National Association for Behavioral Healthcare

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SUBMITTED VIA: www.regulations.gov

Ms. Seema Verma
Administrator, Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare and Medicaid Programs: *Patient Protection and Affordable Care Act*; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans in the Federally- Facilitated Exchanges and Health Care Providers (CMS–9115–P)

3 June 2019

Dear Ms. Verma:

As an association representing behavioral healthcare provider organizations and professionals, the National Association for Behavioral Healthcare (NABH) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) "Medicare and Medicaid Programs: *Patient Protection and Affordable Care Act*; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans in the Federally- Facilitated Exchanges and Health Care Providers" (CMS–9115–P).

Founded in 1933, NABH represents and advocates for behavioral healthcare provider systems that are committed to delivering responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Our members are behavioral healthcare provider organizations that own or manage more than 1,000 specialty psychiatric hospitals, general hospital psychiatric and addiction treatment units and behavioral health divisions, residential treatment facilities, youth services organizations, and extensive outpatient networks. These providers deliver all levels of care, including partial hospitalization services, outpatient services, residential treatment, and inpatient care.

CMS' proposed regulations seek to address the coordination of care for patients with behavioral healthcare conditions through a new Medicare Conditions of Participation (CoPs) that requires inpatient psychiatric facilitates to generate Admission, Discharge and Transfer (ADT) electronic patient event notifications. Through exchange standards incorporated in federal regulations, the rule requires hospitals to send notifications that include, at a minimum, patient health information, practitioner name, institution name, and patient diagnosis to "licensed and qualified practitioners." The rule limits the applicability of this provision to psychiatric hospitals "which currently possess EHR systems" capable of meeting the technical specifications required in the rule.

We agree with CMS that there is a tremendous need to improve care coordination for patients with behavioral healthcare conditions. This is why NABH has worked with CMS, accrediting agencies, consumers, and other stakeholders to develop and support using inpatient psychiatric performance measures.

NABH is one of the original organizations that spent more than 10 years developing the Hospital Based Inpatient Psychiatric Services (HBIPS) measures that were among the Inpatient Psychiatric Facilities Quality Reporting (IPFQR) program's first performance measures. We have long supported improving the

effectiveness of transitions of care for patients with behavioral healthcare conditions. Although we are pleased to see CMS address this important topic, we are concerned with some of the rule's provisions.

Creating a new special CoP in the Medicare program that is targeted to 30 to 40 percent of psychiatric hospitals—which make up only a small segment of all hospital in the Medicare program— raises a number of concerns for our members.

First, this unprecedented move would cause a disruptive change to how CoPs apply to hospitals within a specific specialty. Historically CoPs have applied to all hospitals or all hospitals within a specialty, such as psychiatric hospitals. Applying a CoP to a small set of hospitals within a specialty would create two separate regulatory structures for facilities providing the same services. While we agree with CMS that the proposed CoPs are clearly relevant for those inpatient psychiatric facilities that have an EHR, it is premature to establish this CoP because it is inconsistent with long-standing CMS policy to apply CoPs to all hospitals or to all hospitals within a specialty.

In addition, the current costs for psychiatric hospitals related to complying with the existing "special" CoPs applicable to psychiatric hospitals and the "safe setting" CoP is a staggering $1.5 billion annually. Adding regulations to an already overloaded regulatory structure will do little to improve patient care.

NABH's recent report *The High Cost of Compliance: Assessing the Regulatory Burden on Inpatient Psychiatric Facilities* analyzed this topic and concluded: "Because of these B-tag ["special" CoPs] interpretations, clinicians must spend time crafting highly tailored free-text plans and progress notes. Often, these documents must be written out by hand because many freestanding psychiatric hospitals do not have electronic health records (in part, because they were excluded from the $38 billion Incentive Program that CMS established in 2011). This approach is out of step not only with standard practice in non-psychiatric disciplines, but also with the medical industry's trend toward appropriate use of check boxes and standardized language, which saves clinicians time and which (when contained in an electronic record) makes the data more searchable, analyzable, and portable."

We propose an alternative option for CMS to consider before implementing the final rule. Our option meets the needs of beneficiaries; is consistent with CMS' goals related to advancing interoperability and improving patient access to health information; and is feasible for psychiatric hospitals to implement. Below we provide some context on this important issue.

Background on BHIT Incentives

In 2008, President George W. Bush signed the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA), which prevents commercial health insurers that provide mental health or substance use disorder benefits from imposing more restrictive benefit limitations on those benefits than on medical and surgical benefits. MHPAEA has improved U.S. behavioral healthcare coverage considerably and established the idea of "conceptual parity" between physical and mental illness in the public discourse. Conceptual parity is based on the idea that behavioral healthcare conditions should not be treated is ways that are unequal to how we treat physical illness.

Unfortunately, we still see too many violations of conceptual parity, which we view as a form of discrimination against patients with behavioral health conditions. These violations prevent people with behavioral health disorders from living their lives fully. They also send a message that people with behavioral health conditions are less deserving of federal support than beneficiaries with physical healthcare conditions. The federal electronic health record (EHR) incentive program, which the *HITECH Act* created, is an example of a policy that needs to comply with conceptual parity.

The goal of widespread adoption of health information technology (HIT) — to save American lives through improved care coordination — is particularly relevant to persons with behavioral healthcare conditions. Individuals with serious mental illnesses die, on average, 25 years earlier than other Americans due to a high incidence of untreated co-occurring chronic medical conditions in this patient population. These conditions include cancer, hypertension, diabetes, asthma, heart disease, and cardio-pulmonary conditions. This is why it's critical that behavioral health patients have coordinated care, which HIT would help improve. However, behavioral healthcare providers were excluded from the *American Recovery and Reinvestment Act of 2009,* which provided about $38 billion in HIT funding.
A study published in the *Journal of the American Medical Association* found that the federal HIT funding had a "dramatic" impact on EHR adoption and that "HITECH can serve as a model for other countries seeking to increase EHR adoption among hospitals and for other policy efforts seeking to promote technology adoption more generally." The lack of HIT incentives for behavioral healthcare providers has left little or no incentive for electronic health record (EHR) vendors to develop behavioral healthcare-specific platforms. Consequently, behavioral healthcare providers have been slow to adopt EHRs.

In excluding behavioral healthcare providers from this federal funding, the law has created a system that violates conceptual parity and has consequently hurt behavioral healthcare patients in the process. We need to change federal policy to correct this mistake.

Extending EHR Incentive to Behavioral Healthcare Providers
Only a small portion of behavioral healthcare providers are using electronic health records. According to data from CMS' IPFQR program, about 30 to 40 of psychiatric hospitals use EHRs, a level that has remained constant. The fiscal year 2019 (FY19) Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) rule emphasizes this, noting: "performance on this measure [use of and electronic health record] has remained relatively static for the past two program years."

CMS noted in its FY 19 rule there "is evidence demonstrating the positive effects of EHRs on multiple aspects of medical care." Furthermore, we know that more behavioral healthcare providers would adopt EHRs if they had the same financial incentives the federal government applies to medical and surgical providers. Section 6001 of the *SUPPORT Act for Patients and Communities Act* last year included an authorization for CMS to provide incentive payments to behavioral healthcare providers to encourage EHR adoption. We ask CMS to exercise this authority.

In addition, under this provision in the *SUPPORT Act*, CMS could establish a program—perhaps within the Innovation Center— that would extend EHR incentives to the behavioral healthcare providers who were excluded from the *HITECH Act*. Extending this funding to behavioral healthcare providers will do far more to improve care for Medicare beneficiaries than any change to the CoPs.

SEC. 6001 does not include a process or funding to take the demonstration from the project level to the national implementation level. We recommend that CMS conduct the demonstration project and use the project as a guide to help Congress draft legislation that would implement EHR adoption among behavioral healthcare providers nationally. CMS could also draft a report for Congress, which would include details on:

- The amount of funding that would be required to implement a nationwide plan;
- The type of behavioral healthcare-specific meaningful use criteria that should be included; and
- Additional information regarding how to make the program work effectively.

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This report from CMS would serve as a roadmap to achieve conceptual parity because it would help ensure that behavioral healthcare patients have the same access to electronic health records as medical and surgical patients.

We look forward to continuing our work with you and your team to help identify other opportunities to improve the Medicare and Medicaid programs through regulatory, sub-regulatory, policy, practice, and procedural changes.

If you have questions, please contact me directly at 202-393-6700, ext. 100, or contact NABH Director of Policy and Regulatory Affairs Scott Dziengelski at 202-393-6700, ext. 115.

Sincerely,

Mark Covall
President and CEO