October 16, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations--Pathways to Success

Dear Administrator Verma:

The undersigned national organizations dedicated to advancing effective mental health and substance use care in our nation thank the Centers for Medicare and Medicaid Services (CMS) for the opportunity to comment, and would like to take this opportunity to offer several recommendations to support the Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP) in addressing mental health, addiction, and suicide in the individuals they serve.

ACOs can play a critical role in addressing the growing overdose and suicide epidemics in the United States, but they need additional CMS support. ACOs are currently incentivized to report on Depression Remission at Twelve Months (the only patient-reported outcome performance measure (PRO-PM) across mental health, addiction, and suicide). According to the most recent Public Use File, among ACOs reporting this measure and excluding ACOs that reported a score of zero, the median rate of depression remission at twelve months in ACOs was approximately 9%. A recent meta-analysis estimated that the rate of spontaneous remission at twelve months in an untreated population is approximately 53%.[1] We do not have data on PRO-PMs related to substance use or outcomes related to suicide. ACOs need additional support from CMS in addressing mental health, addiction, and suicide.

The undersigned offer recommendations in three areas:

1. Promote Behavioral Health Capacity in All ACOs

CMS should work with ACOs to ensure that each has the capacity to meaningfully address mental health and substance use in their population. The U.S. Preventive Services Task Force noted in 2016:

> In 2009, the USPSTF recommended screening all adults when staff-assisted depression care supports are in place and selective screening based on professional judgment and patient preferences when such support is not available. In recognition that such support is now much more widely available and accepted as part of mental health care, the current recommendation statement

[1] Whiteford HA, Harris MG, McKeon G, Baxter A, Pennell C, Barendregt JJ, Wang J. Estimating remission from untreated major depression: a systematic review and meta-analysis. Psychological medicine. 2013 Aug;43(8):1569-85.

has omitted the recommendation regarding selective screening, as it no longer represents current clinical practice.[2]

While rates of depression screening have improved over the past several years, the poor performance on Depression Remission at Twelve Months indicates that there may be widespread gaps in post-screening follow-up. The same is likely true of addiction and suicide services. CMS should support ACOs, using CMS's technical assistance, quality improvement, and learning collaborative infrastructures, as well as financial incentives, to implement effective mental health and substance use interventions that work in their practice context, such as the Collaborative Care Model or other forms of evidence-based behavioral health integration using the newly created billing codes,[3] certified peer support specialists and/or other forms of recovery support services, tele-behavioral health, and/or digital health interventions.

2. Explore Ways to Enhance Data Collection for Patient-Reported Outcomes (PROs) in Mental Health and Substance Use

The majority of performance challenges in the Depression Remission at Twelve Months measure may be attributable to loss to follow-up – the ACO was not able to screen a second time to determine if remission was achieved. Data collection for mental health and substance use PROs could be maximized and made more efficient by allowing individuals to screen at home. Mental health and substance use screening could also be built into the beneficiary engagement incentives, so that repeated screening with an online portal integrated into the Certified Electronic Health Record Technology is part of the incentivized healthy behaviors. This approach is especially salient as the evidence grows for measurement-based care and the value to patient outcomes for repeated mental health and substance use screening.[4] CMS should explore whether supporting ACOs in implementing home-based collection of mental health and substance use PROs to determine if doing so allows ACOs to better follow-up and address the behavioral health needs of their population.

3. Offer Additional Outcomes-Based Payments in Behavioral Health

Additional investment in mental health and substance use services, supports, and infrastructure may help build new capacities and catalyze further innovation in ACOs. To ensure cost-neutrality for CMS, CMS can tie new payments to predicted future savings. For example, increased rates of depression remission likely predict savings to CMS in reduced total health care spending over the next several years. CMS could develop a methodology to share some of these predicted future savings with ACOs as they achieve specified behavioral health outcomes, assuming appropriate protections can be built in to avoid cherry-picking issues. Note that the methods could be similar to those being used in the Outcomes-Based Credits in the recently

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[2] Siu AL, Bibbins-Domingo K, Grossman DC, Baumann LC, Davidson KW, Ebell M, García FA, Gillman M, Herzstein J, Kemper AR, Krist AH. Screening for depression in adults: US Preventive Services Task Force recommendation statement. Jama. 2016 Jan 26;315(4):380-7.

[3] Press MJ, Howe R, Schoenbaum M, Cavanaugh S, Marshall A, Baldwin L, Conway PH. Medicare payment for behavioral health integration. New England Journal of Medicine. 2017 Feb 2;376(5):405-7.

[4] Fortney JC, Unützer J, Wrenn G, Pyne JM, Smith GR, Schoenbaum M, Harbin HT. A tipping point for measurement-based care. Psychiatric Services. 2016 Sep 1;68(2):179-88.

CMS-approved Maryland Total Cost of Care Model.[5] With a methodology for sharing expected CMS savings with ACOs, CMS could justify outcomes-based investments in mental health and substance use care.

Conclusion

The undersigned thank CMS for the opportunity to comment and look forward to continuing to work with the Administration on addressing our nation's addiction and suicide epidemic. Please do not hesitate to contact Nathaniel Z. Counts, J.D., Senior Policy Director of MHA, at ncounts@mentalhealthamerica.net for follow-up or questions.

Sincerely,

Mental Health America

American Foundation For Suicide Prevention

Depression and Bipolar Support Alliance

Facing Addiction with the The National Council on Alcoholism and Drug Dependence (NCADD)

The National Alliance on Mental Illness

The National Council for Behavioral Health

Patient-Centered Primary Care Collaborative

Shatterproof

[5] https://innovation.cms.gov/initiatives/md-tccm/