December 8, 2014

Center for Medicare and Medicaid Services
Department of Health & Human Services
Attn: Administrator Marilyn Tavenner
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-3819-P Comment- Behavioral Health Providers

Dear Administrator Tavenner:

On behalf of the Behavioral Health Information Technology (BHIT) Coalition, we are writing to submit an official comment to the recently proposed rule "Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies" (CMS-3819-P). Specifically, we are writing to address III (D)(3) Clinical Records (Proposed Section 484.110) subsection *(B) HHS Policy Priority to Accelerate Interoperable Health Information Exchange, including Use of Certified Electronic Health Record Technology*.

The BHIT Coalition is a group of behavioral health care providers, practitioners, and payers joined together to advocate for federal funds to allow behavioral health providers to purchase interoperable electronic health records (EHRs). **We strongly believe that to have an effective interoperable Health Information Exchange (HIE), behavioral health care settings must receive meaningful use payments because they are acute care providers.**

Under the HIE standards section, we disagree with the classification of behavioral health settings as post-acute and long-term care. Behavioral health providers, including psychiatric hospitals, community mental health centers, practicing psychologists, and inpatient/outpatient addiction providers, are in fact **acute care providers**. The proposed rule implies otherwise, stating:

> "To increase flexibility in the regulatory certification structure established by the Office of the National Coordinator for Health Information Technology (ONC) and expand HIT certification, ONC has proposed a voluntary 2015 Edition EHR Certification rule (http://www.gpo.gov/fdsys/pkg/FR-2014-02-26/pdf/2014-03959.pdf) to more easily accommodate HIT certification for technology used by other types of health care settings where individual or institutional health care providers are not typically eligible for incentive payments under the EHR Incentive Programs, **such as home health agencies, any other long-term and post-acute care and behavioral health settings**." (III (D)(3)(B) paragraph 1).

We respectfully request the behavioral health providers/facilities and practices be categorized as acute care providers by the ONC.

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Behavioral health providers are acute care providers because persons with serious mental illnesses have crisis-level overall health status.

There are 8 million persons in the behavioral health setting - mostly individuals with severe and persistent mental illnesses - served by the public mental health system. A wide array of recent studies indicate that these patients possesses an exceedingly poor overall health status. For example, a *Synthesis Project* analysis issued by the Kaiser Family Foundation with support from the Robert Wood Johnson Foundation points to a strikingly high incidence of comorbid cancer, heart disease, diabetes and asthma among Americans with mental disorders. Specifically, according to federal government data for Medicaid SSDI recipients:

- **76.2%** of disabled Medicaid recipients with **asthma and/or COPD** also have severe mental disorders and comorbid addiction disorders.
- **73.7%** of disabled Medicaid recipients with **coronary heart disease** also have severe mental illnesses and comorbid addiction disorders.
- **67.9%** of disabled Medicaid recipients with **diabetes** also have serious mental and substance use disorders.

Among Medicare beneficiaries, those with serious mental illness (SMI) such as major depression, bipolar disorder and schizophrenia are more than twice as likely to have three or more chronic, comorbid conditions. Furthermore, in a recent study of New York City hospitals, "Two-thirds of adult discharges with major behavioral health conditions had at least two other forms of chronic diseases (three or more in total). Among other hospitalizations, 72% had two or more chronic diseases and most had three or more." ("*Updated Data on Prevalence and Severity of Behavioral Health Conditions among General Hospital Inpatients in New York State"*, ArthurWebbGroup, December 2014.)

A study published in a Centers for Disease Control and Prevention (CDC) publication *Preventing Chronic Disease* found the predictable consequences. In short, people with SMI – particularly those served in state mental health systems - die 25 years sooner than other Americans while experiencing elevated levels of morbidity. It is important to put these studies in context: there are very few patient populations served by any federal health program that experience such poor overall health. In fact, the available data suggests 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).

CMS Should Expand HIE Funding for Behavioral Health Settings

The BHIT Coalition strongly agrees with CMS that an interoperable Health Information Exchange is the key to coordinated care in integrated settings such as home health agencies, and the proposed certification rules are needed to attain truly interoperable EHRs. In fact, people living with conditions like schizophrenia and bipolar disorder are in desperate need of the integrated care made possible by HIE. At

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the same time, the undersigned organizations are now deeply concerned that without access to meaningful use payments and HIE for behavioral health settings, it will soon become impossible to provide clinical care coordination for this highly vulnerable population, which requires regular interaction between mental health/addiction services providers, primary care physicians and medical specialty personnel. *Further, the above-referenced data and other similar information makes clear that unlike clinical laboratories, pharmacies and nursing facilities, behavioral health providers serve a population with highly acute mental illnesses, substance use disorders and life threatening comorbid medical/surgical chronic diseases.*

In constructing the proposed rule and for further strategic measures, we ask that your agency use discretionary funds to expand HIE funding for behavioral health settings to address the high risk population identified above. At a minimum, the ONC should end the practice of characterizing psychiatric hospitals, community mental health centers, psychologists, and addiction treatment facilities as solely "post-acute care" providers. In order to accommodate this request, significant changes to CMS-3819-P will likely be needed.

Sincerely,

American Psychological Association

Association for Behavioral Health and Wellness

Centerstone

National Association of Counties

National Association of County Behavioral Health Directors

National Association of Psychiatric Health Systems

National Association of State Alcohol/Drug Abuse Directors

National Council for Behavioral Health

Netsmart Technologies

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