

November 9, 2010

National Committee for Quality Assurance
Submitted electronically at <http://publiccomments.ncqa.org/>

RE: Accountable Care Organizations (ACO) 2011

To Whom it May Concern:

The National Council for Community Behavioral Healthcare (“National Council”) welcomes the opportunity to respond to NCQA’s 2011 Draft Accountable Care Organization Criteria. The National Council, a non-profit association representing over 1,700 community-based mental health and addiction providers, is dedicated to fostering clinical and operational innovation and promoting policies that ensure the more than 8 million low-income children, adults, and families our members serve have access to high quality services. Our community mental health and addiction organizations have more than 40 years of experience and expertise in providing a range of clinic-based services and recovery supports for millions of individuals with multiple chronic health problems.

Thank you for this opportunity to submit comments on the draft criteria. Overall, we support the Proposed ACO Standards and elements, and suggest minor changes in the explanations to ensure that mental health and substance use (MH/SU) disorders are addressed in ACO development and operations.

General comments:

In our previous comments on the revised standards for Patient Centered Medical Homes, we encouraged NCQA to clarify the role of PCMHs to provide on-site treatment for mild to moderate MH/SU conditions, proposing the following language: *Assesses and provides on-site treatment for mild to moderate mental health and substance use conditions and arranges off-site treatment for those requiring more intensive MH/SU specialty services.*

We would urge that the same premise (*planned screening and intervention for mild to moderate MH/SU conditions in primary care and stepped care to MH/SU specialty services for more intensive service needs*) be incorporated into ACO standards. The U.S. Preventive Services Task Force combines screening with an expectation of an intervention. On-site treatment for mild/moderate depression is consistent with the IMPACT model of stepped care, and has been well demonstrated in a range of practice sites through the DIAMOND (MN) initiative. In addition, screening, brief intervention, and referral to treatment (SBIRT) for substance use conditions has been shown to be effective in primary care settings. An additional feature should include documentation of referral relationships/protocols for MH/SU specialty services.

Specific comments:

Pg 6: Resource stewardship.

In the explanation, regarding written UM decision-making criteria: we recommend that you ADD to the first mention of behavioral healthcare in this section the following: *includes addressing mental health and substance use conditions as well as behavioral medicine interventions targeted to physical health diagnoses.*

Pg. 8: Arranging for Services.

In the first paragraph of the explanation, we recommend that you ADD behind “specialists” the following: *including those addressing mental health and substance use conditions.*

Pg.13: Assessing Network Needs.

In the first paragraph of the explanation, we recommend specialty care practitioners should include an additional bullet: *those addressing mental health and substance use conditions.*

Pg. 26: Practice Team.

In the first paragraph of the explanation, for the sentence that reads “Team-based care involves both clinical and non-clinical staff (e.g., clinicians, nurses, medical assistants,” we recommend that you ADD “*behavioral health care managers.*”

Pg. 28: Guidelines for Important Conditions.

In element D, part 3, which reads “Third important condition must be related to unhealthy behaviors, mental health or substance abuse,” we recommend that you DELETE “abuse” and REPLACE WITH *use conditions.*

In the explanation for Factor 4 – “Complex or high-risk patients may include two or more of the following issues: Multiple co-morbidities, including mental health” – we recommend that you ADD *or substance use conditions.*

Page 34: Self-Care Process.

In the explanation, for the last sentence of the section for referrals to support programs, we recommend that you REWRITE this sentence to read: *Self-management programs include weight loss, substance use and smoking cessation programs, depression management, asthma education, diabetes education, and other health education classes or groups.*

Page 40: Identify High Risk Patients.

In the explanation, regarding the criteria for identifying complex or high-risk patients, we recommend for the bullet point “Multiple co-morbidities, including mental health” that you ADD *or substance use conditions.*

Page 50. Identifying Care Needs.

In the explanation, under examples for Documented Process and the bullet point “Description of the population health management programs or services patients are eligible for (e.g. tobacco cessation, diabetes disease management,” we recommend that you ADD *depression care management*).

Comments on Appendix A: ACO Measure Grid. Prevention Measures.

We recommend that you ADD to the appendix the following:

NQF # 0518 Depression Assessment Conducted

National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices:

Screening and Case Finding

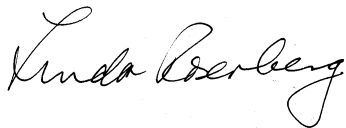
- 1. During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use.*
- 2. Healthcare providers should employ a systematic method to identify patients who use drugs that considers epidemiologic and community factors and the potential health consequences of drug use for their specific population.*

Diagnosis and Assessment

- 3. Patients who have a positive screen for—or an indication of—a substance use problem or illness should receive further assessment to confirm that a problem exists and determine a diagnosis. Patients diagnosed with a substance use illness should receive a multidimensional, biopsychosocial assessment to guide patient-centered treatment planning for substance use illness and any coexisting conditions.*

The National Council would like to thank NCQA for the opportunity to comment on the 2011 Draft ACO Criteria. Please let us know if you have any questions.

Sincerely,



Linda Rosenberg
President/CEO