



August 24, 2017

VIA ELECTRONIC MAIL

CMS Innovation Center
CMMIBH Summit mailstop 08-64
2810 Lord Baltimore Drive, Suite 130
Windsor Mill, MD 21244-1850

Dear CMMI Administrators,

The Health Care Transformation Task Force (“HCTTF”) is a 43-member consortium comprised of patients, providers, payers and purchasers, that strives to accelerate the pace of value-based transformation. Our payer and provider members are committed to placing 75 percent of their business into value-based payment arrangements by 2020. As part of our commitment to value-based care, we are actively engaged in identifying areas for improvement among the high-need, high-cost population. Among the most critical areas identified by the HCTTF for the advancement of value-based care is improved integration of behavioral health services.

Given the HCTTF’s commitment to value and innovation, we strongly support efforts by the Center for Medicare and Medicaid Innovation (“CMMI”) to integrate multi-stakeholder feedback in the development of behavioral health models. The HCTTF notes that there are already a number of innovative efforts underway to address patients’ behavioral health needs. One example is New York’s Delivery System Reform Incentive Payment Program, which uses a Medicaid waiver to reinvest in a restructured delivery system, including implementation of a primary and behavioral health integration model. Despite existing efforts, there is much more to be done; here are areas of potential consideration for future behavioral health models.

A. Increased flexibility on privacy requirements for data-sharing

The HCTTF highly encourages CMMI to coordinate with SAMHSA to increase flexibility in patient data sharing requirements. The HCTTF previously provided comments to SAMHSA on the Confidentiality of Substance Use Disorder Patient Records Final Rule, which implements changes to 42 CFR Part 2; the HCTTF urged SAMHSA to include care coordination and case management in the list of services permitted to receive/share substance use disorder records. In future behavioral health models, the HCTTF supports the modernization of data sharing requirements, as they play an integral role in improving health outcomes by monitoring and identifying patients for population health management. We also support the inclusion of consent policy best practices, including an examination of the limitations presented by the 42 CFR Part 2 provisions on the ability for providers to engage in the recommended data sharing approaches and provide high quality treatment and care coordination that address all of a patient’s health needs. Coordination on these fronts will hopefully mitigate many practical challenges, such as the difficulty in obtaining member consent from Alzheimer’s patients to share data with their families and caregivers.

B. Focus on widespread adoption of existing models, a unifying funding approach, and better state/federal coordination

A rich body of research and evaluation already exists for effective integration of behavioral health into medical care, along with examples of successful integration. While the HCTTF acknowledges that this is a great first step, we also note that there has been relatively little uptake and scaling of this research. While new G-codes and CPT codes were recently introduced to improve coding and payment for behavioral health integration efforts, these codes have been limited in their applicability and uptake. The HCTTF encourages CMMI to develop scalable, replicable models built on this existing body of behavioral health integration research, and to develop broader, more flexible payment structures to support these integrated approaches. Furthermore, the HCTTF encourages CMMI to work with states to streamline federal and state regulations for behavioral health services.

C. Specificity of model design by patient population and market dynamics

Behavioral health needs vary significantly from patient to patient and market to market. Treatments that may be suitable for one subpopulation may not be appropriate for another; hence the challenge with a one-size-fits-all behavioral health model. The HCTTF highly encourages CMMI to engage in exploration and analysis of specific patient subpopulations and market dynamics. For example, in certain geographic areas, skilled nursing facilities have closed many of their wandering dementia units due to underuse, making it difficult to locate appropriate providers and engage members in these settings. We also support the development of multiple models and/or widening the applicability of existing integration models to address a broader range of behavioral health issues.

The HCTTF welcomes further opportunity to share the knowledge of its members and collaborate with CMMI on the development of behavioral health models. Please contact HCTTF Director of Transformation Facilitation and Support Caitlin Sweany (caitlin.sweany@hcttf.org; 510.506.8972) or Clare Wrobel, Director of Payment Reform Models (clare.wrobel@hcttf.org; 202.774.1565) for follow up. We look forward to working with you on this important initiative.