August 25, 2017

Amy Bassano
Acting Director
Center for Medicare and Medicaid Innovation
7500 Security Boulevard
Baltimore, MD 21244

RE: [CMS-5525-N] - Medicare, Medicaid and Children's Health Insurance Program (CHIP); Meeting on Behavioral Health Payment and Care Delivery

Dear Ms. Bassano,

On behalf of the Behavioral Health Information Technology (BHIT) Coalition, the undersigned organizations are writing to applaud the Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services (CMS) for their interest in designing a potential payment or service delivery model to improve health care quality and access, while lowering the cost of care for Medicare, Medicaid, or CHIP beneficiaries with substance use and mental health conditions. While we feel that this is an outstanding step towards improving the field of behavioral health, the BHIT Coalition urges CMMI to include reimbursement for health information technology to providers who participate in this demonstration.

Previously, the Health Information Technology for Economic and Clinical Health (HITECH) Act (P.L 115-5) significantly expanded efforts to establish a national electronic health records (EHRs) system by creating health IT incentive payments for hospitals and physicians. Such a system would enable authorized health care professionals and hospitals to, among other things, access centralized information such as lab test results and medication lists to provide safer and more efficient patient care. The Act includes significant protections for mental health record confidentiality.

Unfortunately, the Act excluded behavioral health providers from receiving Medicare and Medicaid incentive payments and grant funds to adopt EHRs, which we believe has hampered efforts to integrate behavioral health into the larger American health care system. We believe the drafters of the Act were incorrect to not include behavioral health providers as eligible recipients of reimbursement for health information technology. Mental health and substance use data are critical pieces of information in treating the whole person.

It is unsurprising to us that since the HITECH Act's implementation, studies consistently have found behavioral health providers now lagging behind the general health care system in the adoption and application of health IT. One recent survey documented that although 97 percent of hospitals and 74 percent of physicians have implemented interoperable electronic health records (EHRs), only 30 percent

of behavioral health providers have done so.[1] An earlier study by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) with the U.S. Department of Health and Human Services similarly found that although some ineligible providers – such as behavioral health providers – are adopting some level of technology to meet clinical and business needs, they are not investing in interoperable technology that supports a patient-centered approach.[2]

Yet, people with mental illness and addiction disorders are a highly acute patient population. As ASPE itself noted, these are patients for whom health information exchange is particularly important given the number of providers and transitions involved in their care. Just as ASPE concluded, advancing the adoption of health IT by these providers will help support the goals of a nationwide HIT infrastructure, new models of care delivery and coordination, and the Medicare and Medicaid EHR incentive programs.

Persons with Substance Use Disorders

Researchers have shown that people with substance use disorders die as much as 20 years younger than others of the same age from cancer, cardiovascular disorders, HIV/AIDs and STDs, injuries, and many other illnesses.[3] More than 100,000 people in the United States die annually of alcohol or drug related causes, making it the fourth leading cause of preventable death, according to the Centers for Disease Control and Prevention (CDC).[4] Alcohol and drug-related illnesses and injuries cause one in 10 deaths for adults of working age.[5] Depression, bipolar disorder, post-traumatic stress, nicotine dependence, and sleep disorders co-occur with alcohol and drug use commonly.[6] Medically ill inpatients who also have alcohol or drug disorders are at a greater increased risk of rapid re-hospitalization after discharge and greater health care use and costs.[7] Patients who have medical illnesses, such as diabetes or cardiovascular disorders, and who

[1] P. Ranallo, A. M. Kilbourne, A. S. Whatley et al., "Behavioral Health Information Technology: From Chaos to Clarity," Health Affairs, June 2016 35(6):1106–13.

[2] 2013 Assessing the Status and Prospects of State and Local Health Department Information Technology Infrastructure https://aspe.hhs.gov/system/files/pdf/76631/hitech_rpt.pdf

[3] Neumark YD, Van Etten M, & Anthony JC (2000). "Alcohol dependence" and death: survival analysis of the Baltimore ECA sample from 1981 to 1995. Substance use & misuse, 35(4), 533-549.

[4] 2013 Mortality Multiple Cause Micro-data Files. Detailed Tables for the National Vital Statistics Report "Deaths: Final Data for 2013." http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf; Centers for Disease Control and Prevention. Alcohol-Related Disease Impact. Atlanta, GA: CDC. Stahre M, Roeber J, Kanny D, Brewer RD, Zhang X. Contribution of excessive alcohol consumption to deaths and years of potential life lost in the United States. Prev Chronic Dis 2014;11:130293. Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. JAMA 2004;291(10):1238–45.

[5] Stahre M, Roeber J, Kanny D, Brewer RD, Zhang X. Contribution of excessive alcohol consumption to deaths and years of potential life lost in the United States. Prev Chronic Dis 2014;11:130293.

[6] Whiteford HA, Degenhardt L, Rehm J, Baxter A, Ferrari A, Erskine HE, & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet, 382(9904), 1575-1586. Lim SS, VosT, Flaxman AD, Danaei G, Shibuya K, Adair-Rohani H & Davis A. (2013). A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet, 380(9859), 2224-2260.

[7] Boyd C, Leff B, Weiss C, Wolff J, Hamblin A, & Martin L (2010). Faces of Medicaid: Clarifying multi-morbidity patterns to improve targeting and delivery of clinical services for Medicaid populations. Center for Health Care Strategies. Walley A, Paasche-Orlow M, Lee EC, Forsythe S, Chetty VK, Mitchell S, & Jack BW. (2012). Acute care hospital utilization among medical inpatients discharged with a substance use disorder diagnosis. J Addict Med, 6(1), 50-56. Bradley KA, Rubinsky AD, Sun H, Bryson CL, Bishop MJ, Blough DK & Kivlahan DR. (2011). Alcohol screening and risk of postoperative complications in male VA patients undergoing major non-cardiac surgery. J Gen Intern Med, 26(2), 162-169.

also have a substance use disorder use health care services two to three times more often than their peers with just diabetes or heart problems, and the cost of care is similarly much higher.[8] Untreated, alcohol or drug use during pregnancy dramatically increases risk of poor birth outcomes, neonatal intensive care use and greater infant and maternal health care use.

Persons with Mental Illness

Similarly, persons with severe mental illness experience extremely high rates of mortality and morbidity. Comorbidity between mental and medical conditions is the rule rather than the exception. Specifically, people with schizophrenia and bipolar disorder are up to three times more likely to have three or more chronic medical/surgical conditions compared to Americans without these mental disorders. In the Medicaid/Medicare context, it's estimated that fully one-third of the 9 million dually eligible beneficiaries have a primary diagnosis of severe mental illness. An earlier study published in a Center for Disease Control (CDC) publication Preventing Chronic Disease found that patients/consumers served in state mental health systems die 25 years sooner than other Americans while experiencing evaluated levels of morbidity.[9] It's important to put these studies in context: the available data seems to show that people with mental illnesses like schizophrenia and bipolar in the United States have average life expectancy similar to the citizens of poor Sub-Saharan African nations (who lack access to clean water and vaccinations against preventable communicable diseases).

How Will Information Technology Improve Behavioral Health Care Coordination?

The optimal way to treat mental illness and substance use disorders is to couple it with primary care services – treating the "whole person" with comprehensive, multidisciplinary services systematically combined to provide the best outcomes. Information technology provides the vital link in this process by facilitating the exchange of authorized health data between care providers. This gives clinicians a complete picture of the person's health, enabling them to make fully-informed treatment decisions. Providing technology-enabled coordinated, integrated care to this high-risk population can enhance outcomes, improve efficiency and lower costs across the entire healthcare spectrum.

The Cost of Not Providing IT Incentives to Behavioral Health Providers

In the absence of Electronic Health Records (EHRs), challenges in managing these patients lead to extraordinary costs. For example, a 2014 Rutgers University study of 13 low income communities in New Jersey found that Medicaid recipients with serious mental health and addiction disorders accounted for an astounding 43.2 percent of all hospitalizations in these communities between 2008 and 2011, and this patient population composed 75 percent of all "higher users."

These extreme circumstances call for arming psychiatric hospitals, Community Mental Health Centers, psychologists, social workers, and addiction treatment providers with the electronic tools they need to

[8] Rehm J, Mathers C, Popova S, Thavorncharoensap M, Teerawattananon Y & Patra J. (2009). Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. Lancet, 373(9682), 2223-2233.
[9] Colton, CW & Manderscheid, R.W. (2006) Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease: Public Health Research, Practice, and Policy*, 3(2), 1-14.

effectively manage these patients and address this emerging public health crisis. Electronic health records improve the quality of care, safety, and coordination of care, reducing risks of medical errors.

Your proposed model program–which would potentially create a new behavioral health financing model–is a key first step. However, it is imperative that CMMI includes reimbursement for health information technology to the behavioral health providers who participate in this demonstration.

Sincerely,

American Psychological Association

Association for Behavioral Health and Wellness

Centerstone

The Jewish Federations of North America

National Association of Counties

National Association of County Behavioral Health Directors

National Council for Behavioral Health

National Association for Rural Mental Health

National Association of Social Workers

Netsmart