February 16, 2018

The Honorable Orrin Hatch
Chairman
Senate Committee on Finance
104 Hart Senate Office Building
United States Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance
221 Dirksen Senate Office Building
United States Senate
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden,

On behalf of the Behavioral Health Information Technology (BHIT) Coalition, the undersigned organizations applaud the members of the U.S. Senate Committee on Finance for their continued dedication to comprehensively address the opioid epidemic. We are submitting our comments below in reference to your solicitation for stakeholder feedback dated February 2, 2018.

Established in 2010, the Behavioral Health Information Technology (BHIT) Coalition is comprised of organizations dedicated to advancing public policy initiatives that tap the full potential of technology in the delivery of coordinated, integrated services and treatment for people with mental health and addiction disorders. The BHIT Coalition members are dedicated to ensuring that all persons in need of mental health and addiction services receive high-quality, coordinated care from their behavioral health and primary care providers utilizing healthcare information technology as a key element in delivering services and care for the "whole person."

The undersigned organizations strongly support S.1732/HR 3331, introduced on a bipartisan basis by Senators Portman (R-OH) and Whitehouse (D-RI) and Representatives Jenkins (R-KS) and Matsui (D-CA), that would authorize a CMMI health IT demonstration program, including providers such as public or private psychiatric hospitals, community mental health centers, accredited residential or outpatient opioid treatment facilities, clinical psychologists, and clinical social workers. **It is time to end the use of paper records and faxes in the delivery of mental health care and addiction treatment in America.**

Effect of Opioid Use Disorder (OUD) on Medicare and Medicaid

At the BHIT Coalition, we recognize the impact that the opioid crisis has on the Medicare and Medicaid programs. At least half of all U.S. opioid overdose deaths involve a prescription opioid.[1] Furthermore, upwards of 500,000 people on Medicare Part D are addicted to prescription opioids.[2] Seven hundred and

[1] Patient-Centered Outcomes Research Institute. (2017). *Research Spotlight on Opioid Use*. https://www.pcori.org/painopioidsspotlight
[2] Office of the Inspector General. (2017). *Opioids in Medicare Part D: Concerns about Extreme Use and Questionable Prescribing*, OEI-02-17-00250

thirty thousand Seniors on Medicare are at risk for opioid addiction,[3] and more than 6 out of every 1,000 Medicare patients are diagnosed with an opioid disorder, compared with 1 of every 1,000 patients covered by private insurance.[4]

Additionally, treating opioid use disorder within Medicare and Medicaid poses a significant cost to both programs. The total Medicare cost of treating and stabilizing patients after an overdose is $6.4 billion, and Medicare is the largest single-payer for opioid overdose hospitalizations.[5] This cost has increased each year as after 2000, hospital charges per opioid-driven hospitalization increased $73 per hospitalization per year.[6]

The staggering financial effect of opioids has not gone unnoticed by the Centers for Medicare and Medicaid Services (CMS), not only for substance use treatment, but for other accompanying co-morbidities. A recent CMS letter to State Medicaid Directors on strategies to address the opioid epidemic states that "Medicaid beneficiaries who struggle with addiction to opioids or other substances have high rates of comorbid physical and mental health conditions, resulting in higher spending for general medical services. Recent research has reaffirmed that most spending on individuals struggling with addiction is not on treatment for those conditions, but instead focused on co-morbid physical conditions. Between 2010 and 2013, among adult Medicaid beneficiaries treated for a behavioral health disorder, 75 percent of spending for these individuals was for treatment of co-morbid conditions as opposed to their behavioral health condition. At least one state has found significant reductions in medical costs among Medicaid beneficiaries who accessed addiction treatment compared to those who did not."[7] Allowing integrated care for treatment of individuals with OUD among providers not only saves cost, but improves the quality of care they can provide.

Clinical Circumstances for Persons with OUD

With respect to the clinical circumstances for people with OUD, 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.[8] Each year, more than 100,000 people in the United States die of alcohol or drug related causes, making it the fourth leading cause

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[3] American Mental Health Counselors Association. (2017). *Virtual Action Day Advocate Packet*. http://higherlogicdownload.s3.amazonaws.com/AMHCA/6664039b-12a0-4d03-8199-32c785fe1687/UploadedImages/Site%20Photos/Advocacy/AMHCA_Grassroots_Packet.pdf

[4] Vestal, C. (2016). *Older Addicts Squeezed by Opioid Epidemic*. http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/07/26/older-addicts-squeezed-by-opioid-epidemic

[5] Rhyan, C. (2017). *The Potential benefit of Eliminating Opioid Overdoses, Deaths, and Substance Use Disorders Exceeds $95 Billion Per Year*. https://altarum.org/sites/default/files/uploaded-publication-files/Research-Brief_Opioid-Epidemic-Economic-Burden.pdf

[6] Song, Z. (2017). Mortality Quadrupled Among Opioid-Driven Hospitalizations, Notably Within Lower-Income And Disabled White Populations. Health Affairs, 36(12). https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0689

[7] Centers for Medicare & Medicaid Services (2017). *Strategies to Address the Opioid Epidemic:* SMD # 17-003.

[8] 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.

of preventable death, according to the Centers for Disease Control and Prevention (CDC).[9] Depression, bipolar disorder, post-traumatic stress, nicotine dependence, and sleep disorders commonly co-occur with alcohol and drug use.[10] 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.[11] 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.

With that as background, the BHIT Coalition will respond to the three questions most relevant to our Coalition's work.

Question #3: How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to ensure beneficiaries receive evidence-based prevention, screening, assessment, and treatment for OUD and other SUDs to improve patient outcomes?

As noted earlier, bipartisan congressional legislation has been introduced (S. 1732/HR 3331) by Senators Portman (R-OH) and Whitehouse (D-RI) and Representatives Jenkins (R-KS) and Matsui (D-CA), that would authorize a CMMI health IT demonstration program, for mental health and addiction treatment providers. In light of the opioid crisis, and the recent Health Emergency Declaration by President Trump, we strongly believe that the availability and adoption of health information technology and EHRs and their use for coordinated care is a necessary and valuable component to the treatment of those affected by substance use disorders.

Unfortunately, despite the high need among mental health and substance use providers, health IT infrastructure is often lacking within behavioral health care settings. **At the Medicaid and CHIP Payment and Access Commission (MACPAC) January 25, 2018 meeting, Principal Analyst Erin McMullen remarked on the lack of EHR availability, stating, "many community-based substance use treatment providers have not adopted EHRs at the same rate as the rest of the medical system. Participants noted**

[9] 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.

[10] 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.

[11] 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.

that many of these providers continue to share information by paper, phone, or fax. The roundtable discussion also attributed the slow adoption of EHR to a lack of financial incentives. Substance use providers were not eligible for financial incentives under HITECH that the rest of the health care system was able to access."[12] Without the support of programs similar to the EHR incentive programs available to other providers, mental health and substance use providers have lagged behind on the adoption of EHRs and require financial support to initiate this process, ultimately affecting the quality of care they can provide to their patients.

Question #6: What can be done to improve data sharing and coordination between Medicare, Medicaid, and state initiatives, such as Prescription Drug Monitoring Programs (PDMPs)?

There will be little or no data sharing among Medicare, Medicaid and state initiatives, such as PDMPs, unless EHRs are provided to substance use and mental health providers. Electronic health records and related connectivity services are increasingly the means by which data is shared.

Question #7: What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts or incorporated into Medicare?

The Center for Medicare and Medicaid Innovation (CMMI) within CMS is considering 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. We believe this financing demonstration should include behavioral health information technology as a means of addressing the opioid crisis. Behavioral health and substance use treatment providers are critical to mitigating the opioid crisis, as well as improving overall population health and reducing healthcare costs.

We cannot hope to address the opioid crisis successfully without providing EHRs and supporting health information technology within behavioral health settings. As the Committee contemplates possible actions to address the opioid epidemic, any comprehensive solution should provide incentives to substance use and mental health providers for the adoption of health information technology. Thank you for this opportunity to provide comment to the Committee on this important issue.

Sincerely,

American Psychological Association

Association for Behavioral Health and Wellness

[12] Medicaid and CHIP Payment and Access Commission. (2018). [Public meeting transcript]. Retrieved from https://www.macpac.gov/wp-content/uploads/2017/07/January-2018-MACPAC-Meeting-Transcript.pdf

Centerstone

The Jewish Federations of North America

National Association of Counties

The National Association of County Behavioral Health and Developmental Disability Directors

National Alliance on Mental Illness

National Association of Psychiatric Health Systems

The National Association for Rural Mental Health

National Association of State Alcohol and Drug Abuse Directors

National Association of Social Workers

National Council for Behavioral Health

Netsmart