October 12, 2018

Mr. Adam Boehler
Director
Center for Medicare and Medicaid Innovation (CMMI)
U.S. Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244-1850

RE: BHIT Coalition Meeting Request to Discuss Implementation of Behavioral Health IT Incentives CMMI Demonstration Program

Dear Director Boehler:

On behalf of the Behavioral Health Information Technology (BHIT) Coalition, we respectfully request a meeting to discuss the implementation of section 6001 of The SUPPORT for Patients and Communities Act (HR 6), crafted to combat the opioid epidemic. **As the only Center for Medicare and Medicaid Innovation (CMMI) provision of this law, The Improving Access to Behavioral Health Information Technology Act, takes a crucial step to furnish mental health and substance use providers with the health IT infrastructure necessary to implement the rest of the provisions within HR 6.**

Electronic Health Records (EHRs) are a vital tool in proper care coordination and treating the whole individual. However, behavioral health providers, such as community mental health clinics, county behavioral health authorities, psychiatric hospitals, clinical psychologists and clinical social workers, continue to lag behind in the adoption rates of EHRs. Congress's leadership ensuring the inclusion of health IT incentives in the SUPPORT Act effectively promotes patient safety and significantly improves care coordination.

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."

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.[1] Each year, more than 100,000 people in the United States die 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).[2] Depression, bipolar disorder, post-traumatic stress, nicotine dependence, and sleep disorders commonly co-occur with alcohol and drug use.[3] 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.[4] 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.

Importance of Behavioral Health Information Technology: MAT

In our view, health IT promotes both patient safety and the application of e-prescribing to oral addiction treatment medications, resulting in significantly improved care coordination. **The BHIT Coalition recognizes that mental health and addiction treatment providers would struggle to participate in MAT expansion without access to EHRs. We know that you agree that our nation cannot hope to address the opioid crisis successfully without providing health information technology within behavioral health settings, supporting your vision to expand MAT.**

HIT can also enhance the quality of MAT through e-prescribing. Both methadone and buprenorphine are controlled substances subject to diversion; e-prescribing would hinder diversion attempts. Since we are at the beginning of the MAT revolution in substance use treatment services, an e-prescribing requirement would yield critically important data by electronically tracking prescribers, dosages, dispensing facilities, the specific patients receiving MAT and information regarding clinical outcomes – ushering in a new era of accountability.

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[1] 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.

[2] 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.

[3] 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.

[4] 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.

As the only CMMI provision in this new opioid package, our diverse coalition is ready to meet with you and your staff to discuss the implementation of this historic legislation. We appreciate your efforts in combatting the opioid crisis and are ready to stand shoulder to shoulder with CMMI to ensure smooth and thoughtful implementation.

Sincerely,

American Psychological Association

Association for Behavioral Health and Wellness

Centerstone

The Jewish Federations of North America

Mental Health America

National Alliance on Mental Illness

The National Association of County Behavioral Health and Developmental Disability Directors

The National Association of Rural Mental Health

National Association for Behavioral Healthcare

National Association of Social Workers

National Council for Behavioral Health

Netsmart