BEHAVIORAL HEALTH IT COALITION

September 30, 2013

The Honorable Max Baucus
Chairman
Senate Finance Committee
219 Dirksen Senate Office Bldg.
Washington, D.C. 20510

The Honorable Orrin G. Hatch
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Bldg.
Washington, D.C. 20510

Dear Chairman Baucus and Senator Hatch:

The Behavioral Health Information Technology Coalition, an alliance of mental health providers, vendors and country behavioral health organizations, is writing in response to your letter of August 1, 2013 inviting comment on the Senate Finance Committee's efforts to improve care for people living with mental health and addiction disorders.

Behavioral Health Providers Omitted From The HITECH Act: When the HITECH Act was enacted in 2009, it omitted behavioral health providers. As a consequence, similar to nursing homes, labs, pharmacies and imaging facilities, our communities were frozen out of the Medicare and Medicaid reimbursement systems created under the program. With the exception of psychiatrists, behavioral health facilities and providers are ineligible for federal assistance to purchase and install Health Information Technology [HIT] including:

- Psychiatric hospitals
- Community Mental Health Centers (CMHCs)
- Clinical psychologists
- Clinical social workers
- Outpatient and inpatient addiction providers.

Subsequent to enactment, authorizing committee staff at the time explained that facilities and professionals that serve people with mental health and substance abuse disorders were not "acute care" providers. But this policy judgment directly conflicts with clinical reality. Acute mental health care is broadly defined as a short-term response to the urgent needs of individuals experiencing a mental health crisis.

Generally speaking -- a danger of suicide, harm to self as a result of intentional acts or impaired self-care, or harm to others – are the standards commonly used to identify a person's need for acute care services. Last year, the nation's psychiatric hospitals served more than 750,000 persons in need of acute mental health care. In addition, a huge percentage of the 8 million

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people with serious mental health and addiction disorders that Community Mental Health Centers (CMHCs) serve every year arrive at intake in various stages of acute psychiatric distress.

Another important clinical consideration is the striking percentage of the patient/consumer population with co-occurring medical/surgical chronic diseases. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), as many as 70% of persons with schizophrenia and bipolar disorder served by public mental health agencies also have diabetes, cirrhosis, cancer, asthma, heart disease, COPD and cardiovascular diseases of every kind.

In turn, while patients/consumers with comorbid psychiatric disabilities and medical/surgical chronic diseases compose 9.5% of the total Medicaid caseload, they composed nearly 25% of the most expensive Medicaid patients. Similarly, people with a primary diagnosis of severe mental illness make up fully one quarter of the patient population eligible for both Medicare and Medicaid [so-called dual eligibles].

<u>Senate Finance Committee Questions</u>

I. "What administrative and legislative barriers prevent Medicaid recipients from obtaining the mental and behavioral health care they need?"

According to the website of the Office of the National Coordinator: "Electronic health record (EHR) systems can decrease the fragmentation of care by improving care coordination. EHRs have the potential to integrate and organize patient health information and facilitate its instant distribution among all authorized providers involved in a patient's care. For example, EHR alerts can be used to notify providers when a patient has been in the hospital, allowing them to proactively follow up with the patient. With EHRs, every provider can have the same accurate and up-to-date information about a patient. This is especially important with patients who are:

- Seeing multiple specialists
- Making transitions between care settings
- Receiving treatment in emergency settings

Better availability of patient information can reduce medical errors and unnecessary tests. Better availability of information can also reduce the chance that one specialist will not know about an unrelated (but relevant) condition being managed by another specialist.

Better care coordination can lead to better quality of care and improved patient outcomes."

***The Behavioral HIT Coalition strongly agrees with the ONC**. But existing HITECH Act reimbursement policy actively impedes the promise of care coordination for persons with serious mental health and addiction disorders – effectively discriminating against that patient/consumer population – solely because they served primarily by behavioral health providers. This discrimination even extends to technical assistance. The vast majority of Regional Extension Centers [REC] refuse to provide technical assistance to*

mental health and substance use facilities and professionals because they are ineligible for HITECH Act financing.

Here is the end result: mental health and addiction providers face significant financial challenges in trying to adopt comprehensive EHR systems, **and fewer than 30%** (LINK to NCBH health IT survey) have been able to implement full or partial EHR systems.

II. "What are the key policies that have led to improved outcomes for beneficiaries in programs that have tried integrated care models."

In response to truly alarming data about life expectancy and the very poor overall health status of the public mental health patient/consumers, Congress enacted two programs in the Affordable Care Act (ACA) with the goal of better integrating care for vulnerable populations. The first example is the Medicaid Health Home state option (Sec. 2703). Because of the Stabenow amendment, persons with severe mental illnesses and addiction disorders are specifically included as eligible patient populations. CMS has approved twelve (12) states for Medicaid Health Homes and many more are in the process of submitting State Plan Amendments. As a result of the emergency room and nursing home costs commonly associated with individuals served in the public mental health system, most are focusing all or part of their Health Homes on the severe mental illness population.

The ACA also took important steps to improve care coordination for dual eligibles by creating a Federal Coordinated Health Care Office within the Center for Medicare and Medicaid Services (CMS) and authorizing what are now called the CMS Financial Alignment Duals Demonstrations, which are attempting to increase the proportion of the duals population served in integrated care settings (Sec. 2601 and Sec. 2602). The FCHCO has focused on severe mental illnesses because of data showing strikingly high levels of schizophrenia, major clinical depression and intellectual/developmental disabilities among dual eligibles.

HIT is the bedrock of any effort to coordinate care for these populations. This reality was recognized in a presentation by Melanie Au from MATHEMATICA during a Center for Studying Disability Policy Research Forum on June 28, 2012. Ms. Lu indicated that states electing to participate in the duals demonstrations may require:

- "Technology linkages and data sharing between providers (e.g., physical, Behavioral Health, Long Term Services and Supports)
- Use predictive modeling to identify those in need of intensive care coordination services
- Use of real-time data (e.g., on hospital admissions and discharges) for care coordination."

From the prospective of behavioral health providers, the question is: how is any of this possible without HIT? Just to take one clinical issue as an example. 40% of dual eligibles under 65 take antipsychotic medications. Nearly 60% take antidepressants. For duals with severe and persistent mental illnesses, the majority are on a psychotropic drug regimen composed of four (4) or (5) pharmaceutical agents. In order to clinically manage these

patients/consumers and, where necessary, initiate reconciliation protocols that integrate psychotropic drugs with medical/surgical pharmaceuticals prescribed for common chronic diseases, mental health and addiction providers must operate sophisticated EHR systems capable of vigorous interoperability with IT systems employed by physicians and hospitals.

"How can Medicaid be cost-effectively reformed to improve access to and quality of care for people with mental and behavioral disorders."

Enact the Bipartisan Behavioral Health Information Technology Act (HR 2957/S. 1517)

These bipartisan bills introduced by Sen. Sheldon Whitehouse (D-RI) and Rep. Tim Murphy (R-PA) would make psychiatric hospitals, CMHCs, clinical psychologists, clinical social workers (in the Senate bill) and outpatient/inpatient addiction providers eligible to participate in the HITECH Act Medicare and Medicaid reimbursement systems. To improve care coordination for vulnerable Medicare and Medicaid patients/consumers with the goal of improving the quality of services while better managing costs, the Senate Finance Committee must take the important step of enacting Behavioral Health Information Technology Act.

The undersigned are dedicated to working closely with you as the Committee explores better policy solutions for people living with mental health and behavioral health conditions. If you have any questions, please contact Al Guida at 202.331.1120 or email him @ aguida@guidelobby.com

Sincerely,

American Psychological Association
Centerstone
National Association of Counties
National Association of County Behavioral Health Directors
National Association of Psychiatric Health Systems
National Association of State Alcohol and Drug Abuse Directors
National Association of Social Workers
National Council for Behavioral Health
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