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February 7, 2018

The Honorable Seema Verma
Administrator
Center for Medicare and Medicaid Services
Room 314G-01
200 Independence Avenue
Washington, D.C. 20201

Seema.Verma@cms.hhs.gov

Re: Suggested Measures for Proposed Medicaid Agency Report Cards

Dear Administrator Verma:

The National Association of State Mental Health Program Directors (NASMHPD), and in particular its Finance and Policy Division, took great interest in your announcement at the November 2017 annual meeting of the National Association of Medicaid Directors (NAMD) that the Centers for Medicare and Medicaid Services (CMS) would be developing an annual report card on State Medicaid Agencies and on CMS itself.

The members of NASMHPD—the state executives responsible for the \$41 billion public mental health service delivery systems serving 7.5 million people annually in 50 states, 4 territories, and the District of Columbia—derive on average about 29 percent of their funding for services from the Federal Medicaid program through State Medicaid Agencies and work closely with the state Medicaid Agencies in meeting the needs of individuals with mental illness or substance use disorders (SUDs).

We agree that providing comparative data on the administration and outcomes of Medicaid service provision is a valuable endeavor and appreciate your leadership in initiating such a system. Because of our close working relationships with the State Medicaid Agencies, we have taken the opportunity in this letter to make general suggestions regarding the development of report cards for Medicaid agencies and to provide suggestions specifically related to widely endorsed and evidence-based behavioral health service measures.

Report cards are point-in-time comparisons, which should be interpreted carefully, over time, and with an understanding of the context in which states operate. The public health infrastructure and health resources available or lacking in a state, geography, economy, culture and other factors play a significant role in health outcomes which may be outside the scope of authority of the state Medicaid agencies.

The development of Medicaid agency report cards should be an evolutionary process which occurs over several years. Report cards could initially include a small set of key standardized, evidence-based and widely endorsed measures that are derivable from extant data sources and processes, such as claims and encounter data

NASMHPD Letter to Administrator Verma on Medicaid Agency Report Cards

sets, and which are commonly collected by state Medicaid agencies and applicable to significant numbers of Medicaid clients and/or expenditures. Reporting parameters should be consistent over time, when possible, to enable the tracking and trending of data, yet flexible enough to reflect changed population health and demographic conditions within the state.

In this letter, we suggest the use of two different categories of metrics:

- 1) Improvements In or Maintenance of Positive Enrollee Health Outcomes: and
- 2) Administrative System Performance.

Improvements In or Maintenance of Positive Enrollee Health Outcomes

In the first category for measurement, while process measures are valuable, we agree with your public statements that an increasing emphasis on outcomes is important. The Centers for Medicare and Medicaid Services' Medicaid core measure sets contain some process and outcome measures that would be appropriate for consideration early in the development of the report card. Examples include:

- follow-up care for children receiving medication to treat ADHD;
- follow-up after hospitalization for mental illness;
- use of first line psychosocial care for children on antipsychotics;
- screening for multiple concurrent antipsychotic use in children and adolescents;
- initiation and engagement in substance use disorder (SUD) treatment;
- medical assistance with tobacco use cessation;
- antidepressant medication management;
- follow-up after emergency department (ED) visits for mental health or SUD issues;
- screening for use of opioids from multiple providers or at a medically unjustified high dosage
- antipsychotic medication adherence for persons schizophrenia; and
- screening to identify concurrent use of opioids and benzodiazepines.

As the reporting system matures, measures can expand to include outcomes for co-occurring physical conditions as well as behavioral health outcomes for subpopulations, such as individuals with serious mental illness (SMI) and serious emotional disturbance (SED). Examples of measures for people with SMI might include cardiovascular and diabetes screening, monitoring, and care; SUD screening; and monitoring for high blood pressure. Understanding the factors driving preventable inpatient admissions and ED visits will require analysis of multiple variables over time.

Additionally, health outcome data can be enriched by including parameters such as social determinants of health. These parameters are significant outcomes in themselves and are also important in understanding and describing differences in health outcomes. Since these data elements are not typically collected within current Medicaid Management Information Systems (MMIS), states would benefit from Federal financial and technical assistance to enable their collection, analysis, and reporting. CMS could also consult with NASMHPD's member state mental health authorities, who typically collect this information as part of client assessment and performance reporting and with

those Medicaid agencies that have experience in attempting to collect and use such data. We would be happy to facilitate consultation with our member state mental health authorities and with the NASMHPD affiliated National Research Institute.

The need for financial incentives and technical assistance would also apply to any collecting and using of clinical outcomes data such as body mass index and lab values, which currently can be a very time-consuming and expensive process for Medicaid agencies, requiring the collection and validation of medical record data directly from providers.

Administration System Performance

Integration of behavioral health into the overall Medicaid system is of great interest to stakeholders. As CMS has observed in the past, there are few extant structural measures of behavioral health integration, so measures of the existence of data-sharing agreements at the state level (between state mental health authorities and Medicaid agencies) and at the provider level are important in understanding how well systems may be working. Other administrative system performance measures could include:

- the array of behavioral health services available through a state's Medicaid plan, including clinical services and rehabilitative services such as peer support;
- Medicaid eligibility policies which promote treatment continuity for populations such as people who have been incarcerated;
- stakeholder engagement in the development of state plan amendments and waivers; and
- value-based purchasing strategies which promote access to and integration of behavioral health services.

We agree that measures applicable to CMS should be included in the report card system. Report card measures applicable to CMS would include process and output measures of key interest to stakeholders, which are congruent with state-level reporting measures. Examples might include:

1. Processes proposed state plan amendments and waivers in a timely manner. (Potential measures: Number of state submissions which have received a substantive CMS response within XX working days. Number and/or percent of waivers and SPAs submitted for approval that are pending for more than XX days.);
2. Effectively engages state Medicaid agencies, allied agencies (such as mental health authorities) and other stakeholders in program and regulation development, as evidenced by stakeholder satisfaction surveys or other methods;
3. Collaborates with states to effectively address state-identified population and health care needs as evidenced by stakeholder satisfaction surveys or other methods;
4. Develops guidance which incorporates evidence-based practices and incentivizes states to develop and/or adopt evidence-based practices (Potential measure: number of EBPs that states report using as a result of CMS guidance / incentives.)
5. Incorporates in endorsed measures, where appropriate, consideration of social determinants of health and mental health; (Potential measure: Documented endorsement processes which consider social determinants.); and
6. Collaborates with other Federal agencies to ensure that Federal programs addressing similar populations are interactive and not siloed or duplicative (Potential measure: number and type of joint efforts, data sharing agreements and other efforts).

7. Complies with all legal notice and comment requirements to ensure that stakeholders have opportunity to provide input into Federal regulatory decision-making and that such input is considered by CMS in a timely and transparent manner and subsequently published.
(Potential measure: Number / percent of comment processes which meet legal notice and comment requirements.)

Thank you for your consideration of these suggestions. We hope you find them helpful.

If you have any questions about this correspondence, please do not hesitate to contact NASMHPD's Director of Policy and Communications, Stuart Yael Gordon, by [email](#) or at 703-682-7552.

Sincerely,



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

cc: Kirsten Beronio
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