June 3, 2011

Dr. Don Berwick, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

RE: CMS-1345-P

Dear Dr. Berwick,

Thank you for this opportunity to provide comments on the proposed rules and guidance for Accountable Care Organizations (ACOs). The National Association of State Alcohol and Drug Abuse Directors (NASADAD) represents State Substance Abuse Agency Directors who oversee and implement efficient and holistic prevention, treatment and recovery systems. We believe that effective development of ACOs holds tremendous promise for individuals with these and other chronic conditions. We appreciate the opportunity to submit these comments and look forward to working with you to ensure that ACO enrollees in need of MH/SUD related services receive quality care.

While we appreciate the inclusion of a number of MH and SUD provisions, we are very concerned by the omission of some very important quality measures that CMS has previously recognized as being critical to our nation's health. Our recommendations to further strengthen the proposed ACO rules and future guidance for people with MH/SUD service needs are detailed below. We urge CMS to:

- Amend the proposed ACO guidance to include the following quality measures that have been shown to be effective at preventing, managing, and treating mental illness and SUD for ACO enrollees and improving their overall health outcomes:
    - Screening, brief intervention, and referral for treatment for alcohol misuse. Alcohol screening has been determined by the United States Preventive Services Task Force and other expert panels as effective, evidence-based preventive care.
    - Each of the MH and SUD related quality measures recommended by CMS earlier this year in its proposed *Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults*, including follow-up after hospitalization for mental illness, initiation and engagement of alcohol and other drug dependence treatment, certain measures specific to patients managing schizophrenia or bipolar disorder, and mental health utilization.
    - Additional evidence-based MH and SUD related practices.

- As additional guidance on establishing and operating ACOs is developed, we also ask that CMS work to ensure that:
    - The needs of individuals with or at risk for MH and SUD are well addressed

- MH and SUD service providers receive necessary support and technical assistance to best meet the needs of enrollees
- Providers participating in ACOs are educated about confidentiality protections required by federal and state law for individuals with MH and SUD

We also ask CMS to clarify the role of MH/SUD service providers within the ACO construct, including specifically how MH/SUD providers can create, partner with, and otherwise participate in ACOs, and how and under what conditions ACOs should engage in such relationships with MH/SUD providers. Some providers of MH/SUD services will want to create or be a partner in the creation of ACOs, but it is not at all clear from the proposed regulations whether or how that can be done. Also, many ACOs will have to partner with providers of MH/SUD services to ensure enrollees' full range of healthcare needs are met. These partnerships should include a strong role for MH/SUD service providers, including participation by MH/SUD providers in networks of individual practices of ACO professionals, on care teams, on ACO governing boards and/or subcommittees, and other activities. In addition, many ACO enrollees may prefer their MH/SUD provider to serve as their health home, and MH/SUD providers who are able to meet the criteria to act as a health home or other primary care provider within an ACO should be able to do so. However, many details regarding the specific role of MH/SUD providers in ACOs remain unclear in the proposed regulations. We ask that CMS specifically address and clarify the role of MH/SUD providers in ACOs in the final regulation.

We do appreciate the inclusion of a number of important MH and SUD provisions in the proposed ACO regulations. Specifically, we strongly support:

- The inclusion of Depression Screening in the proposed quality measure standards required for ACOs to qualify for shared savings
- The inclusion of Tobacco Use Assessment and Tobacco Cessation Intervention in the quality measure standards
- The recognition and specific mention of the importance of substance abuse education as a key to promoting better health for populations, one of the three-part aims for achieving the highest-level goal for success of the Medicare Shared Savings Program
- The commitment to protecting patient confidentiality and the explicit recognition of the critical protections provided by 42 CFR Part 2 for patient records relating to substance use disorders
- The steps taken to improve the opportunity for groups of solo and small healthcare provider practices to participate in the Shared Savings Program, and recognition that such providers often play an important role in meeting the health needs, including the SUD and MH needs, of specific patient populations.

Our recommendations to further strengthen the proposed ACO rule and future guidance are detailed below.

1. **The proposed ACO guidance should be amended to include screening, brief intervention, and referral for treatment for alcohol misuse in the quality measure standards.**

Alcohol screening has been determined by the United States Preventive Services Task Force (USPSTF) and other expert panels as effective, evidence-based preventive care. Indeed, based on the USPSTF recommendations, CMS recently decided to include screening and behavioral counseling interventions in primary care aimed at reducing alcohol misuse as a Medicare covered service. We strongly support the efforts by CMS to cover alcohol screenings as a preventive service for Medicare Part B enrollees, and strongly encourage the inclusion of this critically important, evidence based prevention and health promotion service as a required quality measure standard in the final regulations governing ACOs in the Medicare Shared Savings Program.

Excessive alcohol use and misuse of psychoactive prescription drugs represent major, but often neglected, public health problems among older Americans, even among those who regularly receive health care from a physician.[1] These problems include heavy drinking, drinking and driving, medication interactions, depressive symptoms, insomnia, poor nutrition, congestive heart failure, impaired cognitive function, osteoporosis, and loss of balance leading to falls, the most common cause of fractures and accidental death in this age group. [2]

Evidence-based screening instruments exist that can detect harmful alcohol and other drug use in this vulnerable population. Brief interventions that can be delivered during a single primary care office visit have been tested in multiple randomized trials, including a multi-center trial in the Medicare eligible age group. They demonstrate that screening and intervention significantly reduce health risks and generate cost-savings of approximately $4 dollars for every dollar invested in providing them.[3]

Substance use problems in the Medicare population are not uncommon. According to the 2009 National Survey on Drug Use and Health (NSDUH), 9.8 percent of individuals aged 65 or older reported binge drinking, that is they consumed five or more drinks on the same occasion at least once in the past 30 days, and 2.2 percent of this age group reported heavy alcohol use, or consuming five or more drinks on the same occasion on each of five or more days in the past 30 days.[4]

In addition, a much larger number of older Americans use alcohol at unhealthy amounts with the potential for dangerous interactions with other medications they take. As many as one in

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[1] Dufour MC, Archer L, Gordis E. Alcohol and the elderly. Clin Geriatr Med 1992; 8: 127-141. Reid MC, Anderson PA. Geriatric substance use disorders. Med Clin North Am 1997;81:999-1016. Fink A, Morton SC, Beck JC et al. The alcohol-related problems survey: Identifying hazardous and harmful drinking in older primary care patients. JAGS;50:1717-1722. . Mokdad A. H., Marks J. S., Stroup D. F., Gerberding J. L. Actual causes of death in the United States, 2000. JAMA 2004; 291: 1238–45.. Darke S., Degenhardt L., Mattick R. Mortality Amongst Illicit Drug Users: Epidemiology, Causes, and Intervention. Cambridge: Cambridge University Press; 2007, p. 20–40.. Adrian M., Barry S. J. Physical and mental health problems associated with the use of alcohol and drugs. Subst Use Misuse 2003; 38: 1575–614.. Rehm J., Room R., Graham K., Monteiro M., Gmel G., Sempos C. T. The relationship of average volume of alcohol consumption and patterns of drinking to burden of disease: an overview. Addiction 2003; 98: 1209–28.

[2] Yuan Z, Dawson N, Cooper GS et al. Effects of alcohol-related disease on hip fracture and mortality : A retrospective cohort study of hospitalized Medicare beneficiaries. Am J Public Health 2000;91:1089-1093.

[3] Fleming M, et al. Guiding Older Adult Lifestyles. J Fam Pract 1999;48:378-84.

[4] Substance Abuse and Mental Health Services Administration, *Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings*, September, 2010.

four older adults take psychoactive medications (i.e., sedative-hypnotics, anxiolytics, and narcotic-analgesics) that have high abuse potential, are frequently prescribed for common geriatric conditions (e.g., insomnia, anxiety, and chronic pain), and that interact dangerously with alcohol and other prescription drugs.[5] Older individuals are more likely to experience adverse side effects from these medications, and their use can lead to significant drug interactions.[6]

Alcohol and psychoactive substance use are also associated with increased risk of hospitalization, nursing home placement and death among older adults.[7] A recent study of Medicare beneficiaries found that the presence of heavy alcohol use more than doubles the risk of hip fractures.[8] Nightly use of benzodiazepines is associated with a significantly increased risk of falls among older adults, and other psychoactive medications (sedative-hypnotics, tranquilizers, and prescription analgesics) appear to also increase risk of falls in the elderly.[9]

The cost to the Medicare program of the lack of routine screening and intervention for substance use is substantial. The annual cost to Medicare for the illnesses and injuries caused or complicated by alcohol use[10,11] exceeds $1 million per 1,000 enrollees ($99.51 per beneficiary per month). This cost included $374,184 per 1,000 patients for outpatient services, $5,197 for emergency services, $735,671 for inpatient care, and $79,063 for time spent in a skilled nursing

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[5] Glantz MD, Sloboda Z: The elderly. In Coombs RH, Ziedonis DM (eds): Handbook on Drug Abuse Prevention: A Comprehensive Strategy to Prevent the Abuse of Alcohol and Other Drugs. Boston, Allyn & Bacon Press, 1995, p 429. Solomon K, Manepalli J, Ireland GA, et al: Alcoholism and prescription drug abuse in the elderly: St. Louis University grand rounds. J Am Geriatr Soc 41:57, 1993. Sorock GS, Shimkin EE: Benzodiazepine sedatives and the risk of falling in a community dwelling cohort. Arch Intern Med 148:2441, 1988. Sheahan SL, Coons SJ, Robbins CA, et al: Psychoactive medication, alcohol use, and falls among older adults. J Behav Med 18:127, 1995

[6] Adams WL: Potential for adverse drug-alcohol interactions among retirement community residents. J Am Geriatr Soc 43:1021, 1995. Glantz MD, Sloboda Z: The elderly. In Coombs RH, Ziedonis DM (eds): Handbook on Drug Abuse Prevention: A Comprehensive Strategy to Prevent the Abuse of Alcohol and Other Drugs. Boston, Allyn & Bacon Press, 1995. Solomon K, Manepalli J, Ireland GA, et al: Alcoholism and prescription drug abuse in the elderly: St. Louis University grand rounds. J Am Geriatr Soc 41:57, 1993.

[7] Reid M. C., Anderson P. A. Geriatric substance use disorders. Med Clin North Am 1997; 81: 999–1016. Reid M. C., Boutros N. N., O'Connor P. G., Cadariu A., Concato J. The health-related effects of alcohol use in older persons: a systematic review. Subst Abuse 2002; 23: 146– 64. American Geriatrics Society. Clinical Guidelines for Alcohol use Disorders in Older Adults. Available at: http://www. americangeriatrics.org/products/positionpapers/alcoholpf.shtml. Geriatric Mental Health Foundation. Substance Abuse and Misuse among Older Adults. Available at: http://www.gmhfonline.org/gmhf/consumer/factsheets/substnabuse_factsheet.html. Moore A. A., Whiteman E. J., Ward K. T. Risks of combined alcohol/medication use in older adults. Am J Geriatr Pharmacother 2007; 5: 64–74. Simoni-Wastila L., Yang H. K. Psychoactive drug abuse in older adults. Am J Geriatr Pharmacother 2006; 4: 380–94.

[8] Yuan Z, Dawson N, Cooper GS et al. Effects of alcohol-related disease on hip fracture and mortality : A retrospective cohort study of hospitalized Medicare beneficiaries. Am J Public Health 2000;91:1089-1093.

[9] Sorock GS, Shimkin EE: Benzodiazepine sedatives and the risk of falling in a community dwelling cohort. Arch Intern Med 148:2441, 1988. Sheahan SL, Coons SJ, Robbins CA, et al: Psychoactive medication, alcohol use, and falls among older adults. J Behav Med 18:127, 1995.

[10] CDC. Alcohol Related Disease Impact (ARDI). https://apps.nccd.cdc.gov/ARDI/HomePage.aspx)

[11] Goplerud EN. Alcohol attributable fractions and Medicare costs. Working Papers, Ensuring Solutions to Alcohol Problems. Washington DC, GWU, 2005.

facility. One out of every six dollars spent by Medicare—more than $53 billion annually—goes to treating alcohol-related illnesses and injuries.[12]

While the current costs to the Medicare program related to alcohol use disorders is staggering, these costs are expected to increase substantially in the next decade. SAMHSA has projected future alcohol and drug use disorders among elderly patients, and estimates that SUD rates in this population will rise by 44 percent by 2020. [13] Thus, it is timely and critical to include routine screening and brief intervention for alcohol and harmful prescription drug use problems as a required quality measure for ACOs that serve the Medicare population.[14,15]

We strongly urge that alcohol screenings be included in the ACO quality measure preventive health domain.

2. The proposed ACO guidance should be amended to include each of the MH- and SUD-related quality measures recommended by CMS earlier this year in its proposed *Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults.*

Earlier this year, CMS released the Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults, for voluntary use by State Medicaid programs, health insurance issuers and managed care entities that enter into contracts with Medicaid, and providers of items and services under these programs. The initial core set included several quality measures related to MH and SUD that are not included among the quality measures listed in the proposed ACO regulations, such as

- Screening, brief intervention, and referral for treatment for alcohol misuse (discussed above),
- Follow-up after hospitalization for mental illness
- Several specific bipolar and schizophrenia related measures, and
- The initiation and engagement of alcohol and other drug dependence treatment and mental health utilization.

This initial core set was developed by reviewing measures from nationally recognized sources, including those endorsed by the USPSTF, the National Quality Forum, those submitted by

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[12] Kaiser Family Foundation. Medicare spending by state of enrollee, 2004. http://www.statehealthfacts.org/comparemaptable.jsp?ind=628&cat=6

[13] Han B, Gfroerer JC, Colliver JD, Penne MA. Substance use disorder among older adults in the United States in 2020. Addiction. 2009;104:88-96.

[14] Glantz MD, Sloboda Z: The elderly. In Coombs RH, Ziedonis DM (eds): Handbook on Drug Abuse Prevention: A Comprehensive Strategy to Prevent the Abuse of Alcohol and Other Drugs. Boston, Allyn & Bacon Press, 1995, p 429. Solomon K, Manepalli J, Ireland GA, et al: Alcoholism and prescription drug abuse in the elderly: St. Louis University grand rounds. J Am Geriatr Soc 41:57, 1993. Sorock GS, Shimkin EE: Benzodiazepine sedatives and the risk of falling in a community dwelling cohort. Arch Intern Med 148:2441, 1988. Sheahan SL, Coons SJ, Robbins CA, et al: Psychoactive medication, alcohol use, and falls among older adults. J Behav Med 18:127, 1995

[15] Adams WL: Potential for adverse drug-alcohol interactions among retirement community residents. J Am Geriatr Soc 43:1021, 1995. Glantz MD, Sloboda Z: The elderly. In Coombs RH, Ziedonis DM (eds): Handbook on Drug Abuse Prevention: A Comprehensive Strategy to Prevent the Abuse of Alcohol and Other Drugs. Boston, Allyn & Bacon Press, 1995. Solomon K, Manepalli J, Ireland GA, et al: Alcoholism and prescription drug abuse in the elderly: St. Louis University grand rounds. J Am Geriatr Soc 41:57, 1993.

Medicaid medical directors, measures currently in use by CMS, and measures suggested by the Co-Chairs and members of the Subcommittee of AHRQ's National Advisory Council.

CMS has already included a number of specific quality measures from the initial core set in the proposed quality performance measures to be required of ACOs. These include flu shots, weight screening, breast cancer screening, cervical cancer screening, the measures related to COPD, congestive heart failure, dehydration, bacterial pneumonia, uncontrolled diabetes admission rate, and others. It appears that the majority of the initial core set of Medicaid measures related to MH/SUD were arbitrarily left out of the ACO quality performance measures.

We urge that each of these critically important SUD/MH related measures included in the Initial Core Set of Health Quality Measures for Medicaid Eligible Adults be included in the ACO quality performance measures.

3. The proposed ACO guidance should be amended to include additional evidence-based MH- and SUD-related quality measures.

Like other chronic conditions, mental illnesses and SUD can be effectively prevented, treated, and managed, and millions of Americans are in recovery from these diseases. Full inclusion of MH and SUD in the quality measures is very important to ensure that individuals get the comprehensive care they need to effectively manage their disease.

In addition to the above-described measures, there are several MH- and SUD-related measures that we ask to be included in the ACO quality measures, such as:

- Drug misuse screening, brief intervention, and referral to treatment
- Suicide screening
- Screening for mental health related conditions, including trauma history, bipolar, and multiple mental health conditions
- Follow-up after hospitalization related to a substance use disorder
- Retention in substance use disorder and mental health treatment
- Medication management for medication assisted treatment for substance use disorders
- The use of appropriate patient placement criteria for mental health and substance use disorders.

Inclusion of these prevention and disease management measures will help ensure quality, coordinated care for enrollees with or at risk for MH/SUD. These measures have been used for a number of years and are extremely effective. It is critically important that those in need of the above services receive them for the reasons outlined below.

> Drug misuse screening, brief intervention, and referral to treatment. While the USPSTF has not yet determined the value of screening for illicit and prescription drug use, a significant body of evidence points to its effectiveness. The National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism and other distinguished researchers have demonstrated that screenings for drug use are effective tools to help identify adults in need of brief interventions and treatment services. Recent research

clearly demonstrates that rapid, economical screening and brief interventions reduce substance use and significantly reduce health care costs,[16] the ultimate goal, along with improved quality, of Accountable Care Organizations. Therefore, we ask that you include drug misuse screening, brief intervention, and referral to treatment among the prevention measures ACOs must meet for shared savings.

Suicide screening. Screenings for suicide ideations have been used for a number of years and have been effective tools to help identify many individuals in need of services. Suicide screenings are effective and a suicide screening measure should be included.

Screening for mental health related conditions, including trauma history, bipolar, and multiple mental health conditions. In addition to screening for depression, measures should include screenings for the full range of mental health conditions, including screening for trauma history, for bipolar disorder, and for multiple mental health conditions. Such screenings have been shown to be feasible and effective.[17] Therefore, we ask that you include screening for mental health related conditions, including trauma history, bipolar, and multiple mental health conditions in the ACO quality performance measures.

Given the low risk and low cost of screening for substance use and mental illness, and the current state of knowledge about the consequences of untreated addiction and mental illness, the harms associated with not screening are too severe to be ignored. Therefore, ACO quality measures should include the full range of mental health and substance use preventive services that have demonstrated clear effectiveness in reducing healthcare costs and improving overall health outcomes.

In addition to the above prevention-related recommendations, quality measures related to treatment and disease management for MH and SUD should ensure a continuum of quality services for enrollees, including managing the both the acute and chronic aspects of these diseases. We ask that the following disease management measures also be included:

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[16] See Madras, B.K. et al. "Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and 6 months later." *Drug and Alcohol Depend* [e-pub ahead of print], 2008.
See also Bernstein, J. et al, "Brief motivational intervention at a clinic visit reduces cocaine and heroin use." *Drug Alcohol Dependence* 77(1):49–59, 2005.
See also Humeniuk, R.; Dennington, V.; Ali, R.; and WHO ASSIST Phase III Study Group. *The Effectiveness of a Brief Intervention for Illicit Drugs Linked to the ASSIST Screening Test in Primary Health Care Settings: A Technical Report of Phase III Findings of the WHO ASSIST Randomized Controlled Trial (Draft)*. Geneva, Switzerland, 2008.
See also Devlin, R.J,, and Henry, J.A. "Clinical review: Major consequences of illicit drug consumption." *Crit Care*.12(1):202, 2008. Available at http://www.ncbi.nlm.nih.gov/pubmed/18279535?ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum.

[17] See Gaynes, Bradley et al, "Feasibility and Diagnostic Validity of the M-3 Checklist: A Brief, Self-Rated Screen for Depressive, Bipolar, Anxiety, and Post-Traumatic Stress Disorders in Primary Care." *Annals of Family Medicine*, Vol. 8, No. 2, March/April 2010

Follow-up after hospitalization related to a substance use disorder. We ask that you include a quality measure to ensure follow-up after hospitalization related to a SUD. It is critically important that enrollees in need of SUD treatment and care receive it, and appropriate follow up to acute episodes is necessary to ensure that individuals are placed in the appropriate setting and transitioned to the appropriate level of care.

Retention in substance use disorder treatment. We also ask that you include a quality performance measure on retention in SUD treatment. We know that treatment works, and research has shown length of treatment is clearly linked to better outcomes in both adolescents and adults.[18]

Medication management for medication-assisted treatment for substance use disorders. In addition, we ask that you add medication management for medication-assisted treatment for SUD to required performance measures. A variety of medications for the treatment of substance use disorder exists, and medications, when utilized in conjunction with psychosocial treatment/support, are effective and have been endorsed by the National Council for Quality Assurance[19], the National Quality Forum[20], and other public and private accrediting bodies. Indeed, the National Quality Forum, as part of consensus standards for the treatment of substance use disorders, noted that "pharmacotherapy should be a standard component of treatment for substance dependence when effective drugs exist."[21]However, medication-assisted treatment is largely underutilized for the treatment of SUD. It is therefore essential that medication management for medication assisted treatment for SUD be included.

Use of appropriate patient placement criteria for mental health and substance use disorders. We also ask that use of appropriate patient placement criteria for MH and SUD be included as a measure. High quality care related to these conditions is only possible if individuals are properly evaluated and placed into the appropriate level of care for their mental illness and/or substance use disorder.

4. **As further guidance on ACOs is developed, CMS should continue to work to ensure that the needs of individuals with or at risk for mental illness and SUD are well addressed.**

As CMS understands, and the proposed ACO regulations reflect, performance-based payment approaches may tempt healthcare providers to avoid potentially high-cost or high-risk patients, and/or deny care to those most in need. We applaud the strong emphasis in the proposed regulations aimed at avoiding such practices. However, we are concerned that individuals with or in recovery from MH/SUD may be at particular risk if an ACO or associated professional is able to avoid or otherwise deny care to those with more complex health needs. This is

[18] See Hermann, Richard C. et al, "Quality indicators for international benchmarking of mental health care." *International Journal for Quality in Health Care*, September 2006.31-38.
[19] American Medical Association and National Council for Quality Assurance, "Substance Use Disorders: Physician Performance Measure Set," 2008.
[20] NQF, *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*, 2007.
[21] NQF 2007, pg 13.

particularly important considering the strong and necessary electronic health record component to ACOs, and the potential for data mining to select healthier individuals for enrollment and not those individuals that may be higher cost.

We ask CMS to pay special attention to the unique needs and vulnerabilities of those with MH and SUD needs, and oversee ACOs in a way that prevents them from avoiding or denying care to these individuals. We ask that the strongest consumer protections be enforced. Specifically, we ask that enrollees with MH/SUD be included as a monitored population to ensure ACOs are not avoiding those with MH/SUD needs. We also ask that CMS require ACOs to have effective grievance measures in place to ensure that beneficiaries have recourse against any potential unfair practice.

Similarly, as CMS finalizes regulations regarding the governing structures of ACOs, we ask that regulations require the inclusion of MH and SUD experts on governing boards and other panels with authority over ACOs, to ensure the MH/SUD needs of enrollees are most effectively being met. We also ask CMS to require that ACOs follow strong enrollment facilitation procedures to ensure that all who are eligible and want to participate are easily able to access the full range of quality care they need. This is especially important for individuals with MH and SUD treatment needs, since they are more likely to have difficulties navigating a complicated system. It is also important that efforts be taken to minimize or eliminate geographical barriers to participation and care delivery, particularly in rural areas.

We also ask that the appropriate federal administrators and experts be included in the development and governance of ACOs, including those with MH and SUD expertise. Specifically, we request that the Substance Abuse and Mental Health Services Administration (SAMHSA) be given a consultation and oversight role in the development and ongoing governance of ACOs, similar to the central role of SAMHSA regarding the approval and oversight of the new Medicaid Health Home State Option. We also ask that CMS work with SAMHSA to ensure that enrollees with MH/SUD needs who are targeted as high-risk and for whom individualized care plans are developed are properly identified, their privacy is protected, and their needs are met. Effective attention to the unique needs of enrollees with MH/SUD will result in improved health outcomes and significant cost-savings, helping to ensure that ACOs effectively meet their goals.

SAMHSA has also done significant work related to the development of recovery oriented systems of care, and we urge CMS to work with SAMHSA to integrate recovery oriented systems of care into care coordination models implemented through ACOs.

We also urge CMS to consider existing research on evidence-based practices to prevent and treat mental illness and substance use disorders, and to help individuals sustain their long-term recovery from these chronic diseases. These include: the Comprehensive Community Mental Health Services Program for Children and Families and the Community Support Program (CSP); the National Quality Forum's "National Voluntary Consensus Standards of Care for Treatment of Substance Use Disorders: Evidence-Based Treatment Practices," the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC 2R), various Institute of Medicine (IOM) reports, the USPSTF and Health Resources Services Administration's Bright Futures

guidelines; and several Surgeon General Reports, including "Mental Health: A Report of the Surgeon General," "Mental Health: Culture, Race and Ethnicity," and the Surgeon General's "Call to Action To Prevent and Reduce Underage Drinking." These reports and tools, as well as others, continue to document the effectiveness of treatment for and prevention of mental health and substance use disorders.

Although there have been significant policy gains intended to improve access to MH and SUD related services over the past few years, there remain large treatment gaps, and quality of care for these diseases is not always available or accessible. As CMS continues to develop these and other regulations to implement the Affordable Care Act, we ask that you recognize the barriers and discrimination that have often faced those with MH/SUD and implement policies that reduce and eliminate these barriers to the availability of necessary MH/SUD care. In addition to the above recommendations specific to the implementation of the ACO provisions of the Affordable Care Act, we urge CMS to continue to collaborate with SAMHSA, given their work regarding the implementation of the ACA in identifying a wide range of services that are utilized by individuals and family members of individuals with, at risk for, or in recovery from mental illness and/or SUD.

5. CMS should continue to work with MH and SUD service providers to ensure they are best able to join with ACOs to meet the MH/SUD needs of enrollees.

ACOs must address the MH and SUD needs of enrollees to be successful. Research has shown that chronic physical illnesses very often co-occur with mental health and/or substance use disorders. For example, one recent study of Medicaid beneficiaries found that approximately two-thirds of those with a common chronic physical condition also had at least one MH or SUD condition, and those beneficiaries with co-occurring chronic physical illnesses and a mental health or substance use disorder had associated healthcare costs that were 60 to 75 percent higher than those with only physical chronic illnesses.[22] MH and SUD service providers have a long history of meeting the health needs of these hard-to-serve populations.

Most often the care provided by the MH/SUD system is financed by Medicaid, federal block grant funding, Medicare, and/or state general funds that may not cover the full cost of treatment. Much of the MH/SUD service delivery system is eager to take advantage of the opportunities presented by the Affordable Care Act, including those related to ACOs. However, unlike many other prospective or potential ACO participants, providers of MH and SUD related services are often small and/or non-profit. Most lack the resources, the capital, and the infrastructure available to the larger medical organizations. At the same time, those large healthcare providers that are in the best position to easily join or create an ACO often lack experience and the capability to effectively address and manage the health of individuals with MH and/or SUD service needs. Any ACO that fails to properly address the MH and SUD needs of enrollees will

[22] Cynthia Boyd, Bruce Leff, Carlos Weiss, Jennifer Wolff, Allison Hamblin and Lorie Martin (2010). "Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations." Center for Health Care Strategies, pgs. 4-5. Available at: http://www.chcs.org/usr_doc/clarifying_multimorbidity_patterns.pdf. The common chronic physical conditions were asthma/chronic obstructive pulmonary disease, congestive heart failure, coronary heart disease, diabetes and hypertension.

continue to experience significantly poorer health outcomes and higher costs for the population it serves, undermining its success. Therefore, ACOs have a very strong incentive to partner with MH and SUD service providers, and CMS should work with ACOs and MH/SUD service providers to facilitate their effective participation.

Similarly, there is a great need for SUD and MH providers to have access to resources and technical assistance to establish new or strengthen existing health information technology systems, especially considering the crucial technological capacity needs required of ACOs and their associated providers. Furthermore, most providers of SUD and MH services are ineligible for the meaningful use incentive payments authorized through the HITECH Act. As the SUD and MH fields continue to educate Congress about the need to make SUD and MH providers eligible for meaningful use incentives, we urge CMS to continue to explore additional mechanisms to provide health information technology resources to the SUD and MH communities. We also urge CMS to ensure that providers of SUD and MH services are eligible for and fully included in the various other health information technology initiatives that have been established. Without capacity and infrastructure funding, many MH and SUD providers will be unable to meet the certified EHR and certified Meaningful Use requirements of ACO participation.

Well coordinated, accountable healthcare designed to manage multiple chronic conditions must address mental illness and SUD. MH and SUD service providers have a responsibility to prepare themselves to participate in innovative delivery system models, and CMS and ACOs should work closely with MH and SUD service providers and make available the tools and technical assistance they need to effectively meet the MH and SUD needs of enrollees.

6. CMS should continue to work to ensure that providers participating in ACOs are educated about the confidentiality protections required by federal and state law for individuals receiving MH and SUD care.

We appreciate the specific attention paid to the protection of patient confidentiality in the proposed regulations. Successful development of ACOs and other health system innovations depends on robust data collection and electronic health record systems, and as health information sharing systems are more broadly established we ask that CMS and the Department of Health and Human Services (HHS) continue to prioritize patient confidentiality protections.

We strongly support the goals of integrating MH and SUD care more effectively with the rest of health care and improving communication between SUD and MH service providers and other health care professionals. We believe that electronic health record systems can and should be constructed in a way that protects MH and SUD patient records while allowing them to be shared with other treating professionals as allowed by federal confidentiality rules. The same is true for state laws that mandate enhanced confidentiality protection for mental health, HIV/AIDS, domestic violence and other records. Communication can be enhanced without compromising confidentiality; the advent of electronic health record systems can make achieving these twin goals easier, not harder.

However, there continues to be a huge need for education in all parts of the healthcare system about how information can be shared—especially how SUD records can be included in electronic health record systems while complying with the confidentiality requirements of 42 CFR Part 2. We urge CMS to continue working with HHS's Office of the National Coordinator for Health Information Technology's (ONC) and SAMHSA to ensure that providers are educated about how information can be shared while maintaining privacy protections and to develop guidance to the field, including providers and consumers, about privacy protections and information exchange.

The development, evaluation, and oversight of ACOs remain in the beginning stages of what will be a years-long transition requiring a highly efficient, electronic health records system. Moving forward, we ask that CMS and the Department of HHS continue to work closely with SAMHSA and the MH/SUD field to ensure that the confidentiality of highly sensitive and still stigmatizing health information is protected as health information technology systems are created and maintained.

Thank you again for the opportunity to provide comments on the proposed ACO regulations, and for including MH and SUD services as a top priority. We strongly support the goals of healthcare reform to ensure that all Americans have access to high quality, affordable health care, including mental health and substance use disorder care. We are particularly pleased that MH and SUD are included in a number of key provisions of the Affordable Care Act; indeed, the central goals of health reform to improve overall health and reduce health care costs will only be accomplished if mental illnesses and SUD are addressed and treated as the preventable, treatable, chronic diseases that they are. To achieve these goals, however, it is critically important that ACOs, in particular, address these diseases as they seek to coordinate care, promote outcomes, and reduce costs, and to accomplish that requires the inclusion of the additional MH and SUD quality measures and other provisions described above.

Please feel free to use NASADAD as a resource as you move forward.

Sincerely,

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Robert Morrison
Executive Director

Cc: Flo Stein (N.C.), NASADAD President