The BHCM Pivot Playbook

Turning Michigan’s stranded limited-license clinicians into billable collaborative-care capacity.

A practical guide for Michigan practices, from the team behind the Michigan Behavioral Health Workforce Observatory: what the trials show, what the payers actually pay, what the rules leave open, and the six steps between here and a working program.

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01

THE STRANDED WORKFORCE

Michigan employs tens of thousands of clinicians who hold a supervised-tier license — LLPCs, LLMSWs, and TLLPs working toward full licensure under supervision. They are trained, employed, and seeing patients. And in a growing number of practices, they have quietly become a payroll problem: reimbursement policy changes have made many of them unbillable in the traditional psychotherapy models their practices were built on. The clinician is on staff; the hour of care happens; the claim doesn't go out — or goes out and comes back denied.

I hear versions of the same sentence from practice owners across the state: *"I have good people I can't bill for."* The usual responses — cutting hours, converting roles to unpaid-adjacent admin work, or waiting out the 3,000 supervised hours until full licensure — all burn the practice's money and the clinician's career at the same time.

45,045 — supervised-tier licensees in Michigan — LLPC · LLMSW · TLLP (Observatory count)

13,407 — Michigan practice contacts affected by the reimbursement shift

3,000 — supervised hours required for full licensure

This playbook is about a third option: a care model in which the limited-license clinician is not a billing liability but the central working role — and in which the billing question that stranded them simply does not arise, because the claim never depends on their individual panel status in the first place.

A NOTE ON THE COUNT

Workforce figures from the Michigan Behavioral Health Workforce Observatory's analysis of state licensing records; supervised-hours requirement per Michigan administrative rules for professional counseling.

The problem was never the clinician. It was the billing architecture around the clinician.

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THE MODEL THAT CHANGES THE MATH

Psychiatric Collaborative Care (CoCM) is a team model for treating common behavioral health conditions — depression and anxiety, most often — inside a medical practice. Three roles, in plain language:

The treating physician or practitioner

MD, DO, NP, or PA — keeps overall responsibility for the patient and prescribes.

The Behavioral Health Care Manager (BHCM)

The workhorse: systematic follow-up, symptom measurement (PHQ-9, GAD-7), brief evidence-based interventions like behavioral activation and problem-solving treatment, a patient registry, and the connective tissue between patient, physician, and psychiatrist.

The consulting psychiatrist

Reviews the caseload with the BHCM weekly and recommends treatment changes — without needing to see the patients or join the practice's payroll.

The billing follows the model's logic. CoCM services are billed **under the treating practitioner's NPI** as monthly, time-based codes, described by CMS in its Behavioral Health Integration Services booklet (MLN909432):

CODE	WHAT IT COVERS	TIME THRESHOLD
99492	First calendar month of CoCM — initial assessment, registry entry, care plan	70 min BHCM activity
99493	Each subsequent calendar month of CoCM	60 min
99494	Add-on for each additional block of time in any month	+30 min
G2214	Shorter-increment CoCM add-on/initial code	30 min
99484	General behavioral health integration (non-CoCM BHI)	20 min

A NOTE ON THE SOURCE

CMS, *Behavioral Health Integration Services*, MLN909432 — cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf. Consult the current booklet and your billing staff for full requirements, including patient consent and cost-sharing.

THE KEY FACT · FROM PUBLIC SOURCES

Medicare pays these codes nationally. Michigan Medicaid activated them in bulletin MSA 21-19. And **Blue Cross Blue Shield of Michigan operates a public Collaborative Care designation program** through its PGIP physician organizations, with MICMT — the Michigan Institute for Care Management and Transformation — as the training hub. Michigan is, by national standards, a good-news state for collaborative care.

THE PIVOT

A limited-license clinician can serve as the Behavioral Health Care Manager.

For a practice carrying stranded clinicians, that one fact changes the math. In this model the claim is generated by the treating practitioner's NPI for the team's monthly work — the billing does not depend on the BHCM's own panel status. The role asks for exactly what a well-trained LLPC or LLMSW already brings: structured assessment, brief intervention, measurement, and disciplined follow-up.

One clinician you already employ, one physician you already have, one psychiatrist you contract for a few hours a week: that is the entire staffing model. The rest of this playbook is how to stand it up without falling into the failure modes the research has already mapped.

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THE PIVOT, STEP BY STEP

1 **Inventory your limited-license staff and your payer mix.**

List every LLPC, LLMSW, and TLLP on payroll, their supervision arrangements, and their current billable share. Then pull twelve months of payer mix. CoCM economics run through Medicare, Michigan Medicaid, and BCBSM/BCN first — if those are most of your panel, the math gets interesting quickly.

2 **Talk to your physician organization about the BCBSM CoCM designation path.**

BCBSM's Collaborative Care designation runs through PGIP physician organizations — the PO is the door, and MICMT trains. If you are a primary care (or one of the eligible OB/GYN) practices, ask your PO's practice-transformation team where you sit in the nomination pipeline. If you don't know your PO, BCBSM publishes the roster on its value-partnerships pages.

3 **Secure a consulting psychiatrist — by contract.**

Employment is not required. What you need is a contracted commitment to a weekly, systematic caseload review with your BHCM, with recommendations documented and communicated to the treating practitioner. Psychiatric availability is one of the two long poles in the timeline, so start this conversation early.

4 **Protect the BHCM's time, and stand up a registry.**

Erosion of the BHCM's protected time is the single most documented failure mode in real-world collaborative care. Put the protected hours in the job description and the schedule, and defend them. Then stand up the patient registry that drives the whole model — an EHR module, a standalone tool, or a well-kept spreadsheet are all acceptable; what matters is that it is current and reviewed weekly.

5 **Train the team through Michigan's training partners.**

The Michigan designation pathway expects roughly 16 hours of training for the BHCM, 4 for the treating practitioner, and 4 for the consulting psychiatrist, delivered through the state's training partners — MICMT, Mi-CCSI, or MCCIST — as assigned through your PO. Budget real ramp time beyond the course hours: fluency in registry-driven, 20–30-minute structured work takes a new BHCM three to six months.

6 **Launch weekly case reviews and bill the monthly time-based codes.**

Weekly psychiatric caseload review, documented in the registry; monthly tallies of BHCM minutes; claims out under the treating practitioner's NPI on 99492 for each patient's first month and 99493 thereafter, with 99494/G2214 for additional time. Track consent, minutes, and outcomes from day one — they are what audits and site visits look at.

A realistic timeline is 6–12 months from first conversation to first clean claim. The long poles are the BHCM hire (which you may already have solved — that is the point of this playbook) and psychiatrist time.

THE THREE DOCUMENTED FAILURE POINTS

1 **The BHCM's protected time erodes** under other duties until the caseload quietly stops being managed.

2 **The case-review cadence slips** below weekly, or happens but goes undocumented.

3 **Consent and suicide-protocol paperwork fail the site visit** — programs need documented consent for enrolled patients and a crisis protocol more detailed than "call 911."

Every one of these is boring, and every one of these is fatal. Build the guardrails before launch, not after the first audit letter.

A NOTE ON WHAT AUDITS READ

Consent, minutes, and outcomes, tracked from day one — the same records a site visit asks for first (Step 6).

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WHAT THE EVIDENCE ACTUALLY SAYS

I will not sell you collaborative care as a miracle, because the honest version is more useful: it is one of the best-evidenced service models in behavioral health *and* one of the easiest to implement badly. Both halves matter.

WHAT THE TRIALS SHOW

COCHRANE CD006525 — ARCHER ET AL. PRIMARY SOURCE · VERIFIED AUG 2026

79 randomized controlled trials, 24,000+ patients, within an evidence base of 90+ RCTs: consistent benefit for depression and anxiety in medical settings — a standardized effect around 0.34 for depression.

IMPACT TRIAL — UNÜTZER ET AL. VERIFIED AUG 2026

Roughly doubled treatment response versus usual care in the landmark trial.

IMPACT FOUR-YEAR COSTS — AM J MANAG CARE, 2008 VERIFIED AUG 2026

Participants cost about $3,363 less over four years than usual-care patients — roughly a 6:1 return.

...AND WHAT THEY DON'T

DIAMOND INITIATIVE — MINNESOTA, SOLBERG ET AL. 2015 VERIFIED AUG 2026

Collaborative care rolled into 75 real-world clinics — and **no benefit over usual care**. Fidelity and enrollment failed, so the model on paper wasn't the model in practice.

THE FIDELITY ELEMENTS

The effect lives in an actively used registry, genuinely weekly case reviews, measurement wired to treatment change, and protected BHCM time. Drop them and you keep the costs while losing the outcomes.

ON TRAINING

"Two-day training and go" is a fiction. Competent programs pair training with months of coached ramp-up.

The practical conclusion is not "be discouraged." It is: **the difference between the trial results and the DIAMOND results is a short list of operational habits** — the same habits in Step 4 and Step 6 above. Practices that keep them get the trial-grade model. Practices that don't get an expensive staffing exercise.

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THE OPEN QUESTION THAT COULD MATTER MOST

For the limited-license clinician stepping into a BHCM role, there is a second question hiding behind the billing one: **do the hours count toward full licensure?** I want to give you the honest state of that question, because I have not seen it asked precisely elsewhere — and because the honest answer is genuinely open.

An open question — not a settled one

Michigan's supervised-experience rule for counselors, **R 338.1774**, counts "engagement in the practice of counseling under MCL 333.18101(d)" — expressly including work in health settings — and, unlike states such as Texas, Arizona, or New York, Michigan imposes **no direct-client-contact hours quota** and no activity-type breakdown. The whole test is whether an hour was the practice of counseling under the statute.

Core BHCM clinical activities — administering and interpreting assessments, formulating treatment plans, brief evidence-based interventions like behavioral activation and problem-solving treatment, crisis intervention — **appear on their face to fall within the statutory definition** of counseling practice in MCL 333.18101. Registry data entry, scheduling, and pure care-coordination logistics do not map so cleanly.

But every clause of the previous paragraph carries the same asterisk: **no authority has addressed whether CoCM-specific coordination time counts.** LARA guidance, Board of Counseling FAQs, and published board minutes are silent. Other states' precedent excludes case-management hours — though those states have hours quotas Michigan deliberately lacks, so the analogy is imperfect in both directions.

A NOTE ON THE RULE

Michigan Administrative Code **R 338.1774** — supervised counseling experience.
MCL 333.18101(d) — the statutory definition of the practice of counseling.

TWO CAVEATS THAT MUST SURVIVE EVERY RETELLING

1 **Nobody should count BHCM hours toward licensure without written LARA confirmation** and the advice of a Michigan licensure attorney. Not on this document's account, not on anyone's.

2 **Supervision must be by a qualified LPC throughout**, per R 338.1774(2). The CoCM consulting psychiatrist's weekly case review — however clinically valuable — **does not satisfy the counseling supervision requirement.**

I frame this deliberately as **an advocacy question Michigan should answer**. A workforce of tens of thousands of supervised-tier clinicians, a care model with 90+ trials behind it, and a rule whose text plausibly reaches the clinical half of the BHCM's week: that is exactly the kind of question a licensing board can and should resolve on the record. If your practice employs limited-license clinicians — or you are one — the survey at the end of this playbook is one way to help build the factual record that makes the question impossible to ignore.

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WHERE THIS DATA COMES FROM

The workforce numbers in this playbook come from the **Michigan Behavioral Health Workforce Observatory**, a project I maintain that currently tracks **6.09 million license records across 18 states**, built from public state licensing data. It exists because behavioral-health workforce policy keeps being made on anecdotes, and I would rather it be made on counts.

AN INVITATION, PLAINLY FRAMED

If this playbook was useful, I'd welcome ten minutes of your time on the **Michigan practice survey** — what roles you employ, what you can and can't bill, and what stands between you and a collaborative-care program. The exchange is simple and honest: **the playbook is yours regardless; the survey makes the next edition sharper** — and builds the evidence base for the licensure-hours question above.

{{SURVEY_URL}}

Aggregate results will flow back into future editions of this playbook and into the Observatory's public work. Individual responses stay confidential.

07

SOURCES — A READING-ROOM CATALOGUE

CMS MLN909432 — VERIFIED AUG 2026

Behavioral Health Integration Services — cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf. The public authority for CoCM/BHI billing codes and requirements cited here.

MDHHS MSA 21-19 — VERIFIED AUG 2026

Michigan Department of Health & Human Services, Medicaid bulletin — activation of psychiatric collaborative care codes in Michigan Medicaid.

COCHRANE CD006525

Archer J, et al. *Collaborative care for depression and anxiety problems.* Cochrane Database of Systematic Reviews.

UNÜTZER 2008

Long-term cost effects of collaborative care for late-life depression (IMPACT). *Am J Manag Care.*

SOLBERG 2015

A stepped-wedge evaluation of the DIAMOND collaborative care initiative. *Ann Fam Med* / associated DIAMOND analyses.

BCBSM VALUE PARTNERSHIPS — PUBLIC PAGES

Public Collaborative Care designation program and PGIP physician-organization materials — bcbsm.com/providers/value-partnerships.

MICMT — PUBLIC PAGES

Michigan Institute for Care Management and Transformation, public program pages — micmt-cares.org.

AIMS CENTER

University of Washington — public caseload and implementation guidance for collaborative care.

R 338.1774 · MCL 333.18101

Michigan Administrative Code (supervised counseling experience) and Michigan Compiled Laws (definitions, practice of counseling).

MICHIGAN BEHAVIORAL HEALTH WORKFORCE OBSERVATORY — AUG 2026

Analysis of public state licensing records — 18 states, 6.09M records.

Payer policies, designation requirements, and training expectations change. Verify current requirements against the current versions of the documents above — in particular the current MICMT designation requirements and your physician organization's guidance — before making staffing or billing decisions.