

Collaborative Care Model (CoCM)

Implementation

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What We'll Cover Today

01

The Collaborative Care Model

Principles, the care team, and the evidence behind it

02

Why Kentucky, Why Now

The Medicaid landscape, our progress, and the financial case

03

One Site's Story: Arcare

Implementation in practice

04

Practical Takeaways

What to bring back tomorrow

Five Principles Define Collaborative Care



Patient-Centered

Shared care plans across primary care and mental health



Population-Based

Patient registry ensures no one falls through the cracks



Evidence-Based

Treatments grounded in research evidence



Treat to Target

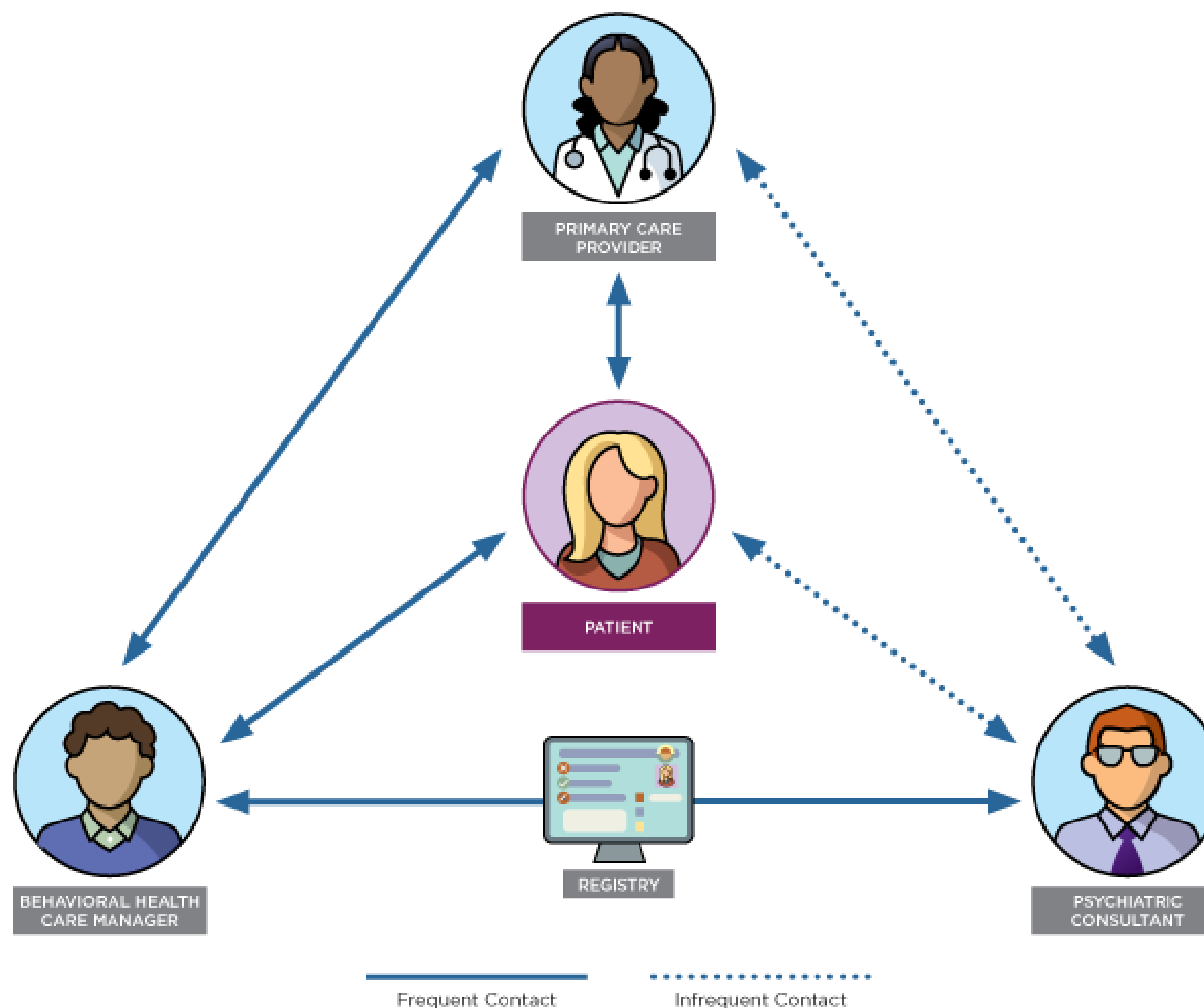
Regularly measure progress and adjust treatment to achieve goals



Accountable

Reimbursement tied to quality and outcomes, not volume

One Team, Built Around the Patient



Source: [Meadows Mental Health Policy Institute](#)

The Evidence is Strong — Clinically and Financially



Clinical Evidence

110+

randomized controlled trials show significantly better outcomes than usual care

2x

as likely to see a 50%+ reduction in depression symptoms ([IMPACT Study](#))

3–8x

more patients reached per psychiatric consultant than usual care ([Carlo et al., 2024](#))



Financial Impact

6:1

return on investment — \$6.50 saved in healthcare costs for every \$1 spent (IMPACT Study)

13%

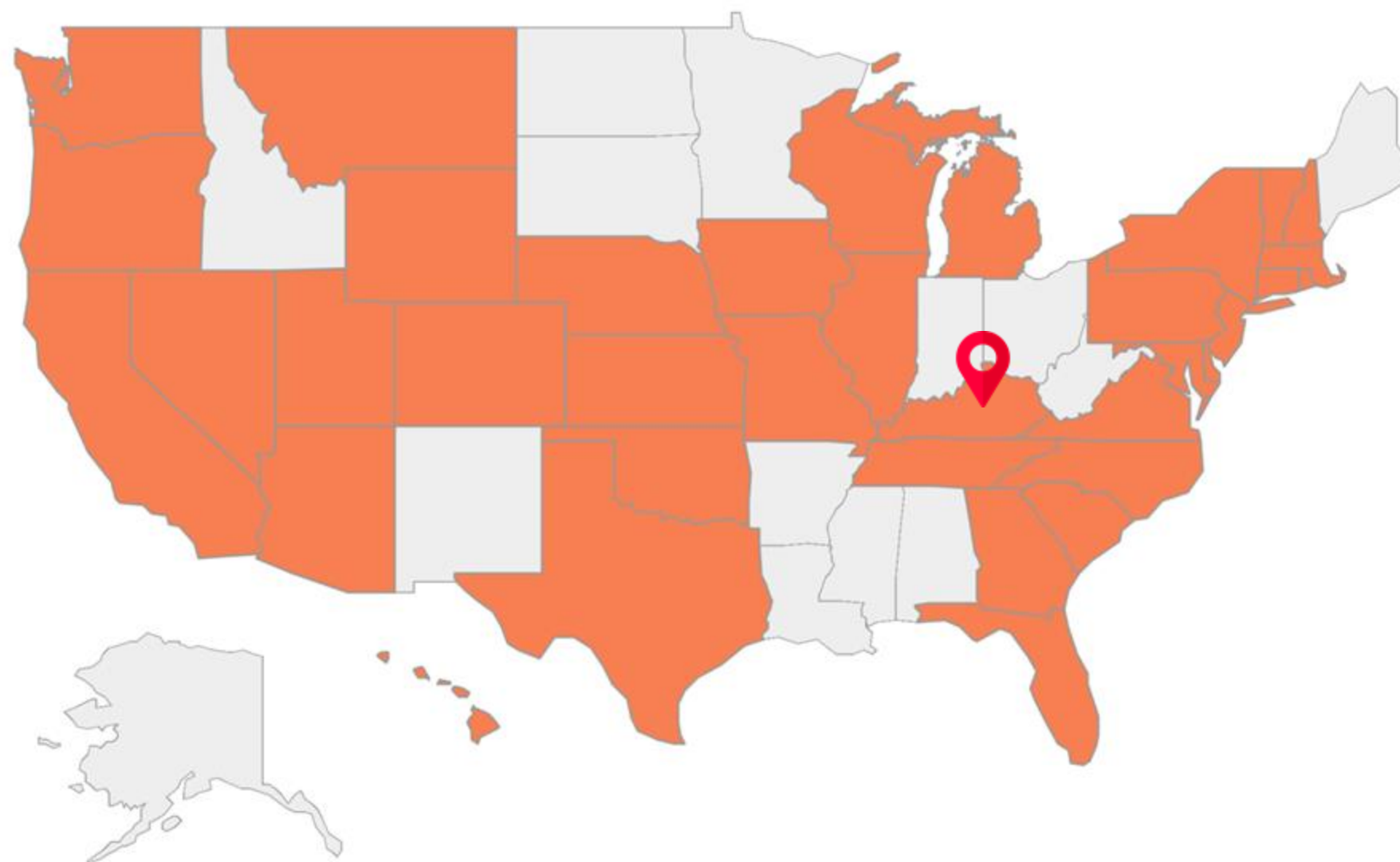
reduction in total healthcare costs within 12 months (Kaiser Permanente, 2024)

\$340

per-member cost reduction in just six months (Arkansas Blue Cross and Blue Shield, 2025)

Kentucky has the policy. The gap is adoption.

State Medicaid Coverage for Collaborative Care Management Codes



The Adoption Gap by the Numbers

KENTUCKY							
	2018	2019	2020	2021	2022	2023	2024
Number: Medicaid CoCM Patients Per Year							
USA (National)	3,519	9,726	15,226	21,453	31,769	44,498	
Kentucky	12	<11	461	563	315	278	
Number: Medicare CoCM Patients Per Year							
USA (National)	6,751	15,107	18,302	28,689	41,689	63,244	
Kentucky	14	17	103	285	334	292	
Number: Commercial CoCM Patients Per Year							
USA (National)	3,814	10,887	25,911	48,876	80,162	115,224	153,356
Kentucky	295	55	194	160	219	206	222

Source: [Path Forward](#) / [Meadows Mental Health Policy Institute](#); [Bowman Family Foundation](#)

Momentum Already Underway

A KORE-funded partnership between KPCA and Zero Overdose

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Kentucky health centers already
implementing CoCM

Sep 2026

target month for the cohort's first
CoCM billing

\$212.9M

new state investment in rural
health, incl. behavioral health
crisis infrastructure

The financial model and tools behind these numbers are already built — not theoretical. Kentucky is investing in behavioral health infrastructure right now.

Making CoCM Self-Sustaining

Code	Description	Medicare Base Rate	Medicare +10% HPSA	KY Medicaid (FFS)
99492	Initial psychiatric CoCM	\$149.62	\$164.58	\$121.51
99493	Subsequent psychiatric CoCM	\$136.59	\$150.25	\$97.56
99494	Initial or subsequent additional time	\$57.73	\$63.50	\$50.50
G2214	Initial or subsequent psychiatric CoCM	\$56.95	\$62.65	Not listed

*The Centers for Medicare & Medicaid Services (CMS) [provides a 10% bonus payment to eligible physicians](#) who deliver covered services within a federally designated Health Professional Shortage Area (HPSA) — most of rural Kentucky qualifies.

Behavioral Health Integration (BHI)



- Started BHI services across KY, AR, and MS
- One Peer Support Specialist / Recovery Coach per state
- Initial focus on the Medication for Addiction Treatment (MAT) population
- Built the foundation for scalable integrated behavioral health services

Why We Started with the MAT Population



- Existing patient engagement and care relationships
- Patients already connected with medical providers
- Therapy services already established
- Recovery coaching already embedded
- A natural population for care coordination and outcome monitoring

BHI Billing Success



Accomplishments:

Consistent utilization of CPT
99484

Established workflows for time
tracking and documentation

Demonstrated ability to
operationalize BHI services

Created the foundation for
transition into CoCM services

Preparing for CoCM



Key Development Activities:

- Recovery coach training in evidence-based interventions and modalities
- Enhanced care management workflows
- Population identification and registry development
- Standardized measurement-based care processes
- Testing CoCM components within current framework

Clinical Readiness Activities



Recent Advancements:

- Suicide Safety Planning training led by Dr. Virna Little
- Overdose Safety Planning training led by Dr. Virna Little
- Brief Addiction Monitoring (BAM) implementation
- Focus on structured outcome measurement
- Emphasis on risk identification and care coordination

Growth and Lessons Learned



"It's working. Patients have been able to see and utilize the support and resources and connect with me."

— Kaylee Ullery, Recovery Coach, Arcare

- Started with limited staffing and a focused population
- Built reproducible workflows before expansion
- Increased staff competency through ongoing training
- Established measurable processes and accountability
- Leveraged existing treatment teams to support adoption
- Created a pathway toward full CoCM implementation

Practical Takeaways for Your Health Center



Start with what you have

Map CoCM onto your existing EMR and registry tools first.



Look at cross-certification

Worth exploring — confirm the specifics for your site before relying on it.



Lead with one data point

One clear metric convinces leadership faster than a framework.



Build the financial model early

A site-specific pro forma makes sustainability concrete.

Thank You

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