VALUEPartnerships
Better Care. Better Outcomes. Better Value.

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan Physician Group Incentive Program 2022 Program Year

Expanding Use of the Collaborative Care Model (CoCM)

I. Background

Health Problem and Significance

Access and quality in behavioral health care are prevailing problems both statewide and nationally. Behavioral health issues are the leading cause of disease burden.[1,2]

- 39% of mental health issues in Michigan go untreated.[3]
- >75% don't receive adequate care.[4]
- 46% report confusion and 42% report cost challenges.[5]
- Major driver of health care costs.
- Traditional models of care are often not evidence-based and have variable outcomes and results.
- 31% increase rate of suicide in last 16 years.[6]
- The U.S. loses $1.68 billion in productivity due to mental health conditions each year.[7]

Currently most patients receive behavioral health treatment in primary care, but less than 40% see significant improvement. Nationally, primary care providers prescribe 67% of psychotropics and 80% of antidepressants.[8,9]

Studies show:

- 50% of patients referred to a behavioral health provider do not follow through.
- 10% of depression patients receive care that follows evidence-based guidelines.[10]
- These patients have four times the risk of behavioral health conditions when they have other chronic diseases.[11]
- Medical costs are two to four times higher when patients have untreated coexisting depression.[12]
- Patients are three times less likely to adhere to a treatment plan when they also have depression.[13]
- Patients with depression have six times more emergency department visits.[14]

Blue Cross Statistics

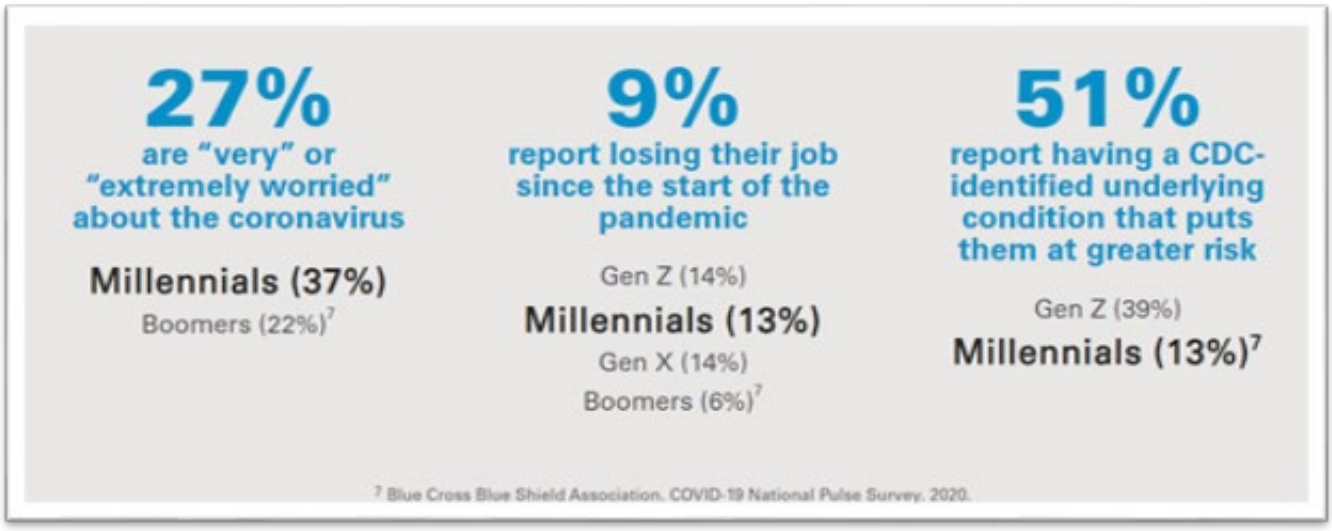
Blue Cross 2018 claims showed that when compared to non-behavioral health patients:

- Patient spend for medical and surgical services is 50% higher.
- The patient medical/surgical per utilizing member per month is 80% higher both for inpatient and emergency department costs.
- 14% of our behavioral health members account for 26% of total spend.

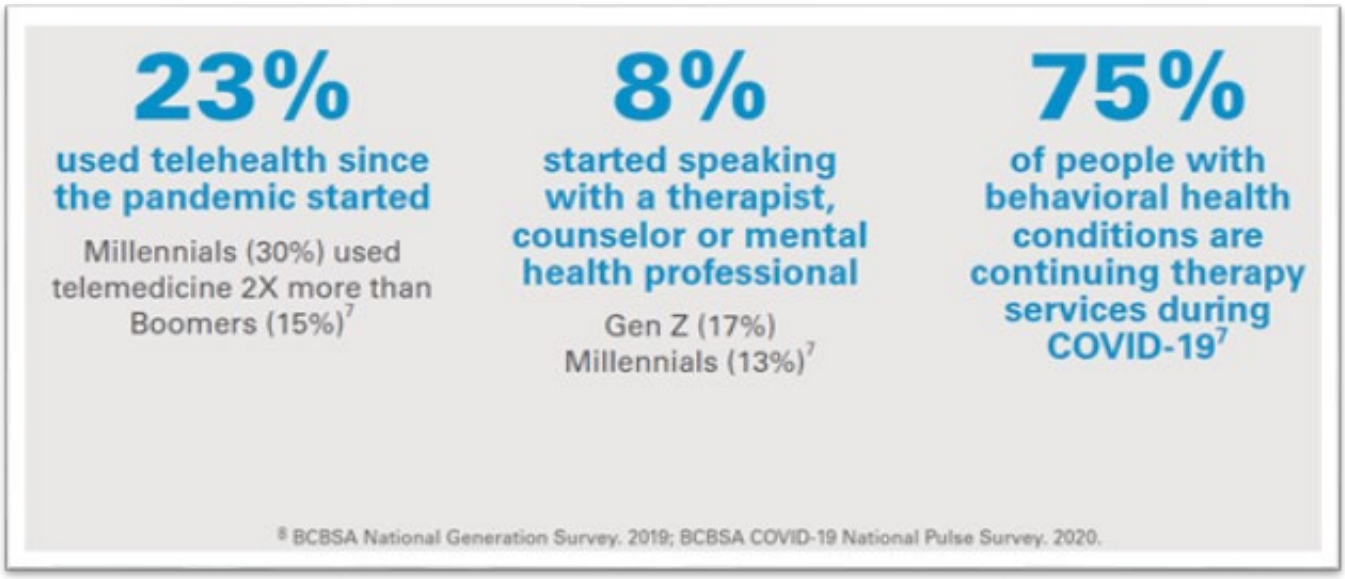
Impacts of COVID-19

Behavioral health needs have been made even more apparent with the impacts of COVID-19.[15]

The number of mental-health related emergency department visits rose by 24% among children ages 5 to 11 and by 31% among youth ages 12 to 17 from March through October of 2020 compared to the same period in 2019, according to a November 2020 Centers for Disease Control and Prevention report.



Virtual care has increased 1.6 times since summer 2019, and half that growth came since the start of the COVID-19 pandemic, according to BCBSA National Generation Survey. 2019; and BCBSA COVID-19 National Pulse Survey. 2020.



Possible Solutions

CoCM has proven to be the most effective in bringing more patients to remission in less time according to more than 80 randomized studies.

By integrating behavioral health services into a primary care setting, the patient is more likely to address behavioral health issues. In addition, costs and barriers to care are reduced, resulting in better-managed care.[16]

Blue Cross funded Michigan Center for Clinical System Improvements (Mi-CCSI) as they piloted similar integration projects through the IMPACT, DIAMOND and COMPASS models.

The AIMS Center at University of Washington developed and expanded use of this model outside of academics and research. They continue to lead national efforts to CoCM adoption.

Although there are competitors and other Blue plans who pay for the CoCM benefits, Blue Cross and BCN are *first-to-market* leaders in our expansion efforts which include a robust incentive structure along with training and support offered to physician organizations and practices.

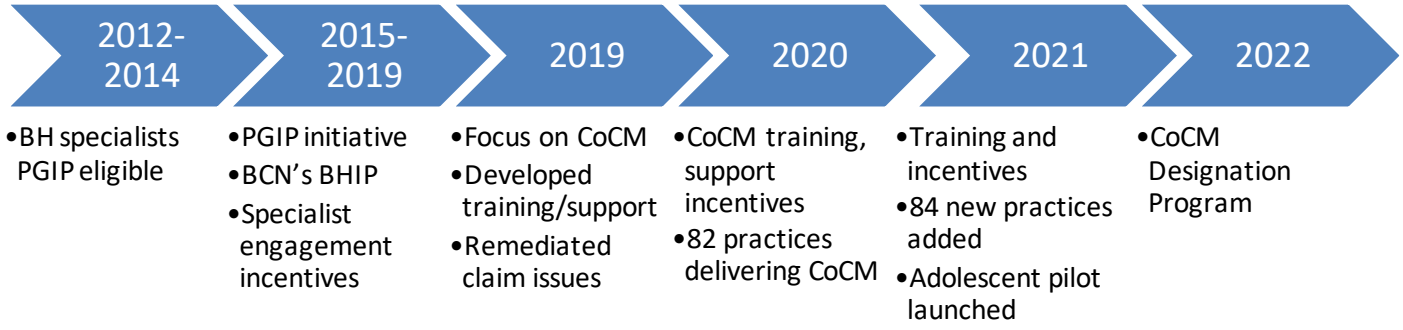
Blue Cross Experience

The Physician Group Incentive Program through Blue Cross and Blue Care Network each developed and offered incentive programs to explore potential solutions to integrating behavioral health into general care in 2014.

In the 2015-2019 PGIP behavioral health initiative, there were a few physician organizations who chose to implement CoCM. University of Michigan Health System and IHA are two physician organizations that have been leaders in CoCM use. They have had good preliminary results in the practices using the model and their outcomes align with national findings.

In 2022, PGIP launched a CoCM Designation Program that builds of the foundational achievements of the PCMH program.

Here is a timeline of our various enterprise behavioral health integration incentive programs:



II. Initiative Description

In 2022, PGIP rolled out the CoCM Designation Program. This program supports those practices that have made substantial progress in implementing and using CoCM processes and tools, resulting in delivery of more coordinated, accessible, and effective health care.

The CoCM Designation Program will build on foundational PCMH capabilities, while not being duplicative. A practice must be PCMH designated in order to receive CoCM designation. The CoCM capabilities are the "must elements" of what is needed to deliver CoCM well.

Here are the steps to designation:

- The physician organization nominates their CoCM practices
- The PO reports on the required capabilities for each nominated practice (two required capabilities in 2022)
- Our field team will conduct site visits to validate that the capabilities are fully in place.

We believe that creating the designation program does the following:

- Strengthens the role of primary care physicians in the delivery of CoCM; and assists them in achieving patient engagement and care coordination that build on the Patient-Centered Medical Home process and philosophy.
- Demonstrates Blue Cross' continued commitment to the improvement of meaningful, evidence-based, behavioral health care processes.
- Fulfills Blue Cross' responsibility, shared with health care practitioners and members, to advocate for the highest quality health care services, enabling our members to achieve and maintain optimal health.

CoCM has been payable at Blue Cross and BCN for all product lines since the procedure codes were initially rolled out in 2017. The enterprise decided in 2019 to focus on CoCM.

Corporate projects removed barriers identified by the early adopting physician organizations. PGIP rewards which began in 2020 established a robust training, support and incentive program.

Delivering CoCM does the following:

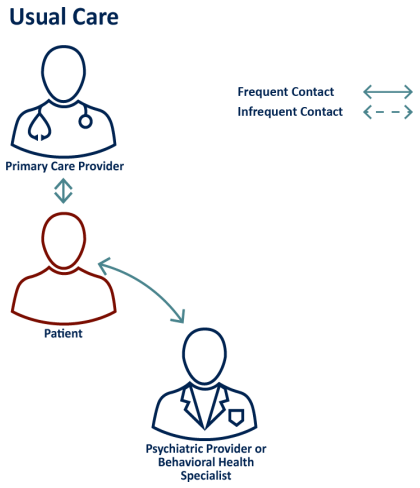
- **Improves quality**: The CoCM model improves the quality of care by using the services of a consulting psychiatrist and behavioral health care manager to better manage and monitor a patient's treatment plan.
- **Improves access:** The consulting psychiatrist works as part of the care team to regularly provide treatment recommendations. Treatment decisions are made by the primary care provider. Consultation and case review can be done by phone, which allows a psychiatrist to provide input outside of the area they normally practice. For example, a psychiatrist located in West Michigan can provide systematic case review for patients in the Thumb area, where access to a psychiatrist is very limited.
- **Reduces cost:** Patients with a behavioral health diagnosis have higher health care costs. By managing the care of the patient, costs can be avoided through better-managed chronic conditions, reduced inpatient admissions or emergency department visits and better medication management for anxiety and depression.
- **Improves outcomes:** Data demonstrate that coordinating behavioral and physical health not only improves patient outcomes but also provides a strong return on investment.
- **Reduces stigma**: Patients are more likely to follow through with behavioral health treatment through CoCM than when they're given a referral to a psychiatrist, psychologist or other mental health professional.

The CoCM model requires the following:

- **Weekly systematic case review meetings:** The consulting psychiatrist and behavioral health care manager meet weekly, typically by phone, for one to two hours to review the behavioral health case manager's caseload.
- **Patient treatment plan:** The primary care provider reviews the suggested patient plan with the behavioral health care manager, but the PCP makes final treatment decisions. Patient outreach occurs regularly to ensure the patient is adjusting to and is following the recommended treatment plan.
- **Primary care provider billing:** The PCP's NPI is used to bill the collaborative care codes for all members of the care team; the psychiatrist does not bill the insurer directly for his or her time.

Here is how CoCM differs from usual care:

Usual Care

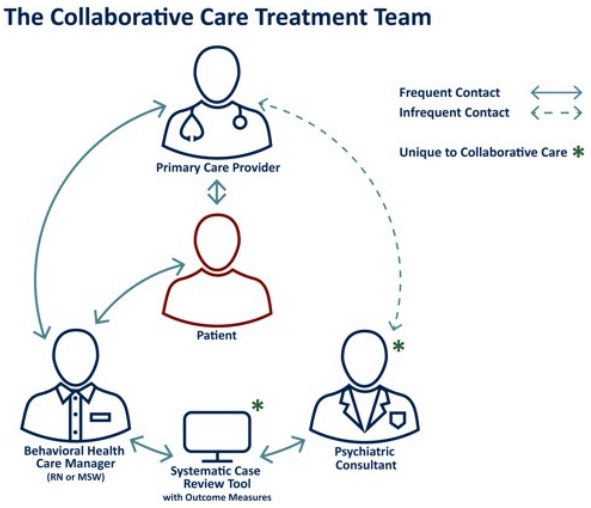


- PCP sees patient. If behavioral health needs arise during visit, the PCP refers patient out to behavioral health specialist.
- Communication between PCP and behavioral health specialist is limited.
- Treatment plans and goals are not typically shared between practitioners.
- No structured ongoing monitoring of patient progress in the PCP office.
- PCP visits not scheduled to follow behavioral health needs.

Follow-up visits with PCP for behavioral health needs may be limited by patient's benefit design.

- Next interaction between patient and PCP would only occur as medical needs dictate.
- No systemic process in place to discuss behavioral health progress with patient resulting in inconsistently managed disease state.

CoCM Care



CoCM adds:

- A behavioral health care manager
- A consulting psychiatrist

The consulting psychiatrist and BHCM meet weekly to review the caseload of patients. This is called a Systematic Case Review.

The BHCM brings the psychiatrist's recommendations to the PCP, who decides whether or not to change the patient's treatment.

- Cycle repeats until patient is in remission.

- Improves patient quality of life, better self-management of all conditions.
- More rewarding experience for both the patient and the practitioner.

CoCM is:

- Patient-centered – Effective collaboration between behavioral health care managers, PCPs and psychiatrists allow patient goals to be incorporated into the treatment plan.
- Measure-based treating to target – Measurable treatment goals and outcomes are defined and tracked for each patient. Treatments are actively revised until clinical goals are achieved.
- Population-based – Having a defined and tracked patient population ensures no one falls through the cracks.
- Based on accountability – Providers are accountable and reimbursed for quality of care and clinical outcomes.

A unique feature of CoCM is that the codes are *billed monthly using the PCP's NPI* based on the number of minutes the total care team has serviced a particular member. The psychiatrist and behavioral health care manager are reimbursed under a separate agreement by the PCP. *Neither Blue Cross nor BCN reimburses these two provider types for CoCM services*.

- **Role of therapy:** Therapy is an important part of overall mental health care. Although the CoCM model doesn't require a therapist to be a part of the overall CoCM care team, the behavioral health care manager will work closely with the patient and can help patients obtain therapy. Neither psychotherapy services nor patient-to-physician psychiatry visits are billed as part of CoCM. The coverage and cost of these services for members is based on their behavioral health benefit design and cost share requirements.

Deliverables

PGIP has partnered with Mi-CCSI and Michigan Collaborative Care Implementation Support Team (MCCIST) at Michigan Medicine to develop a statewide, comprehensive training and support structure.

Training

The training includes two full-day sessions for the PCPs, behavioral health care managers, consulting psychiatrists, physician organizations and champions related to each role.

Support

For up to a year post-training, our partners will support practices through site visits, shadowing opportunities, and ongoing webinars to learn and share best practices. The partners will use tailored approaches to successfully implement and sustain CoCM services

Incentives

PGIP will incentivize the use of this model through increasingly outcomes based measures:

Primary care provider incentives:

- Eligible primary care providers will receive value-based reimbursement at 105% of the standard fee schedule.
- Rewards PCP practices for time spent training and with implementation activities
- No cost for training and ongoing support

Physician Organizations:

PGIP rewards physician organizations to aid new practices by providing the following:

- Building the care team. physician organization may contract with the psychiatrist or care manager and share those resources between multiple practices.
- Helping practices obtain and adopt data tools such as a systematic case review tool and symptom screening scales (PHQ-9, GAD-7).
- Identifying practices who are nearing readiness and help
- Selecting Practitioner Champions to spread enthusiasm and knowledge about the model
- Considering workflows among practices and facilitate shared arrangements with psychiatrists and behavioral health care managers

PGIP will not provide new data mechanisms to support this initiative.

Physician Organization

Participating physician organizations are expected to assist their practices by:

- Identifying a psychiatrist to support the model, and to help negotiate a contract with that psychiatrist.
- Assist in identifying and hiring a behavioral health care manager.
- Consider workflows among practices and facility arrangements with psychiatrists and behavioral health care managers when appropriate.

Work with training partners to help practices identify best approaches to:

- Routine screening of patients for depression (and anxiety)
- Developing and maintaining a registry
- Developing and maintaining a systematic case review tool

Collect patient data elements and provide them to Value Partnerships:

- Patients referred to CoCM
- Patients referred but do not participate in CoCM
- Baseline and follow up depression (and possibly anxiety) scores
- Patient identifiers for Blue Cross and BCN patients
- "Dummy" identifiers for non-Blue patients

Incentive Model Methodology

Practices will be rewarded VBR for earning and maintaining CoCM designation status based on CoCM Capabilities. For the practice's first year, the capabilities will be limited to developing a care team and training. In future years, more capabilities will apply.

Blue Cross reserves the right to use discretion in making incentive payments based on the data and relative physician organization performance.

III. Initiative Assessment

In order to conduct an annual assessment Value Partnerships will examine specific short-term and intermediate measures to evaluate physician organization and PU activities and participation, any behavioral and knowledge changes on behalf of practice units and physician organizations, and impact on reported performance metrics. The annual evaluation is intended to provide insight into the effectiveness of the designed Initiative and payment metrics.

- Improved patient outcomes
- Increased billing of the CoCM codes
- Year-over-year cost avoidance

A full listing of designation capabilities is in the appendices.

Data are tracked, compiled, and reported to Value Partnerships leadership teams, physician organizations and other stakeholders on an annual basis.

Long-term evaluation of cost savings achieved through this and other PGIP initiatives will be conducted by analytic departments within Blue Cross.

IV. Results

In 2020, 14 physician organizations and 54 practices have completed training and begun implementation activities.

In 2021, increasing the number of new practices to 75 was a corporate goal. The goal was exceeded, as there were 84 new practices. Additionally, Value Partnerships worked with PGIP-physician organizations to share best practices, monitor initiative progress, and guide physician organizations on helpful analytics. There were ~160 practices who completed training and are delivering CoCM. Value-based reimbursement was awarded to ~800 PCPs.

A pilot for Delivering CoCM to the Adolescent Population launched in Sept. 2021.

Blue Cross reserves the right to modify its evaluative and administrative processes.

Appendix I
Projected cost avoidance

Literary Review Summary

Academia:

* 5 studies identified cost savings associated with collaboration of care for members with behavioral health and medical/surgical conditions
* Variation exits in the types of behavioral health and medical/surgical conditions included in the studies
* Population sizes range between 106 and 329 participants
* Study timelines for savings estimates range from 12 months to 60 months
* Annualized savings per member ranked low to high are as follows: $157, $297, $565, $781, $1683

Milliman:

* Study estimated economic impact for Commercial and Medicare populations associated with integrated care for members with behavioral health and chronic medical comorbidities
* Slight variation exits between Commercial and Medicare populations in the types of medical conditions included in the study
* Population member months were 2.3 billion for Commercial and 556 million for Medicare
* Study timeline for the savings estimates is 24 months
* Annualized savings, assuming full member participation, per Commercial member range from $80 to $159, and per Medicare member range from $72 to $144
* Annualized savings, assuming 50% provider and 30% member participation, per Commercial member range from $318 to $636, and per Medicare member range from $289 to $579

Attributed Only Members			Provider Participation			Member Engagement ****		
LOB	Product	Member Count	Yr 1 - 10%	Yr 2 - 30%	Yr 3 - 50%	Yr 1 - 50%	Yr 2 - 50%	Yr 3 - 50%
BCN	Commercial	2,849	285	855	1,425	142	427	712
	Medicare Advantage	1,898	190	569	949	95	285	475
PPO	Commercial	21,358	2,136	6,407	10,679	1,068	3,204	5,340
	Medicare Advantage	13,476	1,348	4,043	6,738	674	2,021	3,369
Total		39,581	3,958	11,874	19,791	1,979	5,937	9,895

Attributed Only Members			Cost/Mbr			Net Savings/Mbr		
LOB	Product	Savings/Mbr	Scenario 1*	Scenario 2**	Scenario 3***	Scenario 1*	Scenario 2**	Scenario 3***
BCN	Commercial	$ 350	$ (76)	$ (240)	$ (130)	$ 274	$ 110	$ 220
	Medicare Advantage	$ 350	$ (76)	$ (240)	$ (130)	$ 274	$ 110	$ 220
PPO	Commercial	$ 350	$ (76)	$ (240)	$ (130)	$ 274	$ 110	$ 220
	Medicare Advantage	$ 350	$ (76)	$ (240)	$ (130)	$ 274	$ 110	$ 220
Total		$ 350	$ (76)	$ (240)	$ (130)	$ 274	$ 110	$ 220

Attributed Only Members		Estimated Savings (Scenario 1*)			Estimated Savings (Scenario 2**)			Estimated Savings (Scenario 3***)		
LOB	Product	Yr1	Yr2	Yr3	Yr1	Yr2	Yr3	Yr1	Yr2	Yr3
BCN	Commercial	$ 39,031	$ 117,094	$ 195,157	$ 15,670	$ 47,009	$ 78,348	$ 31,339	$ 94,017	$ 156,695
	Medicare Advantage	$ 26,003	$ 78,008	$ 130,013	$ 10,439	$ 31,317	$ 52,195	$ 20,878	$ 62,634	$ 104,390
PPO	Commercial	$ 292,605	$ 877,814	$ 1,463,023	$ 117,469	$ 352,407	$ 587,345	$ 234,938	$ 704,814	$ 1,174,690
	Medicare Advantage	$ 184,621	$ 553,864	$ 923,106	$ 74,118	$ 222,354	$ 370,590	$ 148,236	$ 444,708	$ 741,180
Total		$ 542,260	$ 1,626,779	$ 2,711,299	$ 217,696	$ 653,087	$ 1,088,478	$ 435,391	$ 1,306,173	$ 2,176,955

*Scenario 1 - Based on PDCM Average costs in 2016, costs were estimated at $76 per year per engaged member who received services
**Scenario 2 - Based on 2018 PDCM Average cost per procedure ('98961', '98962', '98966', '98967', '98968', 'G9001', 'G9002') of $48 and an assumption of 5 procedures
***Scenario 3 - Based on PDCM Average costs in 2016 ($76) plus an upward adjustment for anticipated additional Case Manager touch points for BH population
****Member Engagement - Based on PDCM engagement rates higher than Health Plan Delivered Care Management (49% PDCM v 13% HPDCM).

Appendix II

Interpretive guidelines and description of capabilities for Collaborative Care (CoCM) Designation Program

Goal: Build Collaborative Care Model (CoCM) provider care teams, which adds both a behavioral health care manager (BHCM) and a consulting psychiatrist to a primary care practice. CoCM requires patient awareness of, and active engagement with, the CoCM model and to clearly define CoCM-specific medical and behavioral health team responsibilities. Integrating this model into practices will increase patient access to behavioral health specialist expertise, reduce stigma associated with specialist visits and allow better behavioral health care in a familiar setting with known providers.

Designation: The Collaborative Care Designation Program recognizes a CoCM practice's commitment to creating an empowered care team, that can deliver the evidence-based care to best meet a patient's behavioral health needs in a patient-centered medical home environment.

The CoCM Designation Program builds on the essential foundation of Blue Cross' longstanding PCMH program to create a culture of sustained attention to the "whole person" philosophy—a critical goal for organizations to thrive.

Blue Cross' first-to-market CoCM Designation Program will be value-based and population-based. It rewards collaboration between practitioners in areas where inter-specialty communication traditionally has not been a part of usual care; this communication dramatically helps improve both access to critical services and ultimately, clinical outcomes.

In 2022, only two capabilities will be needed for a practice to be eligible for CoCM designation.
Capability 1.1 – The practice must have assembled their care team and understand the interactions within the provider triad.
Then one of these two capabilities:

- Capability 1.2 – A practice member from each of the three roles attends the PGIP-sponsored training.
- Capability 1.3 – A practice is deemed to be delivering CoCM with fidelity to the model.

In 2023, all of the capabilities in this document will need to be in place to be eligible for Year 2 CoCM designation. We are sharing this document with physician organizations now for their ongoing CoCM planning.

All capabilities and guidelines are applicable to primary care practices for eligible current patients regardless of insurance coverage. The definition for "current" patients is the same as for the Patient-Centered Medical Home program.

1.0 Training and Model Building

Primary care, behavioral health care managers, and psychiatrist roles are clearly defined to ensure that care is delivered with fidelity to the original model as described by the University of Washington AIMS Center and is more recently described by Centers for Medicare & Medicaid Services.

CoCM is a unique model that adds the following to the primary care team:

- Care management support for patients receiving behavioral health treatment.
- A treat-to-target approach to population health.
- Regular psychiatric inter-specialty consultation.
- A team of three individuals to deliver CoCM: the behavioral health care manager (BHCM), the consulting psychiatrist and the primary care provider.
- A tool, accessible to all members of the care team, used to document patient scores, outcomes, recommendations and treatment changes. We refer to this as a systematic case review tool (SCR-tool).

1.1

Practice's care team consists of the provider triad described by the CoCM model.

Guidelines

Roles and responsibilities for each member include:

a. **Primary care provider** – A state-licensed physician or advanced practice provider who is qualified to prescribe medications.
   - Directs the behavioral health care manager
   - Oversees treatment plans and overall patient care
   - Determines whether or not to implement recommendations of the consulting psychiatrist
   - Prescribes all medications
   - Refers patients to CoCM
   - Claims for CoCM services must be billed under the PCP's NPI

b. **Behavioral health care manager** – A state-licensed, designated individual with formal education or specialized training in behavioral health.
   - Works under the oversight and direction of the primary care provider
   - Conducts screening assessments at regular intervals
   - Coordinates care with the PCP
   - Provides patient education about CoCM and behavioral health disorders, medications, and other treatment options

- Supports psychotropic medication management as prescribed by medical providers, focusing on length of time to reach therapeutic range, side effects, adverse reactions, and the potential effects of discontinuance or dosage adjustment.
- Provides brief interventions, motivational interviewing, problem solving treatment and behavioral activation to facilitate patient engagement and self-management
- Monitors and tracks treatment response
- Conducts systematic case reviews (SCRs) with the consulting psychiatrist
- Communicates recommendations and patient discussions with the PCP and consulting psychiatrist through the SCR-tool (can be in EHR, in a stand-alone tracking system, or in a registry)
- Facilitates treatment plan changes
- Completes relapse prevention self-management planning
- Track patient management activities for the care team to support appropriate billing. Time when two care team members are involved in the same activity cannot be duplicated.
- Bills for services using the PCP's NPI

c. **Consulting psychiatrist** – A state-licensed medical professional trained in psychiatry and qualified to prescribe the full range of medications.
- Consulting psychiatrist does not meet with patients or prescribe medications.
- Participates in the SCR at least weekly
- Advises the PCP and behavioral health care manager about diagnosis and treatment recommendations
- Provides options for resolving issues, including patient adherence, efficacy or side effects
- Recommends adjustments to the treatment plan for newly enrolled patients and patients not progressing.

Required for CoCM Designation: YES	**Predicate Logic: n/a**
Validation notes for CoCM site visit	
• Practice identifies each of the three care team members and describe how they interact.	

1.2

A member from each of the three roles supporting the practice attends the PGIP-sponsored training; unless they meet Capability of 1.3 – being deemed to be delivering CoCM with fidelity to the CoCM model.

Guidelines

a. PGIP-sponsored training requires: A care team member from each role has attended PGIP-sponsored training delivered by our training partners. Base training requires:

- 16 hours for BHCMs
- 4 hours for PCPs
- 4 hours for consulting psychiatrists

Required for CoCM Designation: YES, unless Capability 1.3 is met	**Predicate Logic: n/a**
Validation notes for CoCM site visit	
• Show evidence of PGIP-sponsored training, such as a practice list from the PO, or a CME certificate from the training.	

1.3

A practice is deemed to be delivering CoCM with fidelity to the CoCM model unless they meet Capability 1.2 capability – attending PGIP-sponsored training.

Guidelines

These are the steps to receiving fidelity status. Once the Fidelity Attestation is delivered, the practice is eligible for designation.

1. PO and practice complete the Fidelity Assessment Worksheet.
2. Training partner will have a site visit with the PO and practice to assess fidelity using the Fidelity Assessment document.
3. The training partner will discuss results with Blue Cross.
4. Training partner will deliver a Fidelity Attestation to the PO, practice and to Blue Cross.

The practice may have trained through the PGIP-sponsored training, AIMS Center Training or other training.

Fidelity assessment will include review of the following:

- Care team members
- Clinical protocols
- Tools and technology

If the practice is found to be delivering CoCM with fidelity to the CoCM model, the training partner will complete a Fidelity Attestation signed by the PO and training partner.

Required for CoCM Designation: YES, unless Capability 1.2 is met	**Predicate Logic: n/a**
Validation notes for CoCM site visit	
• Show executed Fidelity Attestation.	

1.4

The practice has a BHCM with dedicated/protected time to carry out CoCM activities.

Guidelines:

a. The BHCM is secured through employment or contract either by the practice or through their physician organization. This person supports and coordinates the mental and physical health care of patients on an assigned patient caseload with the patient's medical provider and, the consulting psychiatrist.
b. The BHCM may be involved in other care management activities, such as provider-delivered care management, however, there must be separate and distinct time set aside for CoCM activities. BHCMs who are assigned numerous other duties in a fast-paced clinic setting often fall behind on effectively managing their CoCM caseload.
c. The BHCM may be involved with other behavioral health activities in the office, such as an MSW providing counseling sessions, however there must be separate and distinct time set aside for CoCM activities.

d. If the BHCM is to work within the office setting, the practice has dedicated and private space for patient outreach and for SCR.
e. The BHCM enters patient information and outcome measure scores into the SCR-tool and maintains the SCR-tool to use for the SCR sessions with the consulting psychiatrist.
f. The SCR-tool should contain:

- Notes from patient intake and ongoing discussions.
- Progression of a patient's results from the PHQ-9 (or PHQ-A)
- Notes from brief interventions, such as motivational interviewing, to facilitate patient engagement and symptom self-management.
- Notes about current treatment discussion including medication effectiveness, side effects, etc.
- Notes about the consulting psychiatrist's recommendations from an SCR.
- Details about how/when the PCP accesses those recommendations
- Notes from the PCP about the specific recommendation, regardless of whether it is accepted, denied, or modified.
- Notes that show communication with the patient about PCP-approved recommendations.

Required for CoCM Designation: Not in 2022	**Predicate Logic: n/a**
Validation notes for CoCM site visit	
• Show provider schedule documenting dedicated time to SCR • If BHCM has other responsibilities (e.g., PDCM or BH counseling), show policy and procedure for keeping these programs separate and distinct. • If BHCM services are office-based, show the dedicated and private space (describe if remote).	

1.5

Practice has regularly scheduled time with a consulting psychiatrist to participate in SCRs.

Guidelines:

a. The consulting psychiatrist is secured through employment or contract either by the practice or through their physician organization.
b. The consulting psychiatrist is responsible for a caseload of patients and primarily interacts with the BHCM and sometimes with the primary care provider.
c. SCRs may be conducted by telephone, video, or in person.
d. SCRs are scheduled at least weekly.

e. The consulting psychiatrist should enter discussions into the SCR-tool, through EHR or other means.
f. If the consulting psychiatrist does not have access to the EHR, the BHCM can document the SCR-tool. Practice must have a process for the consulting psychiatrist to review the accuracy of the recommendation documentation.

Required for CoCM Designation: Not in 2022	**Predicate Logic: n/a**
Validation notes for CoCM site visit	
• Provide documentation of the provider's availability, schedule, and contact information, along with regularly scheduled time. • Show notes or other documentation of a discussion of consulting psychiatrist recommendations, including treatment, cadence of patient/PCP follow up. • Show how the SCR is used to manage population health by using SCR time to discuss multiple patients. • Provide SCR schedule • Show an example of a recommendation a consulting psychiatrist wrote in the SCR-tool. • If the consulting psychiatrist does not have access to the EHR, show the written process and an example of a consulting psychiatrist who reviewed a recommendation documented by a BHCM.	

1.6

The practice's PCPs is able to select appropriate candidates for CoCM, make referrals to the BHCM, read and respond to consulting psychiatrist's recommendations timely, and support the BHCM.

Guidelines

a. Identifies and engages the patient
   - Introduces Collaborative Care to a patient
   - May acquire informed patient consent (the BHCM may do this depending on practice workflow)
   - Initiates a warm connection to a BHCM when possible

b. Determines the diagnosis
   - Formulates using validated screeners, exams, and history
   - Works with care team to diagnose and treat complex behavioral health conditions
   - Observes over time
   - Adjusts diagnosis as appropriate

c. Treats
   - Works with care team and patient to develop a treatment plan
   - Works with care team to implement treatment and make treatment adjustments
   - Prescribes medications as needed
   - Addresses safety concerns
   - Monitors physical health and potential medication interactions
   - Reads psychiatric consultant's recommendations and implements recommendations with patient consent and understanding

d. Claims for the care team's activities are submitted using the PCP's NPI

Required for CoCM Designation: Not in 2022	**Predicate Logic: n/a**
Validation notes for CoCM site visit	
• Show examples of medical records where the PCP has identified and engaged the patient, diagnoses the patient, and treats the patient • Practice has a written process to show how the PCP is alerted to activity taken and documented by the BHCM. • Show examples of a PCP's response to BHCM notes and consulting psychiatrist's recommendations. • Show where consent is tracked in the patient's medical record and how it is accessible	

2.0 Process Implementation

2.1

The practice has policies or procedures to show an established process to screen patients for depression using Patient Health Questionnaire–9 (PHQ-9, or PHQ-A)

Guidelines:

a. CoCM care team members are able to screen and interpret the results in order to identify patients that need further assessment.
b. Practices screen all patients annually for depression.
c. PHQ-9 (or PHQ-A) results should be recorded and included in the patients' record and enrolled in the SCR-tool upon enrollment
d. For patients who score less than 10, usually no further activity is needed at this time.
e. Patients who score positive on the PHQ-9 (or PHQ-A) should be further evaluated to determine whether they meet provisional criteria for depression or mood disorder.
f. The PHQ-9 (or PHQ-A) is administered to all patients enrolled in the CoCM program monthly to measure progress toward remission.

g. The practice has a mechanism, detailed in a written policy or procedure, in place to track PHQ-9 (or PHQ-A) results for CoCM patients over time.

Required for CoCM Designation: Not in 2022	**Predicate Logic: n/a**
Validation notes for CoCM site visit	
• Show written policy or procedure for screening frequency, interpreting, and tracking results. • Show SCR-tool examples of PHQ-9 (or PHQ-A) scores for tracked over time for CoCM patients.	

2.2

Practice unit team obtains consent, as defined by Centers for Medicare & Medicaid Services, from 100% of CoCM patients prior to delivering CoCM services.

CMS-defined consent:

"Advance Consent

Prior to beginning BHI services, the beneficiary must give the billing practitioner permission to consult with relevant specialists, which would include conferring with a psychiatric consultant. The billing practitioner must inform the beneficiary that cost sharing applies for both face-to-face and non-face-to-face services even if supplemental insurers cover cost sharing. Beneficiary consent may be verbal (written consent is not required) but must be documented in the medical record."

See MLN909432 March 2021 *for details.*

Guidelines:

a. Practice has a written procedure and systematic process to obtain consent from patients prior to delivering CoCM services.
b. Discussion of consent elements, either written or verbally, can be held between the BHCM and the patient or the PCP and the patient and includes:
   - Explaining to the patient that their symptoms could be helped by including the CoCM team in their treatment.
   - Briefly introducing CoCM. This includes describing additional care team members (BHCM and consulting psychiatric consultant) and their roles within the program.
     – It can be helpful to have a brochure or handout with this information available to give to patients. Customizable templates are available on the PGIP Collaboration site.
   - Informing the patient there may be associated cost, depending on their insurance, and suggest they contact their insurance carrier or the practice's billing department for more information.
c. Obtains written or verbal consent from the patient to participate in the CoCM program.
d. Documents written or verbal consent in the patient's electronic health record and ensure it's available to all care team members.

Required for CoCM Designation: Not in 2022	Predicate Logic: n/a
Validation notes for CoCM site visit	

• Show the procedure document that documents the systematic process for obtaining consent.
• Provide any examples of patient education materials if materials are part of the process
• Show evidence that consent contains these elements:
  ○ I have discussed the CoCM program with the patient, including the roles of the behavioral health care manager and psychiatric consultant.
  ○ I have informed the patient that they will be responsible for potential cost-sharing expenses for both in-person and non-face-to-face services.
  ○ The patient has agreed to participate in the CoCM and for consultations to be conducted with relevant specialists.
• Show where consent is tracked in the patient's medical record and how it is accessible to all care team members.
• The documentation used for the Patient-Provider Partnership agreement for PCMH capability 1.1 does not meet the intent	

2.3

The practice has policies or procedures to show an established patient selection process and referral pathway.

Guidelines:

a. CoCM care team members are able to assess appropriate treatment pathway for patient who either score over nine on the PHQ-9 (or PHQ-A) or who talk with the PCP about depression or mood disorder during the course of an office visit.
b. There is an established process for the PCP to refer the patient to the BHCM for further assessment and evaluation for the CoCM program.
c. There is a documented referral pathway to other providers or to other types of treatment.
d. Practice has a written policy and procedure about patient selection including what makes a patient a good candidate for CoCM and about treatment options for patients not entering CoCM.

Required for CoCM Designation: Not in 2022	Predicate Logic: n/a
Validation notes for CoCM site visit	
• Show written policy or procedure for identifying patients who may be appropriate for treatment via the CoCM model, and a referral pathway to CoCM providers or other treatment.	

2.4
Practice has an established suicide protocol.

Guidelines:

a. The practice has established suicide protocol if a patient screens positive on the PHQ-9 (or PHQ-A) questionnaire, or if a patient indicates at any given time that they are suicidal or having suicidal ideations.
b. The practice has established response and management protocol in place if patients are suicidal.
c. Process has a response outlined for instances where the patient presents with suicidality in person as well as over the phone or virtually.
d. Practice care team receives training at time of hire and annually. At a minimum the PCP, BHCM and consulting psychiatrist must receive this training, but may be extended to other practice unit members.

Required for CoCM Designation: Not in 2022	Predicate Logic: n/a
Validation notes for CoCM site visit	
• Documented written protocol that outlines the process initiated when a patient presents with suicidality in person, virtually, or by phone. • Protocols are more detailed and specific than just indicating that a practice or staff person will "Call 911." • Documentation of training staff on suicide protocol within the last 12 months	

2.5

Practice has a written policy and/or procedure that outlines expectations for length of patient engagement in CoCM, reasons for ending participation, established transition plans, and individualized relapse prevention plans.

Guidelines:

Patients enrolled in CoCM programs typically see improvement and stay on a caseload for six to nine months. However, CoCM participation may end for number of reasons including:

- Patient has realized maximum improvement or remission.
- Patient isn't improving despite appropriate treatment revisions or has a change in status necessitating transition to another level of care.
- The patient choses to move to specialist care, or otherwise chooses to discontinue CoCM.
- Patient has left the practice
- Patient is no longer actively participates in CoCM (not returning phone calls, etc.)

Defining Improvement:

Using the validated outcome measures:

- PHQ-9 (or PHQ-A) – Depression screening
  Improvement:
  - 5-point reduction in score = Improvement
  - 50% reduction in score = Response
  - Score less than 5 = Remission

- The GAD-7 (Generalized Anxiety Disorder) – Anxiety screening (recommended, but not required).

a. The BHCM, together with the patient and other providers on the care team, develop a self-management plan that leads to patient improvement as defined above.
b. Self-management plan is documented in the patient's medical record or is otherwise available to all members of the treatment team.
c. Ensure that the patient had an active role in developing their self-management plan.
d. BHCM has frequent contacts, often weekly in the beginning of a CoCM episode, but contact may be less frequent later in the episode. During the CoCM episode, the BHCM performs the following:
   - Conducts full assessments, including use of validated screening and symptom monitoring tools
   - Monitors patient with validated symptom outcomes measures (PHQ-9 or PHQ-A)
   - Works with patient to create and adjust self-management plan
   - Monitor's medication and any side effects
   - If PCP approves the consulting psychiatrist's recommendation, lets the patient know about any change, and determines patient interest in adopting the PCP-approved recommendations.
   - Provides brief therapeutic interventions such as motivational interviewing, problem solving treatment, and behavioral activation.
e. The BHCM documents all activity in the SCR-tool.
f. When the patient reaches target improvement the BHCM should, in consultation with the PCP and consulting psychiatrist, prepare a transition plan.
g. Create relapse prevention plan with patient.

h. If the patient isn't improving despite appropriate treatment revisions, or has a need to transition to another level of care, the BHCM should consult with the other care team members to develop a transition plan to see that patient to the next level of care. This may include making referrals, following up on referrals or suggesting appropriate community resources.
i. If the patient chooses to move to specialist care or otherwise discontinues CoCM, the BHCM's follow up should include outreach in an effort to create a transition and/or relapse prevention plan.
j. The written transition/relapse plan should be developed with input from patient whenever possible.
k. A written copy of the transition/relapse plan is be provided to the patient.
l. BHCMs ensure that patients have a clear understanding of the transition plan including:
   - Current medication list
   - Recognizing individualized relapse warning signs
   - Self-management techniques, such as exercise, meditation, and mindfulness to address symptoms before they fully manifest
   - Who and when to call if they begin to experience a relapse.

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Required for CoCM Designation: Not in 2022	**Predicate Logic: n/a**
Validation notes for CoCM site visit	
• Show the written policy and procedure to document the points to be discussed at each BHCM/patient interaction. • Show examples of self-management plans that show how these points are addressed. • Show where the self-treatment plan is located and how it is available to all care team members. • Show where ongoing screening results and symptom monitoring are captured • Show documentation of the patient agreement with treatment plan and short term goals. This can include notes such as, "Patient stated that their end goal is X. Patient has agreed to exercise for three hours this week." • Show the written policy and procedure to document transition/relapse plans with the elements above listed. • Show that BHCM is documenting brief psychotherapeutic interventions.	

Appendix III

Contacts

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Endnotes

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