3M Health Information Systems, Inc.
1425 K St NW, Ste 300
Washington, DC 20005

November 1, 2021

The Honorable Ron Wyden
Chairman
Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

RE: Policy Proposals to Address Unmet Mental Health Needs
Submitted via mentalhealthcare@finance.senate.gov

Dear Chairman Wyden and Ranking Member Crapo,

3M Health Information Systems (HIS) appreciates the opportunity to submit comments on policies and solutions to address barriers to and quality of mental and behavioral health across Federal and State healthcare programs. 3M applauds the committee for seeking data-driven and evidence-based approaches to these important healthcare issues.

3M comments will address the following issues related to the request for information:

- Risk Adjustment to Drive Quality and Equity
- Data
- Telehealth
- Quality Oversight

Risk Adjustment as the Foundation for Assessing Quality and Health Equity

Critical to all 3M has done to support Federal and state health care program initiatives is a strong belief in clinical risk adjustment. Most risk adjustment methodologies are regression-based with inherent limitations leading to baked-in inequities tied to prior utilization and lack of standard identification of cohorts for analysis over time. 3M recommends grouping beneficiaries into similar illness burden cohorts to aid the comparison of individuals with similar clinical complexity for assessing equity in care delivery and quality outcomes over time.

It is essential to avoid mis-identifying or misinterpreting the reasons for variation in beneficiaries' clinical outcomes by assuming it is due to inequitable care delivery. Conversely, it is essential to be able to compare individuals and cohorts with similar clinical complexity to expected outcomes, to understand extra-clinical factors like

neighborhood or racism which may be inappropriately leading to inequitable quality outcomes.

Risk adjustment should incorporate legitimate reasons for performance variation in efficiency or quality outcomes, such as gender or age. Using the patient's clinical condition in the risk adjustment means that the patient's clinical condition is judged to be a legitimate reason for different levels of per capita expenditures or outcomes. Once a patient characteristic is included in the risk adjustment, differences based on that characteristic disappear from any comparison of performance. Thus, the risk adjustment automatically removes (adjusts for) the impact of the characteristic on the outcome of interest.

Inclusion of factors relating to equity or disparities in the method of risk adjustment increases the chance of perpetuating structural biases because performance differences across racial and ethnic subgroups will be hidden in the analysis, as discussed above. Such differences in performance need to be highlighted, not eliminated by risk adjusting for them. Including race and ethnicity in the risk adjustment could essentially perpetuate low performance expectations for some racial groups.

To demonstrate how one might identify variation based on race and ethnicity while adjusting for clinical conditions, please visit the analysis of geographic differences in the risk of poor clinical outcomes from COVID for Medicare beneficiaries using 3M's Clinical Risk Grouper (CRG) methodology[1].

Risk adjustment should control for clinical characteristics and basic demographic characteristics (age and sex), which are legitimate reasons for variation in outcomes since they are biologically based. With this risk adjusted outcomes approach, it would then be possible to highlight and quantify differences due to race, ethnicity, language, poverty, or other social variables where there are observed inequities.

As the Committee seeks to address mental and behavioral health issues, we recommend that clinical and social issues not be considered in isolation. Rather, we urge that the clinical and social risks be viewed together to get a complete patient picture. Overlaying clinical and social risks creates the following advantages:

- ✓ Identifies high risk patients for prevention and care management outreach, which will drive desired health outcomes and avoid catastrophic health events.
- ✓ Allows for an effective communication through a language for payers and providers to use to describe and understand patient burden of illness and expected resource needs.
- ✓ Facilitates the comprehensive specification of the interaction among multiple comorbid diseases that is essential for identifying high risk patients and creates an unbiased assessment of care provision, benchmarked to an achievable and

[1] 3M-CER-COVID-study-May-2020-final5.3.pdf (netdna-ssl.com)

expected patient outcome norm.
- ✓ Sets up a clinical, statistically reliable model to monitor the effectiveness of care provision, identify instances of poor care delivery, and surface areas for collaboration with community-based organizations.

Comparing patients to understand if care needs are being met requires comparing patients with similar clinical needs. Only then can the variation in care be isolated for determining root causes for the differences and making needed changes to improve care for everyone.

Data

While the impact of social determinants of health is important across healthcare, these factors can be critically impactful in the behavioral and mental health space. Unfortunately, most data sets do not include the necessary patient information, some of which could be provided through z-codes, to identify the social influencers of health impacting the patient. Z codes are standardized as a segment of ICD-10 diagnosis codes and should be promoted to comprehensively and accurately capture SDOH to advance interoperability and equity of care objectives. To minimize reporting burden, it is important to have these data elements become part of the claims data so that the analysis of quality performance adds minimal extra reporting burden to the already over-stretched quality reporting systems.

Of note, in February 2021, the Centers for Medicare & Medicaid Services (CMS) released an infographic on using Z Codes (ICD-10-CM encounter codes used to capture social determinants of health (SDOH) data and Medicare contractors have updated coding guidelines that went into effect for Medicare in January 2021. The 2022 release of ICD-10 CM includes new z codes for education, food insecurity, and housing effective October 1, 2021. These updated coding guidelines are a big step forward to supporting whole person care. The move formally recognizes how SDOH can contribute to moderate medical decision-making complexity when a social need or social risk significantly limits diagnosis or treatment. It is now listed under risk for complications and/or morbidity or mortality of patient management, noting SDOH as one of the components for moderate level of medical decision making.

Providers have historically documented social history, and Z codes (Z55-Z65) capture these social needs and risks within the ICD-10 framework. Recognizing social needs have long been part of the visit and care plan, but now there is recognition that billing can be a factor in social needs limiting diagnosis or treatment as one of the components that would support a moderate physician evaluation and management (E&M) visit (using CPT codes 99214 or 99204).

With this new guidance, there is now enhanced payment recognizing that social risks or needs significantly impact diagnosis and treatment. The updated guidance signals to providers, patients, and payers that CMS considers SDOH a relevant component in the

financing and delivery of health care. This change should make the identification and capture of social needs more important for care teams knowing that it is not just for care planning, but for payment too. The Z code can be billed regardless of provider type, signaling the importance of care management and team coordination, including social workers and discharge planners.

This payment enhancement implemented for Medicare is recommended for all government funded behavioral and mental health programs. 3M recommends incentivizing the documentation of z-codes along with payment adjustments to reflect increased resource demands to meet patient treatment and care needs.

Telehealth

Audio and video telehealth have played a crucial role, during COVID-19 to improve access to care and to remotely manage patients. Telehealth decreases no-show rates, allows insights into the patient reality, and can alleviate patient anxiety related to in-office physician visits. This has been well documented even in underserved communities, including a study showing increased access to primary care services during the pandemic due to telehealth (audio and video) at a Washington, DC federally qualified health center (FQHC).[2]

We strongly support continued access to telemedicine services including audio-only as well as store-and-forward technologies, especially in the case of tele-mental health services. Due to insufficient supply of mental health clinicians and outdated payment policies, mental health service access is limited. In-person visits needlessly perpetuate these delays. Innovations in tele-mental health services reduce delays in diagnosis and treatment while improving access and should not require a face-to-face visit prior to engaging the telemedicine care.[3]

While we believe the value of face-to-face visit is overblown, it is reasonable to compare the impact of tele-mental health care with and without face-to-face care of varying intervals. Given the broad public attraction to virtual mental health care it should not be difficult to recruit beneficiaries into a comparative study assessing the impact on granular disease metrics (e.g. PHQ9) as well as indicators of population health outcomes (e.g. potentially preventable emergency department visits).

Barriers for video telehealth opportunities going forward include the temporary coverage and payment for telehealth as well as limited access for some to equipment needed for video telehealth, computer literacy, and broadband availability. For those without

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[2] https://www.himss.org/resources/providing-telehealth-visits-underserved-communities-case-study

[3] Yellowlees, Peter M, Alberto Odor, Michelle Burke Parish, Ana-Maria Iosif, Karen Haught, and Donald Hilty. "A Feasibility Study of the Use of Asynchronous Telepsychiatry for Psychiatric Consultations." Psychiatric Services (Washington, D.C.) 61, no. 8 (August 2010): 838–40. https://doi.org/10.1176/appi.ps.61.8.838.

technology access or in areas with limited broadband, audio telehealth was a primary avenue for provider access and should be considered as a permanent option for certain patients going forward. With the shortages of mental health care providers now and for the foreseen future, and the insights that telehealth gave providers into the patient reality, telehealth opportunities should also be continued to allow for more patients to be treated.

While there is research proving the value that telehealth brings to the patient and the healthcare system, ongoing concerns about over-utilization and effectiveness of the treatment modality suggest further research into cost-effectiveness and clinical outcomes may be helpful. 3M recommends that research be conducted to assess the impact telemedicine has had on the reduction of potentially avoidable health events, such as potentially avoidable hospital admissions, readmissions, or ER visits. Having clearly measurable outputs that can help track appropriate utilization allows for benchmarking for clinically similar cohorts, regardless of overlaid social factors. A number of state Medicaids, such as New York[4], Florida[5], and Texas[6], have adopted outcomes-based measures that compare actual to expected rates of potentially avoidable hospital admissions, readmissions and ER visits and incentivize performance that exceeds expected results. Such measures are comprehensive, balanced, and focused on potentially avoidable events that are adjusted based on a patient's clinical risk.

Quality Oversight

Whether it be for traditional behavior and mental health services or via telehealth options, 3M recommends the use of quality measures that focus on population outcome performance that speak to quality and cost over disease process measures.

Disease process indicators is a highly granular approach to quality measurement that creates a significant burden of work for clinicians in practice, often articulated as a great loathing of clinical documentation resulting in clinician burnout. In spite of advances in technology that mitigate this burden, the emphasis on granular process indicators misses too much of what is important in health care delivery: it implies that guideline-driven care processes are the pinnacle of practice, reducing clinician-patient relationship to a series of gaps-in-care transactions.

In addition, well-designed systems of care go beyond the actions of an individual clinicians. Administrative data can and should shed light on risk-adjusted rates of potentially preventable hospitalizations, emergency room use, complications etc. Population performance measures should reflect the broad population and not only a subset with a handful of conditions. These rates identify opportunities for improvement

[4] All Payer Potentially Preventable Emergency Visit (PPV) Rates by Patient Zip Code (SPARCS): Beginning 2011 | State of New York (ny.gov)
[5] Quarterly_SMMC_Report_PPE_Winter_2018.pdf (myflorida.com)
[6] Texas Healthcare Learning Collaborative (thlcportal.com)

at the intersection of cost and quality and better reflect the effectiveness of a system of care, thus better serve the needs of Medicare, Medicaid, CHIP, and ACA beneficiaries and taxpayers.

Again, we thank you for the opportunity to comment. If you have any questions, please do not hesitate to contact me at mmivory@mmm.com for further information.

Sincerely yours,

Megan Ivory Carr
Vice President, Regulatory and Government Affairs
3M Health Information Systems