



CENTER FOR
INTEGRATIVE NEUROSCIENCE

The BHCM Pivot Playbook

*A different role for mental health clinicians inside
Collaborative Care.*

NATIONAL MODEL, MICHIGAN NOTES • 2026

01 THE ROLE 02 THE TEAM 03 THE MONTH 04 THE RULES PRIMARY SOURCES

Written from the primary sources and the Behavioral Health Workforce
Observatory's records. CMS booklet MLN909432 and public payer
sources, checked August 2026. Free, ungated, and yours either way.

Could a clinician you already employ take a different role in integrated care?

When a reimbursement pathway narrows, the first thing a practice looks at is a position. This Playbook exists because there is a question worth asking before that: whether the work itself could be different.

Collaborative Care creates a behavioral health care manager role that is not psychotherapy: following patients between medical visits, tracking symptoms, coordinating care, and working with the medical provider and psychiatric consultant. This document shows what would have to change for that role to work, and what it would mean for the person doing it.

WHO THIS IS FOR

- A practice owner looking at positions and hours and not liking the arithmetic.
- A clinical director asked whether existing staff could work differently.
- A limited-license clinician who has heard this discussed and wants it explained plainly.
- A medical practice weighing whether to bring the role in-house.

YOU WILL LEAVE KNOWING

- What the care-manager role actually is, against the therapy role it is not.
- Who else has to exist for the role to function at all.
- What a month of the work looks like, and what has to be tracked.
- Which rules govern the change, and which questions remain open.
- What to calculate before assuming this preserves a position.

HOW TO READ THIS DOCUMENT

Three kinds of line, and the difference is the whole method.

The key first, then what this particular document covers.

SOLID LINE

A cited public source establishes this.

The source is named where the claim is made, and dated. If you want to check it, you can.

DASHED LINE

This describes what happens today.

Current practice, or your own situation. True as a description, and not asserted as a rule.

DOTTED LINE, ENDING IN ?

The record does not tell us this yet.

Nobody has measured it. A question mark is printed rather than a confident-sounding phrase standing in for a number.

AND WHAT IT COVERS

THIS PLAYBOOK CAN ANSWER

What the role is, what the model requires, and what a practice would have to change.

Written from CMS booklet MLN909432 and published payer material.

THIS PLAYBOOK CANNOT ANSWER

Whether your clinician, in your practice, under your payers, qualifies.

Confirm any proposed structure with the payer or your Physician Organization before implementing it.

01 • THE ROLE

Same clinician. A different clinical role.

The most common misunderstanding is that this is a billing maneuver: the same work, submitted differently. It is not. The job changes, and if the job does not change, none of the rest applies.

FIGURE 01

What changes, and what stays the same.

The current therapy role sits under a dashed rule because it describes what a practice does today. The care-manager role sits under a solid rule because the model defines it.

CURRENT THERAPY ROLE

- Psychotherapy.
- A visit-based service.
- Reimbursement follows the payer's rules for that clinician's license.

POSSIBLE CARE-MANAGER ROLE

- Follow-up between medical visits.
- Symptom measurement with a validated tool.
- Brief interventions appropriate to the role.
- Coordination inside the Collaborative Care team.
- Qualifying work contributes to the monthly service billed by the medical practitioner.

The clinician did not become more qualified because the billing changed. The job being performed changed.

CENTER FOR INTEGRATIVE NEUROSCIENCE · ROLE REQUIREMENTS PER CMS BOOKLET MLN909432 ·
CHECKED AUGUST 2026 · [INTEGRATIVE-NEUROSCIENCE.COM/GUIDES/ORG-IMPACT](https://www.integrative-neuroscience.com/guides/org-impact)

Collaborative Care is not a way to rebill psychotherapy. The clinician must actually perform the care-manager role, and the whole arrangement must meet the requirements of the model and the payer. A practice that changes the paperwork and not the work has not made this change.

What it means for the person doing it

This is the part usually left out of the conversation, and it is the part that decides whether the change survives contact with reality. The work is a different rhythm: shorter contacts, more of them, a caseload rather than a schedule, and daily proximity to a medical team. Some clinicians find it a better fit than a therapy caseload. Others do not. It is worth asking the person before deciding for them.

02 · THE TEAM

The Collaborative Care care-manager role does not exist on its own.

Without a medical practitioner directing care and a psychiatric consultant reviewing the caseload, what remains is a clinician with a new job title rather than this role. Three roles, or none of this applies.

MEDICAL PRACTITIONER	CARE MANAGER	PSYCHIATRIC CONSULTANT
Keeps the patient, directs the team, prescribes, and bills the monthly service.	Does the month's work: follow-up, measurement, brief intervention, registry.	Reviews the caseload and advises the medical team, usually without seeing the patient.

Two kinds of oversight. Do not confuse them.

PSYCHIATRIC CONSULTANT	LICENSURE SUPERVISOR
Part of the Collaborative Care model. Reviews the caseload and makes treatment recommendations to the medical team.	Supervises a limited-license clinician's professional practice under Michigan licensing requirements.

They solve different problems. One does not replace the other, and a practice that assumes otherwise has a supervision gap it cannot see.

03 • THE MONTH

The unit of work is a month, not an appointment.

This is the operational shift that catches practices by surprise. Nothing about the month is reconstructed afterward. It is tracked as it happens, because the service being billed is the month itself.

FIGURE 02

One month, four movements.

Repeated for every enrolled patient, every month, until the patient improves or the arrangement ends.

01

REACH

The care manager contacts each enrolled patient, on a rhythm rather than an appointment.

02

MEASURE

Symptoms are scored with a validated tool, and the score is dated so a trend exists.

03

REVIEW

The caseload is reviewed with the psychiatric consultant, who advises the medical practitioner.

04

ADJUST

Treatment changes are made by the medical practitioner, and the result is tracked into the next month.

If nobody can say which patients have not been contacted this month, the month is not being managed.

CENTER FOR INTEGRATIVE NEUROSCIENCE · MONTHLY STRUCTURE PER CMS BOOKLET MLN909432 ·
CHECKED AUGUST 2026 · INTEGRATIVE-NEUROSCIENCE.COM/GUIDES/ORG-IMPACT

What has to be tracked

Enrolled patients and consent. Each measurement with its date, so a trend is visible. Contacts and care-management time within the month. Caseload review dates and the consultant's recommendations. Treatment changes and whether the patient responded. Patients who are not improving, surfaced rather than buried.

04 · THE RULES

What the sources establish, and what they do not.

Under the model, the monthly service is billed by the treating medical practitioner rather than by the clinician furnishing the care-management work. That single fact is why this question is worth asking at all.

You may have more options than you thought.

Because the medical practitioner bills the service, who may serve as the behavioral health care manager is answered by the model requirements and the payer's published rules, rather than by that clinician's own billing status. A practice that assumed the door was closed has a question worth asking.

And then the other half, which matters just as much. That does not establish that every limited-license clinician, or every staffing arrangement, qualifies. The clinician still has to perform the actual care-manager role, and the arrangement must satisfy the applicable CMS, scope, supervision, documentation, employer or contracting, and payer requirements. Confirm the proposed structure with the payer or your Physician Organization before implementing it.

A MICHIGAN NOTE • BCBSM AND BCN

BCBSM and BCN recognize the Collaborative Care and general behavioral health integration codes, and BCBSM follows the Collaborative Care model described in CMS booklet MLN909432. Separately, BCBSM supports Collaborative Care through its Physician Group Incentive Program, with practices working through their Physician Organization for participation and implementation guidance. BCBSM's publicly described Collaborative Care designation currently covers primary-care and OB/GYN practices.

Code recognition and PGIP participation are separate facts. The designation is a program status a practice holds, not a billing permission, and a practice asks its own Physician Organization about participation requirements.

OPEN QUESTION

Whether qualifying care-manager work counts toward Michigan's required supervised experience remains unresolved. It is a question the state should answer. This Playbook does not answer it in either direction, and a practice should not plan on either answer.

The economics: existing staff changes the question, it does not answer it

A practice hiring an entirely new care-management team has one cost structure. A practice that already employs a clinician who could appropriately fill the role may have another. The calculation involves more than comparing therapy revenue with Collaborative Care revenue. It includes the clinician's available time, the work the new role requires, psychiatric consultation, medical-provider participation, registry and administrative work, payer rates, and the number of enrolled patients.

This Playbook shows what a practice needs to calculate. It does not promise the answer will be yes.

WORKSHEET

Before you propose the pivot

Ten boxes, all of them from what this document has already told you. Print it, or put it on the wall.

- | | |
|---|--|
| ☐ The clinician has been asked whether they want this role. | ☐ The care-manager duties are written down as a job, not a title. |
| ☐ A medical practitioner will direct care and bill the monthly service. | ☐ A psychiatric consultant arrangement exists and can be evidenced. |
| ☐ Licensure supervision is still in place, separately from psychiatric consultation. | ☐ Scope of practice checked against the duties, not against the title. |
| ☐ A registry and a validated measurement tool are chosen. | ☐ A way to track care-management time as it happens. |
| ☐ The payer or Physician Organization has been asked about the proposed structure. | ☐ The economics run with your own numbers, including what the therapy caseload gave up. |

If those boxes are checked, take the proposal to your payer.

BEFORE YOU PROPOSE THE PIVOT · CENTER FOR INTEGRATIVE NEUROSCIENCE · SOURCES CHECKED
AUGUST 2026

THE OPEN QUESTION

What happens when a reimbursement pathway changes but the payroll does not?

WHAT IS ESTABLISHED

The model, the roles, the monthly structure, and who bills are published, and this Playbook cites them.

WHAT IS NOT MEASURED

What practices are actually doing with limited-license positions: hours affected, hiring decisions, supervision capacity, and whether a different role was even considered.

Limited-license positions affected statewide ?

Clinical hours becoming harder to reimburse ?

Practices that considered this role and rejected it ?

You may know one of the numbers nobody has.

If you paused hiring, cut hours, restructured a position, or looked at this and decided against it, your experience belongs in the record above. Payroll records show the outcome, not the reasoning, and no public dataset holds it.

Put your experience in the record.

About ten minutes, the longest of the six studies, because the practice side has the most moving parts.

TELL THE OBSERVATORY WHAT HAPPENED →

integrative-neuroscience.com/research/org-impact

Findings return to respondents before broader publication. Participation is optional. The Playbook is yours whether you answer or not.

NEXT MOVE

You have the role. What comes next depends on why you are here.

- | | |
|--|---|
| → I am weighing this for a clinician we employ | Work the checklist, then have the conversation with the clinician before the one with the payer. The role only works if the person wants it. |
| → We do not have the medical side of the team | The CoCM Startup Brief covers the model from the medical practice's side, which is the partner this role requires. |
| → I am the clinician being asked about this | The Career Path Guide describes the role from your side, including what remains unresolved about how it relates to licensure. |
| → I want help getting this done
JOIN KEDGE EARLY ACCESS → | Understanding the role is not the same as standing it up. Kedge is building guided enrollment and implementation for practices and clinicians, with step-by-step help based on your role, state, payer, and practice structure.

Kedge is a separate software platform, and it is not open yet. The Playbook is free and complete whether or not you ever use it. |

PRIMARY SOURCES

Everything above comes from these, and each carries a date.

Public sources only. No payer or agency correspondence appears in this document. Where a source is a landing page rather than a specific section, that is stated rather than hidden.

SOURCE	USED FOR	CHECKED
CMS booklet MLN909432	The care-manager role, the three-role team, the monthly structure, and the billing practitioner	August 2026
CMS behavioral health integration code descriptors	What the monthly service represents and what contributes to it	August 2026
BCBSM and BCN published payer pages	Michigan recognition of the Collaborative Care and integration codes	August 2026
Michigan Institute for Care Management and Transformation, Collaborative Care Model page micmt-cares.org/collaborative-care-model-cocm-1	That Physician Organizations implement Collaborative Care as part of BCBSM's Physician Group Incentive Program	August 2026
BCBSM Collaborative Care article, 30 September 2025	That BCBSM operates a Collaborative Care designation, and that the designated practices are primary-care and OB/GYN	August 2026
Michigan licensing rules on supervised experience	That the hours question is unresolved, and that licensure supervision is separate from psychiatric consultation	August 2026

Requirements change. Confirm what applies to your practice with the relevant payer, your Physician Organization, and your compliance advisor before acting on anything here.

COLOPHON

*Independent educational research
and practice guidance, grounded in
primary sources.*

Educational information, not medical, legal, billing, or licensure advice.

Payer and regulatory requirements change; confirm what applies to your practice with the relevant payer, agency, and compliance advisor. Each publication carries the date its sources were last checked. Do not send protected health information.

AUTHORSHIP

Co-authored by the co-founders of the Center for Integrative Neuroscience, from the primary sources and the Behavioral Health Workforce Observatory's records.

CORRECTIONS

info@integrative-neuroscience.com
integrative-neuroscience.com/sources

FOUR NAMES, FOUR JOBS

Center for Integrative Neuroscience · what the public rules say

Kedge · guided enrollment, in build. A separate company

Behavioral Health Workforce Observatory · what the record cannot show. The Center's research arm

Integral Neuroscience Initiative · evidence carried into public-interest work. A separate nonprofit

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