HB 1682

Department of Legislative Services

Maryland General Assembly
2018 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

House Bill 1682 (Delegate Morales, *et al.*)
Health and Government Operations Finance

Maryland Medical Assistance Program - Collaborative Care Pilot Program

This bill establishes a Collaborative Care Pilot Program to establish and implement a collaborative care model in primary care settings in which health care services are provided to HealthChoice Medicaid recipients. The Maryland Department of Health (MDH) must apply for an amendment to the State's § 1115 HealthChoice Demonstration Waiver if necessary to implement the pilot program. By November 1, 2023, MDH must report to the Governor and the General Assembly on the pilot program. For fiscal 2020 through 2023, the Governor must include in the annual budget an appropriation of $550,000 for the pilot program. **The bill takes effect July 1, 2018, and terminates June 30, 2024.**

Fiscal Summary

State Effect: Application for the waiver amendment can be handled using existing resources. Medicaid expenditures increase by $550,000 (50% general funds, 50% federal funds) annually in FY 2020 through 2023, which corresponds to the funding mandated in the bill and assumes approval of the waiver amendment. Thus, federal fund revenues increase correspondingly. **This bill establishes a mandated appropriation beginning in FY 2020.**

(in dollars)	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
FF Revenue	$0	$275,000	$275,000	$275,000	$275,000
GF Expenditure	$0	$275,000	$275,000	$275,000	$275,000
FF Expenditure	$0	$275,000	$275,000	$275,000	$275,000
Net Effect	$0	($275,000)	($275,000)	($275,000)	($275,000)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate increase; (-) = indeterminate decrease

Local Effect: None.

Small Business Effect: Minimal.

Analysis

Bill Summary: MDH must administer the pilot program and select up to three sites at which a collaborative care model must be established over a four-year period. The sites selected must be adult or pediatric nonspecialty medical practices or health systems that serve a significant number of Medicaid enrollees. To the extent practicable, one of the sites must be located in a rural area of the State. The sites selected by MDH must ensure that treatment services, prescriptions, and care management that would be provided to an individual under the pilot program are not duplicative of specialty behavioral health care services being received by the individual.

MDH must provide funding to sites participating in the pilot program for (1) infrastructure development; (2) training staff; (3) staffing for care management and psychiatric consultation provided under the collaborative care model; and (4) other purposes necessary to implement and evaluate the collaborative care model.

MDH must collaborate with stakeholders in the development, implementation, and outcome monitoring of the pilot program. MDH must also collect outcomes data on recipients of health care under the pilot program to (1) evaluate the effectiveness of the collaborative care model, as specified, and (2) determine whether to implement the collaborative care model statewide in primary care settings that provide health care services to Medicaid recipients.

The bill may not be construed to prohibit referrals from a primary care provider to a specialty behavioral health care provider.

Current Law/Background: The 2016 *Joint Chairmen's Report* asked MDH (then the Department of Health and Mental Hygiene) to report on collaborative care initiatives that involve an evidence-based approach to integrating somatic and behavioral health services in primary care settings. In its January 2017 report, the department reported on:

- ***The Extent of Primary Behavioral Health Services Currently Delivered by Medicaid Managed Care Organizations:*** In calendar 2015, an estimated 114,905 enrollees received some form of behavioral health services that were billed to managed care organizations (MCOs).

- ***Medicaid Initiatives Underway that Connect Participants to Appropriate Care:*** The report noted two specific initiatives: encouraging the adoption of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services, and specifically noting that Medicaid issued guidance in July 2016 to Medicaid providers to incorporate SBIRT into their practices; and the Chronic Health Home program created as an option under the federal Patient Protection and Affordable Care Act.

- ***Evidence-based Practices Used by MCOs to Treat Individuals with Mild to Moderate Forms of Depression and Other Common Behavioral Disorders:*** MCOs noted (1) the use of internal data to identify at-risk participants to see if behavioral health needs are being met; (2) case management; (3) outreach to enrollees who have fallen out of care; and (4) embedding behavioral health workers in primary care sites.

- ***The Findings of Several Collaborative Care Studies, Including Two (in New York and Washington) Aimed at Medicaid Participants:*** The New York model awards funds to 50 sites (academic medical centers, community health clinics, and private practices) that have adopted patient-centered medical homes incorporating the collaborative care model.

- ***The Cost of Implementing a Collaborative Care Model throughout HealthChoice:*** As most studies on the adoption of the collaborative care model have been focused on intervention for depression, Medicaid developed an estimate for a model with a similar focus. Based on calendar 2015 data, this would involve 5,015 enrollees with a primary diagnosis of depression and 28,598 with a secondary diagnosis. Using the cost estimate to implement a program similar to that used by New York Medicaid, $150 per member per month, would cost $9.0 million for those with a primary diagnosis of depression, or $60.5 million for all potentially eligible, including those with a secondary diagnosis.

The report concluded that, while the collaborative care model is interesting, potential savings are difficult to quantify and would not accrue immediately. The report noted that a limited pilot collaborative care model might be possible (subject to approval through a federal waiver).

State Fiscal Effect: This estimate assumes that MDH applies for an amendment to the HealthChoice Demonstration Waiver, the amendment process takes one year, and the amendment is granted. Thus, the collaborative care pilot program begins on July 1, 2019, and Medicaid expenditures increase by $550,000 (50% general funds, 50% federal funds) in fiscal 2020 through 2023 to implement the pilot program, consistent with the mandate for funding in the budget and the bill's specification for a four-year pilot program. Federal matching fund revenues increase correspondingly. If the waiver amendment is not granted, then the mandated funding must be provided exclusively with general funds.

Following completion of the pilot program at the end of fiscal 2023, Medicaid can report to the Governor and the General Assembly on its findings and recommendations by November 1, 2023, using existing budgeted resources.

Additional Information

Prior Introductions: None.

Cross File: SB 835 (Senator Madaleno, *et al.*) - Finance.

Information Source(s): Department of Budget and Management; Maryland Department of Health; Department of Legislative Services

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