Maryland HealthChoice
Section §1115 Waiver Demonstration

Request for Application (RFA) Package for Collaborative Care Model Pilot Program

Published: April 10, 2019

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Background

HB 1682/SB 835—*Maryland Medical Assistance Program – Collaborative Care Pilot Program* (Chapters 683 and 684 of the Acts of 2018) establishes a Collaborative Care Pilot Program. Specifically, the bill requires the Maryland Department of Health (MDH) to establish and implement the Collaborative Care Model (CoCM) in primary care settings in which health care services are provided to Medical Assistance Program participants. SB 835 requires MDH to administer the Pilot Program and to select up to three CoCM Pilot Sites with certain characteristics to participate. The bill also requires the Governor to include in the annual budget $550,000 for fiscal years (FY) 2020, 2021, 2022, and 2023 for the Pilot Program. The bill stipulates that MDH shall apply to the Centers for Medicare and Medicaid Services (CMS) for an amendment to the State's §1115 HealthChoice Demonstration Waiver if necessary to implement the Pilot Program. Lastly, MDH shall report to the Governor and the General Assembly the findings and recommendations from the Pilot Program by November 1, 2023.

MDH shall review, approve, and make awards to up to three sites to participate in the CoCM Pilot Program using the criteria outlined in Appendix B. Application Selection Criteria. CoCM Pilot Sites must target delivery of services to HealthChoice participants.[1] CoCM Pilot Sites may target individuals diagnosed with mild to moderate depression using Patient Health Questionnaire-9 (PHQ-9) screening tool or may specify a different target population with a behavioral health need (either substance use disorder or mental health).

CoCM Pilot funding awards will consist of two parts:

- Infrastructure funding up to $225,000 across all CoCM Pilot Sites to be used during FY 2020 (between July 1, 2019 and June 30, 2020); and
- Funding available to support delivery of Collaborative Care services from January 1, 2020, through June 30, 2023, up to $225,000 in FY20 and $550,000 annually in FY21, FY22, and FY23.

Payments are for services not otherwise covered or directly reimbursed by Medicaid. Payment for services will be made only for care delivered to Medicaid participants enrolled in HealthChoice. MDH will be seeking a §1115 waiver amendment from CMS for the delivery of services through the CoCM Pilot. MDH anticipates submitting the §1115 waiver amendment no later than July 2, 2019.

Successful CoCM Pilot Site Applicants will be expected to enter a Memorandum of Agreement (MOA) with MDH covering receipt of funding and scope of work as well as a Data Use Agreement (DUA) and Business Associate Agreement (BAA) governing exchange of data required for billing and evaluation purposes.

The CoCM Pilot Application Timeline is as follows:

1. Letter of Intent (LOI) Instructions and Collaborative Care Pilot Request for Applications (RFA) Published by MDH	April 10, 2019
2. LOI Due to MDH (Optional)	April 19, 2019
3. CoCM Pilot Applications Due to MDH	May 22, 2019
4. CoCM Pilot Award Notifications (Expected Date)	June 14, 2019

[1] Medicaid participants who receive services on a fee-for-service basis, including dually eligible participants who have Medicare and Medicaid, are not eligible for this Pilot Program. Pilots Sites must verify enrollment in an MCO at the time of service delivery through the Eligibility Verification System (EVS).

5. CoCM Pilot Program Infrastructure Funding Start Date	July 1, 2019
6. CoCM Pilot Program Service Delivery Begins (Expected Date)	January 1, 2020
7. CoCM Pilot Program Ends	June 30, 2023

Overview of Collaborative Care

Goals and Workflow

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 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, 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 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. For more information on PHQ-9 scoring, please see Guidelines for Using the PHQ-9.

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.

The Maryland Medicaid CoCM Pilot

Overview of Required Components and Tasks

The goal of the CoCM Pilot Program is to improve health outcomes for Maryland Medicaid participants who have experienced mental illness or a substance use disorder, but have not received effective treatment, and to further integration of somatic and behavioral health care.

MDH expects CoCM Pilot Sites to deliver the following essential elements of Collaborative Care:

- **Staffing Model**
  - PCPs trained in screening and providing evidence-based, stepped care for certain targeted behavioral health diagnoses. There should be at least one trained PCP at each CoCM Pilot Site. The PCP must be enrolled as a Medicaid provider.
  - BH Care Managers in the primary care setting who oversee and provide mental health care support; screening; patient engagement, education and follow-up; ongoing patient contact; monitoring of adherence with psychotropic medications; mental health and substance use disorder referrals; brief interventions appropriate for primary care settings; and related activities. There should be at least one BH Care Manager at each CoCM Pilot Site. Please see the resources in Appendix E: Additional Resources for details.
  - Designated Psychiatric Consultant must provide regular (e.g., weekly) systematic case review of patients who are not improving with the BH Care Manager and/or PCP. The designated psychiatric consultant can provide caseload supervision remotely, but must have access to the patient care registry. This role may be filled by a licensed psychiatrist, a psychiatric nurse practitioner, an addiction medicine specialist or any other behavioral health medicine specialist as allowed under federal regulations governing the model.
  - If not managed by the BH Care Manager, there should be at least one person serving as the billing and data lead.
  - If not managed by another role, there should be at least one person serving as the Pilot Program Lead.
- **Patient Identification and Diagnosis**
  - CoCM Pilot Sites must indicate their target population, including how individuals will be identified for participation in the Pilot. CoCM Pilot Sites may target individuals diagnosed with mild to moderate depression using Patient Health Questionnaire-9

(PHQ-9) screening tool or may specify a different target population with a behavioral health need (either substance use disorder or mental health).
    - Screen for behavioral health problems using validated clinical tools, such as the PHQ-9. CoCM Pilot Sites should specify the validated clinical tool(s) they intend to use and rating scale that will be used.
    - Diagnose behavioral health problems and related conditions
- **Engagement in Integrated Care Team**
    - Warm hand-off to the BH Care Manager.
    - Introduce Collaborative Care team and engage patient in integrated care program.
    - Initiate patient tracking in population-based registry.
- **Evidence-based Treatment**
    - Develop and regularly update a biopsychosocial treatment plan.
    - Provide patient and family education about symptoms, treatments, and self-management skills.
    - Provide evidence-based counseling (e.g., Motivational Interviewing, Behavioral Activation).
    - Provide evidence-based psychotherapy (e.g., Problem Solving Treatment, Cognitive Behavioral Therapy, Interpersonal Therapy).
    - Prescribe and manage psychotropic medications as clinically indicated
    - Utilize a treatment-to-target approach, using the PHQ-9 as a monitoring tool to identify patients that are not improving. CoCM Pilot Sites electing to use a different validated clinical tool must specify the instrument they intend to use and the rating scale that will be used to assess improvement over time and set treatment targets.
    - Change or adjust treatments if patients do not meet treatment targets
- **Systematic Follow-up, Treatment Adjustment, and Relapse Prevention**
    - Use of a patient care, population-based registry for ongoing and systematic performance monitoring that can track the following (please see the resources in Appendix E: Additional Resources for details). CoCM Pilot Sites must be able to report the following metrics monthly:
        - Name of participant
        - MA Identification Number
        - Treatment status
        - Number of engagements with participant
        - Date follow-up due and/or indicator for next follow-up due
        - Actual contact dates
        - Type of contact (e.g., in person, phone, clinical v. non-clinical, etc.)
        - Billable minutes
        - PHQ-9 score (or score from instrument selected by the CoCM Pilot Site)
        - Change in PHQ-9 score (or other instrument selected by the CoCM Pilot Site)
        - Indicator for psychiatric consultant case review needed
    - Proactively reach out to patients who do not follow-up.
    - Monitor treatment response at each contact with valid outcome measures.
    - Monitor treatment side effects and complications.
    - Identify patients who are not improving to target them for psychiatric consultation and treatment adjustment.
    - Create and support relapse prevention plan when patients are substantially improved.

- **Communication and Care Coordination**
  - Coordinate and facilitate effective communication among providers.
  - Engage and support family and significant others as clinically appropriate.
  - Facilitate and track referrals to specialty care, social services, and community-based resources.
  - Coordination with the behavioral health ASO to ensure CoCM services are not duplicative of other services individual is already receiving and referral to specialty behavioral health ASO services as deemed necessary.
- **Systematic Psychiatric Case Review and Consultation**
  - Conduct regular (e.g., weekly) caseload review on patients who are not improving.
  - Provide specific recommendations for additional diagnostic work-up, treatment changes, or referrals.
  - Provide psychiatric assessments for challenging patients in-person or via telehealth.

CoCM Pilot Sites will also be required to meet certain reporting requirements as outlined in the Monitoring and Evaluation section.

Additional factors considered in the selection of CoCM Pilot Sites will include past and current experience delivering Collaborative Care and the capacity to scale up an existing Collaborative Care initiative to include Medicaid participants enrolled in HealthChoice.

Application Review Process

MDH shall select up to three CoCM Pilot Sites at which a CoCM shall be established over a 4-year period. The CoCM Pilot Sites selected by MDH shall be adult or pediatric non-specialty medical practices or health systems that serve a significant number of Medical Assistance Program participants enrolled in HealthChoice. To the extent practicable, one of the CoCM Pilot Sites selected by MDH shall be located in a rural area of the state. The CoCM Pilot Sites selected by MDH shall ensure that treatment services, prescriptions, and care management that would be provided to an individual under the CoCM Pilot Program are not duplicative of specialty behavioral health care services being received by the individual through the Medicaid behavioral health administrative services organization (ASO), Beacon Health Options.

MDH shall review and select CoCM Pilot Sites in accordance with the requirements using the Application Selection Criteria outlined in Appendix B. Application Selection Criteria.

Funding Purposes for Collaborative Care Model Pilot Program

The CoCM Pilot Program is effective for Fiscal Year (FY) 2020 through FY 2023. The Governor shall include in the annual budget an appropriation for $550,000 for the pilot program. Generally, MDH shall provide funding to sites participating in the CoCM Pilot Program for:

- Infrastructure development, including the development of a patient registry and other monitoring, reporting, and billing tools required to implement CoCM;
- Training staff in order to implement;
- Staffing for care management and psychiatric consultation provided under CoCM; and
- Other purposes necessary to implement and evaluate.

MDH will award funding for two categories of expenditures (1) infrastructure development and (2) direct service delivery. MDH will allocate funding between the selected CoCM Pilot Sites based on demonstrated need and the prospective number of Medicaid participants served.

Billing Maryland Medicaid for Collaborative Care

CoCM Pilot awards will consist of two parts: (1) up to $225,000 in infrastructure funding available between July 1, 2019 and June 30, 2020, and (2) funding available to support delivery of Collaborative Care services from January 1, 2020, through June 30, 2023, up to $225,000 in FY20 and $550,000 annually in FY21, FY22, and FY23.

(1) Infrastructure Funding

MDH will award up to $225,000 effective July 1, 2019, across all CoCM Pilot Sites to support infrastructure development by the selected CoCM Pilot Sites during FY 2020. Available funds will be allocated between the selected CoCM Pilot Sites based on demonstrated need.

Types of expenditures for which infrastructure funding may be used include:

- Development of a patient registry and/or integration of a patient registry into an electronic health record (EHR) system that includes the delivery of services; patient responses through routine use of the relevant screening tool; and ongoing performance improvement.
- Development of other monitoring, reporting, and billing tools required to implement CoCM;
- Training staff in order to implement; and
- Other infrastructure investments as defined by the CoCM Pilot Site.

Infrastructure funding is only available during the first year of the CoCM Pilot Program, FY 2020 (July 1, 2019 - June 30, 2020). Infrastructure funding will not be available in FY 2021, FY 2022, or FY 2023.

CoCM Pilot Sites interested in receiving infrastructure funding for these activities should describe their unique infrastructure needs, a plan and timeline for how these needs will be met using CoCM Pilot funding on or before June 30, 2020, and requested funding with justification for specific costs.

(2) Service Delivery

MDH 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 MDH 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.

Billing for services by CoCM Pilot Sites will occur outside the standard Medicaid billing process through the managed care organizations (MCOs) and Fee-For-Service process. All services must be tracked and submitted in an invoice to MDH. 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

approved Service Delivery Budget for the FY, they will not be eligible for reimbursement.

CoCM Pilot Sites will be responsible for tracking services on a monthly basis. Invoices must be submitted quarterly. MDH has provided a reporting template for data collection and invoicing purposes (please see Appendix F: Reporting Template). After a patient scores positive on the screening tool, is diagnosed with the targeted behavioral health condition by a PCP, has an initial assessment and treatment plan completed by the BH Care Manager, and has been entered into the approved registry, billing for CoCM services may begin.

Additionally, to bill for services for a Medicaid patient receiving Collaborative Care, the PCP and/or BH Care Managers must:

- Enter the patient into a registry that includes the components in the Overview of Required Components and Tasks Section on initial diagnosis by the PCP and completion of an initial assessment and treatment plan by the BH Care Manager;
- Have a minimum of one clinical contact[2] with the patient and a completed symptom scale (e.g. PHQ-9) every 30 days;
- Have seen the patient face-to-face with a licensed provider for at least 15 minutes at least once during the most recent three months (90 days); this may be their PCP, licensed BH care manager or other licensed professional staff;
- Keep a record of all patient contacts; and
- Consult for one hour or more per week, depending on case load, with a designated consulting psychiatrist regarding patients in the registry, including all patients who are not improving in terms of their symptom scores. This psychiatric consultant cannot bill Medicaid for the CoCM consultation work unless they perform in-person evaluations and consultation services directly with the patient. The psychiatric consultant must be enrolled as a Medicaid provider in order to bill separately for services.

NOTE: SBIRT Billing - When appropriate, billing for SBIRT services delivered may also occur, using existing fee-for-service or managed care payment methods. This payment would be separate from payments made for CoCM services.

MDH has adopted the Medicare payment structure for the CoCM Pilot Program. MDH will release more information on coding requirements at a later date. The fee schedule is as follows:

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

[2] 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.

Monitoring and Evaluation

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 unless otherwise specified. Final approval of this application 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. CMS may require additional evaluation measures to those listed below. MDH may assess additional measures independent from CoCM Pilot Program Evaluation.

*CoCM Pilot Sites electing to target a behavioral health condition other than depression must specify how they will assess and track Measures 4-10.

The following are the currently proposed monitoring measures:

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
    i. Numerator: Patients that have had at least one clinical contact this month
    ii. Denominator: Total number of patients enrolled during this month
    iii. **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
    i. Numerator: Patients whose most recent PHQ-9 is below 5
    ii. 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

   i. Numerator: Patients who have had their case reviewed by the Consulting Psychiatrist OR had a change documented in their treatment plan this month
   ii. 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.
   i. Numerator: Patients that received a PHQ-2 or 9 during this visit, or have been screened in the last year
   ii. 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
   i. Numerator: Patients that scored a 10 or higher on their initial PHQ-9
   ii. Denominator: All patients screened with a PHQ-9 during that month

MDH requires that CoCM Pilot Sites have a patient registry capable of capturing the data necessary to analyze the aforementioned measures. CoCM Pilot Sites must use an existing registry, use the template provided by MDH for reporting purposes, or procure a registry as part of infrastructure development in order to participate in the CoCM Pilot.

General Application

Instructions

Thank you for your interest in applying to the CoCM Pilot Program. MDH will select up to three sites at which the CoCM shall be established over a 4-year period.

To apply, the organization that will serve as a CoCM Pilot Site must complete, sign, and submit this application by the due date. Prior to completing this application, it is strongly suggested that applicants carefully review the documents that govern the CoCM Pilot Program, available on the MDH website (Please see the link in Appendix E: Additional Resources).

Please complete the CoCM Pilot Program application and return it to MDH.healthchoicerenewal@maryland.gov no later than **5 p.m. EST on May 22, 2019**. Incomplete or late applications will not be considered. In order for this application to be considered complete for the purposes of submission, all components of the application must be completed, and the application must be signed by an authorized representative of the Applicant Site.

Project Abstract

Please provide a written summary of the proposed Pilot Program. The summary should be no longer than one page.

Project Narrative

Within the sections below, make a written detailed statement about the capabilities of the CoCM Pilot Site and the proposed scope of the CoCM Pilot Program. Please title and organize the project narrative per the sections outlined below in this RFA.

1. Staffing

To participate in the CoCM Pilot Program, proper staffing is required. Please provide the contact information and resumes for the team members listed in this table. If additional staff members will be used, please add additional rows to the table. For more information, please see Appendix E: Additional Resources.

Role	Name	Degree/ licensure	NPI (Individual Provider and Group Practice) (if applicable)	Email address	Telephone Number
Program Lead (BH Care Manager or PCP may serve in this role)					
BH Care Manager					
PCP					
Psychiatric Consultant					
Billing & Data Lead(s) (optional)					

Please provide a brief description of the qualifications and experience of each staff member. Indicate whether any of the above mentioned staff have previous experience in delivering care through the CoCM and the training they have received.

The BH Care Manager should have training in one or more of the following psychotherapy interventions. Please indicate in which skills they have been trained:

- Behavioral Activation
- Problem Solving Therapy (PST)
- Cognitive Behavioral Therapy (CBT)
- Interpersonal Therapy (IPT)

To the extent that the above roles are not yet filled, please indicate the qualifications that will be used to select successful candidate(s) and training these individuals will be required to receive.

The CoCM requires CoCM Pilot Sites to refer participants with high needs (who fall outside of the scope of Collaborative Care) to specialty behavioral health services. Please describe your existing connections to the current behavioral health administrative service organization (ASO), Beacon Health Options, and other specialty behavioral health providers, as well as your ability to facilitate referrals and confirm that services delivered by the CoCM Pilot Site do not duplicate services delivered by the ASO.

2. Workflow

Please describe your workflow from both the patient's and providers' perspectives.

3. Required Components and Tasks

Please describe how each of the required components and tasks specified below will be met. MDH has identified the following components and tasks central to CoCM (for more information, see the Overview of Required Components and Tasks Section and Appendix E: Additional Resources):

- Staffing Model (addressed in Section 1)
- Patient Identification and Diagnosis
- Engagement in Integrated Care Team
- Evidence-based Treatment
- Systematic Follow-up, Treatment Adjustment, and Relapse Prevention
- Communication and Care Coordination
- Systematic Psychiatric Case Review and Consultation

4. Target Population

CoCM Pilot Sites may target individuals diagnosed with mild to moderate depression using the PHQ-9 screening tool or may specify a different target population with a behavioral health need (either substance use disorder or mental health).

Reimbursement through the CoCM Pilot Program is limited to the cost to provide services to Medicaid participants enrolled in a HealthChoice MCO. Please describe the population currently served by your practice. The response should address the following:

- Number of patients served at site annually;
- Number of Medicaid participants served by site annually;
- Number of Medicaid participants estimated to qualify for CoCM services; and
- Number of patients (non-Medicaid) receiving CoCM services through the practice already (if applicable).

MDH anticipates that one BH Care Manager can handle a caseload from 50 to 150 participants based on the complexity of the patient population. If your site has implemented Collaborative Care and/or you anticipate using one BH care manager to treat patients both in and outside of Medicaid, please describe the number of both Medicaid and non-Medicaid patients you anticipate your BH care manager will treat.

5. Geographic Area

Please describe the geographic area in which the CoCM Pilot Program will operate, including a list of ZIP codes, counties, or incorporated cities that the proposed CoCM will serve.

6. Data Reporting

The CoCM Pilot Site will be required to track certain measures and delivery of services on a monthly basis for quarterly submission to MDH. MDH's reporting template is included in Appendix F: Reporting Template. Data reporting will be required at the Medicaid beneficiary level.

MDH has proposed measures within the *Monitoring and Evaluation* section. CoCM Pilot Sites electing to target a behavioral health condition

other than depression must specify how they will assess and track Measures 4-10. MDH reserves the right to modify the measures that will be required from the CoCM Pilot Site prior to final approval of an application and upon approval of the §1115 waiver amendment by CMS.

Please affirm that you agree to participate in the collection of required monitoring and evaluation measures identified for the CoCM Pilot Program if selected.

Please indicate how the CoCM Pilot Site will provide the required monthly data to MDH. CoCM Pilot Sites may (1) use an existing patient registry that can capture the requisite data and produce a monthly data extract (specify file types available), (2) use the template provided in Appendix F: Reporting Template, or (3) procure a patient registry with infrastructure funding capable of producing a monthly data extract.

7. Data and Reporting Requirements as a Condition of Funding

As a funding requirement, the Applicant is required to make available program and financial data to MDH in the form, manner, and timeframes indicated in the final MOA and DUA, Moreover, pursuant to 42 CFR 431.107(a)(b)(1)(2), providers must agree to create and maintain all records necessary to fully disclose the extent and eligibility for services provided to individuals in the Medicaid program, as well as any information relating to payments billed by providers for furnishing CoCM Pilot Program services.[3]

Please affirm that the CoCM Pilot Site understands and is able to comply with these funding requirements.

8. Funding

Please outline how the CoCM Pilot Site anticipates using grant funds, addressing both Infrastructure Costs (if requested) and Service Delivery. In addition, please provide a detailed breakdown of cost in the attached Excel spreadsheet (see Appendix D: Budget Outline).

A. Infrastructure Costs

CoCM Pilot Sites interested in receiving infrastructure funding for these activities should describe their unique infrastructure needs, a plan and timeline for how these needs will be met using CoCM Pilot Program funding on or before June 30, 2020, and requested funding with justification for specific costs.

Although not required, CoCM Pilot Sites have the opportunity to apply for infrastructure funding. MDH will award up to $225,000 effective July 1, 2019 through June 30, 2020, across all CoCM Pilot Sites to support infrastructure development during FY 2020. Available funds will be allocated between the selected sites based on demonstrated need.

Types of expenditures for which infrastructure funding may be used include:

[3] Maryland Medicaid is prohibited from paying for any items or services furnished, ordered, or prescribed to excluded individuals or entities (General Provider Transmittal No. 73,). It is the responsibility of the awardee to attest monthly that all employees and contractors have been routinely searched, as per the aforementioned transmittal. The Grantee must be able to demonstrate, upon request, that this verification has been performed utilizing the following databases: www.exclusions.oig.hhs.gov;

- Development of a patient registry and/or integration of a patient registry into an electronic health record (EHR) system that includes the delivery of services; patient responses through routine use of the relevant screening tool; and ongoing performance improvement.
- Development of other monitoring, reporting, and billing tools required to implement CoCM;
- Training staff in order to implement; and other developments as needed by the CoCM Pilot Site; and
- Other infrastructure investments as defined by the CoCM Pilot Site.

Infrastructure funding is only available during the first year of the Pilot Program, FY 2020 (July 1, 2019 - June 30, 2020). Infrastructure funding will not be available in FY 2021, FY 2022, or FY 2023.

B. Service Delivery

Service delivery will be reimbursed according to the fee schedule below up to the CoCM Pilot Site's awarded Service Delivery Budget for the Fiscal Year. Direct reimbursement of staff salaries and related indirect costs are not eligible for reimbursement.

Please include the estimated number of Medicaid participants to be served for each fiscal year, estimated per person costs, and total costs for each fiscal year. MDH estimates that one full-time BH care manager can handle a caseload between 50 and 150 patients.

MDH has adopted the Medicare payment structure for the CoCM Pilot Program. The fee schedule is as follows:

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

9. Timeline

Please provide your anticipated timeline for implementation, including any necessary infrastructure improvements. MDH anticipates CoCM Pilot Program infrastructure funding to begin on July 1, 2019 and end on June 30, 2020. CoCM Pilot Sites may begin delivering services to patients on January 1, 2020.

10. Previous Experiences

Please describe any previous experience with Collaborative Care or other forms of behavioral health integration currently adopted at the proposed CoCM Pilot Site.

Appendix A. Application Requirements

A summary of required Application components for submission by CoCM Pilot Sites includes:

1. Project Abstract (no longer than one page)
2. Project Narrative (maximum 15 pages, 12 pt. font, single spaced, one (1) inch margins)
3. (Optional) Letters of support from relevant stakeholders*
4. Resumes of Key Personnel*
5. A signed and dated copy of Appendix C: Attestations and Certification*
6. Model Budget Narrative Excel Spreadsheet Appendix D: Budget Outline

** Not included in the CoCM application page limit requirement*

Appendix B. Application Selection Criteria

The Maryland HealthChoice §1115 Waiver CoCM Pilot application evaluation is a competitive process that will result in the selection of up to three qualified CoCM Pilot Sites based on the program need, quality and scope of their application. MDH will conduct the evaluation process in two phases: (1) Quality and Scope of Application and (2) Funding Decision. CoCM Pilot applications that do not meet the basic requirements of the MDH application guidance offered via this RFA will be disqualified.

Overview

Program Need, Quality and Scope of Application

CoCM Pilot applications will be assigned a numerical score of up to 100 points based on the site's need for CoCM Pilot services, and the quality and scope of the application. Applications must receive a pass score on all pass/fail criteria to be eligible to participate.

Funding Decision

The funding amount for each CoCM Pilot Site will be determined based upon the reasonableness of the funding request, the amount requested, and the methodology and justification used to develop the service costs.

There will be a review period after MDH receives applications that will allow MDH to ask clarifying questions to CoCM Pilot Applicants. CoCM Pilot Applicants' responses may influence their final score.

If the CoCM Pilot Applicant is currently out of compliance or delinquent on any MDH corrective action, the CoCM Pilot Applicant is not eligible for funding.

Applications Will Be Assigned a Numerical Score

Each application will be assigned a numerical score. Scores may range from 0 up to 100. Multiple MDH reviewers will score applications and then assign a total average score.

Applications must be received in the MDH.healthchoicerenewal@maryland.gov mailbox by May 22, 2019 at 5 PM EST.

Required Application Sections and Point Values

PROJECT ABSTRACT	**10 Points**
PROJECT NARRATIVE	**75 Points Overall**
1. Staffing	15 Points
2. Workflow	5 Points
3. Required Components and Tasks • Staffing Model (addressed in Section 1) • Patient Identification and Diagnosis • Engagement in Integrated Care Team • Evidence-based Treatment • Systematic Follow-up, Treatment Adjustment, and Relapse Prevention • Communication and Care Coordination • Systematic Psychiatric Case Review and Consultation	25 Points
4. Target Population	5 Points
5. Geographic Area	10 Points
6. Data Reporting 7. Data and Reporting Requirements as a Condition of Funding	5 Points
9. Timeline 10. Previous Experiences	10 Points
ADDITIONAL REQUIRED DOCUMENTATION	**15 Points Overall**
Letter(s) of Support	0 Points
Resumes of staff identified in Section 1, Staffing	0 Points, staff qualifications assessed above
Attestations and Certification (Appendix C)*	5 Points
Model Budget Narrative (Appendix D)**	10 Points

***Attestations and Certification - Pass/Fail**
Pass = Applicant checks box and provides signature
Fail = Applicant does not check one or more boxes and/or does not include a signature.

Applicant may not be selected as CoCM Pilot Site unless Appendix C receives a score of "Pass."

****Model Budget Narrative**

Applicant will not be considered if Appendix D is not attached or incomplete.

Appendix C. Attestations and Certifications

Attestation

I certify that, as the representative of the CoCM Pilot Site, I agree to the following conditions:

☐ I hereby certify that all information provided in this application is true and accurate to the best of my knowledge, and that this application has been completed based on a good faith understanding of CoCM Pilot Program participation requirements as specified in the Collaborative Care Pilot Program Request for Applications.

☐ I hereby certify that in the event the CoCM Pilot Site is selected to receive funding, that the CoCM Pilot Site will participate in the collection of all required monitoring and evaluation measures as determined by MDH or required by CMS.

I hereby certify that I will have processes in place necessary to track patient treatment and outcomes over time and capture other required data. In order to fulfill this obligation, I will (check at least one and all that apply):

☐ Use an existing patient registry
☐ Use the reporting template provided by MDH
☐ Procure a patient registry

Signature of Site Representative:	**Date:**

Appendix D: Budget Outline

Please see attached Excel Spreadsheet.

Appendix E: Additional Resources

Helpful Links

CMS Resources

- Behavioral Health Integration Services, Fact Sheet and Coding Summary: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
- Behavioral Health Integration Services, FAQs: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf

MDH Collaborative Care Website

- https://mmcp.health.maryland.gov/Pages/Collaborative-Care.aspx

University of Washington, AIMS Center—Select CoCM Resources

- BH Care Manager Description: http://aims.uw.edu/collaborative-care/team-structure/care-manager)
- The AIMS Center Integrated Care Team Building Tool: http://aims.uw.edu/resource-library/team-building-and-workflow-guide
- Cheat Sheet on Medicare Payments for Behavioral Health Resources: https://aims.uw.edu/sites/default/files/CMS_FinalRule_BHI_CheatSheet.pdf)
- Care Manager Caseload Guidelines: https://aims.uw.edu/sites/default/files/CareManager_CaseloadSize_Guidelines.pdf

Guidelines for Using the PHQ-9

Using the PHQ-9 for Initial Management

Score/ Symptom Level[4]	Treatment[5,6,7]
0-4 No Depression	• This score suggests the patient may not need depression treatment • Consider other diagnoses
5-9 Minimal Depression	• Consider other diagnoses • If diagnosis is depression, watchful waiting* is appropriate initial management • Provider uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
10-14 Mild Depression	• Consider watchful waiting • If active treatment is needed, medication or psychotherapy is equally effective • Provider uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
15-19 Moderate Depression	• Active treatment for depression is recommended, using medication, psychotherapy, and/or a combination of treatment
20-27 Severe Depression	• Warrants treatment for depression, using medication, psychotherapy, and/or a combination of treatment. • People with severe symptoms often benefit from consultation with a psychiatrist**

*Watchful waiting means:

- Provider is actively following a person with a PHQ-9 once a month, but not actively treating their depression.
- Patients on watchful waiting benefit from self-care activities.
- Patients with persistent symptoms after 2-3 months need active treatment.

**Formal referral to specialty behavioral health care is recommended for the following groups of patients:

- Those with persistent scores above 20, especially with any suicidal risk.
- Those who appear to have psychiatric co-morbidities such as panic disorder, PTSD or active substance abuse.
- Those for whom there is concern about possible bipolar disorder.
- Those with a history of psychiatric hospitalization.

Patients should be excluded if[8]:

[4] PHQ9 Copyright © Pfizer Inc. All rights reserved. Reproduced with permission. PRIME-MD ® is a trademark of Pfizer Inc.
[5] Adapted from University of Michigan: https://www.med.umich.edu/1info/FHP/practiceguides/depress/score.pdf
[6] Adapted from Maine Health: https://www.nhms.org/sites/default/files/Pdfs/PHQ9-Depression-Scale.pdf
[7] STABLE Resource Toolkit: https://www.integration.samhsa.gov/images/res/STABLE_toolkit.pdf
[8] Moore, M., Ali, S., Stuart, B., Leydon, G. M., Ovens, J., Goodall, C., & Kendrick, T. (2012). Depression management in primary care: an observational study of management changes related to PHQ-9 score for depression monitoring. *The British journal of general practice : the journal of the Royal College of General Practitioners*, *62*(599), e451-7.

- Examination of their medical records suggest a diagnosis of postnatal depression
- Scores on PHQ-9 fall below the cut-off point for mild depression (PHQ-9 score of <5)

Recommended Frequency of Administering the PHQ-9[3]:

- Monthly until remission or for first 6 months after diagnosis.
- At least quarterly while on active treatment.
- At least annually after that.

Suicidality:

Providers must always use the PHQ-9 Follow-up Questions (Attachment **) for patients scoring a 1-3 on question number nine. If a patient responds 'Yes' on items 3, 4, or 5 it should be reported to behavioral health staff before patient leaves the site so a decision can be made regarding actions to take[9].

Every site that practices integrated care needs to have a specific protocol in place in terms of what to do in a true emergency.

General suggestions[10]:

- Have someone watch the patient
- Call 911
- Take the patient to the emergency department for evaluation
- A protocol should also be in place in case the patient doesn't want to cooperate

Using the PHQ-9 to assess response to treatment – first 3 months[3]

PHQ-9 Change from last score, measured monthly	Treatment Response	Treatment Plan
Drop of 5 or more points each month	Good	**Medication and/or Psychotherapy:** No treatment change needed. BH Care Manager follow-up in 4 weeks.
Drop of 2-4 points each month	Fair	**Medication:** May warrant an increase in dose.
		Psychotherapy: Probably no treatment change needed. Share PHQ-9 with psychotherapist.
Drop of 1 point, no change or increase each month	Poor	**Medication:** Increase dose or augment or switch; informal or formal psychiatric consult; add psychotherapy.
		Psychotherapy: 1. If depression-specific psychotherapy (CBT, PST, IPT) discuss with supervising psychiatrist, consider adding antidepressant. 2. For patients satisfied in other psychotherapy consider adding antidepressant. 3. For patients dissatisfied in other psychotherapy, review treatment options and preferences.

[9] PHQ-9 Follow-up Questions for Patients Scoring 1-3 on Question #9: http://aims.uw.edu/sites/default/files/PHQ9FollowUpQuestions.pdf

[10] Suicidality: http://aims.uw.edu/collaborative-care/step-step-implementation-guide/step-2-plan-clinical-practice-change/suicidality

Using the PHQ-9 after the first 3 months[3]

PHQ-9	Treatment Response	Treatment Plan
Less than 5	Remission	Continue treatment for 6-12 months, then consider long term maintenance if appropriate
Lower than 50% of baseline score	Clinically significant improvement	Modify treatment to reach remission, as per 'Poor response' above.
Other than above	Persistent symptoms	As per 'Poor' above.

Appendix F: Reporting Template

Please see attached Excel Spreadsheet.