



July 11, 2014

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2125 Rayburn House Office Bldg.
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Rep. Diana DeGette
Ranking Member
House Energy and Commerce
2368 Rayburn House Office Bldg.
Washington, DC 20515

RE: Comments on the Energy and Commerce Committee Digital Health Care Initiative

Dear Chairman Upton and Ranking Member DeGette:

The National Association of State Mental Health Program Directors (NASMHPD) appreciates the House Energy and Commerce Committee’s leadership on health information technology issues, and we are grateful for the opportunity being afforded by the Committee to offer our recommendations for improving the digital health care environment. NASMHPD is the member organization representing the state executives responsible for the \$37 billion public mental health service delivery systems serving 7.2 million people annually in 50 states, 4 territories, and the District of Columbia.

Our recommendations to the Committee center on three issues:

1. The need for the Federal government to align the privacy restrictions governing disclosure of substance use disorder treatment information under 42 U.S.C §§ 290dd-2 and 42 C.F.R. Part 2 with the privacy mandates of the Health Insurance Portability and Accountability Act (HIPAA). We believe a greater alignment is critical to ensuring that all patient data is made available to providers so they can better integrate treatment for individuals with substance use disorders and concurrent physical and mental health conditions and diseases.
2. The need to extend the meaningful use incentives provided under the Medicaid and Medicare programs to mental health services and substance use disorder treatment service providers, to provide an incentive for including behavioral health¹ treatment information in more comprehensive patient electronic health records (EHRs), and thereby facilitate the coordination of care across the care continuum, as is proposed under H.R. 2957, H.R. 3717, and H.R. 4574.
3. The need to align Federal and state telehealth standards to facilitate patient access to providers in remote areas, particularly in the 4,000 Health Resources and Services Administration (HRSA)-designated mental health professional shortage areas.

Aligning Substance Abuse Treatment Privacy Standards with HIPPA Privacy Rules

Across the country, state Medicaid agencies and providers are rapidly embracing approaches to delivering integrated care through models such as health homes, coordinated care entities, and accountable care organizations. Development and adoption of EHRs, health information technology (HIT), and health information exchange (HIE) mechanisms have provided new, more efficient and effective tools for coordinating care and realizing our shared goals around improved patient health and outcomes. These efforts, which rely on information sharing and team-based care, are focused on improving the delivery of services for Medicaid beneficiaries. However, the fundamental tenets of these models have proved challenging and in some cases impossible to apply with respect to populations with substance use disorders.

Most aspects of the Substance Abuse and Mental Health Services Administration's (SAMHSA's) 42 CFR Part 2 patient treatment data disclosure restrictions, adopted pursuant to the decades-old statutory prohibitions codified at 42 U.S.C §§ 290dd-2, are a major barrier to providing high quality, coordinated care for individuals with substance use disorders covered by Medicaid or receiving care through the public mental health delivery system. The language of 42 CFR Part 2 limits the flow of vital electronic health information and impedes team-based care for those with substance use disorders. Permitting the transfer of this information for the purposes of treatment, care coordination, and case management would improve the quality of care for those with substance use disorders and allow those individuals to benefit from advances in care delivery. It would also help to further patient safety and reduce the stigma of substance use disorders that acts as a disincentive for individuals to seek treatment.

With regard to safety, the risk of an adverse drug event (ADE) increases if access to medication history is restricted.ⁱⁱ Restricting access to information about certain prescribed medications increases the likelihood of ADEs because providers cannot fully assess the risk of prescribing a new medication. ADEs have also been found to increase linearly with the increase in the number of unique medications in the patient's drug regimen.ⁱⁱⁱ Further, studies also show that one of the largest drivers of hospital readmissions is inappropriate or unreconciled drug regimens.^{iv} According to the Centers for Disease Control and Prevention, the health care system spends an amount equal to the cost of the medications themselves on associated ADEs.^v

In addition, NASMHPD members believe that having separate health information privacy requirements for substance use disorder treatment is discriminatory and perpetuates stigma. The requirements keep persons with substance use disorders and the providers who treat them marginalized and disadvantaged compared to other patients and providers in the health care system. Separate health information privacy requirements for substance use disorder treatment make it significantly less likely that people with substance use disorders, including Medicaid beneficiaries, will receive the attention and time to support continuing remission. It even makes it less likely they will have early recurrence identified. When general health care providers know a person has had a chronic condition, they inquire about it and look more closely for signs that the person remains healthy in that area. For a patient with a substance use disorder, keeping the condition secret deprives the individual of the additional care and treatment they would receive if they had any other chronic condition.

Another consequence of the special requirements of 42 CFR Part 2 is that they impose significant administrative burdens and costs on the providers least able to bear them. Specialty substance use disorder individual treatment providers and organizations are arguably the most underfunded and

under-capitalized providers in the health care system. 42 CFR Part 2 was implemented well before health information and related technologies were even contemplated, and has not been meaningfully updated to reflect modern technology. As a result, 42 CFR Part 2 adds a financial burden and enormous complexity to HIT initiatives. Further, the requirements associated with 42 CFR Part 2 necessitate expensive customization of EHRs and requires service providers to commit additional funds and resources to manage EHR integration into their practice workflow. Attempting to segregate substance use disorder information from the EHR is exceptionally costly and may result in changes that threaten federal certification status of an EHR. The added complexity and cost make it likely substance use disorder information will be omitted altogether from HIEs and EHRs.

We appreciate the recent proposal by the Office of the National Coordinator (ONC) for the Department of Health and Human Services in its proposed new 10-Year Strategy to work to improve substance use disorder patient treatment information standards, technology, and workflow to enable the electronic collection and management of consent as well as the electronic exchange of related information within existing legal requirements. However, more immediate steps are needed to support coordination of care across providers and government programs.

Our members ask that the House Energy and Commerce Committee advance legislative language to repeal the provisions of 42 U.S.C §§ 290dd-2 not aligned with the privacy provisions of Health Insurance Portability and Accountability Act (HIPAA) or its underlying regulations. We recommend retaining only the provisions of 42 U.S.C §§290dd-2(c) which prohibit the use of covered drug or alcohol abuse treatment records to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient. The perception that substance use records of an individual in treatment can be used to launch or substantiate a criminal investigation—whether legally justified or not—often serves to discourage individuals who need treatment from seeking that treatment, while sharing the information with courts, criminal justice agencies, and other entities outside the healthcare delivery system would not further the desired goal of increasing the integration of care for those individuals. At the same time, retaining this existing exception for investigations would not impede the sharing of health care information among a patient’s health care providers.

In calling for this change, we recognize there are concerns about the disclosure and use of the sensitive information contained in the electronic records of patients with substance use disorders. States take these concerns very seriously and place a high priority on protecting the privacy of Medicaid enrollees and patients of our public mental health system, including information pertaining to substance use disorder treatment. However, as policymakers have done in all other areas of personal health information, including for those with mental health conditions, they must balance privacy protections with the health, safety and welfare of patients, their families, and their communities.

We want to be clear that we are *not* calling for changes to the penalties for individuals or entities that would violate the modernized privacy regulations nor to other law that protects these individuals. As these individuals receive higher quality care – and ultimately achieve a higher quality of life – patient privacy would continue to be robustly protected through the use of the financial penalties already in place to deter inappropriate uses of patient information.

In addition, we recommend that education initiatives be implemented nationally to help consumers understand how their health information is protected, shared, used, and disclosed. We believe the promise of improvements in care and safety stemming from this regulatory change far outweigh

concerns about the potential release of sensitive information. Federal and state partners and other stakeholders must do more to help promote this change of culture and public sentiment.

Extending Medicaid and Medicare Meaningful Use Incentives to Mental Health and Substance Use Treatment Providers

Persons with serious mental illness (SMI) experience high levels of co-morbid health conditions and die up to 25 years sooner than the general population.^{vi} The benefits of integrating personal behavioral health data with personal health data are demonstrably great, and appropriate policies and practices permitting the sharing of behavioral health data can be very effective in producing positive patient outcomes.

Unfortunately, recent federal enactments that have had a major impact on the promotion of HIT and EHRs have failed to address the needs of mental health and substance use disorder treatment providers. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) provisions of the American Recovery and Reinvestment Act of 2009, authorized approximately \$20 billion for the payment of Medicare and Medicaid program incentive bonuses to physicians, hospitals, and other health providers who adopt electronic health records, as well as millions of dollars in funding for the implementation of HIEs designed to enable providers to share their EHR data and thereby better coordinate and improve care.^{vii} Unfortunately, mental health and substance use disorder treatment providers were not included in the categories of providers eligible to receive EHR incentives, which were limited to hospitals and providers falling within the definition of “physician” under §1861(f) of the Social Security Act.^{viii}

As a result, in many states, behavioral health providers have not been active participants in adopting EHRs or HIT. Although HHS has funded HIT Regional Extension Centers to work with providers on the implementation and utilization of EHRs, in many states the State Behavioral Health Agencies (SBHAs) and their stakeholder providers do not appear to be a focus of the Centers. ONC officials have suggested in public meetings that while an SBHA may not be eligible for the Medicaid and Medicare incentive payments, individual psychiatrists and nurse practitioners employed by the agency might be able to apply for incentive payments for their individual professional services. However, the ONC has not provided subsequent clarification on exactly how this reimbursement could be accomplished, or the potential amounts that behavioral health providers could receive in incentive payments. Behavioral health providers need to know not only whether this is a viable source of revenue to support EHR initiatives, but also whether the size of the revenue stream actually warrants pursuing EHR implementation.

NASMHPD asks that Congress clarify the means for qualified behavioral health providers to become eligible for meaningful use incentive payments under existing statutory authority. If the existing statutory authority is inadequate, we ask that Congress amend federal law to make those providers eligible for the incentive payments available under the Medicaid and Medicare programs, as is proposed under H.R. 2957, H.R. 3717, and H.R. 4574.

In addition we ask that funding be authorized to enable CMS to provide technical assistance to SBHAs, state Medicaid agencies, and their stakeholder behavioral health providers on modifying HIT systems and EHRs to meet behavioral health meaningful use needs. Regional Extension Centers should be statutorily mandated to address behavioral health meaningful use issues and include SBHAs and local behavioral health provider representation in their target populations.

Need to Align Federal and State Telehealth Standards

Telehealth is viewed as a cost-effective alternative to more traditional face-to-face methods of providing medical care to patients in remote areas, but the lack of uniform telehealth standards makes it difficult to expand telehealth services on a national basis. Forty-four states provide reimbursement for telehealth services through live video, but no two of those states are identical in how they define and regulate telehealth. While some similarities exist where statutory language may have been borrowed from other states, notable differences exist even under those circumstances. In some states, telehealth policies mirror Medicare standards, while other states have developed distinct state policies for their Medicaid program. In fact, some of the states use the term “telemedicine” and others use “telehealth,” while at least one state, Alabama, uses no single defined term.^{ix} The federal Medicaid statute does not recognize “telemedicine” as a distinct service.

The 44 states vary in what they will reimburse, who can be reimbursed, when they can be reimbursed, and what state program is responsible for reimbursement. Most states reimburse through their Medicaid program, but three reimburse through their state’s aging services program. In addition to live video services, 11 states reimburse for remote patient monitoring, while 7 reimburse for “store and forward.” States also vary in whether they authorize prescribing as a follow-up to on-line encounters, the form of informed consent required, the mandated nature of the originating or distant site, and the type and jurisdiction of licensing or certification required. Some States require a pre-existing relationship/in person exam prior to on-line consultation, while others do not.^x

In the private market, as of April 2013, 19 states had adopted mandates for coverage of telemedicine by private payers under commercial plans, but state mandates differed in their details.

At the federal level, Medicare Part B regulations define telehealth services to specifically include consultations, office visits, office psychiatry services, and any additional service specified by the Secretary of Health and Human Services, when delivered via an interactive telecommunications system that permits two-way, real-time interactive communication between the patient and distant-site provider. Medicare telehealth services are limited by regulation in frequency and can only be furnished to an eligible telehealth beneficiary from one of eight qualifying originating sites defined by regulation. The provider must be one of eight specifically defined categories of practitioner licensed under state law. The patient must receive services in an approved clinical site at a rural health professional shortage area, a rural census tract, or a county outside a Metropolitan Statistical Area.^{xi}

Despite increases in Medicare payment rates for telehealth services, expansions of covered services, reductions in provider requirements, and the provision of federal grants to encourage telehealth, the growth in adoption of telehealth among Medicare providers has been modest. A 2013 study by the Medicare Payment Advisory Commission (MedPAC) of 2009 Medicare claims found that only 369 providers had 10 or more Medicare telehealth consultations. Roughly half of the 369 providers were mental health professionals, and about one-in-five of the 369 were non-physician professionals (e.g., physician assistants and nurse practitioners).^{xii}

For telehealth services to become more readily accessible and widely used, there must be a consistent, if not uniform, set of standards across the nation and all reimbursement programs. Such consistency/uniformity is necessary to facilitate predictability regarding regulatory expectations of providers and ease the burden of provider compliance across multiple venues. A consistent or uniform set of standards would also likely facilitate greater uniformity in reimbursement levels for services. NASMHPD members ask that Congress develop a uniform, or consistent, set of telehealth standards.

NASMHPD looks forward to an ongoing, engaging dialogue with your Committee regarding the confidentiality of alcohol and drug abuse records, the need to expand incentives for meaningful use of health information technology to behavioral health providers, and appropriate national standards for telehealth services. If you have additional questions regarding the issues raised in this correspondence, please feel free to contact NASMHPD's Director of Policy and Health Care Reform, Stuart Gordon, at stuart.gordon@nasmhpd.org or 703-682-7552.

Sincerely,



Robert W. Glover, PhD.
Executive Director
National Association of State Mental Health Program Directors

ⁱ Throughout this correspondence, the term “behavioral health” is used to reference both mental health services and substance use treatment services. While many states continue to have separate agencies to govern each, a growing number of states have combined their mental health services and substance use treatment services agencies into one umbrella behavioral health services agency in order to further integration of care.

ⁱⁱ Zwicker, D. and Fulmer, T., “Reducing Adverse Drug Events,” In: Boltz M, Capezuti E, Fulmer T, Zwicker D, eds. *Evidence-Based Geriatric Nursing Protocols for Best Practice*, <http://www.guideline.gov/content.aspx?id=43938> (2010). FitzGerald, R.J., “Medication Errors: the Importance of an Accurate Drug History,” *Br J Clin Pharmacol*, 67(6), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2723207/pdf/bcp0067-0671.pdf> (June 2009).

ⁱⁱⁱ Silva, D.C.B., Araujo, O.R., Arduini, R.G., et al., “Adverse Drug Events in a Paediatric Intensive Care Unit: a Prospective Cohort,” *BMJ Open*, <http://bmjopen.bmj.com/content/3/2/e001868.full.pdf+html> (2013).

^{iv} Institute for Safe Medication Practices and Maryland Patient Safety Center, “Taking Charge of Your Medication Safety Challenges,” <http://www.marylandpatientsafety.org/html/education/medsafe/2011/documents/SCarson.pdf> (Nov. 3, 2011). New England Healthcare Institute, “Improving Medication Adherence and Reducing Readmissions,” <http://www.nacds.org/pdfs/pr/2012/nehi-readmissions.pdf> (October 2012).

^v Centers for Disease Control and Prevention, “Medication Safety Basics,” <http://www.cdc.gov/medicationsafety/basics.html#ref> (August 14, 2012). New England Healthcare Institute, “A System-wide Approach to Improving Patient Medication Adherence for Chronic Disease,” http://adhereforhealth.org/wp-content/uploads/pdf/ThinkingOutsidethePillbox_Report.pdf (August 2009).

^{vi} Parks, Joseph, MD, et al., “Morbidity and Mortality in People with Serious Mental Illness,” National Association of State Mental Health Program Directors Medical Directors Council, October 2006.

^{vii} Division A, Title XIII and Division B, Title IV, Pub. L. No. 111-5 (2009).

^{viii} 42 U.S.C. §1395x(r).

^{ix} State Telehealth Laws and Reimbursement Policies: A Comprehensive Scan of the 50 States and the District of Columbia, Center for Connected Health Policy, National Telehealth Policy Resource Center (July 2013).

^x Ibid.

^{xi} 42 C.F.R. 410.80.

^{xii} Gilman, M. and Stansland, J., “Telehealth and Medicare: Payment Policy, Current Use, and Prospects for Growth,” *Medicare and Medicaid Research Review*, Vol. 3(4) (2013).