February 16, 2018

The Honorable Orrin G. Hatch
Chairman, Senate Finance Committee
Washington, DC 20510-6200

The Honorable Ron Wyden
Ranking Member, Senate Finance Committee
Washington, DC 20510-6200

Dear Chairman Hatch and Ranking Member Wyden:

Mental Health America (MHA) applauds the Senate Committee on Finance for its attention to the nation's opioid epidemic, and for the opportunity to provide feedback on possible solutions.

MHA – founded in 1909 – is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and to promoting the overall mental health of all Americans. Our work is driven by our commitment to promote mental health as a critical part of overall wellness, including prevention services for all, early identification and intervention for those at risk, integrated care, services, and supports for those who need it, with recovery as the goal. Drawing from this experience and expertise, MHA offers responses to questions three, five, seven, and eight:

3. How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to ensure beneficiaries receive evidence-based prevention, screening, assessment, and treatment for OUDs and other SUDs to improve patient outcomes?

All of the quality measures in Medicaid and Medicare related to substance use are process measures. For example, the Medicaid Adult Core Set contains Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment, which measures rates of treatment initiation and follow-up after diagnosis.[1] It does not measure outcomes – any individual who initiates treatment and has two or more additional services appears the same on the measure regardless of whether they achieve full recovery or overdose a month later.

On its own, an outcome measure of substance use would be unlikely to bend the overdose curve. We have a good measure of outcomes in depression in Medicare – Depression Remission at Twelve Months – but last year the Accountable Care Organizations (ACOs) reported a median rate of depression remission at twelve months of nine percent.[2] For people in ACOs, we can only

[1] Adult Health Care Quality Measures. Centers for Medicare and Medicaid Services. https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html
[2] Shared Savings Program Accountable Care Organizations (ACO) PUF. Centers for Medicare and Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/SSPACO/

confirm that nine percent of those that screened positive for depression got better twelve months later. Outcomes for substance use would might not be much better, absent additional changes.

Therefore, MHA recommends that the Committee on Finance explore (1) weighting value-based payment for substance use outcomes, and (2) working with Qualified Entities and Quality Improvement Organizations to ensure that outcomes are presented to providers in a way that promotes continuous quality improvement.

(1) Currently, all quality measures are weighted equally, regardless of their implications for future health care spending. Remission of addiction to illicit substances has profound implications for future savings to Medicare and Medicaid when compared to non-remission, but these outcomes are treated the same right now. The issue gets worse for substance use initiation. Currently, providers receive incentives when someone screens positive for illicit substance use and then the provider treats it, but receive no incentives if the provider intervenes early to prevent illicit substance use initiation entirely. From the provider, patient, and CMS perspectives, it would be better for individuals to never initiate illicit substance use. Measurement instruments do exist that predict next year substance use initiation, and the use of these would allow for the construction of a risk-adjusted "non-initiation at twelve months" quality measure.[3]

Providers who perform well in either of these areas, preventing illicit substance use or promoting remission, should be able to share in the predicted savings – which would also provide sufficient financial incentive for positive practice transformation without increasing downside risk for providers. Note that, to avoid potential disagreement over appropriate substance use outcomes, the outcome created could be a newly constructed measure of overdose risk, much like we have measures of cardiovascular disease risk.[4] Providers could be incentivized to reduce that risk through value-based payment in whatever way works best for that community.

- CMS should create outcome measures of non-initiation of substance use and reduced risk of overdose, and value performance on them based on predicted future savings to CMS

CMS will need to be careful that the measures do not disincentivize effective pain management. Pain remains a very real issue, and the pendulum should not swing too far in the other direction as our nation reacts to the opioid crisis. Value-based payment will also need to continue to promote effective pain management, and individuals will need access the full array of pain drugs and therapies.

- CMS should ensure that the substance use outcome measures work in tandem with pain management outcome measures to incentivize safe and effective practice.

[3] Ridenour TA, Willis D, Bogen DL, Novak S, Scherer J, Reynolds MD, Zhai ZW, Tarter RE. Detecting initiation or risk for initiation of substance use before high school during pediatric well-child check-ups. Drug & Alcohol Dependence. 2015 May 1;150:54-62.

[4] Sanghavi DM, Conway PH. Paying for prevention: a novel test of medicare value-based payment for cardiovascular risk reduction. JAMA. 2015 Jul 14;314(2):123-4.

- CMS should review current formularies and other limitations that may prevent individuals accessing pain management therapies that might be most effective and decrease the likelihood of illicit substance initiation.

(2) Financial incentives are only part of the issue – outcomes need to be salient to providers, and ideally accompanied by clinical decision supports, to enable continuous improvement.

- CMS should work with the Qualified Entities, Quality Improvement Organizations, and other contractors to ensure that information presented to providers enables continuous quality improvement for performance on substance use outcomes measures

5. How can Medicare or Medicaid better prevent, identify and educate health professionals who have high prescribing patterns of opioids?

In addition to targeted education for overprescribing, CMS can take several additional steps to prepare the workforce for effective intervention.

CMS can ensure that providers entering the workforce are well-trained to address substance use. New Collaborative Care Model and Behavioral Health Integration billing codes facilitate best practices in non-residential substance use treatment. CMS currently offers some kinds of technical assistance to providers in correctly using new codes.

- CMS should extend its technical assistance on use of Collaborative Care Model codes to clinical and paraprofessional training programs to promote effective practice in the workforce pipeline.

Effective practice should also be reinforced through the information technology systems that providers and patients use. A recent report from the National Academy of Medicine funded by the Office of the National Coordinator, *Optimizing Strategies for Clinical Decision Support*, noted the promise of clinical decision support (CDS) tools to help providers rapidly make data-informed decisions, but also noted that these tools were not well developed in behavioral health – especially for supporting behavioral interventions and supports. It is also unlikely that the most effective CDS will be developed top-down.

- CMS should work with its contractors to support providers and patients in rapidly designing and testing substance use CDS across its various programs.

Note that without complete access to information about an individual, CDS approaches will likely not be successful.

- 42 CFR Part II should be conformed with HIPAA to the extent necessary to promote comprehensive, integrated care, while protecting against illegal disclosures.

7. What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts or incorporated into Medicare?

Medicaid reimburses for certified peer support specialist services in more than half of the states in America. Medicare does not offer reimbursement for services provided by a certified peer

support specialist. Mental health and substance use certified peer support specialist services offer additional flexibility to decrease inpatient and emergency department utilization while improving health outcomes.

- CMS should use Medicaid data to study options for reimbursing certified peer support specialist services in Medicare that will be cost-neutral to CMS.

Communities across America are experimenting with innovative ways to coordinate clinical and community-based services to improve substance use treatment outcomes. Some of these initiatives are at the individual-level, such as ensuring that people get both clinical and social supports after release from residential treatment. Others are at the community-level, such as bringing together community stakeholder organizations to work together and address community needs that prevent substance use and/or promote recovery.

Each community stakeholder involved in individual-level coordination has distinct payment and reporting structures, many of which are influenced by the federal government. To the extent that the incentives are not aligned between health care providers and the community-based organizations that provide needed services to improve outcomes and reduce overall costs such as supported housing and supported employment, it makes starting a collaboration difficult, and does not reward collaboration when successful. CMS promotes experimentation for health care providers' payment and reporting structures through alternative payment models (APMs). In the majority of APMs, there is no role for community-based services, even when it would improve outcomes and lower costs.

- CMS should promote experimentation with cross-sector alternative payment models (APMs) that align incentives between health care providers and community-based partners.

The issues with cross-sector collaboration are amplified when working at the community-level. Community-level collaboration is essential because substance use initiation and recovery do not happen in a vacuum. Illicit substance use initiation, as well as subsequent recovery, are influenced by community social and economic factors – Are there opportunities for meaningful and productive employment? Do people have the supports they need to access available opportunities? Are individuals included in vibrant community life? No one sector in a community can address these issues, but communities working together, with appropriate support and information, can begin to.

The Innovation Center's Accountable Health Community Model (AHCM) – Alignment Track offers CMS's first foray into supporting this work on the ground. AHMC reimburses to coordinate health care with services with health-related social needs, and supports health care's engagement in community-wide planning to meet identified community needs. While the AHCMs are likely to have an impact on substance use, they are not specifically tailored to address substance use and behavioral health.

- CMS should support communities in the creation of AHCM-like models that focus both health-related social need services and community improvement planning on substance use prevention and recovery.

8. What human services efforts (including specific programs or funding design models) appear to be effective in preventing or mitigating adverse impacts from OUD or SUD on children and families?

Family-focused preventive interventions have demonstrated efficacy in reducing substance use across family units.[5] These interventions work with parents to reduce their substance use and help them build additional skills to support their child's healthy development, while working with children to build resilience to future behavioral health concerns. Rather than paying for one of these programs though, CMS should remove barriers to implementation of these evidence-based interventions and incentivize the outcomes they achieve. An outcomes-focused approach would ensure that interventions are effectively implemented on the ground while leaving room for community-led innovation.

- CMS should examine existing policy barriers to the implementation of family-focused preventive interventions in primary care, as well as incentives for their adoption in APMs.

Thank you for your time and consideration.

MHA looks forward to the Finance Committee's next steps, and 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,

Paul Gionfriddo
President and CEO
Mental Health America

[5] Leslie LK, Mehus CJ, Hawkins JD, Boat T, McCabe MA, Barkin S, Perrin EC, Metzler CW, Prado G, Tait VF, Brown R. Primary health care: potential home for family-focused preventive interventions. American journal of preventive medicine. 2016 Oct 1;51(4):S106-18.