MDHHS Michigan Department of Health & Human Services

Medical Services Administration
BULLETIN MSA

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Distribution: Federally Qualified Health Centers, Medicaid Health Plans, Local Health Departments, Practitioners, Rural Health Clinics, Tribal Health Centers, Prepaid Inpatient Health Plans, Community Mental Health Services Programs

Issued: July 1, 2020

Subject: Coverage of Psychiatric Collaborative Care Model Services

Effective: August 1, 2020

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild

The purpose of this policy is to establish Medicaid program coverage conditions and requirements for Psychiatric Collaborative Care Model (CoCM) Services effective for dates of service on and after August 1, 2020. The goal of these services is to improve access to effective care for mild to moderate behavioral health disorders within the primary care setting for Medicaid Fee-for-Service (FFS) and Medicaid Health Plan beneficiaries. Participation in CoCM services is voluntary and participation is not required prior to obtaining a referral to specialty behavioral health services.

I. General Information

CoCM is a model of integrated behavioral health service which is typically provided within the primary care setting. The evidence-based model includes a person-centered care team, weekly and/or monthly monitoring of person-centered goals, and referral to behavioral health support services if goals are unmet after an initial six-month episode of care. CoCM uses team-based collaborative and management services which are provided under the direction and supervision of a treating physician or other qualified healthcare professional and utilizes a measurement-based treatment-to-target approach. The CoCM team includes the primary care provider, a behavioral health care manager, a psychiatric consultant and the FFS or Medicaid Health Plan beneficiary. The model requires the use and maintenance of a patient registry, typically maintained by the behavioral health care manager, which is to be accessible by the primary care provider and psychiatric consultant. CoCM allows for behavioral health integration services to be delivered in a familiar setting that helps engage beneficiaries in care, adapts to their changing needs over time, and reduces the likelihood of duplication of services by addressing both physical and behavioral health care in one setting.

II. Target Population

CoCM is intended for beneficiaries who typically have behavioral signs and/or symptoms of a newly diagnosed behavioral health condition, need help engaging in treatment, have not responded to care delivered in a non-psychiatric setting or require further assessment, engagement and management prior to consideration of a referral to a psychiatric care setting.

These services are not intended to manage severe and/or persistent conditions which require specialty care. Eligible conditions include, but are not limited to, mild to moderate depression, anxiety, bipolar disorder, attention deficit disorder, substance use disorder (SUD), and individuals who may not be deemed eligible for specialty services through the Community Mental Health Services Program (CMHSP).

III. The Psychiatric Collaborative Care Model

Medicaid enrolled providers must be able to demonstrate they are following the evidence-based best practices of CoCM. The model is most effective when all five core principles are in place and incorporated into service delivery. These principles include:

- Person-centered care: the beneficiary is part of the team and makes the ultimate decisions regarding their treatment and based on their own goals.
- Measurement-based treatment-to-target strategy: the use of validated tools allows measurement of beneficiary signs and symptoms.
- Population-based care: the patient registry allows monitoring of beneficiary outcomes by the care team over time and can be utilized in conjunction with, or alongside, existing beneficiary health records.
- Evidence-based treatment: beneficiaries are offered evidence-based treatment that may include medications and brief therapeutic interventions.
- Accountable care: the CoCM team of providers is accountable for all beneficiary care, including quality and clinical outcomes for beneficiaries receiving CoCM support services.

A. Episode of Care

An episode of care begins when a beneficiary starts CoCM and an episode of care ends when a beneficiary either:

- Fulfills treatment goals and the beneficiary returns to usual primary care follow-up,
- Fails to attain treatment goals, fails to improve or their condition worsens and requires referral to specialty services, or
- A break in services for six consecutive months or more occurs, at which point a new episode of care begins.

B. Measurement-Based Treatment-to-Target Strategy

The model utilizes validated tools which allows for measurement of beneficiary signs and symptoms. At a minimum, the plan of care (POC) for each beneficiary should be adjusted every 10-12 weeks based on the goal of reducing measured symptoms. Outcome measures are tracked in a patient registry. For example, if a beneficiary is recommended to engage in evidence-based therapy and does not exhibit symptom measurement improvement after 10 weeks, the psychiatric consultant may recommend an adjustment to treatment in an effort to reach person-centered goals.

C. Required Documentation

CoCM is a data-driven service delivery model that requires the use of a patient registry and corresponding POC for each beneficiary. The registry can be part of, or maintained alongside, an already existing Electronic Health Record (EHR). Typically, the behavioral health care manager is responsible for maintaining these tools and ensuring all documentation is included. CoCM services are most effective when the psychiatric consultant has direct access. Documentation must support the services provided and follow Medicaid documentation requirements, including consent for treatment. Services must be provided within the confines of state and federal law. Behavioral health care managers are required to ensure all aspects of registry/POC are included in the documentation.

Documentation requirements, at a minimum:

- Beneficiary information,
- Assessment, treatment plan, including evidence-based treatment interventions,
- Monitoring of individual beneficiary progress,
- Referrals, and
- Medication management.

The patient registry, at a minimum, must include the following key components:

- Date of enrollment and date of most recent contact with care team,
- Initial and most recent validated outcome measure,
- Prompt treatment-to-target strategies for treatment adjustment according to changes in validated tool scores, such as a flagging/alert system or systematic weekly review of the patient registry, and
- Facilitation of efficient, systematic psychiatric caseload review.

IV. Collaborative Care Team Criteria

All team members must participate in the care and treatment of the beneficiary to be considered as a covered CoCM service. Services are reported by the primary care provider and include the services of the treating physician, behavioral health care manager and the psychiatric consultant who is contracted to provide consultative services to the primary care provider. Psychiatric consultants typically make recommendations to the behavioral health care manager who will then convey recommendations to the treating physician. The psychiatric consultant does not typically provide direct consultation to the treating physician or direct treatment to beneficiaries, but instead works through the behavioral health care manager.

- **Primary care provider or treating physician**: a licensed Medicaid-enrolled health care provider (e.g., MD/DO, Nurse Practitioner [NP], Clinical Nurse Specialist [CNS], Physician Assistant [PA]), who will:

  - Direct the behavioral health care manager,
  - Continue to provide and direct beneficiary behavioral health and physical care,
  - Prescribe and manage medications based on psychiatric consultant recommendations, and
  - Make referrals to specialty care as needed.

- **Behavioral health care manager**: a licensed master's or doctoral level clinician, or individual with specialized training in behavioral health (such as a licensed social worker, registered nurse, or licensed psychologist) working under the direction and supervision of the primary care provider, who will:

  - Provide care management services through face-to-face and non-face-to-face interactions,
  - Assess beneficiary needs,
  - Develop a POC,
  - Administer validated screening tools (PHQ-9 or GAD-7) at least monthly, or more frequently if clinically indicated,
  - Provide evidence-based interventions,
  - Engage in ongoing collaboration with the primary care provider,
  - Maintain the patient registry, and
  - Consult weekly with the psychiatric consultant (may be non-face-to-face).

- **Psychiatric consultant**: medical professional (MD or DO) who is trained in psychiatry or behavioral health and qualified to prescribe the full range of medications. The psychiatric consultant will:

  - Recommend treatment strategies,
  - Recommend medication and changes in medication based on beneficiary status,
  - Recommend referral to specialty services when needed,
  - Consult weekly with the behavioral health care manager,
  - Consult with and advise the treating primary care provider as clinically indicated,

- Have infrequent contact with beneficiaries (see Reimbursement for details), and
- On rare occasions, directly prescribe medications to a beneficiary.

- **The beneficiary:** the beneficiary is an active member of the care team and participation in care has proven to increase motivation, adherence to treatment plan, satisfaction with care and positive beneficiary outcomes.

V. Coverage of CoCM Services

CoCM is a covered service for beneficiaries who are diagnosed with a psychiatric disorder that requires behavioral health care assessment; establishing, implementing, revising, or monitoring a care plan; and brief interventions. For primary medical care practices that meet all CoCM team criteria, Medicaid will cover CoCM services provided by the care team and rendered by the primary care provider for six months of care. After the initial six months, prior authorization is required for six additional calendar months if the beneficiary shows improvement and there is a need for continued care. If no improvement occurs after the initial six months or their condition worsens, the beneficiary is to be referred to specialty services. An episode of care does not have to be six consecutive months. A beneficiary can be absent from services for five months and still return to their initial episode of care. After a six-month break in service, a new episode of care begins and prior authorization is not required.

CoCM services are based on reaching person-centered goals through the planning and management of the behavioral health care manager and primary care provider all in consultation with the psychiatric consultant.

CoCM services must include:

- **Initial assessment:** Face-to-face visit in which the beneficiary sets goals and is screened by a diagnosis-appropriate and consistent validated clinical rating scale, such as the PHQ-9 or GAD-7, which also must be done prior to subsequent CoCM services.

- **Continued monitoring:** Face-to-face or non-face-to-face weekly to monthly follow-up by the behavioral health care manager that must include monthly screening with validated rating scale, monitoring of goals and/or medication, and may include recommended evidence-based therapies.

- **Monthly monitoring:** Continues until goals are met, the beneficiary stops participating or the beneficiary is referred to specialty services.

VI. Non-covered Services

Psychiatric CoCM services do not include:

- Treatment related to severe and persistent behavioral health conditions that require specialty care beyond the intent of CoCM services.

- Direct interaction between the beneficiary and the psychiatric consultant, either in person or by telephone. CoCM services typically include the psychiatric consultant as recommending treatment to the behavioral health care manager and are ultimately directed by the primary care provider.
- SUD-related Medication Assisted Treatment (MAT) is not covered under CoCM services and should be reported separately.

VII. Prior Authorization

After an initial six-month episode of care, prior authorization is required for an additional six months. Prior authorization requests must include documentation showing progress toward beneficiary goals through validated screening tool scores and an explanation for the medical necessity of continued services. If a six-month lapse in CoCM occurs, a new episode of care can begin without prior authorization. (Refer to the Practitioner chapter of the Medicaid Provider Manual, Prior Authorization subsection for additional information. The Medicaid Provider Manual can be accessed on the Michigan Department of Health and Human Services website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.)

VIII. Reimbursement

CoCM is a bundled monthly payment that represents a model of care rendered by all team members. The primary care provider is the sole biller for CoCM and services are not to be billed by the psychiatric consultant. The primary care provider agency is expected to have its own contract with the psychiatric consultant and will pay for his or her services as part of the CoCM. Providers are expected to adhere to the American Medical Association's Current Procedural Terminology (CPT®) coding guidelines for Psychiatric Collaborative Care Management Services as reported by CPT codes 99492, 99493, and 99494.

Direct consultant services delivered to beneficiaries by the psychiatric consultant outside of CoCM, such as evaluation and management or therapeutic interventions, may be reported separately.

To avoid duplication of services, CoCM services should not be provided to beneficiaries receiving the following Medicaid program services:

- MI Care Team benefit,
- Behavioral Health Home benefit,
- Opioid Health Home benefit, or
- Other care management services that include mental health treatment.

Providers may check the beneficiary's assigned benefit plan information in the Community Health Automated Medicaid Processing System (CHAMPS).

IX. Federally Qualified Health Center and Rural Health Clinic Reimbursement

CoCM services provided by a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) provider (e.g., MD/DO, Nurse Practitioner [NP], Clinical Nurse Specialist [CNS], Physician Assistant [PA]) do not qualify as an encounter. It may, however, be reimbursed outside of the Prospective Payment System. FQHCs and RHCs should use Healthcare Common Procedure Coding System (HCPCS) code G0512 to report CoCM services.

X. Substance Use Disorder CoCM Reimbursement

For Medicaid Health Plan enrolled beneficiaries, CoCM services provided for a primary diagnosis of SUD are carved-out of the Medicaid Health Plans. Such services will be reimbursed by the Prepaid Inpatient Health Plans, or FFS as applicable, per Medicaid policy.

Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Kate Massey, Director
Medical Services Administration