Maryland Collaborative Care Case Study

System Structure

HealthChoice – Maryland's statewide Medicaid managed care program – was implemented in 1997 under authority of Section 1115 of the Social Security Act. Since that time, specialty mental health services have been carved-out of the HealthChoice benefit package with delivery of those services overseen by a managed behavioral health organization (more commonly referred to in Maryland as an administrative services organization (ASO)). Recently, following a multi-year stakeholder process to streamline delivery of services for individuals with co-occurring serious mental health (MH) and substance use disorders (SUD), a decision was made to carve SUD services out of the HealthChoice benefits package as well. Since January 1, 2015, all specialty MH and SUD services for Medicaid recipients and the uninsured have been administered by the ASO.

The carve-out notwithstanding, Maryland's 1115 waiver has, since its inception, required the delivery of primary mental health treatment within the Medicaid managed care organizations (MCOs), and reimbursement for these services is included in MCO capitation rates.

Legislative and State Activity

In 2016, the Maryland General Assembly voiced an interest in the development of a collaborative care model for the delivery of primary behavioral health services through the HealthChoice program. Recognizing that the model has "demonstrated both improved outcomes and lower overall health costs," the legislature requested, through budget narrative adopted during the FY17 state budget process, that the state Department of Health and Mental Hygiene (DHMH) report on: (1) the extent of primary behavioral health services currently delivered by 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.

In its review of the model, DHMH indicated that it was interested in adopting collaborative care on a limited basis because of its "potential … to control costs, improve access and clinical outcomes, and increase patient satisfaction." However, the report concluded that it would be too costly to implement the model at the time based on an estimation of the HealthChoice population that would receive the services.

The legislature responded with an additional budget narrative request in 2017. DHMH was asked to re-examine the collaborative care model as part of its charge from the Centers for Medicare and Medicaid Services – required under the state's 1115 HealthChoice waiver renewal – to better integrate the delivery of somatic and behavioral health services. Furthermore, DHMH was requested to develop the framework for a pilot collaborative care model, including any required waiver submission, with a view for implementation in the fiscal 2019 budget. The agency is expected to report by October 1, 2017 with a summary of its activities toward development of the pilot.