

March 12, 2010

Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-0033-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Acting Administrator Frizzera,

The National Council for Community Behavioral Healthcare (National Council) is pleased to respond to the Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) **42 CFR Parts 412, et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program, Proposed Rule.**

The National Council, a non-profit association representing over 1700 community mental health centers and other community-based mental health and addiction providers, is dedicated to fostering clinical and operational innovation and promoting policies that ensure that the more than 6 million low-income children, adults, and families our members serve have access to high quality services.

Community mental health and addiction organizations have more than 40 years of experience and expertise in providing a range of clinic-based services and recovery supports for some of the nation's most vulnerable citizens. Community mental health and addiction organizations are essential to the very fabric of the nation's health care safety network and coordinate care for millions of individuals with chronic health problems.

The National Council wishes to thank CMS for the leadership it has shown in collaborating with the Office of the National Coordinator for Health Information Technology (ONC) on this proposed rule. The National Council, along with the Community Behavioral Health Organizations (CBHOs) it represents, recognize the opportunities that exist in the adoption of electronic health records: improved quality of care, increased efficiency in practice, and greater collaboration among providers to better serve those in need. In line with the intent of the Health Information Technology for Economic and Clinical Health Act, we believe that the adoption and utilization of electronic health records is a vital component of the appropriate delivery of high-quality health care and builds upon previous advancements to better serve consumers.

Health care for general, mental, and substance-use problems and illnesses must be delivered with an understanding of the *inherent interactions between the mind/brain and the rest of the body.*

The Federal government should encourage *the widespread adoption of electronic health records*, computer-based clinical decision-support systems, computerized provider order entry, and other forms of information technology for M/SU [Mental Health and Substance Abuse] care by:

- Offering financial incentives to individual M/SU clinicians and organizations for investments in information technology needed to participate fully in the emerging NHII.
- Providing capital and other incentives for the development of virtual networks to give individual and small-group providers standard access to software, clinical and population data and health records, and billing and clinical decision-support systems. (emphasis added)¹

Background

On February 17, 2009 President Obama signed the American Recovery and Reinvestment Act of 2009 (Recovery Act), making available critical resources to stimulate the economy, preserve and grow jobs, and sustain and improve the quality and efficiency of health care. Two titles of the Recovery Act—Title XII, Division A, Health Information Technology and Title IV, Division B, Medicare and Medicaid Health Information Technology—comprise the Health Information Technology for Economic and Clinical Health Act (HITECH), which provide a significant strategic direction and financial incentives for adoption and meaningful use of certified Electronic Health Record (EHRs) technologies that enable the:

1. Improvement of quality of care through individual care coordination, continuity and medical errors reduction, and through population health by reducing disparities and advancing research and education;
2. Secure, private electronic exchange of health information protecting sensitive individually-identifiable health information from disclosure;
3. De-identification of information for exchange and research;
4. Use of EHRs nationwide by 2014;
5. Account and auditing of permitted disclosures;
6. Comprehensive collection of patient demographic data, including race, ethnicity, primary language and gender information;
7. Design and use technologies to address the needs of children and other vulnerable populations; and

¹ Institute Of Medicine of the National Academies (2006) **Improving the Quality of Health Care for Mental and Substance-Use Conditions**, Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders; Board on Health Care Services, The National Academies Press, Washington, DC.

8. A nationwide technology infrastructure for electronic use and accurate exchange of health information.

According to the National Coordinator for HIT, David Blumenthal, M.D., M.P.P., "The EHR incentive program under Medicare and Medicaid will accelerate and facilitate health information technology adoption by more individual providers and organizations in the health care system,"² The incentive payments for adoption and meaningful use of Health Information Technology (HIT) and qualified EHRs are part of a broader effort pursuant to the HITECH Act to accelerate the adoption and meaningful use of certified EHRs to improve health outcomes, care delivery and cost efficiency.

The widespread adoption and meaningful use of health information technology is essential to improving the outcomes of persons with mental and addictive disorders.

Behavioral Health

- Each year, more than 33 million Americans receive health care for mental or substance-use conditions, or both. Together, mental and substance-use illnesses are the leading cause of death and disability for women, the highest for men ages 15-44, and the second highest for all men.³
- Approximately, 28–30 percent of the adult U.S. population suffers from a mental or substance use (i.e., behavioral health) disorder during the course of a year. About 5–7 percent of adults have a serious mental illness. A similar percentage of children, roughly 5–9 percent, have a serious emotional disturbance.
- Of the ten leading causes of disability worldwide in 2000 for people ages 15–44, four were psychiatric conditions and alcohol abuse.⁴
- Underlying mental illness and substance abuse disorders account for up to 70 percent of all primary care visits in the United States. Depression is predicted to be the second leading cause of disability in the U.S. by 2020.
- Severe mental illness is associated with 31.2% highly likelihood of hospitalization in a given year.
- People with serious mental illnesses die 25 years earlier than the general population, not necessarily as a result of the mental illness, but as a result of co-occurring physical ailments.⁵

² HHS Press Office, CMS and ONC Issue Regulations Proposing a Definition of 'Meaningful Use' and Setting Standards for Electronic Health Record Incentive Program, Dec. 30, 2009. Accessed March 10, 2009 at <http://www.hhs.gov/news/press/2009pres/12/20091230a.html>.

³ Institute of Medicine of the National Academies, *Improving the Quality of Health Care for Mental and Substance-Use Conditions*; Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders Board on Health Care Services; The National Academies Press, Washington, DC, 2006

⁴ Mark, T., Coffey, R., Vandivort-Warren, R., Harwood, H., King, E. (2005). *U.S. Spending for Mental Health and Substance Abuse Treatment 1991-2001*, Health Affairs.

Medicaid

- Medicaid is the single largest payer for mental health services in the United States totaling \$27 billion in 2001.⁶ While Medicaid pays for 16 percent of overall health spending, it funds more than 25 percent of all mental health spending⁷ and pays for more than 50 percent of all public spending on mental health services.⁸
- Prescription drugs are the fastest-growing component of mental health spending and Medicaid is the nation's primary purchaser of antipsychotic medications, accounting for approximately 80 percent of all antipsychotic prescriptions in 2001.
- In a 2006 survey of Medicaid directors in 35 states responded that their most important mental health challenge is the need for new or redesigned care management and coordination services for individuals with mental illness.⁹
- "In Medicaid, the elderly and adults with disabilities make up only 25 percent of the beneficiaries, but account for a majority of program spending. Within this population, fewer than 5 percent of beneficiaries account for more than 50 percent of overall Medicaid costs. Most of these high-cost beneficiaries – many of who have multiple chronic physical and behavioral conditions—receive care within an unmanaged fee-for-service delivery system, and the majority of them would greatly benefit from more integrated systems of care."¹⁰
- Nationally, Medicaid beneficiaries who are disabled represent a minority of all Medicaid beneficiaries (16%) but account for a substantial portion of Medicaid expenditures (45%), and " 49 percent of Medicaid beneficiaries with disabilities have a psychiatric condition, and this percent rises to 52% percent of persons who are dually eligible for Medicare and Medicaid.

⁵ Manderscheid, R.W., "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), 2006.

⁶ Centers for Medicare and Medicaid Services, Overview of Mental Health Services, retrieved from <http://www.cms.hhs.gov/MHS/>.

⁷ Mark, T., Coffey, R., Vandivort-Warren, R., et al, *US Spending for Mental Health and Substance Abuse Treatment, 1991-2001*, Health Affairs, Mar 29, 2005, ppW5-133--W5-142.

⁸ Rowland, D., *Helping Families with Needed Care: Medicaid's Critical Role for Americans with Disabilities*, Testimony before the U.S. House of Representatives Committee on Energy and Commerce

Subcommittee on Health, Kaiser Commission on Medicaid and the Uninsured January 16, 2008.

⁹ Edwards, B., Smith, V. (2007). *Insights and Opportunities: Medicaid Directors Identify Mental Health Issues, Psychiatric Services*, Vol. 58, No. 8.

¹⁰ Kaiser Commission on Medicaid and the Uninsured, and the Urban Institute estimates based on MSIS 2004.

- Medicaid spending on mental health and substance abuse treatment expected to double between 2003 and 2014 (\$239 billion) with increasing share of expenditures falling to the States.

Co-morbidity

- Cardiovascular, pulmonary and infectious diseases account for 60% of premature deaths in persons with schizophrenia.
- The prevalence of diabetes, ischemic heart disease, cerebrovascular disease, arthritis and heart failure was three times higher among the SMI Medicaid population (Medi-Cal) population compared to the general population, according to a 2007 study.¹¹
- About 75% of individuals with serious mental illness are tobacco dependent as compared with 22% of the general population.
- The Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) found that among persons diagnosed with schizophrenia, appropriate medical treatment was not received by
 - 30.2% of persons with diabetes
 - 62.4% of persons with hypertension
 - 88.0% of persons with dyslipidemia.
- Second generation antipsychotic medications are highly associated with weight gain, diabetes, dyslipidemia, insulin resistance, and metabolic syndrome, and that established monitoring and treatment guidelines to lower risk are underutilized in SMI populations.
- “Although the individual correlation between psychiatric illness and cardiovascular disease is moderate or 16 percent, nearly 60% of beneficiaries with cardiovascular disease were found to also have psychiatric illness — suggesting, for example, that efforts to improve the integration of physical and behavioral health care for people with heart disease should be a clinical priority.”¹²

Recognizing that behavioral healthcare is an essential component of overall health, efforts have been made to ensure primary care, mental health and addiction providers have the capability to communicate with each other; these efforts increase opportunities to coordinate care and improve the overall well-being of consumers served. Integrating health care often requires reorienting the health care process to create a seamless process which allows access to a broad range of physical, psychological, social, preventive, and therapeutic services.

¹¹ Study of Medi-Cal data by Jan Associates (2007).

¹² R.G Knoick, M. Bella, T.P. Gilmer, The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions, Center for Health Care Strategies, Inc, October 2009.

CBHOs provide care for populations with complex, and often co-morbid conditions; the current language in this Proposed Rule threatens to make effective care for this population even more challenging by leading CBHOs and people who receive their services further behind in the digital divide. In a recent presentation the Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), Pamela S. Hyde, J.D. provided examples illustrating the extent of the current digital divide:

- 8.2 percent of surveyed CBHOs have an EHR as compared to 10-12 percent of primary care *physicians*
- 50 percent of treatment programs had an IT system—used for billing, not clinical care
- 1.8 percent of total IT spending is for CBHOs as compared to 3.5 percent for physical health care
- 20 percent of 175 counseling centers surveyed had no IT system—not e-mail or voice-mail

While the National Council is aware and supportive of SAMHSA's request of \$4 million in new funds for BHC HIT for the Office of the National Coordinator in the 2011 budget, we strongly urge that this request not be viewed as adequate to close the gap, and should not be viewed as a alternative to our recommendations.

Given that the Proposed Rule is meant to support the "Expanded use of health information technology (HIT) and EHRs [to] *improve the quality and value of American health care,*" the EHR incentives should be readily accessible to CBHOs, whose providers treat many consumers with chronic health conditions.

Recommendations

Based on this, the National Council submits the following recommendations to CMS:

Recommendation: *In order to avoid establishing duplicative requirements across and within programs, the National Council recommends that CMS cite these requirements in the final rule, require State Medicaid agencies to confirm these requirements are followed, and provide the EHR incentive payment directly to the CBHO that employs the EP.*

The requirements in the Proposed Rule relating to physicians having to reassign their EHR incentive payment to an organization, such as a CBHO, are unnecessarily complicated, convoluted and duplicative. We recommend changes to prevent the Proposed Rule from having an unintended chilling on the participation of CBHOs, who are essential to the fabric of the health care safety network and provide some of the most complex and costly behavioral health care services to citizens across the country.

Title IV, Division B of the HITECH Act establishes incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that meaningfully use certified EHR

technology. While the HITECH Act holds the promise of improved health care quality and coordination, and the reduction of costs, errors and inefficiencies through a network of interoperable EHRs and Health Information Exchanges (HIEs), the definitions and Interpretation in the Proposed Rule threatens to undermine that promise and further isolate persons with behavioral health care conditions and the providers that serve them.

The Proposed Rule covers three programs: Medicare Fee-for-Services, Medicare Advantage and Medicaid and “seek[s] to create as much commonality between these three programs as possible...” and “contain[s] many common elements and certain provisions of the HITECH Act encourage avoiding duplication of payments, reporting and other requirements, particularly in the area of demonstrating meaningful use of certified technology.”¹³ The rule indicates incentive payments are available for *Eligible Professionals (EPs)* and *Eligible Hospitals*. A “Medicaid professional eligible for a EHR incentive payment [is] a physician, a dentist, a certified nurse-midwife, a nurse practitioner, a physician assistant practicing in a Federally Qualified Health Center or Rural Health Clinic, which is so led by a physician assistant,” pursuant to § 495.304 (b).

The rule allows an EP to reassign the entire incentive payment amount to an employer or entity with which the EP has a contractual arrangement allowing the employer or entity to bill and receive payment for the EP’s covered professional services, pursuant to §495.10(f). However, the reassignment process described in the rule is cumbersome, unnecessary convoluted and has a chilling effect on the very purpose of the rule.

Recommendation: *The National Council recommends creating commonality on areas of EHR Incentive payment reassignment by extending Section 1842(b) (6) (A) of the Act to clarify that payments made under the Medicaid EHR Incentive program can be reassigned “to an employer or entity with which the EP has a contractual relationship allowing the employer or entity to bill and receive payment for the EP’s covered professional services.”*

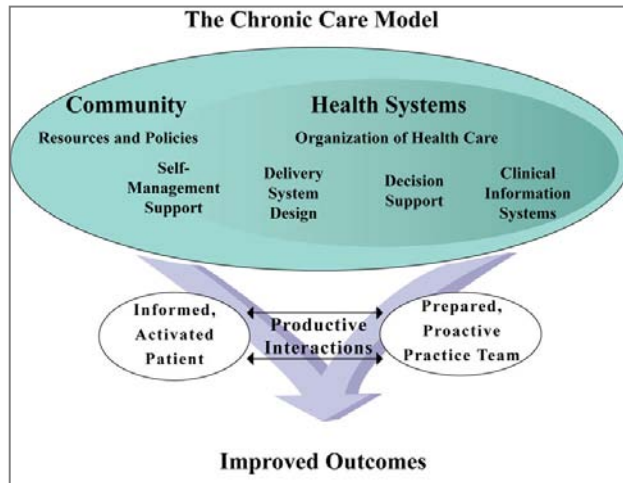
Such a policy would eliminate duplicative requirements, since current Federal Medicaid requirements on payment already “prohibits State payments for Medicaid services to anyone other than a provider,” pursuant to 42 CFR Section 447.10. State Medicaid agencies are required to document “who may receive payments” pursuant to their State Plan and that payments for “Individual Practitioners,” such as physicians, can be made directly to the employer, which includes CBHOs, if the practitioner is “required as a condition of employment” or “contract under which the organization submits the claim.”

A foundation for such a policy exists already. The Medicaid Clinic Option already requires that all such professional services are documented, billed and reimbursed through the CBHO in order to receive reimbursement. Additionally, provider agreements and professional service employment contracts reinforce this policy; professional services covered by Medicare and Medicaid provided by a physician in a CBHO are billed by and directly reimbursed to the clinic. State Medicaid Surveillance Utilization Review Systems (SURS) already monitor these practices to prevent fraud. Furthermore, the patient volume requirement in §495.10 can only be documented

¹³ Proposed Rule, 42 CFR Parts 412, et. al.; I. Background

through a review of clinic patient records to determine the total patient volume and percentage of Medicaid recipient served by a physician under a professional services agreement. This same process could be used to document that a physician employed by a clinic met the patient volume threshold necessary for the EHR incentive payment.

Recommendation: *The National Council recommends that the rule needs to proactively address the need for CBHOs to be an integral part of a transformed patient-centered health care home.*



There is growing evidence of the efficacy of team-based, chronic care models to improve health outcomes, care delivery and population health. A core element of Wagner’s Chronic Care Model is the need for “Clinical Information Systems” that organize client and population data to facilitate efficient and effective care using timely reminders, sub-population identification for proactive care, and information for care planning, care coordination and monitoring performance.

This team-based approach has gained support within the primary care environment as evidenced by the growth of the Patient-

Centered Medical Home (PCMH) model. The Patient-Centered Health Care Home model builds on the PCMH concept to support the integration of physical and behavioral health care. Regardless of the care model the need for better integration of physical and behavioral health care supported by the meaningful use of EHR technologies is essential.

Recommendation: *The National Council stresses the need for CMS to adopt a more gradual approach in Stage 1 criteria. We encourage CMS to adopt a streamlined set of meaningful use criteria for Stage 1, and to allow additional time for participants to transition to higher levels of meaningful EHR use. The National Council urges CMS to reconsider the proposed thresholds and the methods for demonstrating compliance so that EPs can focus their efforts on implementing EHRs, rather than generating reports.*

While the National Council is supportive of the overall direction of the Proposed Rule, we are concerned that the timeframe may be too aggressive and requirements too complex at early stages to truly *incentivize* the meaningful use of EHRs. While many have voiced opposition to the “all or nothing” approach for determining meaningful use, we urge a scaling back

| Prioritized List of High-Impact Medicare Conditions | | NQF THE NATIONAL QUALITY FORUM |
|---|-------|-----------------------------------|
| Condition | Votes | |
| 1. Major Depression | 30 | |
| 2. Congestive Heart Failure | 25 | |
| 3. Ischemic Heart Disease | 24 | |
| 4. Diabetes | 24 | |
| 5. Stroke/Transient Ischemic Attack | 24 | |
| 6. Alzheimer’s Disease | 22 | |
| 7. Breast Cancer | 20 | |
| 8. Chronic Obstructive Pulmonary Disease | 15 | |
| 9. Acute Myocardial Infarction | 14 | |
| 10. Colorectal Cancer | 14 | |
| 11. Hip/Pelvic Fracture | 8 | |
| 12. Chronic Renal Disease | 7 | |
| 13. Prostate Cancer | 6 | |
| 14. Rheumatoid Arthritis/Osteoarthritis | 6 | |
| 15. Atrial Fibrillation | 5 | |
| 16. Lung Cancer | 2 | |
| 17. Cataract | 1 | |
| 18. Osteoporosis | 1 | |
| 19. Glaucoma | 0 | |

of the objectives and measures at earlier stages to incent involvement and investment, and then build on these basic functions at later stages.

Within the national measurement community, there are similar gaps in understanding and clinical measurements of behavioral health care. At its March 9, 2009 meeting on “Prioritization of High-Impact Conditions and Measure Gaps,” the National Quality Forum reported that two behavioral health care conditions are within the top six Prioritized High-Impact Medicare Conditions” for measurement development. For these reasons, we find it critical that CBHOs should be clearly eligible to receive direct incentive payment and that the Stage 1 criteria be reduced to encourage CBHOs to participate in early stages of the EHR incentive program. This will also help to ensure that their expertise will be included in the technical expert panel to develop of clinical measures for the prioritize high-impact conditions.

While we support the clinical measurement as a means to improve quality of care, we request reexamination of the timing of the following measurement requirements in order to be eligible to receive EHR incentive reimbursement:

- Use of CPOE for orders directly entered by authorizing providers,
- Electronically exchange key clinical information among providers of care and patient authorized entities,
- Provide patients with an electronic copy of their health information within 48 hours of their request,
- Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge,
- Perform medication reconciliation at relevant encounters and each transition of care,
- Provide summary of care record for each transition of care and referral,
- Plot and display growth charts for children, including BMI,
- Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT,
- Incorporate clinical lab test results into EHR as structured data,
- Implement 5 clinical decision support rules related to a high priority hospital condition,
- Submit electronic data to immunization registries,
- Provide electronic submission of reportable lab results to public health agencies,
- Provide electronic syndromic surveillance data to public health agencies, and
- Implement drug-drug, drug-allergy, and drug-formulary checks.

Recommendation: *The National Council appreciates the leadership shown for ONC and CMS to coordinate national quality efforts and align with existing CMS quality initiatives, We recommend that more time be permitted in the Proposed Rule for compliance with electronic quality reporting, and that this time frame should incorporate adequate time not only for measure definition and development but also for system specification, development and testing*

of electronic reporting. We recommend that the reporting of quality measures directly from the EHRs be required, once those measures have been tested and CMS successfully receives and validate data from its ongoing pilot program.

The Proposed Rule requires EPs to attest in FY 2011 (Stage 1) that they can electronically report clinical quality measures and report these measures electronically by FY 2012. Many of the clinical quality measures are not yet ready for electronic reporting. For example, only 8 of the measures required for hospitals have been endorsed by the National Quality Forum and approved by the Hospital Quality Alliance. As a result, the majority of clinical measures have not been completely scoped and electronic specifications are not available for electronic reporting. While automated quality reporting is critically important to the meaningful use of electronic health records, even EHR systems in use today are not able to automatically and electronically produce a full set of proposed measures. Because of this, the Proposed Rule should give ample time and opportunity for EHR systems to meet the reporting requirements.

The National Council wants to thank CMS for their leadership in developing such a comprehensive and forward-thinking Proposed Rule. Please accept our comments on behalf of our membership as supporting the strategic direction of the rule and requesting revision of provisions to clarify how CBHOs can actively engage in this process and receive incentives for the meaningful use of EHRs.

Sincerely,

Linda Rosenberg, President & CEO
National Council for Community Behavioral Healthcare