MEDICAID POLICY INFORMATION SHEET

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Initial ☐ Public Comment ☒ Final ☐

Brief description of policy:

The purpose of this policy is to establish reimbursement for Psychiatric Collaborative Care Model (CoCM) services, which is a model of integrated behavioral health services and typically provided within the primary care setting.

Reason for policy (problem being addressed):

To increase access to behavioral health services for those with mild-moderate behavioral health conditions within the primary care setting.

Budget implication:

☒ budget neutral
☐ will cost MDHHS $, and (select one) budgeted in current appropriation
☐ will save MDHHS $

Is this policy change mandated per federal requirements?

No.

Does policy have operational implications on other parts of MDHHS?

Program Review Division related to prior authorization.

Does policy have operational implications on other departments?

No.

Summary of input:

☐ controversial (Explain)
☒ acceptable to most/all groups
☐ limited public interest/comment

Supporting Documentation:

State Plan Amendment Required: ☐ Yes ☒ No If Yes, please provide status: ☐ Approved ☐ Pending ☐ Denied Date: Approval Date:	Public Notice Required: ☐ Yes ☒ No If yes, Submission Date:

DRAFT FOR PUBLIC COMMENT Michigan Department of Health and Human Services		
	Project Number: 1945-CoCM	**Date:** March 11, 2020

Comments Due: April 15, 2020
Proposed Effective Date: June 1, 2020
Direct Comments To: Janell Troutman
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Policy Subject: Coverage of Psychiatric Collaborative Care Model Services

Affected Programs: Medicaid, Healthy Michigan Plan, MIChild, Maternity Outpatient Medical Services

Distribution: Federally Qualified Health Centers, Medicaid Health Plans, Local Health Departments, Practitioners, Rural Health Clinics, Tribal Health Centers

Summary: The Psychiatric Collaborative Care Model (CoCM) is a model of integrated behavioral health services typically provided within the primary care setting. The goal is to increase access to behavioral health services for those with mild to moderate behavioral health disorders.

Purpose: To increase access to behavioral health services for those with mild-moderate behavioral health conditions within the primary care setting.

Cost Implications: Budget neutral – matching state general funds are provided through a grant from the Michigan Health Endowment Fund.

Potential Hearings & Appeal Issues: None anticipated

State Plan Amendment Required: Yes ☐ **No** ☒ **If yes, date submitted:**	**Public Notice Required: Yes** ☐ **No** ☒ **Submitted date:**

Tribal Notification: Yes ☐ **No** ☒ - **Date:**

THIS SECTION COMPLETED BY RECEIVER

☐ **Approved**	☐ **No Comments**
	☐ **See Comments Below**
☐ **Disapproved**	☐ **See Comments in Text**

Signature:	**Phone Number**
Signature Printed:	
Bureau/Administration *(please print)*	**Date**

Proposed Policy Draft

Michigan Department of Health and Human Services
Medical Services Administration

Distribution: Federally Qualified Health Centers, Medicaid Health Plans, Local Health Departments, Practitioners, Rural Health Clinics, Tribal Health Centers

Issued: May 1, 2020 (Proposed)

Subject: Coverage of Psychiatric Collaborative Care Model Services

Effective: June 1, 2020 (Proposed)

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild, Maternity Outpatient Medical Services

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 June 1, 2020. The goal of these services is to improve access to care for mild to moderate behavioral health disorders within the primary care setting for Medicaid Fee-for-Service (FFS) and Medicaid Health Plan beneficiaries.

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 patient-centered care team, weekly and/or monthly monitoring of patient-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 patients 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 patients 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 and substance use disorder (SUD).

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:

- Patient-centered care: the patient 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 patient signs and symptoms.
- Population-based care: the patient registry allows monitoring of patient outcomes by the care team over time and can be utilized in conjunction with, or alongside, existing patient 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 patient care, including quality and clinical outcomes for patients receiving CoCM support services.

A. Episode of Care

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

- Fulfills treatment goals and the patient 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 patient signs and symptoms. At a minimum, the plan of care (POC) for each patient should be adjusted every 10-12 weeks based on the goal of reducing measured symptoms by 50%. Outcome measures are tracked in a patient registry. For example, if a patient 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 patient-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.

The patient registry and/or POC must include, at a minimum:

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

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

- Tracking of clinical outcomes across a target population utilizing patient goals and validated tool scores to establish symptom severity and progress.
- Tracking of patient engagement across a caseload.
- Prompt treatment-to-target strategies (i.e., a flagging/alert system) for treatment adjustment according to changes in validated tool scores.
- Facilitation of efficient, systematic psychiatric caseload review.
- Patient contact, including initial services, follow-up and most recent contact.

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 has contracted directly with the primary care provider to provide consultation. 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 patients, 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 patient behavioral 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 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 patient needs,
  - Develop a POC,
  - Administer monthly or weekly validated screening tools (PHQ-9 or GAD-7),
  - 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 patient status,
  - Recommend referral to specialty services when needed,
  - Consult weekly with the behavioral health care manager,
  - Have infrequent contact with the primary care provider,

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

- **The patient:** the patient 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 patient outcomes.

V. Coverage of CoCM Services

CoCM is a covered service for patients 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 patient shows improvement and a need for continued care. If no improvement occurs after the initial six months or their condition worsens, the patient is to be referred to specialty services. An episode of care does not have to be six consecutive months. A patient 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 patient-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, 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 beneficiary and 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 is 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. PA requests must include documentation showing progress toward patient 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 PA. (Refer to the Practitioner chapter of the Medicaid Provider Manual, Prior Authorization section for additional information.)

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 consultants. 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.

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 cannot be billed with the following:

- MI Care Team benefit,
- Opioid Health Home benefit, or
- Other care management services.

For additional information about CoCM reimbursement, providers should refer to the Medicaid Code and Rate Reference tool 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 or Rural Health Clinic provider (physician, NP, PA or Certified Nurse Midwife [CNM]) does not qualify as an encounter. It may, however, be reimbursed outside of the Prospective Payment System.

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 through FFS consistent with applicable Medicaid policy.