	0.0	$686,967	$219,601	$0	$2,032,906		Row E + Row F
H	**Total Request**	**$1,575,367**	**0.0**	**$368,170**	**$117,691**	**$0**	**$1,089,506**		**Row A + Row D + Row G**

Table 3.1 Projected Costs for Behavioral Assessments					
Row	**Item**	**FY 2025-26**	**FY 2026-27**	**FY 2027-28**	**Notes**
Utilization Subsituting from Existing Short Term Behavioral Health Utilization					
A	Current Utilizers of Short Term BH Codes	36,105	36,105	36,105	Distinct Utilizers of Short Term Behavioral Health Evaluation Codes in FY 2022-23
B	Estimated Percentage of Short Term BH Utilizers that will use HABI Services instead	38.10%	38.10%	38.10%	Table 3.2 Row F
C	Total Estimated Annual Utilizers	13,756	13,756	13,756	Row A * Row B
New Utilizers of Health and Behavioral Health Assessments					
D	Potential New Integrated Care Utilizers	13,183	13,183	13,183	FY 2023 Data on Members with a chronic condition, active PCMP utilization, and Emergency Department utilization.
E	Percentage of Providers able to provide services	32.75%	32.75%	32.75%	Percentages of Primary Care Medical Practices that utilized Short Term Behavioral Health
F	Estimated Percentage of Patients Using HBAI	88.00%	88.00%	88.00%	See Narrative
G	Total Estimated Annual Utilizers	3,800	3,800	3,800	Row A * Row B
H	**Total Estimated in Utilizers**	**17,556**	**17,556**	**17,556**	**Row G + Row H**
I	Average Estimated Rate Paid	$253.85	$253.85	$253.85	Table 3.3 Row H
J	**Total Estimated Cost**	**$4,456,546**	**$4,456,546**	**$4,456,546**	**Row C * Row D**

Table 3.2 Provider Survey Results				
Row	**Provider Substitution**	**Assumed Percentage**	**Percent of Responses**	**Notes**
A	0-20%	10%	35.70%	
B	21-40%	30%	26.20%	
C	41-60%	50%	16.70%	
D	61-80%	70%	4.70%	
E	81-100%	90%	16.70%	
F	**Average Substution**		**38.1%**	**Weighted Sum of Row A through Row E**

Table 3.3 Average Cost of HBAI Service per Client					
Row	**Item**	**Estimate[1]**	**Procedure Code used for estimate**	**Other Procedure Codes**	**Notes**
A	Health Behavior Assessment Rate	$97.25	96156	N/A	Medicare Non-Facility Rate
B	Health Behavior Intervention Rate	$65.82	96158	96159, 96164, 96165, 96167, 96168, 96170 , and 96171	Medicare Non-Facility Rate
C	FQHC Behavioral Health Encounter Rate	$205.35	N/A	N/A	FY 2024-25 Behavioral Health Encounter Rate
D	Percentage of Clients Assumed to have a follow up Visit	83%	N/A	N/A	See Narrative
E	Average Cost under Fee for Service	$151.88	N/A	N/A	Row A + (Row B * Row D)
F	Average Cost under FQHC	$375.79	N/A	N/A	Row C + (Row C * Row D)
G	Percentage of Clients visiting an FQHC	45.54%	N/A	N/A	Based on FY 2022-23 Expenditure for STBH Services
H	**Average Cost of HBAI Service per Client**	**$253.85**			**(Row E * (1-Row G)) + (Row F * Row G)**

[1] Department is proposing to open up procedure codes 96156, 96158, 96159, 96164,96165,96167, 96168, 96179, and 96171 in alignment with Medicare Rates.

Table 4.1 Total Projected Costs of Short Term Behavioral Health Services					
Row	**Item**	**FY 2025-26**	**FY 2026-27**	**FY 2027-28**	**Notes**
A	Total Short Term Behavioral Health Costs	$15,277,304	$15,277,304	$15,277,304	FY 2022-23 Short Term Behavioral Health Expenditure
B	Total projected reduction in costs	38.10%	38.10%	38.10%	Table 3.2 Row F
C	Total Cost Anticipated to be Billed under the Behavioral Health Capitation	$9,456,651	$9,456,651	$9,456,651	Row A * (1-Row B)
D	Total Savings in Fee for Service Billed Services	($15,277,304)	($15,277,304)	($15,277,304)	Row A * -1
E	Total Cost of Short Term Behavioral Health Services	($5,820,653)	($5,820,653)	($5,820,653)	Row C + Row D

Table 5.1 Total Projected Costs and Saving for CoCM Services					
Row	**Item**	**FY 2025-26**	**FY 2026-27**	**FY 2027-28**	**Notes**
A	Total Projected Costs of CoCM Services	$3,102,932	$3,102,932	$3,102,932	Table 5.2 Row I
B	Total Projected Savings for CoCM Services	($163,458)	($163,458)	($163,458)	Table 5.3 Row K
C	**Total Projection of CoCM Service Implementation**	**$2,939,474**	**$2,939,474**	**$2,939,474**	**Row A + Row B**

Table 5.2 Projected Cost for CoCM Services					
Row	**Item**	**FY 2025-26**	**FY 2026-27**	**FY 2027-28**	**Notes**
Members Currently Utilizing BH Medication Services					
A	Current Members with BH Medication in a Primary Care Setting	28,471	28,471	28,471	FY 2022-23 Data for Members between 18 and 64 years old with 2 or more Psychiatric Medications
B	Percentage of Patients expected to use CoCM	56%	56%	56%	See Narrative
C	Average Annual Cost per Member	$980.44	$980.44	$980.44	Row B
D	Projected Costs to Existing Utilizers	$15,631,900	$15,631,900	$15,631,900	Row D * Row E
E	**Total Projected Costs of CoCM Services**	**$15,631,900**	**$15,631,900**	**$15,631,900**	**Row C + Row F**
F	Projected Provider Capacity	19.85%	19.85%	19.85%	See Narrative
G	Adjusted Total Costs	$3,102,932	$3,102,932	$3,102,932	Row E * Row F

Table 5.3 Projected Savings for CoCM Services					
Row	**Item**	**FY 2025-26**	**FY 2026-27**	**FY 2027-28**	**Notes**
Reductions to Inpatient Psychiatric Care					
A	Inpatient Psychiatric Care Expenditure	$15,525,235	$15,525,235	$15,525,235	FY 2022-23 Data
B	Estimated Reduction in Costs from CoCM implementation	-8.00%	-8.00%	-8.00%	See Narrative
C	**Projected Savings to Inpatient Psychiatric Care**	**($1,242,019)**	**($1,242,019)**	**($1,242,019)**	**Row A * Row B**
Reductions to Emergency Department Visits					
D	Emergency Department Expenditure for Members with Psychiatric Care	$1,343,851	$1,343,851	$1,343,851	FY 2022-23 Data
E	Estimated Reduction in Costs from CoCM implementation	-17.00%	-17.00%	-17.00%	See Narrative
F	**Total Projected Savings**	**($228,455)**	**($228,455)**	**($228,455)**	**Row A * Row B**
Total Savings from Implementing CoCM on Existing Services					
G	Total Projected Savings	($1,470,474)	($1,470,474)	($1,470,474)	Row C + Row F
H	Percentage of Patients expected to use CoCM	56.00%	56.00%	56.00%	Table 5.2 Row B
I	Projected Provider Capacity	19.85%	19.85%	19.85%	Table 5.2 Row F
J	**Total Adjusted Savings from CoCM on Existing Services**	**($163,458)**	**($163,458)**	**($163,458)**	**Row G * Row H * Row I**