January 27, 2016

The Honorable Orrin Hatch
Chairman
Senate Finance Committee
219 Dirksen Senate Office Bldg.
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Bldg.
Washington, D.C. 20510

The Honorable Johnny Isakson
131 Russell Senate Office Bldg.
Washington, D.C. 20510

The Honorable Mark Warner
475 Russell Senate Office Bldg.
Washington, D.C. 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

The undersigned members of the Behavioral Health Information Technology (BHIT) Coalition laud you for releasing the "Bipartisan Chronic Care Working Group Policy Options Document" last month. This correspondence focuses on the portion of the white paper devoted to addressing the need for behavioral health among chronically ill Medicare beneficiaries.

In particular, the Coalition strongly believes that it is likely very difficult to "improve the integration of care for individuals with chronic disease combined with a behavioral health disorder" without including mental health and substance use providers in the HITECH Act. Given the Senate Finance Committee's recent decision to authorize Meaningful Use incentive payments for the Puerto Rican hospital system, now is the time to accord equal treatment for behavioral health providers.

Mental illness and addiction disorders complicate the management of medical/surgical chronic disease in Medicare recipients, with new data showing that behavioral health conditions are associated with strikingly high mortality and morbidity rates independent of comorbid chronic conditions.

<u>Substance Use Disorder/Suicide Causing Rising Death Among 45 to 55 Year Olds</u>

In an examination of Centers for Disease Control & Prevention (CDC) data, the *New York Times* discovered a rising mortality rate among white adults and middle aged Americans in the 45 to 54 year old age group.[i] "Rising rates of overdose deaths and suicide appear to have erased the benefits from advances in medical treatment for most age groups of whites. **Death rates for drug overdoses and suicide, "are running counter to those chronic disease" like heart disease, said Ian Rockett, an epidemiologist at West Virginia University.**

The Coalition takes this opportunity to remind the Committee that behavioral health providers were excluded from the HITECH Act in 2009 because mental health and addiction disorders were deemed "post-acute" conditions.

Alarming Number of Medicare Beneficiaries with Behavioral Health Disorders & Chronic Diseases

The incidence rate of comorbidity between medical/surgical chronic disease and mental health and substance use disorders in the Medicare patient population can only be described as staggering. For example, according to 2012 data from the Centers for Medicare and Medicaid Services (CMS), approximately 90% of Medicare beneficiaries with clinical depression are also diagnosed with at least one comorbid medical/surgical chronic disease (e.g., high blood pressure, diabetes, ischemic heart disease, COPD, stroke, etc.).[ii] Perhaps even more surprising, CMS estimates that 40% of Medicare recipients with depression have *more than five* comorbid chronic conditions.

The cost implications are similarly troubling. Medicare patients with depression tend to spend longer times in hospitals, have higher emergency room utilization, and experience exacerbated functional disabilities in nursing facilities and other congregate care settings, according to the American Association of Geriatric Psychiatry.[iii]

While clinical depression is the most widely prevalent chronic illness among Medicare recipients, similar trends apply to other chronic conditions. For example, kidney diseases are highly correlated to behavioral health issues – specifically to major substance use disorders – across the entire spectrum of treatment from initial causation to end-stage renal disease.[iv]

Injection drug use and alcoholism are significant contributors to causing Hepatitis C and cirrhosis of the liver among Medicare beneficiaries.[v] On the other end of the treatment continuum, "Hospitalization with a psychiatric illness is common among the U.S. end-stage renal disease population. Depression….and drug-related disorders were especially common. The coexistence of psychiatric and substance use illness in patients with renal failure who require specialized medical regimens represents a challenge to nephrologists in diagnosis and treatment," according to the *American Journal of Medicine.*[vi]

And the discussion above does not encompass low-income Medicare beneficiaries who are also eligible for Medicaid – commonly known as "dual-eligibles." Even experienced policy makers are often surprised to learn that fully one-third of persons eligible for both Medicare and Medicaid have a *primary* diagnosis of severe mental illness – most commonly schizophrenia. Further, CMS data shows that 70% of dual-eligibles with serious mental disorders also have a wide array of comorbid

medical/surgical chronic diseases including lung cancer, emphysema, asthma, and heart failure. [ii]

Adding To Policy Under Consideration – Behavioral Health Information Technology

The Coalition is broadly supportive of the recommendations included in the Senate Finance Committee white paper, including the integration of behavioral health with medical/surgical services and a General Accountability Office (GAO) study examining the integration of behavioral health and primary care among private sector Accountable Care Organizations (ACOs), public sector ACOs, and ACOs participating in the Medicare Shared Savings Program (MSSP). In order to avoid duplication, the Coalition encourages the Committee to contact the HHS Assistance Secretary for Planning and Evaluation, which initiated somewhat similar studies within the last eighteen months.

While all these policies have value, the reality is stark. As your paper states, "ACOs and other models face challenges integrating primary care and behavioral health services, despite the benefits of doing so." In part, this is because the providers cannot communicate with each other.

Psychiatric hospitals, clinical psychologists, clinical social workers, Community Mental Health Centers, and outpatient/inpatient addiction providers have been ineligible for incentive payments since the inception of the Meaningful Use program. In the modern digital medical era, these providers cannot communicate with – and cannot coordinate care with – hospitals, physicians, cardiologists, endocrinologists, and nephrologists without Electronic Health Records (EHRs).

In the 114th Congress, the Senate Health Education Labor and Pensions Committee has held a series of hearings highlighting the lack of "interoperability" among EHR systems; Senator Whitehouse and Senator Cassidy recently introduced the TRUST IT Act (S. 2141) to further those reforms. In addition, leading members of the Senate Finance Committee, including Senator Roberts, Senator Enzi, Senator Thune, and Senator Burr, have joined together in calling for Meaningful Use to be "rebooted" because of interoperability issues ranging from active information blocking to incompatible medical data sets.

In our view, reform of the Meaningful Use program involves both vigorous enforcement of the interoperability provisions in the Medicare Access and CHIP Reauthorization Act (PL 114-10) as well as enactment of the Behavioral Health Information Technology Act. Senator Whitehouse and Senator Portman introduced companion bills (S. 1517/S. 1685) in the 113th Congress, and Representative Tim Murphy included nearly identical legislative language in the Helping Families in Mental Health Crisis Act (H.R. 2646).

Thank you for seeking input from the BHIT Coalition. We look forward to working closely with you and your staff as you translate the working group white paper into legislation.

Sincerely,

American Psychological Association

Association of Behavioral Health and Wellness

Centerstone

The Jewish Federations of North America

Mental Health America

National Alliance on Mental Illness

National Association of Counties

National Association of County Behavioral Health & Developmental Disability Directors

National Association of Psychiatric Health Systems

National Council for Behavioral Health

Netsmart

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[vi] Kimmel, P.L., Thamer, M., Richard, C.M., Ray, N.F. (1998). Psychiatric illness in patients with end-stage renal disease. *American Journal of Medicine*, 105(3), 214–221.