

DRAFT

**Maryland Section 1115 Waiver
Amendment Submission**

May 17, 2019

Table of Contents

Amendment Introduction and Objectives	3
Introduction.....	3
Overview of Collaborative Care	4
Interest in the Collaborative Care Model in Maryland	5
Requested Policy Changes, Objectives, and Rationale	6
Pilot Award Payment Structure and Award Payments	7
Anticipated Outcomes.....	7
Evaluation Design.....	8
Budget Neutrality.....	9
Public Process and Indian Consultation Requirements.....	10

Maryland Section 1115 Waiver Amendment Submission

Amendment Introduction and Objectives

The Maryland Department of Health (the Department) is pleased to submit this §1115 waiver amendment application for the HealthChoice program. HealthChoice, Maryland's statewide mandatory Medicaid managed care program, was implemented in July 1997 under authority of a waiver through §1115 of the Social Security Act. The initial waiver was approved for five years. In January 2002, the Department completed the first comprehensive evaluation of HealthChoice as part of the first §1115 waiver renewal. The 2002 evaluation examined HealthChoice performance by comparing service use during the program's initial years with utilization during State Fiscal Year (SFY) 1997, the final year without managed care. The Centers for Medicare and Medicaid Services (CMS) approved subsequent waiver renewals in 2005, 2007, 2010, 2013, and 2016.

This amendment would authorize the Department to cover collaborative care services through a limited pilot program, the Collaborative Care Model (CoCM) Pilot Program.

Introduction

The Department is seeking an amendment that will permit the implementation of the CoCM Pilot Program for a limited number of Medicaid participants enrolled in HealthChoice.

Collaborative Care is an evidence-based approach for integrating physical and behavioral health services in primary care settings that includes: (1) care coordination and management; (2) regular, systematic monitoring and treatment using a validated clinical rating scale; and (3) regular, systematic psychiatric caseload reviews and consultation for patients who do not show clinical improvement.

In Maryland, specialty substance use disorder (SUD) and mental health (MH) services are carved out of the HealthChoice managed care organization (MCO) benefits package and are administered by an Administrative Services Organization (ASO). MCOs in HealthChoice are responsible for delivering primary behavioral health services and referring participants to the ASO for specialty services.

The goal of the CoCM Pilot Program is to improve health outcomes for Maryland Medicaid participants who have experienced mental illness or have a substance use disorder, but have not received effective treatment, and to further integration of primary and behavioral health care. CoCM Pilot Sites would have the option to target individuals diagnosed with mild to moderate depression using Patient Health Questionnaire-9 (PHQ-9) screening tool or to specify a different target population with a behavioral health need (either SUD or MH condition).

Pursuant to Chapters 683 and 684 of the Acts of 2018 (HB 1682/SB 835), the Department must establish and implement the CoCM Pilot Program in primary care settings in which health care services are provided to Medical Assistance Program participants enrolled in HealthChoice. SB 835 requires MDH to administer the CoCM Pilot Program and to select up to three pilot sites with certain characteristics to participate. The Department shall review, approve, and make awards to up to three sites to participate in the CoCM Pilot Program via a competitive application process. Funding will include up to \$225,000 for services rendered during the second half of fiscal year (FY) 2020 (January 1, 2020 through June 30,

2020), and up to \$550,000 annually for services rendered for FY 2021, FY 2022, and FY 2023 (July 1, 2020 through June 30, 2023). Following completion of the CoCM Pilot Program, the Department will evaluate its outcomes to assess whether it controlled costs and improved access to care and clinical outcomes.

Overview of Collaborative Care

The CoCM is a patient-centered, evidence-based approach for integrating physical and behavioral health services in primary care settings that includes: (1) care coordination and management; (2) regular, systematic monitoring and treatment using a validated clinical rating scale; and (3) regular, systematic psychiatric caseload reviews and consultation for patients who do not show clinical improvement. A collaborative care team is responsible for delivery and management of patient-centered care. Proponents of the model suggest that merging behavioral health with primary care normalizes and de-stigmatizes treatment for behavioral health disorders for the patient. This in turn encourages patients to seek access to the evidence-based behavioral health services available in their regular primary care clinics resulting in improved patient outcomes.

The CoCM incorporates a team of three providers: (1) a primary care provider (PCP), (2) a behavioral health (BH) care manager, and (3) a psychiatric consultant. In Maryland's Medicaid program, a physician, nurse practitioner, nurse midwife, or physician assistant may serve as a PCP. The BH care manager possesses formal education or specialized training in behavioral health. The role is typically filled by a nurse, clinical social worker, or psychologist that is trained to provide coordination and intervention who works under the oversight and direction of the PCP. Together, the BH care manager and the PCP form the primary care team. The psychiatric consultant is typically either a licensed psychiatrist or psychiatric nurse practitioner. For purposes of the CoCM Pilot Program, an addiction medicine specialist or any other behavioral health medicine specialist as allowed under federal regulations governing the model may also serve as a consultant.

Although there can be variations to the CoCM, all iterations share four essential elements. The provision of care must be: (1) patient-centered and team-driven, (2) population-focused, (3) measurement guided, and (4) evidence-based. In practice, this means that a CoCM must be a joint effort of medical professionals led by a PCP that collaborate to use shared care plans to achieve concrete treatment goals for a defined population of patients. Outcomes are tracked by utilizing a combination of patient reported outcome measures and scientifically proven methods. Because the CoCM is patient-centered, the team makes concerted efforts to actively engage patients in self-management and treatment adherence, while also coordinating and developing flexible recommendations to meet patient needs.

The CoCM can target various behavioral health needs; however, eligible participants usually include individuals who have screened positive for depression according to the PHQ-9 by their PCP. While some studies have shown the effectiveness of Collaborative Care in adolescents, the majority of research supports Collaborative Care as an intervention for adult populations.

The PCP's main role within the model is to provide primary care services, coordinate care, and help the patient access a range of health care services. The PCP acts as the billing provider for CoCM services. The patient is introduced to the BH care manager, who works closely with the PCP. The BH care manager is primarily responsible for supporting and implementing treatment initiated by the PCP, such as the monitoring of medication. The primary care team in consultation with the psychiatric consultant determines the course of treatment and sets measurable benchmarks that they expect the patient to reach in the future.

Once the treatment plan is implemented, the patient's progress is tracked at regular intervals using validated clinical rating scales (e.g., PHQ-9). If a patient is not improving as expected, the treatment plan and goals are systematically adjusted. In addition to working closely with the primary care team, the psychiatric consultant may also meet directly with patients that present significant diagnostic challenges or who are not showing clinical improvements. Interactions with the primary care team and patients may be conducted in-person or via telehealth from the PCP's office to the psychiatric consultant.

Interest in the Collaborative Care Model in Maryland

In March 2016, the Senate Finance and House Health and Government Operations Committees requested the Department to submit a report regarding the opportunities to adopt a CoCM in the Maryland Medicaid program. The Department concluded that while there is potential for the CoCM to control costs, improve access and clinical outcomes, and increase patient satisfaction, the statewide implementation of a CoCM was not feasible due to the substantial start-up costs. The Department recommended a one year pilot in the future.¹ In 2017, the Department submitted an update to the 2016 report, where it committed to continuing to explore the possibility of a one year pilot of a CoCM.² The Department acknowledged the need for additional funding and §1115 waiver authority.

During the 2018 legislative session, the Maryland General Assembly passed and the Governor approved HB 1682/SB 835 (Chs. 683 and 684 of the Acts of 2018) entitled *Maryland Medical Assistance Program – Collaborative Care Pilot*. The bill establishes a Collaborative Care Model Pilot Program for SFYs 2020 through 2023. Specifically, the bill requires the Department to establish and implement the CoCM in up to three pilot sites that deliver primary care services to HealthChoice participants. The Governor must provide an annual budget of \$550,000 for each SFY of the pilot. The bill further stipulates that the Department shall apply to CMS for an amendment to the State's §1115 HealthChoice Demonstration Waiver if necessary to implement the CoCM Pilot Program. Lastly, the Department must report to the Governor and the General Assembly the findings and recommendations from the CoCM Pilot Program by November 1, 2023.

Pilot Sites will have the option to designate the behavioral health need they will target. The impact of CoCM on outcomes for individuals with depression is one area that has been studied. Data on the HealthChoice population suggests that the CoCM has the potential to improve outcomes and reduce costs for this population. Table 1 below shows the number of HealthChoice participants in calendar year (CY) 2017 with a diagnosis of depression who did not access specialty behavioral health services through the ASO. Overall, in CY 2017 there were 7,753 participants in HealthChoice with a primary diagnosis of depression and 46,301 participants with any diagnosis.

¹ 2016 Joint Chairmen's Report (p. 78) – Report on Collaborative Care Initiative, <https://mmcp.health.maryland.gov/Documents/JCRs/2016/collaborativecareJCRfinal12-16.pdf>

² 2017 Joint Chairmen's Report (p. 89) – Report on Collaborative Care Revisited, <https://mmcp.health.maryland.gov/Documents/JCRs/2017/BHIJCRfinal1-18.pdf>

Table 1: Number of Participants Diagnosed with Depression who Receive Services from their MCO (Excluding Visits Paid by Beacon Health Options), CY2017

MCO	CY 2017			
	Total Participants	Primary Diagnosis	Any Diagnosis	Percent with Any Diagnosis
Aetna	*	*	*	0.2%
Amerigroup	318,063	1,309	8,058	2.5%
JAI	*	*	*	6.1%
Kaiser	77,891	242	1,029	1.3%
Maryland Physicians Care	252,695	1,787	10,309	4.1%
MedStar	106,028	717	3,954	3.7%
Priority Partners	340,471	1,996	12,732	3.7%
University of Maryland Health Partners	53,261	317	1,915	3.6%
United	180,575	1,230	6,477	3.6%
Total	1,360,912	7,753	46,301	3.4%

*Cell sizes suppressed.

Requested Policy Changes, Objectives, and Rationale

The Department requests an amendment to the current §1115 waiver to establish a CoCM Pilot Program as mandated by state law in order to better integrate behavioral and somatic care. The purpose of the CoCM Pilot Program is to establish a CoCM in primary care settings to provide services to participants enrolled in HealthChoice. The Department shall select up to three sites over a four year period, with one of those sites being located in a rural area to the extent practicable. The Department would select the participating sites through a competitive application process.

The Department issued an optional letter of interest (LOI) and a Request for Applications (RFA) on April 10, 2019. Interested sites shall submit the LOI to the Department by April 19, 2019 and completed RFAs by May 22, 2019. Submitted RFAs must include:

1. Project Abstract
2. Project Narrative
3. (Optional) Letters of support from relevant stakeholders
4. Resumes of Key Personnel
5. A signed and dated copy of Attestations and Certification
6. A Budget Outline

CoCM Pilot Sites will agree to participate in the collection and monitoring of required performance measures identified for the CoCM Pilot Program. All CoCM Pilot Sites will be required to report metrics quarterly and annually. Approved CoCM Pilot Sites will be subject to the CoCM Pilot Site’s mandatory agreement to the forthcoming MOA, DUA, and BAA, which will incorporate performance measurement requirements and will govern the exchange and utilization of the data involved in the CoCM Pilot Programs.

Pilot Award Payment Structure and Award Payments

For purposes of the CoCM Pilot Program, the Pilot year shall begin on July 1 and end on June 30. The Department will award up to \$225,000 in FY 2020, and up to \$550,000 annually in FY 2021, FY 2022, and FY 2023 to support the cost of service delivery. Available funds will be allocated between the selected CoCM Pilot Sites based on demonstrated need. CoCM Pilot Sites will be required to submit invoices to the Department for services delivered. Invoices must use the billing codes referenced below. Reimbursement will be limited to services delivered to Medicaid participants enrolled in HealthChoice. CoCM Pilot Sites have the discretion to bill other payers for services; however, the cost of services delivered to non-Medicaid participants and Medicaid participants not enrolled in HealthChoice are not eligible for reimbursement through the CoCM Pilot Program.

Table 2: List of Codes for CoCM Pilot Program

Codes	Description	Primary Care Setting Rate
99492	First 70 minutes in the first calendar month or behavioral health care manager activities	\$161.28
99493	First 60 minutes in a subsequent month for behavioral health care manager activities	\$128.88
99494	Each additional 30 minutes in a calendar month of behavioral health care manager activities	\$66.60

All services must be tracked and submitted in an invoice to the Department. Services invoiced will be reimbursed against the CoCM Pilot Site's approved Service Delivery Budget for the fiscal year. To the extent service delivery costs exceed the Pilot Site's approved Service Delivery Budget for any fiscal year, the site will not be eligible for reimbursement.

Anticipated Outcomes

Collaborative Care has been recognized as an official evidence-based practice by SAMHSA and recommended as a best practice by the Surgeon General's Report on Mental Health, the President's New Freedom Commission on Mental Health, and a number of national organizations, including the National Business Group on Health. The Agency for Healthcare Research and Quality reviewed various approaches to integrating MH and substance use treatment with primary care found that the CoCM stood out as having the strongest results.

The CoCM has been tested in numerous randomized controlled trials in the United States and abroad. Studies demonstrate that the model can be more effective than traditional care methods with respect to improving clinical, cost, and quality outcomes.³ Limited studies indicate that collaborative care, when compared to standard care, can double the short- and long-term response rate to depression treatment, with some evidence supporting similar improvement in other MH conditions, such as anxiety, bipolar disorder, and schizophrenia. In addition to its potential positive effects on participants' health outcomes, collaborative care may also reduce health care costs. Depression has been shown to increase a patient's

³ Unützer, Jürgen. The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes.

overall health care costs by up to 50-100 percent.⁴ Effective treatment of depression through the CoCM thus has the potential to reduce a patient’s overall health care costs.

The Department objective seeking this amendment is to determine whether the CoCM Pilot Program will improve access and clinical outcomes.

Evaluation Design

Maryland’s annual HealthChoice evaluation design will be modified to incorporate the CoCM Pilot Program waiver amendment. The Hilltop Institute performs an annual evaluation of the HealthChoice program as mandated by Maryland’s §1115 waiver. This pilot will test whether collaborative care will improve access and clinical outcomes as previously stated using the proposed measures listed below.

As required by state law, the Department will report to the Governor and the General Assembly on the Department’s findings and recommendations from the CoCM Pilot Program on or before November 1, 2023.

The following are the currently proposed monitoring measures that the Department will require selected CoCM Pilot Sites to report:

1. **Enrollment** – The total number of Medicaid patients enrolled in Collaborative Care treatment during this month
2. **Newly enrolled** – Among enrolled patients, the number of patients who were diagnosed with Depression or Anxiety or other targeted behavioral health diagnosis and enrolled in treatment by the BH care manager this month
3. **Average Duration of Treatment** – Average number of weeks between initial assessment to date of discharge from Collaborative Care
4. **Monthly Contact**- Number (#) and proportion (%) of patients receiving active treatment in CoCM defined by those patients who have had at a clinical contact this month
 - a. Numerator: Patients that have had at least one clinical contact this month
 - b. Denominator: Total number of patients enrolled during this month
 - c. **Note:** A “clinical contact” is defined as a contact in which monitoring may occur and treatment is delivered with corroborating documentation in the patient chart. This includes individual or group psychotherapy visits and telephonic engagement **as long as treatment is delivered.**
5. **Clinical Contacts by Phone** – Number (#) and proportion (%) of telephonic touches for patients enrolled in treatment over the total number of touches that month. See note above regarding definition of “clinical contact”.
6. **Improvement Rate** – Number (#) and proportion (%) of patients enrolled in treatment for 70 days or greater who demonstrated clinically significant improvement defined as:
 - a. A 50% reduction from baseline PHQ-9, or
 - b. A drop from baseline PHQ-9 to less than 10
 - i. Numerator: Patients that have met Improvement criteria
 - ii. Denominator: All patients enrolled in Collaborative Care for 70 days or more
7. **Remission Rate** – Number (#) and proportion (%) of patients enrolled in treatment for any length of time who have achieved remission criteria (PHQ-9 below 5) during this month

⁴ Katon WJ, Lin E, Russo J, Unutzer J. “Increased Medical Costs of a Population-based Sample of Depressed Elderly Patients.” Archives of General Psychiatry. September 2003;60(9):897-903.

- a. Numerator: Patients whose most recent PHQ-9 is below 5
 - b. Denominator: Total number patients enrolled during this month
- 8. **Psychiatric Consultation or Change in Treatment Rate** – Among those enrolled in treatment for 70 days or more who did not improve, number (#) and proportion (%) who whose case was reviewed by the Consulting Psychiatrist with treatment recommendations provided to the Primary Care Provider or Depression Care Manager OR had a documented change made to their treatment plan this month
 - a. Numerator: Patients who have had their case reviewed by the Consulting Psychiatrist OR had a change documented in their treatment plan this month
 - b. Denominator: Patients that have been enrolled for 70 days or more who have not met clinical improvement criteria this month
- 9. **Depression Screening Rate** – Number (#) and proportion (%) of all unique adult patients seen during the reporting period who received their annual PHQ-2 or PHQ-9 screening.
 - a. Numerator: Patients that received a PHQ-2 or 9 during this visit, or have been screened in the last year
 - b. Denominator: All patients seen in the practice for any reason that month
- 10. **Depression Screening Yield** – Number (#) and proportion (%) of all unique adult patients who scored a 10 or greater on their initial PHQ-9 during the reporting period
 - a. Numerator: Patients that scored a 10 or higher on their initial PHQ-9
 - b. Denominator: All patients screened with a PHQ-9 during that month

Additionally, the Department will evaluate the impact of the CoCM Pilot Program on the number of and outcomes for individuals who:

- 1. Were not diagnosed as having a behavioral health condition before receiving treatment through the pilot program;
- 2. Were not diagnosed as having a behavioral health condition before being referred to and treated by a specialty behavioral health provider;
- 3. Received behavioral health services in a primary care setting before receiving treatment through the CoCM Pilot Program; and
- 4. Received specialty behavioral health care services before being identified as eligible to receive treatment through the CoCM Pilot Program.

Budget Neutrality

As required by state law, the Department has a budget of \$550,000 per year (\$225,000 during the first fiscal year) for four state fiscal years of the pilot, averaging to approximately \$183,000 for services per CoCM Pilot Site.

Conservatively, the Department estimates that each participant will cost approximately \$190 per member per month (PMPM) for six months of care. The Department estimates that the CoCM Pilot Program will be able to treat approximately 483 participants across all of the Pilot Sites annually, or 161 participants per site on average. The Department estimates that the actual number of participants receiving services may vary based on Pilot Site proposed caseload and staffing, as well as the Site's payer case mix.

The Department anticipates a 50 percent federal match, with \$112,500 federal funds the first fiscal year and \$225,000 in each subsequent year.

Appendices

Public Process and Indian Consultation Requirements

[To be added at the close of public comment period]