STATEMENT OF:

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REGARDING Voluntary Certification for Behavioral Health

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Good morning. I'm Kevin Scalia, Executive Vice-President, Corporate Development at Netsmart Technologies. I greatly appreciate having the honor and privilege to speak to this group about how we see certification, integration and privacy affecting the behavioral health community and the broader healthcare ecosystem. I'll speak to you from the perspective of the largest provider of health information technology to behavioral health organizations, and more broadly to human services organizations. We serve more than 20,000 private behavioral health practices, 40 of the state-operated hospital systems, hundreds of inpatient psychiatric hospitals and approximately one third of all community mental health centers in the country. As it relates to this testimony, we have been participating in the creation of health home care coordination systems and the associated health information exchanges needed to connect behavioral health to physical health for some of the largest populations of SMI health homes.

Introduction

The behavioral health and human services market is complex as prior speakers have testified over your past sessions and behavioral health co-morbidities amplify the cost of physical illnesses. There is no "one-size-fits-all EHR" that is capable of addressing behavioral health providers of all sizes and settings, child welfare, I/DD and social services. As a provider of technology to these settings, we understand that and have developed a continuum of EHRs to meet the needs from the smallest private practice to the largest behavioral health provider to the social service organizations, I/DD providers and child welfare organizations. Our approach was a market driven response to the diverse needs and price points of the behavioral health/human services community. All of our EHRs have received the existing complete Meaningful Use 2014 certification. While it is expensive for us to maintain certification for three EHRs, we felt that for behavioral health to truly be considered an equal partner in the United States healthcare system our clients need to be able to integrate fully with the physical healthcare side of the world. Our clients agree. Adding another certification will just add cost, not remove it. We will still need to have the full Meaningful use certification, as it is required by integrated health systems and is a criteria in many buying decisions made through formal request for Proposals (RFPs).. Adding another certification will only add more confusion and cost to the process. If it is decided to have a behavioral health certification, then it should be a sub-set of the full meaningful use certification so that a system that is certified to the Complete EHR standard would automatically meet the behavioral health standard so duplicate certification would not be required.

Prior speakers have addressed the relatively low adoption rate of health IT among behavioral health providers. I would make the case that nearly all providers have some level of IT in use. Whether they

meet the meaningful use requirements is another question. The complex billing and reporting requirements driven by the states mandate this. I believe the lower adoption of clinical systems is driven more by lack of capital resources and the fact that behavioral health providers and human service organizations are not eligible for meaningful use funding, than the lack of a specific behavioral health certification process. All of our new clients are buying certified systems and most of them are applying for the EP level incentives. I do not believe that the rate of adoption would increase with a new certification system without commensurate incentives to help justify the investment.

The lack of incentives, and exclusion of psychiatric hospitals from meaningful use incentives, is a huge reason that adoption is so low. State mental health systems are collapsing under current financial burdens, and are making reimbursement systems so outrageously complex, that some providers really don't have the skills to bill. For example, some large, well run organizations, do not even bill for Medicare Part D because one state has taken an outpatient process for reimbursement and placed it on top of an inpatient setting. It really does take a rocket scientist to do that billing. What happened to the simplification goals of HIPAA? Something for ONC to seriously consider is whether the funding considered to create another certification for an already financially strapped population could be better used to develop standards for behavioral health across all states that would simplify and make more efficient the billing, reporting and quality measurement of this part of healthcare. Addressing this problem would have a much higher return on investment and would help to drive positive outcomes.

Netsmart has worked to help introduce legislation in Congress to address this disparity. The Behavioral Health Information Technology Act of 2013 (S.1517) introduced by Senator Sheldon Whitehouse of Rhode Island, the Behavioral Health Information Technology Coordination Act of 2013 (S. 1685) introduced by Senator Rob Portman of Ohio, and the Behavioral Health IT Act (H.R. 2957) introduced by Representative Tim Murphy of Pennsylvania all strive to address the disparity in funding to behavioral health providers. I believe this funding is key to driving clinical adoption in behavioral health.

Specifically addressing the question of requiring another certification required I would refer to the current state of certification. Although there has been reference made to the 100's of vendors that provide EHRs to the behavioral health community, less than 10 account for nearly 100% of the total number of installed systems. All of these vendors have passed meaningful use stage 1 certification. Netsmart, as the market share leader, has already passed meaningful use stage 2 testing and I would assume our competitors are right behind us. Our systems are sold on a modular basis. For example if a provider that does not prescribe wants to buy an EHR, they do not need to buy the e-prescribing system, yet they could still have all the interoperability capabilities that the full system has. This is driven by market requirements and competition. Another certification would not improve adoption.

Interoperability and care coordination is the future

The key to bending the cost curve in the United States is the integration and coordination of care, especially for those high cost, high need populations with multiple chronic conditions. Behavioral health consumers often fall into this category and behavioral health providers are key to helping the country address this problem. However, unlike primary care providers who often have to integrate with only one hospital, a community mental health provider needs to integrate with every emergency department in its region – a truly complex and expensive proposition for an under-capitalized portion of the healthcare system - one which is currently ineligible for incentives to do this. Add to that that

meaningful use requirements and CCDs that do not include the ability to transmit many of the behavioral health specific data required to coordinate care. I would stress that the focus needs to be on how we adapt the physical health certification requirements to ensure that physical health systems and certifications mandate the incorporation, and ability to transmit and receive, behavioral health data as well as physical health data.

At a minimum, all EHR certifications should include the capacity to send and receive standardized data elements to support transitions and care coordination across all care settings. CMS should add behavioral health, child welfare, I/DD, and substance use quality measures into the existing certifications so that domain specific quality measures can be used. This can also form the basis for the states to adopt common measures that would simplify the unique state-to-state differences in quality measures. If CMS adopted a quality standard requiring the electronic exchange of these clinical data elements, that standard alone would create the business case for the adoption of certified EHRs.

The healthcare ecosystem is moving. Fast. Innovations designed to transform healthcare and realize the triple aim are being developed and implemented now. Due to SAMHSA's interpretation of the privacy and security laws, behavioral health and substance use providers are all but eliminated from participating in health information exchanges. The speakers to follow are some of the few that allow behavioral health data to be transmitted in their HIE systems. I will discuss this in more detail later, but with that as the basis, and feeling that the field cannot wait for federal regulation to be developed, we have started working with acute care HIT vendors to build point-to-point interfaces using HIE technology so that our clients can participate in health homes, ACOs and other care coordination bodies.

We are working with pilots to prove these apporaches and the results look very promising. (See story at http://www.ntst.com/news/pr_detail.asp?newsID=282). In projects like these and direct connections between inpatient and outpatient providers we have found the need to extend the CCD to allow for the transmission of PDFs attached to the CCD to allow for the incorporation of behavioral health data not included in the CCD. ONC should address this in the meaningful use stage 3 requirements.

Confidentiality and Privacy

As discussed above, almost every HIE in the country will not accept data from behavioral health and especially substance use providers. The 42CFR part 2 regulations that were written in the 1970's in an era of felony convictions for possession of narcotics were designed to encourage substance users to seek treatment without fear of arrest. This was before the use of electronic records in healthcare so the law did not contemplate electronic transfer of data. Today, times have changed Many states are legalizing some drugs, but more importantly stigma associated with mental health and substance use treatment has declined materially. However, the regulations have not kept pace with consumer desires, technology and current culture, and as a result, are actually contributing to, rather than mitigating stigma. An example best illustrates this case. If an adult with Alzheimers or dementia, COPD and diabetes consents to his or her records being shared on an HIE they can do that and they can receive the superior care that can be delivered by exchanging this information, coordinating care and reducing the risk of medication interactions associated with their multiple medications. A second person, one with mild depression, diabetes and a substance use issue, who has part of his or her treatment provided by a substance use provider cannot consent to share their records on an HIE without enormous administrative burden on themselves and their provider, and in most cases this is

impossible to do due to the current technologies in use on HIEs. This unintended consequence is a result of SAMHSA's interpretation of "informed consent". On the face of this it would appear to be discriminatory to a consumer with substance use issues and against the intent of the mental health parity and affordable care act legislations. We need to offer parity to substance use consumers who want to participate in a health information exchange.

SAMHSA's interpretation of 42CFR needs guidance to be issued as behavioral health and substance use providers are effectively barred from almost all HIEs due to the lack of HIEs' ability to meet the SAMHSA requirements. Sub-regulatory guidance allowing a patient to identify "current and future providers in the HIE involved in my care" as an appropriate title under the "To Whom" requirement of a Part 2 consent would help to allow sharing data immediately.

Another point to consider here is that having different privacy standards for general healthcare and behavioral health actually reinforces the old belief that that they are different, it decreases integration and increases stigma. We should have parity for those consumers that choose to exercise this right. We are at a crossroads right now as to whether we finally begin acting like behavioral health IS healthcare and as a result, treat it no differently than physical healthcare or do we continue to divide head from body? There will be difficulties in making this transition but the way to handle that is to enact legislation that prevents discrimination based on any diagnosis. We have historical precedents in two other diseases that were stigmatizing: tuberculosis and cancer. Both had histories of being treated in much the same way as mental illness and substance use is now.

State and Federal Issues

As discussed previously, we effectively have 50 different behavioral health systems in the United States - each state's unique department of mental health and substance abuse (often two different departments in many states). Each state sets the standards for outcomes measures, state reporting and billing requirements. The billing and reporting differences state to state are significantly larger cost drivers to the system than is the certification. Harmonization of these billing/reporting requirements would be much more of a benefit to providers than another certification standard. It would also allow for comparative effectiveness research and population health analysis that is not available today due to the vast variety of assessments and outcomes measures utilized in the industry today. The country used to have 50 different sets of accounting rules until the accounting profession agreed to standards nationwide (GAAP). We can do the same for behavioral health providers.

In our opinion alignment of standard CQM's would provide the most benefit. If the policy committee and standards committee can drive alignment between the state and federal requirements it would provide an enormous return on investment to the system.

Additionally, in human services there are many different reporting requirements across BH, I/DD, SA, HIV/AIDS, Child and Family, and Housing at every governmental level - federal, state, and county departments of mental health and other departments, many of which continue to mandate paper forms, direct data entry in multiple systems, and non-standard electronic interfaces. This is an issue of standards – not interoperability. Simplifying these interfaces would take a huge burden off our clients and make them more efficient as well.

As we look to improve care by analyzing data, looking at comparative effectiveness and benchmarking across providers, we are seeing more and more providers trying to make consumer PHI a proprietary asset. HIPAA permits de-identification and aggregation of clinical data, no doubt in recognition of the value of analyzing this vast amount of data, not to a single provider, but to the cause of research and improvement of the quality of care on a macro level. However, provider's fear of violating their interpretation of consent requirements will restrict the healthcare industry's ability to identify macro trends and results for the benefit of consumers and will create balkanization of valuable clinical data repositories. Clarifying the use of de-identified data for research and benchmarking would help to move the whole industry forward.

Information exchange and interoperability

As discussed above, innovations such as health homes, ACOs, coordinated care organizations, dual eligible programs and other innovations will not succeed until behavioral health organizations are able to share data seamlessly with their physical health care partners in care coordination programs.

Consumers suffering from serious mental illness have increased rates of co-occurring conditions – causing a reduced life expectancy of nearly 25 years which places a huge financial burden on society. The issue that needs to be addressed is how to ensure that primary care/acute care HIT vendors have the capability to accept the unique behavioral data sets so that care can be bi-directionally coordinated. This is an issue more for the physical HIT vendors as behavioral health HIT vendors can already (as part of the current meaningful use certifications) do the vital sign data capture as well as physical health diagnosis. Without these data set requirements being included in the broader MU certifications for all EHR vendors we will not achieve interoperability.

I would lobby strongly NOT to remove the requirement to capture vital signs at the behavioral health organizations as many of them are focusing on integrated care to reduce the early death phenomenon in behavioral health consumers due to co-occurring physical health issues. This was also the feeling of prior ONC leaders Brailor, Kolodner and Blumenthal who felt that identifying consumers with high blood pressure or high BMI and getting them treatment would offset the incremental cost of creating these functions in the behavioral health facility. Having said that, keep in mind that our clients currently do not, for the most part, integrate physical health assessments into their workflow and it will take time and investment to include this in the workflow. Another case for increased HITECH funding to allow them to meet meaningful use.

In summary the key points we would like to make are as follows:

1. We do not recommend or see the need for a behavioral health specific certification

2. We believe that enhancements to the current meaningful use certifications to add behavioral health clinical quality measures and other data into the physical health systems would facilitate communication and coordination

3. Care coordination is key to the future of healthcare. Being able to share data between behavioral health and physical health IT systems will drive positive clinical outcomes.

4. The privacy regulations, especially 42CFR Part 2 needs to be harmonized with physical health privacy regulations and updated to reflect current technology and consumers desires. This can be accomplished with sub-regulatory guidance from SAMHSA. We need to give consumers who want to participate in HIE the ability to participate.

5. A focus by CMS on core clinical quality measures will help reduce the state-by-state burden of 50 different state assessment requirements, different outcomes measures and billing requirements that will help to make the behavioral health system more efficient.

I thank you for this opportunity to submit our recommendations and comments on implementing a voluntary Certification Program for Behavioral Health electronic Health Records.

If you have questions please contact me at kscalia@ntst.com

Thank You,

Kevin Scalia