April 26, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Dear Administrator Verma:

The mental health and substance use communities eagerly anticipate the Centers for Medicare and Medicaid Services' (CMS's) Guidance on Opportunities for Innovation as provided by Section 12003 of the 21st Century Cures Act, Public Law 114-255. The undersigned also look forward to CMS's overall leadership in addressing the mental health and substance use needs of the nation.

Mental health and substance use conditions currently top the lists of the most costly and debilitating conditions in the United States.[1] The rates of both drug overdose deaths[2] and suicides[3] have increased over the past decade, while the rates of so many other causes of death, such as diabetes and strokes, have decreased. To most effectively address these issues, the undersigned urge that CMS both provide initial guidance, and use existing resources to support local innovations and scaling-up those that prove to be cost-effective. CMS guidance on the full range of opportunities to address mental health and substance use issues in a state is appreciated, however CMS also has the ability to have an even greater impact by, for example, using Medicaid and Medicare data on cost and quality in behavioral health prevention, access, and recovery to help states determine which innovations across the country have been most effective in addressing issues similar to the ones they are facing. Utilizing current CMS resources such as data from the Core Quality Measure Collaborative set and the Quality Payment Program set as well as CMS's technical assistance capacities could assist states in reaching their fullest potential.

The initial CMS guidance will also come after recent letters to states from CMS and the Department of Health and Human Services on the use of 1115i waivers in Medicaid and 1332 waivers for the commercial market. The undersigned urge that this guidance offer evidence-based or evidence-informed opportunities for states to consider in designing any waivers, and hope that CMS will offer active technical assistance to states interested in implementing these

[1] Roehrig, C. (2016). Mental disorders top the list of the most costly conditions in the United States: $201 Billion. *Health Affairs*, 10-1377.
[2] Rudd RA, Seth P, David F, Scholl L. Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. *MMWR Morb Mortal Wkly Rep* 2016;65:1445–1452.
[3] Rudd RA, Seth P, David F, Scholl L. Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. MMWR Morb Mortal Wkly Rep 2016;65:1445–1452.

innovations, helping to tailor the approaches to local realities and ensure that innovations are successfully scaled.

As CMS prepares the Guidance on Opportunities for Innovation, the undersigned organizations wish to highlight certain topics that, if included in the guidance, would be most helpful to states and offer the greatest possibility for transformative impact on our nation's mental health and substance use payment and delivery systems – ultimately improving the population's health and reducing overall costs:

- Evidence-based supports to parents or caregivers without the child or individual present when it is more cost-effective to do so, which should include in some cases services for the parent or caregiver's health when it directly impacts the health of the child or individual, such as Triple P billing in Washington[4] or maternal mental health screening in North Dakota;[5]
- Social supports to individuals and families that improve health outcomes, such as employment or housing supports, or flexible payment systems to address health-related social needs, as in Oregon's Coordinated Care Organizations;[6]
- Peer support specialist services, implemented in different payment and delivery systems, such as the range of peer-provided supports in Georgia;[7]
- Provision of services to individuals at risk of a mental health or substance use condition, but that would not yet screen positive for a condition, in order to mitigate that risk, such as the Early Detection and Intervention for the Prevention of Psychosis in Adolescents and Young Adults,[8] and interventions to prevent or mitigate other mental health conditions,
- Services that effectively prevent or mitigate mental health or substance use crises and/or that provide diversion from criminal justice involvement or reduce recidivism, such as crisis respite and crisis intervention in New York;[9]
- Delivery and payment models for coordination or provision of services across sectors and settings, such as child care, education, community-settings, or criminal justice, including ubiquitous behavioral health screening across settings, such as in the Adolescent School Health Program in Louisiana;[10]
- Outcome-oriented quality measurement and/or value-based payment incentives that promote prevention, early intervention, and treatment in mental health and substance use, such as the Quality Incentive Payment System in Minnesota;[11]
- Integrated delivery and payment models between behavioral health services and other health services to address both mental health conditions and health behaviors, including coordinated

[4] https://www.dshs.wa.gov/sites/default/files/CA/cp/documents/TripleP-fee.pdf
[5] https://www.nd.gov/dhs/services/medicalserv/medicaid/docs/cpt/maternal-depression-screen-jan2017.pdf
[6] https://www.oregon.gov/oha/Transformation-Center/Resources/Flexible-services-final.pdf
[7] http://www.gacps.org/
[8] http://www.rwjf.org/en/library/research/2013/10/early-detection-and-intervention-for-the-prevention-of-psychosis.html
[9] https://www.omh.ny.gov/omhweb/bho/harp-mainstream-billing-manual.pdf
[10] http://dhh.louisiana.gov/index.cfm/page/565
[11] http://www.health.state.mn.us/healthreform/measurement/qipsreportupdate_2015_proposed.pdf

specialty care models and advanced or integrated primary care, including but not limited to First Episode Psychosis programs across the country[12] and use of the new Collaborative Care Model codes;[13]
- Effective data-sharing systems that can improve behavioral health outcomes for Medicaid beneficiaries, such as MyHealth Access in Oklahoma;[14]
- Population-level investments for services not provided directly to individuals, but that can demonstrably improve the behavioral health of a community, such as Good Behavior Game in New Mexico;[15]
- Integration of mental health and substance use alternative payment models like Accountable Care Organizations (ACOs), all-payer ACOs, Person-Centered Medical Homes, etc., such as suicide and substance use rates in the Vermont All-Payer ACO Model;[16]
- Uses of telehealth, mobile applications, or other technologies to promote access and more effectively improve behavioral health;
- Use of the waiver process to implement Certified Community Behavioral Health Clinics (CCBHCs—as defined in Section 223 of the Protecting Access to Medicare Act) responsible for providing a comprehensive array of community-based services, with an emphasis on 24-hour crisis care, evidence-based practices, care coordination, and integration with physical health care while qualifying for a Medicaid reimbursement rate that supports expanding services, serving new populations, and engaging patients and families outside the four walls of their clinics.
- Uses of population health analytics and/or integrated data systems that improve the behavioral health of the population served, such as in Springboard Healthy Scranton in Pennsylvania;[17] and
- Any other use of a waivers, "in lieu of," or State Plan Amendment that effectively addressed the prevention, early intervention, treatment, and support for mental health and substance use conditions.

The undersigned also hope that CMS, while analyzing savings associated with the opportunities in the guidance, will quantify long-term savings across sectors. Evidence repeatedly demonstrates that effective mental health and substance use services reduce costs in disability benefits, special education needs, child welfare involvement, and criminal justice involvement, while increasing tax revenues from greater worker productivity.

The undersigned thank CMS for its thoughtful consideration, and look forward to the Guidance on Opportunities for Innovation in mental health and substance use. We stand ready to support CMS in any way in using existing resources to support states and fosters local innovation in

[12] http://www.easacommunity.org/PDF/Directory_V5.pdf
[13] https://aims.uw.edu/sites/default/files/CMS_FinalRule_2017_CheatSheet.pdf
[14] http://myhealthaccess.net/
[15] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/Centennial-Care/nm-centennial-care-qtrly-rpt-jul-sep-2016.pdf
[16] http://gmcboard.vermont.gov/sites/gmcb/files/documents/Implementing%20the%20All-Payer%20Model%202017-01-12FINAL.pdf
[17] http://medcitynews.com/2017/01/geisinger-health-ceo-david-feinberg/

addressing mental health and substance use conditions throughout the country. Please do not hesitate to contact Nathaniel Counts, J.D., Senior Policy Director of Mental Health America, at ncounts@mentalhealthamerica.net at any time with questions or comments.

Sincerely,

Mental Health America
American Foundation for Suicide Prevention
American Psychiatric Association
American Psychological Association
National Association for County Behavioral Health and Disability Directors
National Alliance on Mental Illness
National Association for Rural Mental Health
National Association of State Mental Health Program Directors
The National Council for Behavioral Health