STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Dennis R. Schrader, Secretary

January 20, 2017

The Honorable Edward J. Kasemeyer
Chair
Senate Budget & Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh
Chair
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

Re:2016 Joint Chairmen's Report (p. 78) – Report on Collaborative Care Initiative

Dear Chairmen Kasemeyer and McIntosh:

In keeping with the requirements of the 2016 Joint Chairmen's Report (p. 78), enclosed is the Department of Health and Mental Hygiene's report on adopting the collaborative care model in Maryland's HealthChoice program. The report addresses (1) the extent of primary behavioral health services currently delivered by managed care organizations (MCOs); (2) Medicaid initiatives currently underway to connect participants to appropriate care; (3) the evidence-based practices used by MCOs to treat individuals with mild to moderate forms of depression and other common behavioral disorders; (4) the findings of several collaborative care studies, including two specifically targeting Medicaid participants in New York and Washington State; (5) a financial estimate to implement a collaborative care model throughout HealthChoice; and (6) the possibility of developing pilot collaborative care programs within HealthChoice.

Thank you for your consideration of this information. If you have questions or need more information on the subjects included in this report, please contact Webster Ye, Director of Governmental Affairs at (410) 767-6480.

Sincerely,

Dennis R. Schrader
Secretary

Enclosure

cc: Shannon McMahon
Tricia Roddy
Alyssa Brown
Susan Tucker
Rosemary Murphey
Webster Ye

Opportunities to Adopt the Collaborative Care Model in the HealthChoice Program

Submitted by the Department of Health and Mental Hygiene
December 15, 2016

2016 Joint Chairmen's Report
Page 78

Executive Summary

The Maryland Department of Health and Mental Hygiene (the Department) was requested as part of the 2016 Joint Chairmen's Report (JCR), p. 78, to submit a report regarding the opportunities to adopt a collaborative care model in the Medicaid program. 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.[1] Proponents of the model suggest that merging behavioral health with primary care normalizes and de-stigmatizes treatment for behavioral health disorders. This in turn encourages patients to seek access to the evidence-based mental health services available in their regular primary care clinics.[2]

This report addresses (1) the extent of primary behavioral health services currently delivered by managed care organizations (MCOs); (2) Medicaid initiatives currently underway to connect participants to appropriate care; (3) the evidence-based practices used by MCOs to treat individuals with mild to moderate forms of depression and other common behavioral disorders; (4) the findings of several collaborative care studies, including two specifically targeting Medicaid participants in New York and Washington State; (5) a financial estimate to implement a collaborative care model throughout HealthChoice; and (6) the possibility of developing pilot collaborative care programs within HealthChoice.

Implementation of the collaborative care model in HealthChoice would require a substantial budget initiative. The Department estimates that implementing the model on a statewide basis across the HealthChoice program would cost between $9 million to $60.5 million Total Funds. Given the potential for the collaborative care model to control costs, improve access and clinical outcomes, and increase patient satisfaction, the Department is interested in exploring its adoption on a limited basis for a one-year pilot with a select MCO or a subset of providers. However, in light of the challenging budgetary environment, a pilot may not be feasible in fiscal year 2018.

[1] Unützer, Jürgen. The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes. Health Home Information Resource Center, May 2013. http://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf.

[2] Dissemination of Integrated Care within Adult Primary Care Settings: The Collaborative Care Model. American Psychiatric Association and Academy of Psychosomatic Medicine, 2016. https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/APA-APM-Dissemination-Integrated-Care-Report.pdf.

I. Introduction

Pursuant to page 78 of the 2016 Joint Chairmen's Report (JCR), the Department respectfully submits this report regarding the opportunities to adopt a collaborative care model in the Medicaid Program. Specifically, the JCR requires the Department to detail (1) the extent of primary behavioral health services currently delivered by managed care organizations (MCOs); (2) the evidence-based practices including the collaborative care model, or other clinical models that are used by MCOs to treat individuals with mild to moderate forms of depression and other common behavioral disorders and associated outcome data from these practices or models; (3) a financial estimate to implement a collaborative care model throughout HealthChoice including any projected cost savings; and (4) the possibility of developing pilot collaborative care programs within HealthChoice.

II. Delivery of Primary Behavioral Health Services by the MCOs

HealthChoice—Maryland's statewide mandatory Medicaid managed care program—was implemented in 1997 under authority of Section 1115 of the Social Security Act. As of September 2016, 1,308,971 Marylanders are enrolled in Medicaid. Nearly 85 percent of the state's Medicaid population is enrolled in the HealthChoice program. Participants in the HealthChoice program include children enrolled in the Maryland Children's Health Program (MCHP), Maryland's Children's Health Insurance Program (CHIP). HealthChoice participants choose one of the eight participating managed care organizations (MCOs) and a primary care provider (PCP) from their MCO's network to oversee their medical care.

Though the Federal Government requires every state Medicaid program to cover a specific set of services, states have some flexibility to design their own benefit packages. Generally, services must be equal in amount, duration, and scope for all participants based on medical necessity criteria—in addition to being available across the state. Maryland has incorporated a wide array of mental health (MH) and substance use disorder (SUD) services into its Medicaid programs.

The following MH services are covered under the Maryland Medicaid Program:

- Inpatient care in psychiatric units of acute general hospitals for all ages;
- Inpatient psychiatric services for individuals under 21 years old in free-standing Institutions for Mental Diseases (IMDs);
- Individual MH assessment;
- Individual therapy;
- Group therapy;
- MH targeted case management;
- Family psychotherapy and psychoeducation;
- Psychiatric rehabilitation;
- Psychological testing;
- Assertive community treatment;
- Mobile treatment;

- Intensive outpatient program services;
- Partial hospitalization; and
- Laboratory services.

The following substance use services are covered under the Maryland Medicaid Program:

- Inpatient detoxification in acute general hospitals for individuals of all ages;
- Inpatient detoxification and SUD treatment services for individuals under 21 years old in free-standing Institutions for Mental Diseases (IMDs) - which in Maryland are licensed as Intermediate Care Facilities for Addictions;
- Alcohol and/or drug assessment;
- Individual therapy;
- Group therapy;
- Intensive outpatient program services;
- Partial hospitalization;
- Ambulatory detoxification;
- Opioid maintenance therapy for individuals 18 and over; and
- Laboratory services.

Non-Medicaid reimbursable behavioral health services are also available to qualifying individuals. These services include among other things, supported employment, respite care, crisis services, peer support, recovery services, and residential rehabilitation programs.

Specialty MH services have always been carved out of the HealthChoice MCO benefits package and overseen by an Administrative Services Organization (ASO). Following significant public input over four years, the Department expanded this model to serve as the hub for the provision of both specialty MH and SUD services in Maryland. All services administered by the ASO are provided on a fee-for-service basis. Since many individuals with behavioral health conditions access both MH and SUD services, this change was purportedly made to improve service integration, allow for closer coordination of care, and establish a single entity for managing the behavioral health provider network and single point of entry for authorizations, claims submissions and payment.

Beacon Health Options (formerly ValueOptions Maryland) was selected as the ASO. On January 1, 2015, the ASO launched the process to integrate substance use treatment and specialty MH services into one comprehensive system that includes authorization, claims processing, reimbursement through the State bank account, provider training, and referral services for individuals seeking behavioral health care. Primary behavioral health services are still provided through the MCOs as primary health care may often be the first point of contact for individuals who also need behavioral health services. If more than primary behavioral services are needed, for example if a participant has a serious behavioral health problem such as major depression, anxiety, opioid maintenance therapy, or even diagnosis with schizophrenia, the participant will be referred to the ASO for assistance in locating a specialty MH or substance use provider.

Table 1 shows the number of individuals with a behavioral health diagnosis in HealthChoice. Overall, there were 196,655 individuals with a behavioral health diagnosis in HealthChoice in calendar year (CY) 2015, or approximately 15% of the HealthChoice population.

Table 1: Individuals in HealthChoice with a Behavioral Health Diagnosis by Region, CY15

	MH Only		SUD Only		Both MH and SUD		Neither MD or SUD	
	#	%	#	%	#	%	#	%
Baltimore City	28,384	26.9%	10,746	29.6%	15,780	28.8%	192,565	17.3%
Baltimore Suburban	31,214	29.6%	11,242	31.0%	16,561	30.2%	313,364	28.2%
Eastern Shore	12,166	11.5%	4,501	12.4%	5,939	10.8%	98,158	8.8%
Southern Maryland	4,679	4.4%	1,883	5.2%	2,764	5.0%	56,672	5.1%
Washington Suburban	18,566	17.6%	4,281	11.8%	7,391	13.5%	366,452	32.9%
Western Maryland	10,413	9.9%	3,571	9.8%	6,287	11.5%	84,062	7.6%
Out of State	159	0.2%	47	0.1%	81	0.1%	1,400	0.1%
Total	**105,581**	**100.0%**	**36,271**	**100.0%**	**54,803**	**100.0%**	**1,112,673**	**100.0%**

As shown in Figure 1, the number of HealthChoice participants with a behavioral health diagnosis has increased from 133,233 participants (14%) in 2013 to 196,655 participants (15%) in 2015. Much of this increase can be attributed to the Medicaid expansion under the Affordable Care Act (ACA). The ACA expanded Medicaid to childless adults ages 19-64 with incomes up to 138 percent of the Federal Poverty Level (FPL); in addition, the ACA raised the parent income limits to 138 percent FPL as well. By December 2014, more than 240,000 participants had enrolled in Medicaid through the expansion coverage group. This expansion likely contributed to the increase in behavioral diagnoses from 2013 to 2014 (133,233 to 188,580 participants). Specifically, adults that had been in the Primary Adult Care program (PAC) made up the largest percentage of ACA Medicaid expansion adults with a behavioral health diagnosis.[3] From 2014 to 2015, while the number of participants with a behavioral diagnosis increased, the percentage of the total HealthChoice population remained consistent (15% for both years).

[3] The PAC program offered limited health services, including outpatient specialty MH services, SUD services, and pharmacy benefits, to childless adults with income up to 116% FPL who were not otherwise eligible for Medicaid or Medicare.

Figure 1: Percentage of HealthChoice Participants with a Behavioral Health Diagnosis, CY13-CY15

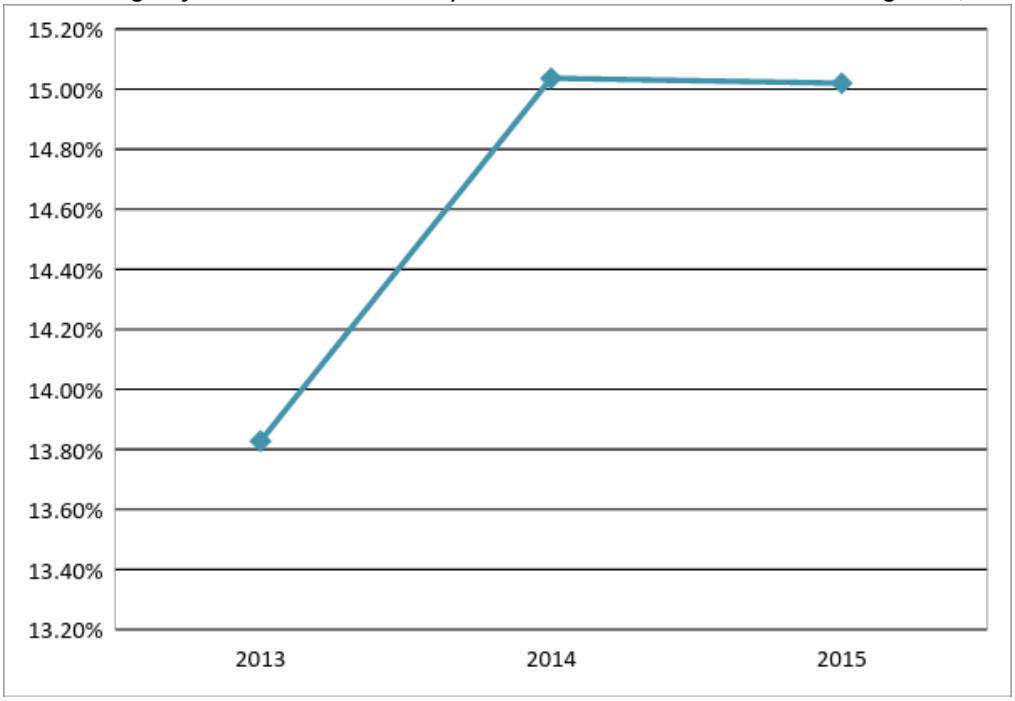


Table 2 shows the number of participants in HealthChoice with services billed to an MCO. Approximately 115,000 participants had a behavioral health MCO encounter. The three MCOs with the highest number of encounters in CY 2015 were Priority Partners, Maryland Physicians Care, and Amerigroup.

Table 2: Individuals in HealthChoice with Behavioral Health Services Billed to MCO, CY 2015

CY 2015		
MCO	**Number of Participants with an MCO Behavioral Health MCO Encounter**	**Percentage**
Maryland Physicians Care	24,108	21.0%
Kaiser Permanente	1,607	1.4%
Riverside	3,307	2.9%
Amerigroup	23,245	20.2%
JAI Medical Systems	3,963	3.4%
United Healthcare	23,083	20.1%
MedStar	6,641	5.8%
Priority Partners	28,951	25.2%
Total	**114,905**	**100%**

III. Medicaid Initiatives to Connect Participants to Appropriate Care

The Department is engaged in a variety of initiatives designed to connect Medicaid participants to necessary and appropriate health care. Two efforts underway focus specifically on participants with behavioral health needs—encouraging the adoption of Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services by PCPs and the Chronic Health Homes program.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services

Screening, Brief Intervention, and Referral to Treatment, or SBIRT, is a public health method for delivering early population screening, intervention, and treatment service for those at risk of developing SUDs. Providers using SBIRT ask patients about substance use during a routine exam, advise their patients, and refer them to SUD treatment if appropriate.

Efforts to increase the adoption of SBIRT on a statewide basis by leveraging several grant funding streams are ongoing.[4] The goals of the Maryland SBIRT initiative include—

1) improving the health status of Marylanders through the integration of behavioral health and medical health care services,
2) increasing identification of and intervention with individuals exhibiting risky substance use,
3) demonstrating reduced substance use among individuals who receive SBIRT services,
4) reducing overdose deaths and promoting health equality through the provision of universal behavioral health prevention and early intervention approaches, and
5) demonstrating increased capacity to treat SUDs in underserved regions of Maryland.

Most recently, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded a $9.8 million, five year grant to Maryland in 2014 to implement SBIRT services. The project provides training to health care providers, SBIRT screening tools, and assistance in adapting electronic health records to incorporate SBIRT screening tools and service documents. Over the course of the five year grant, SBIRT will be implemented in approximately 34 community health centers and seven hospitals in 11 Maryland jurisdictions and is projected to reach more than 300,000 individuals. The selected jurisdictions have the highest rates of intoxication deaths, drug-induced deaths, drug arrests, drug- and alcohol-related car crashes, and numbers of persons treated for drug and alcohol disorders.

In tandem with these statewide efforts, the Medicaid Program introduced new guidance on the provision of SBIRT to encourage Medicaid providers to incorporate screening into their practices.[5] The guidance, issued in July 2016, included clarifications on the provider types eligible to deliver

[4] For additional information, see http://www.marylandsbirt.org/about/initiatives/.

[5] Beacon Health Options Transmittal No. 6. Maryland Department of Health and Mental Hygiene, June 8, 2016. http://maryland.beaconhealthoptions.com/provider/alerts/2016/PT-44-16.pdf.

and be reimbursed for SBIRT services. The Department reimburses eligible providers for one screening and up to four interventions per participant age 12 and older annually.

Preliminary analyses of Medicaid SBIRT data have been positive; 3,493 Medicaid enrollees received SBIRT services from September 2015 through August 2016.[6] Table 3 shows that among SBIRT recipients, 13 percent accepted referrals and attended specialty SUD treatment and 18 percent entered into behavioral health services. Note that SBIRT usually will not identify pathology that warrants referral in all cases because SUDs (excluding tobacco addiction) only affect 12-14 percent of the Medicaid population.[7]

Table 3: Behavioral Health (BH) Service Utilization after First SBIRT for Those with ≥1 Month Medicaid Enrollment (N=3,480)

Group	N (%)
Enrollees with carved-out SUD service	446 (13%)
Enrollees with any carved-out BH service	621 (18%)

Table 4 narrows the sample to those with *no history of Medicaid SUD treatment* in the period before SBIRT, the aim here being to isolate those who might be incident (i.e., new) cases of SUD. This subsample showed lower rates of referral from SBIRT compared to the full sample represented in Table 1.

Table 4: Among Those with No SUD Services before First SBIRT (N=2950)

Group	N (%)
Enrollees with carved-out SUD service	178 (6%)
Enrollees with any carved-out BH service	300 (10%)

Finally, Table 5 narrows the sample again by reviewing data only on those with *no history of Medicaid behavioral health treatment* in the period before SBIRT in order to isolate those who are new to the Medicaid behavioral health system. This subsample showed the lowest rates of referral from SBIRT compared to all the other tables.

[6] Please note that the analysis was performed using data available through August 2016. MMIS2 data are not considered complete until 12 months have passed for submission of fee-for-service (FFS) claims and six months for submission of managed care organization (MCO) encounters. Therefore, utilization data should be considered preliminary and can be revised in future reports.

[7] Adelmann, P.K. (2003). Mental and substance use disorders among Medicaid recipients: Prevalence estimates from two national surveys. Administrative Policy in Mental Health and Mental Health Research Services, 31(2), 111-129.

Table 5: Among Those with No BH Claims before First SBIRT (N=2746)

Group	N (%)
Enrollees with carved-out SUD service	137 (5%)
Enrollees with any carved-out BH service	161 (6%)

As providers' awareness regarding the value of implementing of SBIRT as common practice continues to grow, the Department anticipates utilization will increase and more individuals may be referred to treatment.

Chronic Health Home Program

The ACA created the option for state Medicaid programs to establish Health Homes.[8] In response, the Department began the Chronic Health Home Initiative in October 2013 as a five-year demonstration. Chronic Health Homes are intended to improve health outcomes for individuals with chronic conditions by providing patients with an enhanced level of care management and care coordination while also reducing costs. Health Homes provide an integrated model of care that coordinates primary, acute, behavioral health, and long-term services and supports for Medicaid participants who have: two or more chronic conditions, one chronic condition and a risk for developing a second chronic condition, or a serious and persistent mental illness (SPMI).

The Maryland Chronic Health Homes program endeavors to integrate somatic and behavioral health services, with the aim of improving health outcomes and reducing avoidable hospital utilization. The program targets populations with behavioral health needs who are at high risk for additional chronic conditions, offering them enhanced care coordination and support services from providers from whom they regularly receive care. The program is focused on Medicaid participants with a SPMI; an opioid addiction or substance use disorder and risk of additional chronic conditions due to tobacco, alcohol, or other non-opioid substance use; and children with serious emotional disturbance (SED). In the Chronic Health Home, the center of a patient's care is in a mobile treatment service (MTS), psychiatric rehabilitation program (PRP), or opioid treatment program (OTP). This service delivery method is intended to include nurses and somatic care consultants into these programs and to ensure individuals in MTSs, PRPs, and OTPs receive improved somatic care.

Chronic Health Home providers are eligible for a $100.85 monthly rate per participant for each month in which an enrollee receives at least two qualified health home services. Health home services include care coordination, care management, health promotion, and referrals to community and social support services. The State received a 90% enhanced Federal Medical Assistance Percentage (FMAP) for the provision of health home services during the first eight quarters of the program. As of September 2016, payments to Health Home providers total approximately $10,187,159. Since the inception of the program, more than 7,000 participants have received services from more than 80 Health Home providers across the state of Maryland.

[8] ACA § 2703(a) (42 USC § 1396w-4(a)).

Evaluation of the Chronic Health Home Program is ongoing and the Department submitted an initial report to the General Assembly in December 2015.[9] The results of this preliminary analysis suggest that Health Home participants had a strong demand for the Health Home social services, such as care coordination and health promotion. When comparing the study group and a comparison group of Medicaid participants with similar characteristics, preliminary results are mixed in the overall trends for the health care utilization and outcomes measures for each group. For example, the Health Home study group had larger increases in rates of ambulatory care between CY 2013 and CY 2014 than the comparison group. Additionally, although the comparison group's overall utilization of services was often higher than that of the study group, the comparison group experienced more decreases in inpatient stays, ED visits, 30-day all-cause hospital readmissions, and avoidable ED visits. Finally, despite a higher overall rate of inpatient admissions, the average length of stay for those hospitalized was lower for the study group than the comparison group in both years. Evaluation of the second year of the program is underway and will be complete in early 2017.

IV. Practices and Models Used by MCOs to Treat Participants with Common Behavioral Health Disorders

Effective January 1, 2015, all specialty MH and SUD services for Medicaid participants are administered by Beacon Health Options. However, MCOs still play a critical role in ensuring participants receive the behavioral health care they need. The Department administered a survey to the MCOs in October 2016 to better understand what processes were undertaken to provide care for participants with behavioral health diagnoses and how providers communicated with each other about those participants with co-occurring health concerns.

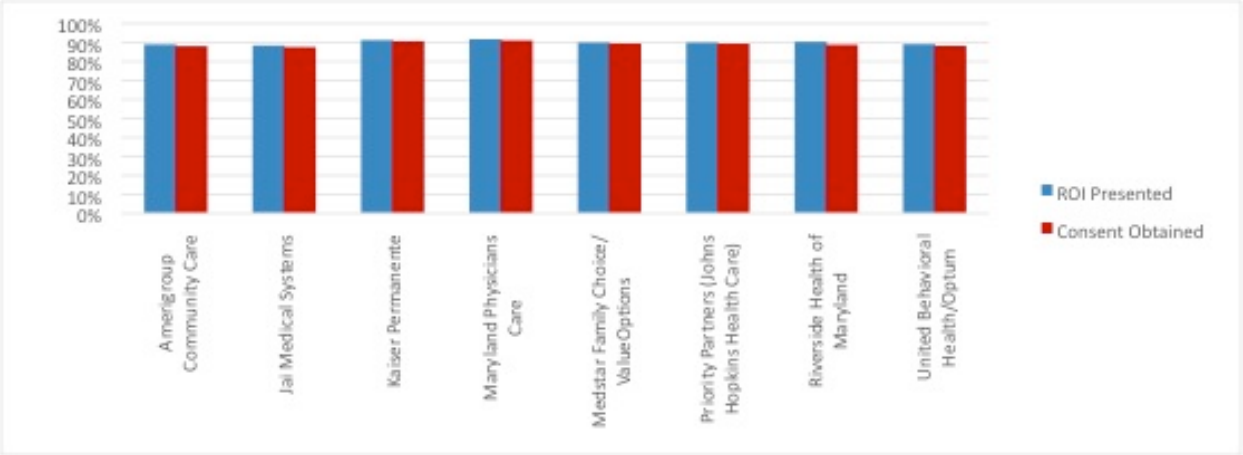
Survey responses highlighted how the MCOs work with Beacon to identify participants and provide clinically meaningful and appropriate care. Many MCOs use their internal data to identify at-risk participants as well as health risk assessments to determine whether participants' behavioral health needs are being met. The MCOs also have case workers or case managers working with their participants with behavioral health needs in varying capacities. Some of the MCOs assign social workers or special needs coordinators to ensure participant's needs are being met, and coordinate patient referrals to Beacon. Others utilize them to reach out to participants who have fallen out of care. Participants with more acute needs are referred to Beacon. Beacon employs a nurse case manager who works with the MCOs for high-risk cases (such as pregnant women) that require coordination between providers and agencies. The nurse case manager holds conference calls and meetings with MCOs as needed.

[9] For more information, please see the *2015 Joint Chairmen's Report (p. 88): Report on Health Homes*, https://mmcp.dhmh.maryland.gov/SiteAssets/SitePages/Health%20Home%20Program%20Evaluation%20and%20Outcomes/2015%20Joint%20Chairmens%20Report-%20Report%20on%20Patient%20Outcomes%20for%20Participants%20in%20Health%20Homes.pdf.

At least two MCOs have developed relationships with primary care sites that have embedded behavioral health providers enabling them to address both behavioral health and somatic care more easily. Enrollees with significant co-occurring care needs are referred to these sites. Finally, one MCO is engaged in a pilot program to test the impact of embedding behavioral health and SUD recovery counselors and supporting psychiatrists into PCP offices to improve the detection, diagnosis and treatment of behavioral health conditions. Inclusion of these provider types is meant to relieve PCPs of their roles as de facto MH providers by targeting participants with complaints like headaches, nausea and unexplained pains often unrecognized as symptoms of underlying behavioral health conditions. Results of the pilot, which may conclude at the end of 2016, are not yet available.

The MCOs identified several challenges with the current behavioral health system. As the provision of SUD services has transitioned to the ASO, some MCOs report that their providers remain confused or unclear regarding which services are provided through Beacon. Concerns regarding restrictions on data sharing tied to the disclosure of SUD treatment and prevention records remain. Disclosure of these records is subject to the restrictive and stringent standard of 42 C.F.R. Part 2 ("Part 2"). Notably, Part 2 prohibits the disclosure of protected health information (PHI) absent specific authorization from the patient. Express patient consent is required before records can be disclosed, subject to a few limited exceptions, and patient records cannot be re-disclosed to third parties. These restrictions exist whether the services are covered under the MCO or carved out. The Department has implemented a process to obtain individual Release of Information (ROI) forms from Medicaid participants accessing SUD services and secure their consent to share data with the MCOs.[10] As shown in Table 6, efforts to obtain consents to share this information have largely been successful—since the implementation of behavioral health integration, 88%-91% of enrollees in each MCO have consented to sharing their information.

Table 6: Counts of member ROI dispositions by MCO, cumulative through September 2016



[10] Additional information regarding this process can be found in the 2015 report to the General Assembly, "Improving the Exchange and Coordination of Care for Medicaid-Eligible Individuals Accessing Specialty Behavioral Health Services", https://mmcp.dhmh.maryland.gov/Documents/JCRs/datasharingJCRfinal11-15.pdf.

Although some MCOs expressed concerns about how long it takes them to get information from Beacon, it should be noted that data feeds containing pre-authorizations and claims information from Beacon and pharmacy data are provided to the MCOs on a weekly basis.

V. Collaborative Care Model

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.[11] Proponents of the model suggest that merging behavioral health with primary care normalizes and de-stigmatizes treatment for behavioral health disorders. This in turn encourages patients to seek access to the evidence-based MH services available in their regular primary care clinics.[12]

Although there can be variations to the collaborative care model, all iterations share four essential elements. The provision of care must be: (1) team-driven, (2) population-focused, (3) measurement-guided, and (4) evidence-based. In practice, this means that a collaborative care model must be a joint effort of medical professionals led by a PCP that achieves concrete treatment goals for a defined population of patients by utilizing a combination of patient reported outcome measures and scientifically proven methods. Because the collaborative care model 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 collaborative care model incorporates a team of three providers: (1) a PCP, (2) a care manager (CM), and (3) a psychiatric consultant. In Maryland's Medicaid program, a physician, nurse practitioner, nurse midwife, or physician assistant may serve as a PCP. In most models, the CM is typically a nurse, clinical social worker, or psychologist that is trained to provide coordination and intervention. Together, the CM and the PCP form the primary care team. The psychiatric consultant is typically either a licensed psychiatrist or psychiatric nurse practitioner.

Although workflows vary in different collaborative care models, individuals typically begin receiving services after a positive screening performed by their PCP. In many cases, individuals are screened using the Patient Health Questionnaire (PHQ-9), a clinical tool used to measure depression severity.

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[11] Unützer, Jürgen. The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes. Health Home Information Resource Center, May 2013. http://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf.

[12] Dissemination of Integrated Care within Adult Primary Care Settings: The Collaborative Care Model. American Psychiatric Association and Academy of Psychosomatic Medicine, 2016. https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/APA-APM-Dissemination-Integrated-Care-Report.pdf.

The PCP's main role within the model is to provide primary care services, coordinate care, and help a patient access a range of health care services. Soon thereafter, the individual is introduced to the CM, who works closely with the PCP. The CM 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 individual to reach in the future. Once the treatment plan is implemented, the individual'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 ("stepped up"). 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.[13]

Expected 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 collaborative care model stood out as having the strongest results.

The collaborative care model has been tested in more than 80 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.[14] 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 overall health care costs by up to 50-100 percent.[15] Effective treatment of depression through the collaborative care model thus has the potential to reduce a patient's overall health care costs.

[13] There has been no noticeable drop-off in the success of the collaborative care model based on the consultation method.

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

[15] 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.

The IMPACT Treatment Program

The Improving Mood–Promoting Access to Collaborative Treatment (IMPACT) Program was the largest randomized trial of collaborative care to date.[16] The study consisted of 1,801 adults aged 60 years and older who had been diagnosed with depression (17%), dysthymic disorder (persistent depressive disorder) (30%), or both (53%).[17] On average, study participants were also diagnosed with 3.5 additional chronic medical disorders. Eighteen clinics in five states participated in the study, including health maintenance organizations (HMO), an Independent Provider Association (IPA), an inner-city public health clinic, and two Veteran's Administration clinics. Payment methods involved fee-for-service and capitated Medicare and Medicaid.

Study participants were randomly assigned to either IMPACT treatment or to usual care. Usual care patients were permitted to use any primary care or specialty MH services available to them. In contrast, IMPACT patients had access for up to 12 months to a depression care manager (DCM), who was supervised by a primary care physician and a consulting psychiatrist. After 12 months, all study participants continued with their regular PCP as usual.

The IMPACT program followed a stepped care design. A personalized treatment plan was created for each patient, systematic outcomes were tracked using the PHQ-9, and treatments were adjusted ("stepped") based on clinical outcomes and evidence-based algorithms. The IMPACT program also required the development of a patient population registry called the Care Management Tracking System (CMTS). Providers used CMTS to track and measure patient goals and clinical outcomes and facilitate treatment adjustment if a patient was not improving as expected.

In the IMPACT program, there were three providers involved in patient care: (1) a PCP, (2) a CM (either a nurse or psychologist), and (3) a consulting psychiatrist. Patients received a 20-minute educational videotape and a booklet about depression, and were encouraged to have an initial visit with a CM at the primary care clinic. At this visit, the CM conducted a clinical and psychosocial history, reviewed the educational materials with the patient, and discussed patient preferences for depression treatment (medication or psychotherapy). New cases and cases needing treatment plan adjustments were discussed with the PCP and consulting psychiatrist during a weekly team meeting. Afterwards, the CM worked with the patient and his/her regular PCP to establish a treatment plan according to a recommended treatment algorithm, but patients and their PCPs made the actual treatment choices. The treatment plans ranged from antidepressant medication to six to eight sessions of psychotherapy for depression, delivered by the CM in the primary care setting. For those who were already taking medication but were still depressed, the

[16] IMPACT: Improving Mood – Promoting Access to Collaborative Treatment for Late-Life Depression. John A. Hartford Foundation, California Heal Care Foundation, Robert Wood Johnson Foundation, and Hogg Foundation. http://aims.uw.edu/sites/default/files/IMPACTstudyoutcomeslides.pdf.

[17] Unützer, Jürgen; Katon, Wayne; Callahan, Christopher; et al. "Collaborative Care Management of Late-Life Depression in the Primary Care Setting, A Randomized Controlled Trial." JAMA. 2002;288(22):2836-2845. http://jamanetwork.com/journals/jama/fullarticle/195599.

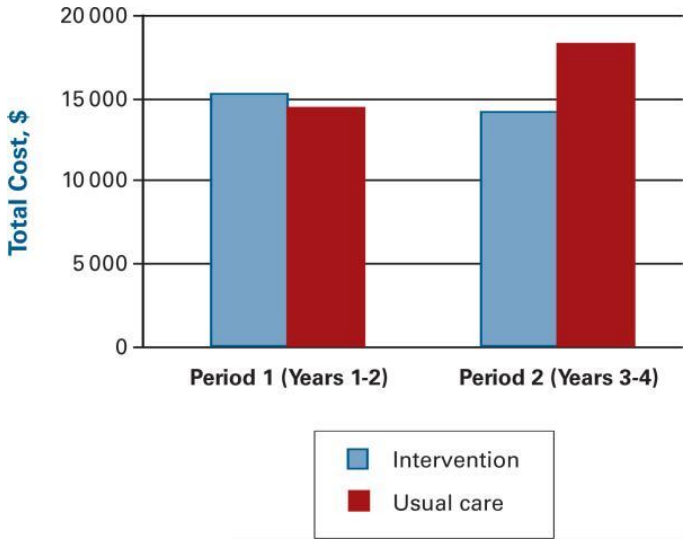
recommendation was to increase the dose or to augment the medication with a trial of psychotherapy.

CMs followed up with patients for up to 12 months and tracked their progress with the PHQ-9 and CMTS. During the acute treatment phase, in-person or telephone follow-up contacts were suggested at least every other week. Patients who achieved recovery from depression were engaged in developing a relapse prevention plan and then followed up with monthly visits by the CM. Patients who did not respond to initial treatment were discussed by the whole IMPACT team and an augmented, stepped plan was developed. The consulting psychiatrist was encouraged to see patients who presented diagnostic challenges or who had persistent depression for in-person consultations in the primary care setting. Patients who did not respond after 10 weeks of the stepped treatment were again reviewed by the team, and additional treatments were considered.

At 12 months, 45 percent of patients who received IMPACT treatment had a 50 percent or greater reduction in depressive symptoms from baseline, compared with 19 percent of usual care participants. IMPACT patients also received higher rates of depression treatment and experienced more satisfaction with depression care, lower depression severity, less functional impairment, and greater quality of life than participants assigned to the usual care group. These results persisted a year after individuals had left the program.

The mean cost of providing IMPACT services was $522 per IMPACT patient for a 12 month period, or $43.05 per member per month (PMPM). These costs include $7 for the educational brochure and videotape, $418 for CM services, $70 for supervision and in-person consultations with team psychiatrists, and $58 for supervision of CMs by PCPs. All visits with CMs and team psychiatrists were provided free of charge to the patient. Patients and their insurers were responsible for all other health care costs, including medication. As shown in Table 7, although IMPACT patients incurred slightly higher total healthcare costs than usual care patients in years one and two, when participants were tracked for four years, IMPACT patients averaged significantly lower total costs, with IMPACT patients reporting lower health care costs in each cost category observed.

Table 7. Comparison of Total Health Care Costs among IMPACT and Usual Care Patients.[18]



Although the IMPACT study did not target only Medicaid-eligible participants, the clinical outcomes were consistent across socioeconomic factors, despite the wide variance in household income ($8,400 to $40,000 per year) and high school education (32% to 93%).

The DIAMOND Initiative

The Depression Improvement Across Minnesota, Offering a New Direction (DIAMOND) Initiative was an attempt to implement the IMPACT program model on a statewide basis.[19] Seventy-five primary care clinics cared for over 12,000 adult participants (18 years and older) who had been diagnosed with depression or dysthymia.[20] One third of the patient population consisted of Medicaid or Medicare beneficiaries.[21] The initiative was led by the Institute for Clinical Systems Improvement (ICSI), a regional quality improvement collaborative. Clinics that wished to participate in DIAMOND were required to complete a six-month training program and implementation certification by ICSI before they were permitted to receive the monthly bundled payments for collaborative care services. A single billing code for DIAMOND services was established and covered CM services, along with weekly consultation and case review by the psychiatrist. Payment amounts

[18] Ibid.
[19] DIAMOND Study Findings. Institute for Clinical Systems Improvement, June 2014. https://www.icsi.org/_asset/nn70fc/ICSI-DIAMOND-Study-Finding-6-4-14.pdf.
[20] Solberg, Leif I., et al. The DIAMOND initiative: implementing collaborative care for depression in 75 primary care clinics. Implementation Science 2013. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3842646/pdf/1748-5908-8-135.pdf.
[21] Solberg, Leif I., et al. A Stepped-Wedge Evaluation of an Initiative to Spread the Collaborative Care Model for Depression in Primary Care. Annals of Family Medicine, September 2015. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4569448/.

and arrangements varied by individual payer contracts with participating clinics, usually in a monthly bundled fee. Implementation was staggered, with groups of clinics starting up every six months, from March 2008 to March 2010.

The DIAMOND design was modeled after the IMPACT Program and had seven main components:

> (1) consistent use of a standardized tool (PHQ-9) for assessing and monitoring depression's severity,
> (2) systematic patient follow-up tracking and monitoring with a registry,
> (3) treatment intensification for patients who did not improve,
> (4) relapse prevention planning for those who go into remission,
> (5) an on-site CM to educate, monitor, and coordinate care for patients in collaboration with the primary care physician,
> (6) scheduled weekly psychiatric caseload review with the CM in order to provide change recommendations to the PCP for those not improving, and
> (7) monthly descriptive data submissions.[22]

There were three providers involved in the provision of patient care: (1) a PCP, (2) a CM, and (3) a consulting psychiatrist. The CM was typically a nurse, social worker, psychologist, or certified medical assistant who scheduled regular face-to-face or phone contacts with each patient. During these contacts, the CM educated patients about MH and the necessity for self-management, administered the PHQ-9, managed the registry, monitored progress, served as the liaison between the PCP and the consulting psychiatrist, and worked with improved patients to prevent relapse. Each clinic also had a consulting psychiatrist who was responsible for reviewing the CM's caseload on a weekly basis and for advising the CM and PCP regarding changes in treatment for patients who are not improving. These changes included medication adjustments or referrals to other MH resources. The PCP and the patient relied on the recommendations from the CM and consulting psychiatrist to make the final decision about the patient's treatment plan.

At the conclusion of the study, participating DIAMOND clinics collectively reported that 30 percent of their patients achieved remission and 40 percent achieved a response (defined as a drop-off of at least 50 percent in initial PHQ-9 score) within six months of initial assessment.[23] After one year, remission and response rates were at 53 percent and 70 percent, respectively.[24] However, another study comparing the impact of DIAMOND care to usual care found that response and remission rates were not statistically different after six months.[25] Moreover, DIAMOND patients did not have

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[22] Solberg, Leif I., et al. The DIAMOND initiative: implementing collaborative care for depression in 75 primary care clinics.
[23] ICSI, The DIAMOND Program Success in Primary Care Depression Treatment And Extension to Other Health Care Challenges, 2013. https://www.icsi.org/_asset/mlvnhh/DIAMOND-White-Paper-2013.pdf
[24] Ibid.
[25] Solberg, Leif I., et al. A Stepped-Wedge Evaluation.

a more marked improvement in work productivity or health status compared to usual care patients.[26]

COMPASS (Care of Mental, Physical, and Substance Use Syndromes)

Care of Mental, Physical and Substance Use Syndromes, or COMPASS, is a collaborative care study targeting patients with depression and diabetes or cardiovascular disease. Funded by the Centers for Medicare and Medicaid Services (CMS), the program reached approximately 4,000 Medicaid and Medicare patients in seven states.[27] Adults over age 18 with diabetes/cardiovascular disease and depression were eligible to participate; special prioritization was given to those with recent hospitalizations and those with Medicare or Medicaid. ICSI ran the initiative from 2012 through 2015.

The primary care team identified eligible patients using clinical screening tools.[28] Primary care teams could be comprised of primary physicians, nurses, or medical assistants depending on the patient's needs. Patients with a positive screening were introduced to the CM, who would discuss COMPASS with them and enroll those interested in participating. CMs included registered nurses, social workers, medical assistants, physician assistants, and nurse practitioners. Unlike the IMPACT and DIAMOND studies, the COMPASS model incorporated not only a consulting behavioral health provider but also a consulting somatic health physician, typically a family or internal medicine physician.[29] After speaking with the patient and their primary care team, the CM met with the consultants for weekly systematic case review sessions to develop treatment recommendations. The CM would then discuss the treatment plan with the patient. Treatment plans focused on encouraging patient self-care to achieve behavioral health, medical, and psychosocial goals. The treatment plan also included frequent scheduled follow-ups with the CM to ensure that the patient was adhering to their benchmarks. If the patient's condition did not improve under the plan, their case would be discussed again at the systematic case review and the treatment plan would be adjusted accordingly. If the patient achieved their goal for at least three months, the CM and the patient would develop maintenance and relapse plans to ensure the patient stayed at their personal targets. Since the study focused on both depression and diabetes or cardiovascular disease, over time, some patients cycled into a maintenance plan for one condition and remained in active treatment for the other. If a patient relapsed, their case was reviewed by the systematic case review and cycled back into active treatment.

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[26] Ibid.

[27] COMPASS (Care of Mental, Physical and Substance Use Syndromes). University of Washington, 2016. https://aims.uw.edu/compass-care-mental-physical-and-substance-use-syndromes.

[28] COMPASS Intervention Guide. The Compass Consortium, January 2015. https://www.icsi.org/_asset/xb2661/COMPASSInterventionGuideb.pdf.

[29] Trevis, Jim. Systematic Case Review: Improving Treatment for Complex Mental and Medical Conditions. Minnesota Physician, Volume XXVIII, October 2014. http://aims.uw.edu/sites/default/files/COMPASSSystematicCaseReview.pdf.

While analysis is still ongoing, preliminary data analysis indicates that COMPASS improved patient outcomes. Approximately 60 percent of patients saw improvements in depression symptoms; the program's goal was 40 percent.[30] The percent of diabetes patients with their HbA1c in control went from 28 percent at baseline to 42 percent, which is above the initiative's goal of 20 percent.[31] Fifty-three percent, or 237 patients out of 450, who had uncontrolled blood pressure at baseline were able to gain control, which is higher than the 20 percent target set initially by the program.[32] Based on preliminary patient interviews, enrollees had a positive experience with the program.[33] While there is no cost analysis currently available, some of the providers participating in COMPASS expressed concern regarding the program due to cost of the additional staff and employee hours needed to implement and maintain the program.[34]

Washington State's Mental Health Integration Program (WMHIP)

The Washington Mental Health Integration Program (WMHIP) is a collaborative care program run by Community Health Plan of Washington (CHPW), a not-for-profit managed care plan serving approximately 300,000 Medicaid participants. When WMHIP launched in 2008, CHPW's enrollees did not have access to MH services and the implementation of a collaborative care model represented an opportunity to treat mild mental disorders such as depression and anxiety in the primary care setting. Initially funded by the state, the program is now funded through a limited MH benefit and the cost savings it is able to generate.[35]

WMHIP's collaborative care model, shown in Figure 2 below, is largely based on the IMPACT model discussed above.[36] Patients identified by their PCP are introduced to the CM (also called a care coordinator). The CM talks to the consulting psychiatrist, who advises the PCP and the CM regarding the patient's treatment plan. The CM shares the plan and checks in with the patient on a regular basis to ensure that the patient does not 'fall through the cracks' or have deteriorating outcomes.[37] The CM can also help the patient connect to other resources as needed. WMHIP also uses a patient registry (CMTS) to track and measure patient goals and clinical outcomes, and facilitate treatment adjustment if a patient is not improving as expected. Patients remain enrolled in the program until functioning and symptoms improve, which is usually 6 to 12 months.[38]

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[30] Trevis, Jim. Systematic Case Review: Improving Treatment for Complex Mental and Medical Conditions.

[31] Ibid.

[32] Ibid.

[33] Patient Stories. Institute for Clinical Systems Improvement, 2016. https://www.icsi.org/dissemination__implementation/compass/patient_stories/.

[34] Trevis, Jim. Systematic Case Review: Improving Treatment for Complex Mental and Medical Conditions.

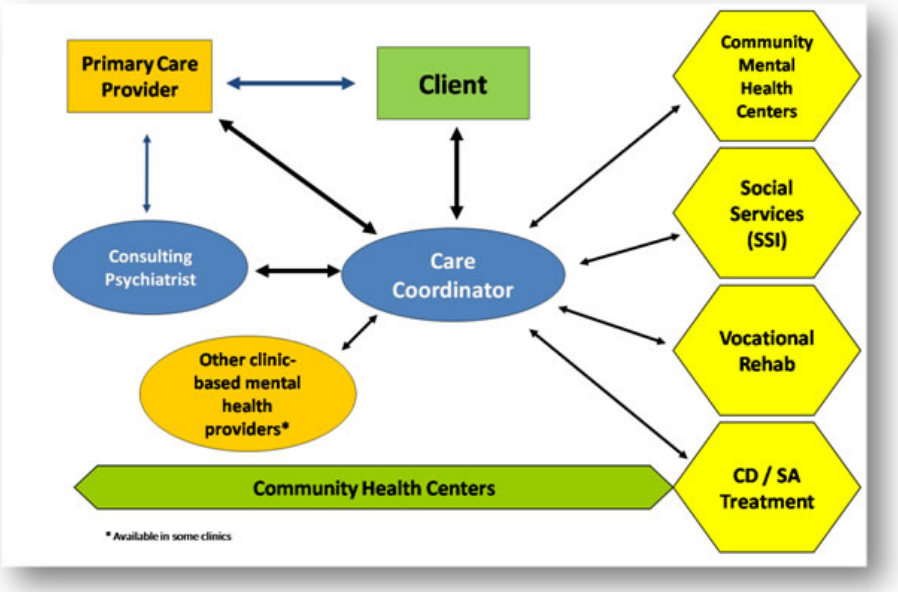
[35] Ibid.

[36] Case Study: Washington State's Mental Health Integration Program (MHIP). Advancing Care Together: Department of Family Medicine, University of Colorado Denver. http://www.advancingcaretogether.org/pdfs/Case%20Study%20MHIP_updated.pdf

[37] Mental Health Integration Program: The Model. http://integratedcare-nw.org/themodel.html

[38] Case Study: Washington State's Mental Health Integration Program (MHIP).

Figure 2: WMHIP Conceptual Model [39]



CHPW has identified several best practices it believes have been crucial to the success of its model. These include,

- Convening an implementation steering committee to develop agreed workflows, protocols, and other procedures necessary to the success of the collaborative care model;
- Development of quality improvement and pay-for-performance incentives including tracking of key quality indicators;[40]
- Use of a patient registry-tracking system as a care management tool; and
- Regular, systematic caseload reviews.

Preliminary analysis suggests that the program has been effective in improving behavioral health outcomes. Compared to counties without the WMHIP program in 2008 and 2009, WMHIP counties saw 17 percent fewer medical admissions and smaller increases in inpatient psychiatric costs, a 24 percent decline in the number of arrests, smaller increases in those living outside or in homeless shelters, and smaller increases in days spent in state hospitals.[41] In 2011, 64 percent of mothers saw

[39] Mental Health Integration Program: The Model.

[40] Quality indicators include (1) use of a patient registry-tracking tool, (2) performance of initial screen (PHQ-9) and subsequent timely patient follow up (2-4 weeks from initial assessment), (3) performance of weekly full patient caseload review with entire care team for patients not showing improvement, and (4) implementation of treatment plan changes as needed to achieve outcomes improvement.

[41] Program Highlights: The Washington State Mental Health Integration Program (MHIP). American Psychiatric Association, 2016. https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/collaborative-care-model/program-highlights.

a 5-point or greater improvement in PHQ-9 score.[42] Forty percent of those enrolled in Washington's disability program saw a 5-point or greater improvement in PHQ-9 score.[43] There have been no published studies looking at the cost effectiveness of the program, but as mentioned earlier the WMHIP program reportedly sustains itself currently in part with cost savings.

New York State Collaborative Care Depression Program

New York State has implemented collaborative care as a part of their Medicaid program. New York first implemented its program in 2011 under the Hospital-Medical Home (H-MH) Demonstration Program, an innovation grant from CMS. Under the program, New York awarded funds to hospitals that transformed their outpatient primary care training sites to Patient Centered Medical Homes (PCMHs) incorporating the collaborative care model. New York began enrolling patients in 2013. When grant funding ended in 2014, the state appropriated funds to continue the project and launched the New York State Collaborative Care Depression Program in 2015. New York's program began with approximately 30 sites and has grown to 50 across the state. Sites include large academic medical centers, community health clinics, and private practices. Due to budget constraints, the number of sites is limited and providers must apply in order to participate.

Each primary care clinic must include a core team comprised of (1) a PCP, (2) a CM, and (3) a designated psychiatric consultant. PCPs must be trained in screening and providing evidence-based, stepped care for depression. Trained behavioral health CMs oversee and provide MH care support; depression screening; patient engagement, education and follow-up; ongoing patient contact; monitoring of adherence with psychotropic medications; MH and SUD referrals; brief interventions appropriate for primary care settings; and related activities. Licensed clinical social workers (LCSW), licensed master social workers (LMSW), bachelors of social work (BSW) with appropriate supervision, licensed mental health counselors (LMHC), licensed marriage and family therapists (LMFT), and registered nurses (RN) with behavioral health training may all serve as CMs. The designated psychiatric consultant provides caseload-focused consultation at least weekly with the CMs or PCPs on patients not responding to care. A psychiatrist or a psychiatric nurse practitioner (NP) with psychiatrist backup serves as the psychiatric consultant. Caseload supervision can be provided remotely (e.g., by phone or video), but the psychiatric consultant must have access to the patient care registry. Many sites also use extenders, such as licensed nurse practitioners and those with a Master's degree in psychology to reach more patients. Given the great variation between the

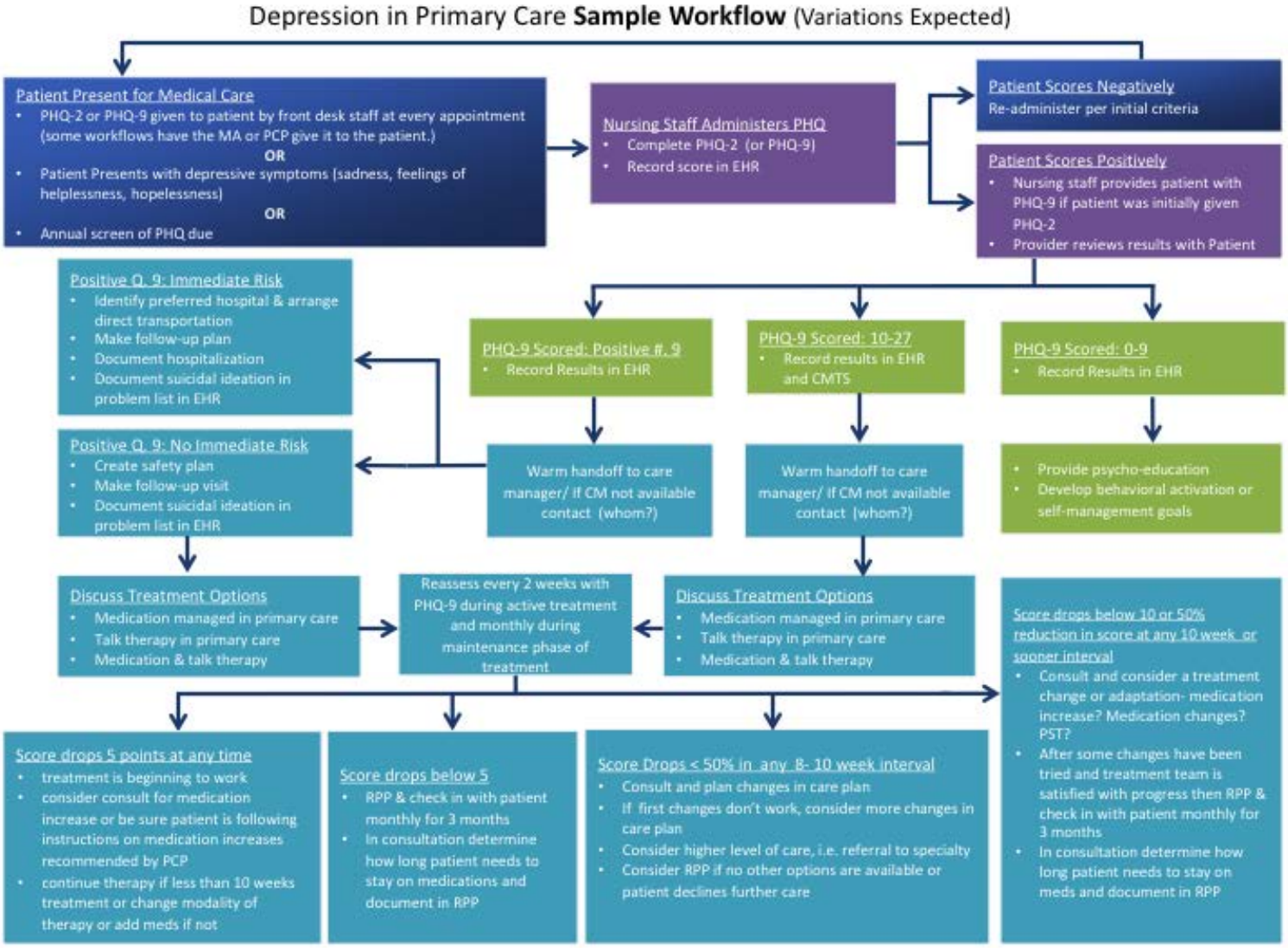
[42] According to the McArthur Initiative on Depression & Primary Care at Dartmouth and Duke, a decrease of 5 or more points on the PHQ-9 is considered an adequate response to treatment.
Description of High Risk and Parenting Women. University of Washington, November 2009. http://integratedcare-nw.org/docs/MothersWebData.pdf.

[43] According to the McArthur Initiative on Depression & Primary Care at Dartmouth and Duke, a decrease of 5 or more points on the PHQ-9 is considered an adequate response to treatment.
Krupski, Toni, et al. Disability Lifeline (DL) and Uninsured Mental Health Integration Program: Implementation Status Report – Highlights for the period of July 1, 2008 – June 20, 2011. Center for Healthcare Improvement for Addictions, Mental Illness and Medically Vulnerable Populations, July 2011. http://integratedcare-nw.org/July_2011_DL_Q1Q2_07-14-11c.pdf.

participating sites, the state does not mandate specific staffing ratios. On average, each site has approximately 70 patients and there is one FTE (usually the CM) per approximately 75 members.

Figure 3 provides a conceptual model for New York's collaborative care depression program, including expected workflows based on PHQ-2 and PHQ-9 results.

Figure 3: New York State Collaborative Care Depression Program Conceptual Model



Sites must also use a state-approved patient care registry for ongoing performance monitoring. As a part of the initial grant funding, New York obtained the Care Management Tracking System (CMTS) in order to manage patient information and billing. For each site, there is a start-up fee and a monthly maintenance cost. Currently about half of the sites utilize CMTS; the others have their own internal systems.

Individuals who receive an initial PHQ-9 score of 10 or greater are eligible to receive collaborative care services. Participating providers are reimbursed a $150 per-member per-month (PMPM) payment. To bill for services the PCP and/or CM must:

- Enter the patient into a state-approved registry based on an initial PHQ-9 score greater than or equal to 10, a confirming diagnosis of depression and completion of an initial assessment and treatment plan by the CM;
- Have a minimum of one clinical contact with the patient and a completed symptom scale (the PHQ-9) every 30 days;
- Have seen the patient face-to-face for at least 15 minutes at least once during the most recent three months (90 days);
- Keep a record of all patient contacts; and
- Consult for one hour or more per week, depending on caseload, with a designated consulting psychiatrist regarding patients in the registry, including all patients who are not improving in terms of their depression scores. This psychiatrist cannot bill Medicaid for the collaborative care consultation work unless they perform in-person evaluations and consultation services.

Twenty-five percent of each monthly payment is withheld by the state and paid to the provider every six months based on provider attestation that all of the requirements above have been met and:

- The patient has been enrolled in the collaborative care program for a minimum of 3 months of treatment; and
- One of the following outcomes was achieved:
    - Demonstrable clinical improvement, defined as a drop in the PHQ-9 score below 10 or a 50% decrease in the PHQ-9 score from the level of the original score; or
    - In cases where there was no demonstrable clinical improvement, a psychiatric consultation occurred and a recommendation for treatment change was made or a change in treatment occurred (e.g., change in medication, change in psychotherapy type or frequency, or completed referral to more intensive specialty MH treatment).

Enrollees can remain in the program for up to 12 months. Providers may seek an additional 12 months of coverage for an enrollee by submitting an application to the state medical director. If the request for a second year's enrollment is approved, the PMPM rate drops to $100. Most enrollees, however, remain in the model for four to eight months. To date, the state has received only two applications seeking to extend services beyond one year. Thus far, no patients have been approved for a second year of treatment.

Evaluation of the New York collaborative care model is underway. The analysis will include a qualitative evaluation of the implementation process and a separate evaluation of Medicaid patient outcomes and costs compared to individuals who did not receive collaborative care services.

VI. Adopting the Collaborative Care Model throughout the HealthChoice Program

Adopting the collaborative care model may improve health outcomes for individuals with MH needs in Maryland Medicaid. Studies that have implemented the collaborative care model, as discussed above, have largely focused on use of the intervention for depression. Table 8 shows the number of HealthChoice participants in each MCO that have been diagnosed with depression who do not currently receive MH services through Beacon Health Options and would be eligible to participate in a potential collaborative care model.

Table 8: Number of Participants Diagnosed with Depression (Excluding MH Visits Paid by Beacon Health Options), CY 2015

MCO	Number of Participants with Depression	
	Primary Diagnosis	Secondary Diagnosis
Amerigroup	767	4,963
Jai Medical Systems	112	1,139
Kaiser Permanente	66	301
Maryland Physicians Care	914	5,685
Medstar Family Choice	401	2,141
Priority Partners	1,200	6,580
Riverside Health of Maryland	164	971
United Healthcare	1,391	6,818
Total	**5,015**	**28,598**

Implementation of the collaborative care model in HealthChoice would require a budget initiative. Assuming the State adopted the $150 PMPM utilized by New York's Medicaid program, annual costs could exceed $9 million to provide services to the 5,015 HealthChoice participants with a primary diagnosis of depression who would likely be eligible to participate.[44] The cost to treat all potentially

[44] While CMS has announced a proposed rule to permit Medicare to begin reimbursing new codes to pay primary care practices that use interprofessional care management resources to treat patients with behavioral health conditions, including some aspects of the collaborative care model, in 2017, rates have not yet been announced. Proposed Policy, Paramagnet, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year (CY) 2017. Centers for Medicare and Medicaid Services, July 2016. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-07-2.html.

eligible individuals would exceed $60.5 million. It is difficult, though, to determine how many participants are being successfully treated today by their PCPs and who would benefit from additional services. Moreover, potential savings are difficult to quantify and likely would not accrue immediately. Given these considerations, the Department does not recommend implementing the model statewide in HealthChoice at this time.

VII. Recommendation: Pilot A Limited Collaborative Care Model in the HealthChoice Program

Given the potential for the collaborative care model to control costs, improve access and clinical outcomes, and increase patient satisfaction, the Department is interested in exploring its adoption on a limited basis for a one-year pilot. As noted above, in most studies, enrollees receive services for no more than a year, making this time period suitable for pilot purposes. Following the Washington MHIP model, the Department could select a single MCO through a competitive application process that would be permitted to test the model with its providers on a limited basis. The Department has undertaken similar demonstrations to measure the effectiveness of evidence-based interventions, including the recently awarded projects on diabetes prevention. Alternatively, following the approach adopted by New York, the Department could implement the model at a limited number of select provider sites, for example Federally Qualified Health Clinics, in order to permit model testing that is agnostic with respect to MCO. Selection could be based on geographic location, provider ability to implement the pilot quickly, and other factors. In both cases, the Department would need to seek authority for the model through an 1115 waiver in order to permit a pilot of the model targeting a specific subset of the HealthChoice population. Given the challenging budgetary environment, a pilot may not be feasible in fiscal year 2018.