May 14, 2012

Marilyn Tavenner, MHA, BSN, RN
Acting Administrator and Chief Operating Officer
Centers for Medicare and Medicaid Services
Department of Health and Human Services,
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-0044-P

Dear Ms. Tavenner:

The TeenScreen National Center at Columbia University, our partners in the CheckUpNow Coalition, and the undersigned organizations are pleased to have the opportunity to comment on the proposed rule outlining Stage 2 of Meaningful Use (MU) for the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs. The transition to MU of EHRs by health care providers presents a very real opportunity to improve quality of care and health outcomes. The objectives and clinical quality measures proposed for Stage 2 will help to realize this potential, and they significantly improve upon Stage 1 by taking a more comprehensive approach to assessing quality of care for those conditions with the greatest disease burden in the United States, including mental and substance use disorders.

Clinical Quality Measures and Reporting Should Assess Whole Health

Reporting on clinical quality measures (CQMs) by eligible professionals is a key component of the Medicare and Medicaid EHR incentive programs' potential to drive improvements in quality of care and public health. CMS' stated goals include assessing the quality of care for conditions that contribute the most to morbidity and mortality and drive healthcare spending by CMS beneficiaries. If quality reporting is to effectively address these goals, mental health and substance abuse measures must be adequately represented in the final rule for Stage 2 MU.

Mental illness and substance abuse disorders account for a significant proportion of morbidity and mortality in the United States and are key drivers of healthcare spending. According to the National Institute of Mental Health (NIMH), one-in-four adults and as many as one in five young people suffer from a diagnosable mental illness that is significant enough to cause functional impairment. In addition, the National Institute on Drug Abuse (NIDA) reports that 22 million Americans suffer from drug abuse or addiction, and mental illness and substance abuse are often comorbid. The economic toll is staggering. The World Health Organization reports that mental illness is the leading cause of disability for Americans 15 to 44 years of age, and it is associated with an increase in other chronic diseases and higher overall health care spending (Katon, 2011 and Welch et al. 2009). Meanwhile, NIDA reports that the economic costs of drug abuse and addiction exceed half a trillion dollars annually, including health and crime-related costs and losses in productivity.
When CMS finalized Stage 1 MU, public comments raised concerns about the lack of CQMs addressing mental and substance abuse disorders. We commend the introduction of a greater number of CQMs relating to these disorders in the proposed reporting sets for eligible professionals in Stage 2 MU. The retention of most or all of the 12 new proposed measures relating to mental health or substance abuse in the final rule for Stage 2 MU would more effectively address the quality of care for prevention, detection and treatment of mental illness and substance abuse across the lifespan. We urge CMS to retain an appropriate balance of mental health measures in the core and menu sets for eligible professionals in the final rule.

**Measure 418 – Screening for Clinical Depression – should remain in the core (table 6) and menu (table 8) CQM sets in the final rule.**

We commend the inclusion of Measure 418 in the proposed core and menu sets of CQMs for Stage 2 MU, and we urge CMS to retain this measure in both sets in the final rule. Measure 418, which assesses “the percentage of patients aged 12 years and older screened for clinical depression using an age-appropriate standardized tool and follow up plan documented,” is wholly consistent with the criteria identified as desirable CQM attributes. It assesses a clinical process linked to evidence based practice guidelines for population and public health; evaluates care for a prevalent, costly, chronic condition responsible for a large proportion of morbidity among CMS beneficiaries; evaluates a known, especially vast gap in quality of care; applies to a broad array of provider types and patient age ranges; and is included as an illustrative measure in the National Quality Strategy. Measure 418 is also an existing PQRS and adult Medicaid (Sec. 2701 of the Affordable Care Act) measure, meaning that it will help to achieve alignment across programs and is a clear indicator that this measure can be successfully implemented within the CMS infrastructure for data collection, analysis and calculation.

According to the NIMH, approximately 9.5 percent of the adult population suffers from depression. Data from the National Survey on Drug Use and Health show a similar rate (8.3 percent) of depression among youth. The effect on health outcomes and quality of life is significant. A 2009 study concluded that “as a mortality risk factor, the effect of depression is comparable in strength to smoking” (Mykletun et al. 2009). The World Health Organization reports that depression is now the leading cause of disability-adjusted life years (DALYs) in the United States and Canada, i.e., it results in the greatest number of years lost to illness, disability or premature death. In total, the U.S. Preventive Services Task Force has estimated that the costs associated with depression in youth and adults equal approximately $83 billion.

Furthermore, depression is also a risk factor for other chronic conditions. Research has established a bidirectional relationship between depression and conditions such as heart disease, diabetes, and obesity, with each condition increasing the propensity for an individual to develop the other. According to the Institute of Medicine (IOM), depression in adolescence and early adulthood is associated with three health behaviors – obesity, smoking and sedentary lifestyle – that are estimated to cause 40 percent of premature mortality in the United States. When it is comorbid with another chronic condition, depression also escalates health care spending. In *Living Well with Chronic Illness: A call for public health action*, the IOM reported that depression increases medical costs for comorbid conditions by 50 to 100 percent.

Fortunately, evidence shows that early detection and intervention for depression can improve outcomes and reduce costs. Decades of research has shown that in youth up to age 21, there is a window of opportunity of two to four years, between the first symptoms and the onset of the full-blown diagnosable disorder, when treatment is most effective at reducing the severity of specific disorders. The need for prevention and early intervention for mental disorders, including
depression, was stressed in the 2009 IOM report, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. However, today, only about one in three youth with a mental disorder are identified and receive services (Merikangas et al. 2005).

To ensure appropriate detection and intervention for depression, clinical guidelines call for routine depression screening. In 2009, the U.S. Preventive Services Task Force (USPSTF) recommended that primary care providers screen all patients age 12 years and older for depression. These recommendations represent the gold standard in preventive care. In addition to the USPSTF recommendation, the American Academy of Family Physicians, the American Medical Association, the American Academy of Pediatrics, and numerous other medical professional, mental health and public health organizations have endorsed routine depression screening beginning in adolescence.

Despite this consensus, there is a considerable gap between the standard of care and clinical practice. One survey of pediatricians and family physicians found that just 23 percent report routinely screening their adolescent patients for mental disorders (Frankenfield et al. 2000). A 2005 survey of pediatricians found that among those who do assess for mental disorders, 71 percent always or almost always rely on a clinical assessment rather than using a standardized screening instrument, despite evidence that this method will fail to identify about 50 percent of all patients suffering from a mental disorder (Sand et al. 2005, Jellinek et al. 1988).

The *National Quality Strategy* has recognized the potential of increased rates of depression screening to improve public health. In addressing the goal of improving the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care, the *National Quality Strategy* identifies “increasing the provision of clinical preventive services for children and adults” as an opportunity for success and cites the “percentage of children and adults screened for depression and receiving a documented follow-up plan” as an illustrative measure. Similarly, *Healthy People 2020* set a goal of increasing the rate of depression screening in primary care settings for patients age 12 and older.

Finally, as noted earlier, the inclusion of Measure 418 in the core and menu sets in Stage 2 MU would further align clinical quality reporting requirements across programs. Measure 418 is currently included in the Medicare PQRS program, as well as the adult Medicaid quality reporting program authorized by Section 2701 of the Affordable Care Act and the Medicare Shared Savings Program. In addition, Measure 418 is applicable to multiple eligible provider types and applies to a broad range of patients, allowing for a more parsimonious reporting set.

Given the strength of this measure when evaluated against the stated selection criteria for CQMs, Measure 418 should be included in the core set of CQMs for Stage 2 MU. We strongly endorse the retention of Measure 418 in the core and menu sets published in the final rule.

A measure on “Closing the Referral Loop” should be retained in the core (table 6) and Menu (table 8) CQM sets in the final rule.

The rate at which primary care providers receive a follow-up report from the provider to whom they have referred a patient is an important indicator of quality of care. A well-crafted CQM addressing this issue would make a valuable addition to the core and menu sets. Because it applies to all health conditions, including mental and substance abuse disorders, and across all patient populations, such a measure also would contribute to parsimonious quality reporting.
Reporting Option 1b Would Most Effectively Drive Improvements in Public Health

To ensure that Stage 2 MU is most effective in spurring improved quality of care and resultant health outcomes, we urge CMS to require that eligible professionals report using Option 1b, i.e., reporting the full set of CQMs in the core set (table 6), plus one CQM from the menu set (table 8). In explaining the selection of CQMs for the core set in Table 6, CMS indicates that it assessed the measures against the following criteria:

- Conditions that contribute the most to Medicare and Medicaid beneficiaries’ morbidity and mortality;
- Conditions that represent national public/population health priorities;
- Conditions that are common to health disparities;
- Conditions that disproportionately drive healthcare costs that could improve with better clinical quality measurement;
- Measures that would enable CMS, states, and the provider community to measure quality of care in new dimensions with a stronger focus on parsimonious measurement; and
- Those measures that include patient and/or caregiver engagement.

The clear advantage of this reporting option is the ability to direct a large segment of health care providers to concentrate their quality reporting, and associated quality improvement efforts, on services for conditions and risk factors associated with the overwhelming majority of morbidity and mortality in the United States. The core measures address chronic conditions and risk factors for chronic conditions, such as obesity, high blood pressure, heart disease, stroke, and depression, which account not just for the majority of morbidity and mortality, but also drive the majority of health care spending. According to the Institute of Medicine (IOM) report *Living Well with Chronic Illness: A call for public health action*, chronic conditions now account for 75 percent of the $2 trillion in annual health care spending.

This approach to quality reporting would also ensure that the clinical quality measures reported by eligible professionals pertain to whole health, including measures relating to depression and tobacco use screening. By contrast, Option 1a, which requires providers to report on 12 measures with at least two from each domain (patient and family engagement; patient safety; care coordination; population and public health; efficient use of healthcare resources; and clinical processes/effectiveness) would most likely result in a significant number of providers failing to report any mental health or substance abuse measures. Consequently, we urge CMS to require reporting under Option 1b.

**Increasing Required Objectives for Stage 2 MU**

The proposal to require a total of 17 core objectives and five menu objectives for Stage 2 MU also has the potential to improve quality of care and health outcomes. Because the objectives focus on assuring processes associated with quality care, rather than specific clinical services, they provide a mechanism to improve care and outcomes for a broad range of conditions. We endorse the proposed increase in the number of required objectives, and we urge CMS to retain these changes in the final rule.
The quality reporting requirements and increased number of objectives proposed for Stage 2 MU of EHRs present an exciting opportunity to improve quality of care and resultant health outcomes in the United States. The TeenScreen National Center, the CheckUpNow Coalition, and the undersigned organizations urge you to make the most of this opportunity by requiring reporting under Option 1b and ensuring that Measure 418 is retained in the core and menu sets in the final rule.

Thank you again for the opportunity to comment. We appreciate your leadership on this incredibly important issue.

Sincerely,

TeenScreen National Center at Columbia University

American Academy of Addiction Psychiatry

American Association on Health and Disability

American Foundation for Suicide Prevention/SPAN USA

American Group Psychotherapy Association

Anxiety Disorders Association of America (AADA)

The Association for Ambulatory Behavioral Healthcare (AABH)

The Depression and Bipolar Support Alliance (DBSA)

The Drug Policy and Public Health Strategies Clinic of the University of Maryland Francis King Carey School of Law

The Jed Foundation

Legal Action Center

Mental Health America (MHA)

NAADAC, The Association for Addiction Professionals

National Alliance on Mental Illness (NAMI)

National Association of State Mental Health Program Directors, Inc. (NASMHPD)

National Council for Community Behavioral Healthcare

Schizophrenia and Related Disorders Alliance of America

State Associations of Addiction Services

Treatment Communities of America