COMMUNITY FIRST HEALTH PLANS

Attestation for Collaborative Care Model (CoCM)

This attestation is for any single provider or provider group to attest that they are actively providing care consistent with the core principles and specific function requirements with the Collaborative Care Model (CoCM) as described in the Texas Medicaid Provider Procedures Manual (TMPPM).

Submission on behalf of individual billing provider or billing group practice:

❑ **Individual Billing Provider**

Billing Provider Name:	Billing Provider NPI:
Billing Provider Address:	Telephone Number:
Email Address:	
Billing/Lead Provider is one of the following: (check provider type) ❑ MD ❑ DO ❑ PA ❑ NP/CNS Delegating Physician's Name:_____	
NOTE: Requires each billing provider submit an attestation	

❑ **Billing Group Practice**

Billing Provider Name:		Billing Provider NPI:
Billing Provider Address:		Telephone Number:
Email Address:		
Servicing Provider Name:	Servicing Provider NPI:	Servicing Location:
Servicing Provider Name:	Servicing Provider NPI:	Servicing Location:
Servicing Provider Name:	Servicing Provider NPI:	Servicing Location:
Servicing Provider Name:	Servicing Provider NPI:	Servicing Location:
Billing/Lead Provider is one of the following: (check provider type) ❑ MD ❑ DO ❑ PA ❑ NP/CNS Delegating Physician's Name:_____		
NOTE: Attestation must cover all servicing providers within the practice, attesting that they are actively leading care consistent the core principles and specific function requirements with the CoCM, and ensure new medical providers that will be leading the collaborative care are trained in CoCM.		

Collaborative Care Model (CoCM)
Attestation Guidelines

A. If your practice bills under one base location and has several servicing locations, each servicing location must submit an attestation to provide and be reimbursed for CoCM service.
B. For practices with multiple sites with their own billing NPI's, each site must submit its own attestation.
C. If there are multiple providers within the practice, you are attesting that those individuals being identified as the servicing provider on the claim billing the CoCM services, are one of the above provider types, are trained and actively providing care consistent with the core principles, and specific function requirements for CoCM.

You attest that your practice is actively providing care in a Collaborative Care Model as described in the Texas Medicaid Provider Procedures Manual (TMPPM) guidelines. This CoCM includes the following required principles:

(Check each to verify.)

- ❑ Patient Centered Team Care
  a. Primary Care Provider (PCP) leads the collaborative care team
  b. Behavioral health care manager works with the lead medical provider
  c. Psychiatric consultant works with the lead PCP
  d. Member participates on the team
- ❑ Team structure with staff identified in the guideline
- ❑ Measurement-based and evidence-based treatment to target using validated tools
  a. Documented personal goals and clinical outcomes, measured by evidence-based tools
  b. Treatments are offered with credible research evidence
  c. Treatment changes if the member is not improving as expected
- ❑ Accountable care using a registry
  a. Providers are accountable and reimbursed for quality of care and clinical outcomes
  b. Outreach is provided for persons who are not improving
  c. Mental health specialists provide caseload – focused consultation

By signing this attestation, you are attesting that you (as an individual provider or a clinic/group practice):

- Have an established CoCM program prior to the delivery of services.
- Are providing CoCM services consistent with the core principles and specific functional requirements of the model and in compliance with 42 C.F.R. 447.10, and as described in the "Collaborative Care Model (CoCM)" section of the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (Vol. 2, Provider Handbooks) in the TMPPM. If at any time you, the individual, or the group practice no longer meets the requirements for CoCM, you will immediately notify Community First by contacting Provider Relations at 210-358-6294.

The person signing this form must have the authority to attest on behalf of the individual or group practice provider, that the CoCM guidelines are being adhered to.

Print Name: _____ Title: _____

Signature: _____ Date: _____

Return the completed and signed form to:
Provider Relations, 12238 Silicon Drive, Suite 100, San Antonio, TX 78249., Attn: Provider Relations. Or, by email to: ProviderRelations@cfhp.com