NASMHPD

National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302, Alexandria, VA 22314 (703) 739-9333 Fax (703) 548-9517

January 8, 2016

Sen. Orrin G. Hatch
Chairman
Senate Finance Committee
104 Hart Senate Office Bldg.
Washington, DC 20510

Sen. Ron Wyden
Ranking Member
Senate Finance Commerce
221 Dirksen Senate Office Bldg.
Washington, DC 20510

Re: Request for Comment on Medicaid Data Gaps and Streamlining Federal Medicaid Reporting Requirements to Reduce Redundancies and Better Inform Federal Policy Decisions and Operational Issues

Dear Chairman Hatch and Ranking Member Wyden:

The National Association of Mental Health Program Directors (NASMHPD)—the member organization representing the state executives responsible for the $37 billion public mental health service delivery systems serving 7.2 million people annually in 50 states, 4 territories, and the District of Columbia—appreciates the opportunity afforded by the Senate Finance Committee to comment on the streamlining of Federal Medicaid reporting requirements.

Align CMS Behavioral Health Measures with SAMHSA Measures

It is one of NASMHPD's greatest frustrations that measures of mental health and substance use disorders developed for the Medicaid and Medicare programs by the Centers for Medicare and Medicaid Services (CMS) with the assistance of the National Quality Forum's Measures Application Partnership (NQF-MAP) are often developed independently or with little input from the Substance Abuse and Mental Health Services Administration (SAMHSA). Although SAMHSA officials often serve ex-officio on NQF-MAP workgroups, they cannot vote and their recommendations are sometimes disregarded. Conversely, until recently—with the proposed measures for the § 223 Excellence in Mental Health Demonstration Program—SAMHSA has not always consulted with CMS in implementing its own quality measures. As a result, CMS's Medicaid behavioral health quality measures are seldom aligned with the quality measures mandated by SAMHSA, leading to undue administrative burden and sometimes conflicting direction.

For example, in the development in 2014 by MAP of the 2015 Medicaid Core Children's Health Quality Measures, SAMSHA had sent a letter of support for a measure of Preventive Care and Screening for Clinical Depression and Follow-Up, one of the five behavioral health measures being considered. That measure

was rejected by the MAP workgroup on October 17, 2014 when it received only five of the necessary seven workgroup votes for quorum passage because only five states were currently doing analogous *adult* screenings and because the screenings could be operationally challenging for providers. MAP workgroup members—including one workgroup managed care member with a clear conflict—contended that not all states or managed care providers had the capacity to conduct the required follow-up planning.

During the October 17 discussions leading to the report recommendations, MAP members indicated they were waiting for more perfect child behavioral health quality measures to emerge from the CMS-designated Pediatric Centers of Excellence. While NASMHPD, like the MAP members, was pleased there were several promising measures in the developmental pipeline, the time had arrived to strengthen quality measurement of Medicaid child behavioral health services. Unfortunately, that did not occur.

Many studies have shown a high prevalence of co-occurring medical conditions among individuals with behavioral health conditions. The rate of depression among those with medical illnesses in primary care settings is estimated at 5 to 10 percent. Among those hospitalized, the rate is estimated at 10 to 14 percent. The more severe the medical condition, the more likely that the patient will experience clinical depression.[i] At the same time, depression and other behavioral health conditions may be a precursor to severe medical conditions. Individuals who get treatment for co-occurring depression often experience an improvement in their overall medical condition, better compliance with general medical care, and a better quality of life.

In its report of recommendations, the MAP workgroup built a strong case for the need for additional behavioral health measures, highlighting the high frequency of emergency department visits by Medicaid children with mood and conduct disorders and noting that the most costly medical conditions among Medicaid children are mental disorders. Unfortunately the final measures recommendation to CMS included only one behavioral health measure—Suicide Risk Assessment—and then ranked that measure only fourth of the six quality measures recommended for addition to the Medicaid Child Core Set in 2015.

An alignment of CMS Medicare/Medicaid and SAMHSA mental health and substance use disorder quality reporting measures would not only relieve the administrative burden on providers, state agencies, and even the Federal agencies administering programs, but also ensure a higher level of reporting compliance and completion and more timely reporting of the measures required by both agencies. NASMHPD believes such an alignment should be a high priority as the Senate Finance Committee assesses how best to streamline Federal Medicaid reporting requirements.

Review Reporting Requirements to Ensure They Remain Relevant and Are Non-Duplicative

NASMHPD is in agreement with the National Association of Medicaid Directors (NAMD) that any new data collection efforts must include a concurrent effort by CMS to pare down existing data reporting requirements that are duplicative or no longer relevant to Medicaid operations and oversight. New data reporting requirements—whether from CMS, SAMHSA, or other Federal agencies—are almost never accompanied by the elimination of existing reporting requirements no longer aligned with the current goals of the mandating agency's programs. Such a review should be

automatic whenever a new regulation is proposed.

In a related area, where the same data is being collected by multiple Federal agencies, those agencies should share collection instruments, collections, and the data collected, rather than burdening states and providers with multiple duplicative collections of the same information.

Share Federal Data More Expeditiously and More Timely with State Agencies

We are also in agreement with NAMD that Federal agencies should share actionable data with state agencies on a timely basis. Although some progress has been made in this regard, and the long-promised launch of the Transformed Medicaid Statistical Information System (T-MSIS) should ensure a sea change of sorts, the lagging publication of data collected by CMS often means the information shared with states, when shared, is no longer meaningful. A more timely and robust process for data-sharing is essential to an efficient and effective meaningful use of data in ensuring a responsive health care system that achieves positive health outcomes for all program consumers.

Thank you for your consideration of these concerns. If you have additional questions regarding the various issues raised in this correspondence, please feel free to contact NASMHPD's Director of Policy, Stuart Gordon, at stuart.gordon@nasmhpd.org or 703-682-7552.

Sincerely,

Brian Hepburn, M.D.
Executive Director
National Association of State Mental Health Program Directors (NASMHPD)

[i] National Institute of Mental Health, “Co-occurrence of Depression with Medical, Psychiatric and Substance Abuse Disorders” (1999).