



# Promoting Behavioral and Physical Clinical Integration Through EHRs

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**Medicaid and CHIP Payment and Access Commission**

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# Overview

- Prior MACPAC work and updates on 42 CFR Part 2 (Part 2)
- Barriers to clinical integration
- Federal efforts to strengthen electronic health record (EHR) adoption
- Basic EHR use among behavioral health providers
- Existing Medicaid authorities to support EHRs
- Next steps

# Prior MACPAC Work and Updates on Part 2

- Chapter in June 2018 report to Congress
  - Confusing Part 2 rules deter information sharing, hindering clinical integration
  - Barriers to sharing information include transmission of Part 2 protected information within EHRs
- September 2019 comment letter in response to proposed rulemaking
  - MACPAC notes changes were modest and did not address broad concerns related to Part 2
- Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136)
  - Permanently aligns 42 CFR Part 2 and the Health Insurance Portability and Accountability Act (HIPAA, P.L. 104-191)

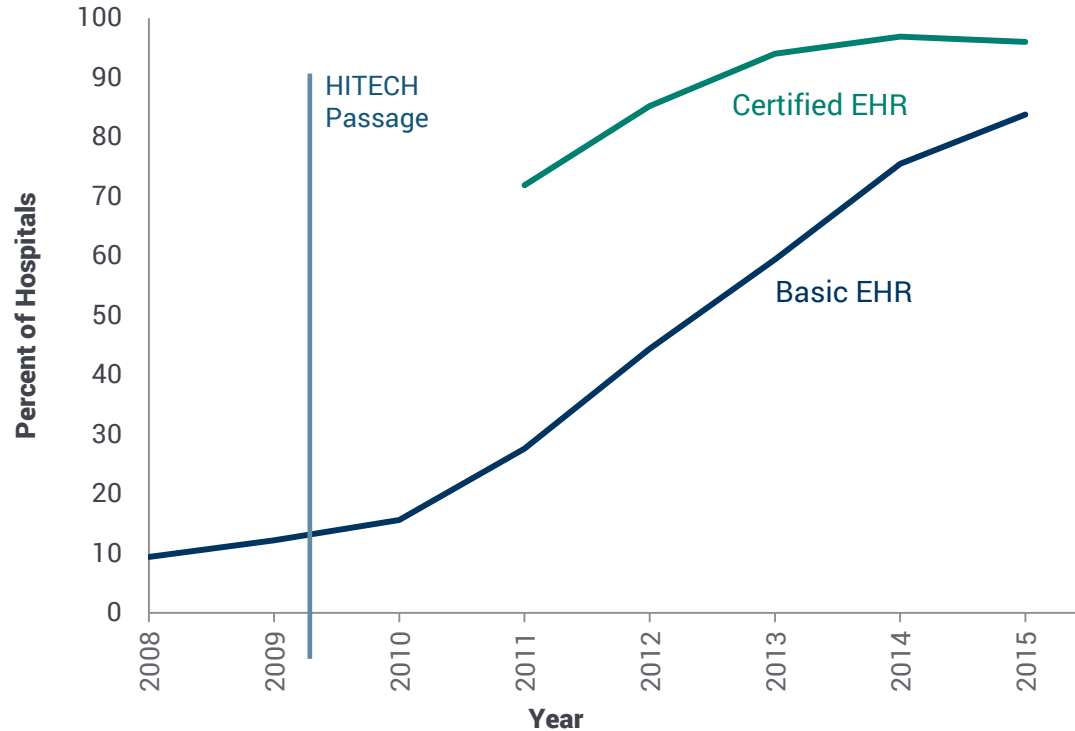
# Barriers to Clinical Integration

- Behavioral and physical health care is often delivered by separate providers
- Behavioral health providers encounter financial and legal barriers to receiving and sharing data within the health care system:
  - Cost of adoption and upgrading to certified EHR technology (CEHRT)
  - Lack of adequate inclusion in federal efforts to digitize health records
  - Confusion around Part 2 and segmentation requirements
  - Poor federal guidance on data sharing
  - Poor investment in high-quality behavioral health EHR systems
- Many EHRs and health information exchanges (HIE) omit substance use disorder (SUD) information from patient medical record. SUD treatment providers often excluded from HIE participation

# Federal Efforts to Strengthen EHR adoption

- Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 created the Promoting Interoperability program
  - Intended to stimulate the digitization of paper health records and promote the meaningful use of EHRs during the recession
  - Incentive payments received a complete federal Medicaid match
  - State administrative costs received a 90 percent federal Medicaid match
  - Providers and hospitals submit data proving meaningful use
- Between 2009 and 2015, basic EHR adoption in non-federally owned hospitals increased from 10 to 80 percent

# Percentage of Non-Federal Acute Care Hospitals with Adoption of at Least a Basic EHR and Possession of a Certified EHR, 2008-2015



**Notes:** EHR is electronic health record. Basic EHR adoption requires the EHR system to have a set of EHR functions which would include items such as electronically collecting data on patient demographics, discharge summaries, medication lists, and viewing various lab or diagnostic results. Certified EHR is EHR technology that meets the technological capability, functionality, and security requirements adopted by the U.S. Department of Health and Human Services. Only includes non-federally owned acute care hospitals **Source:** Henry 2016

# HITECH Focused on Physical Health Providers

- Congressional intent focused on clinical decision makers and facilities with the highest share of medical spending
- HITECH left out many providers that disproportionately serve the Medicaid population
- These facilities lag behind HITECH-eligible providers in EHR adoption
  - In 2015, less than 20 percent EHR uptake among long-term acute care, psychiatric, and rehabilitation hospitals

# Providers Ineligible for Promoting Interoperability EHR Incentive Payments Under Medicaid

Long-term & post-acute care	Behavioral health	Safety net providers	Other
<ul style="list-style-type: none"> <li>- Home health agency</li> <li>- Hospice</li> <li>- Inpatient rehabilitation facility</li> <li>- Intermediate care facility for individuals with intellectual disabilities</li> <li>- Long-term care hospital</li> <li>- Nursing home</li> </ul>	<ul style="list-style-type: none"> <li>- Clinical social worker</li> <li>- Community mental health center</li> <li>- Psychiatric hospital/unit</li> <li>- Residential treatment centers</li> <li>- Clinical Psychologists</li> </ul>	<ul style="list-style-type: none"> <li>- Federally qualified health center</li> <li>- Rural health clinic</li> </ul>	<ul style="list-style-type: none"> <li>- Ambulatory surgical center</li> <li>- Blood center</li> <li>- Renal dialysis facility</li> <li>- Laboratory</li> <li>- Dietitian/nutritional professional</li> <li>- Pharmacist</li> <li>- Pharmacy</li> <li>- Therapist (physical, occupational, speech)</li> </ul>

Notes: EHR is electronic health record. Source: ASPE 2013



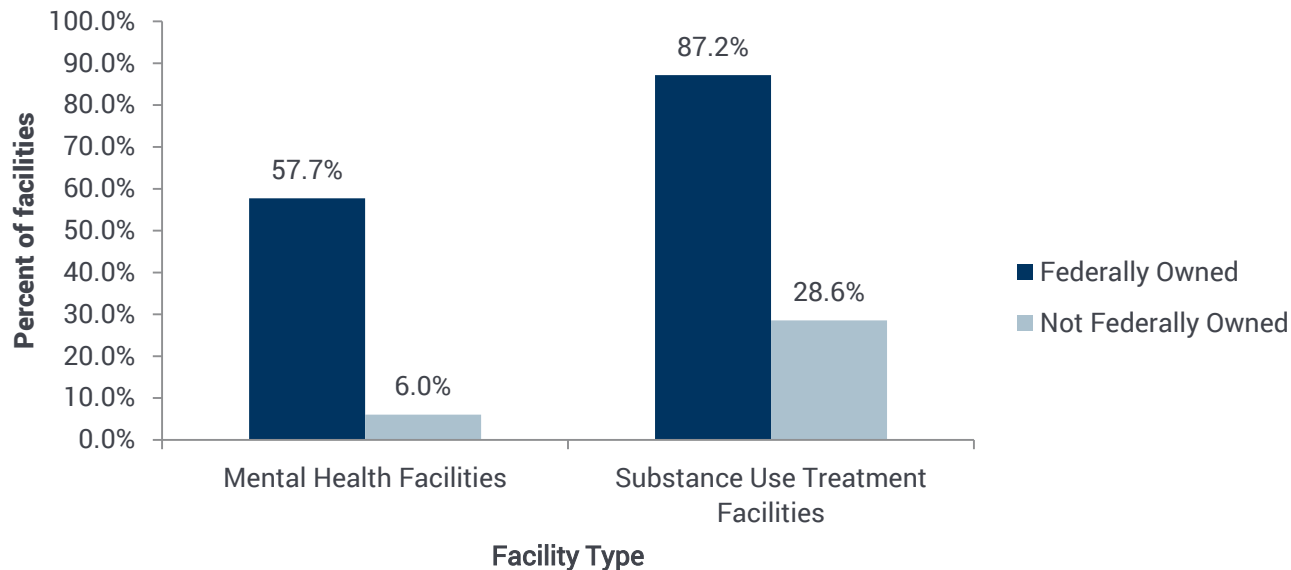
# EHR Adoption Among Behavioral Health Facilities With and Without Federal Financial Support

- Limited data on EHR adoption among behavioral health facilities
- SAMHSA administers two census surveys which ask mental health and SUD treatment facilities about electronic means for basic clinical functions
- Federally owned behavioral health facilities benefit from federal funding to digitize health records
- Federal facilities were compared to non-federally owned behavioral health centers which could not access HITECH's EHR incentive payments
- Surveys do not ask about CEHRT indicating that even among facilities with EHRs, there still could be issues with data sharing

# Behavioral Health Facilities that Accept Medicaid Have Low Rates of Meaningful EHR Adoption and Use

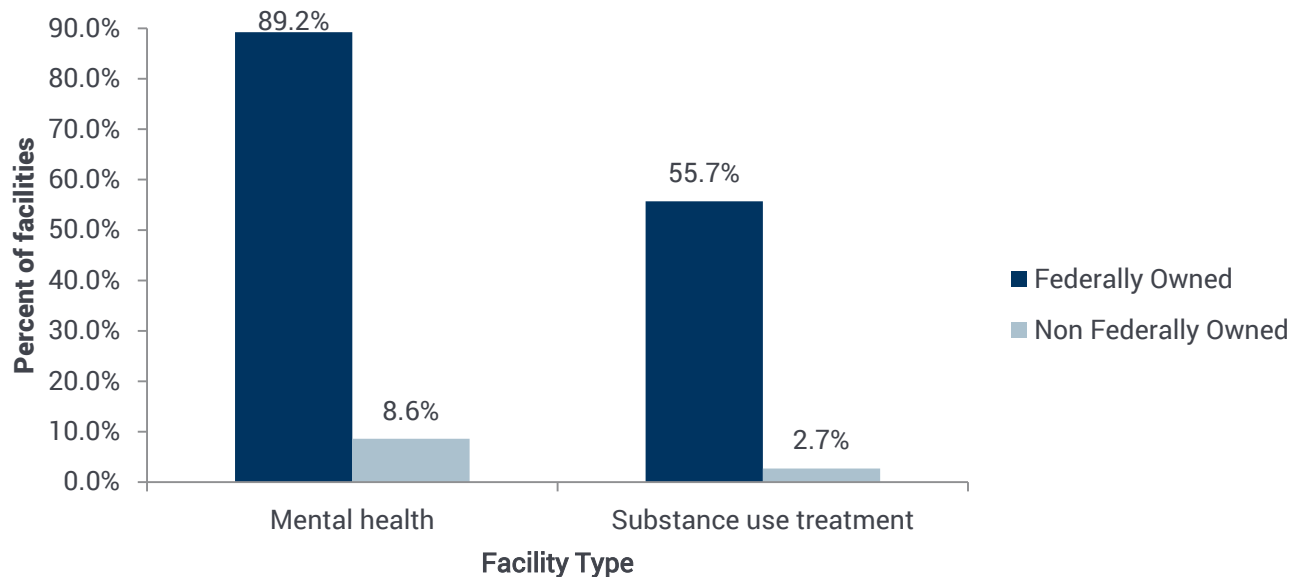
- Behavioral health treatment facilities use electronic means for basic clinical functions at a lower rate compared to hospitals
- Non-federally owned behavioral health facilities have lower rates of EHR use and lower rates of electronic patient data sharing compared to federally owned facilities
- Federally owned behavioral health facilities are over two times as likely to electronically store patient health records compared to non-federally owned facilities
- Federally owned behavioral health facilities are over 10 times as likely to electronically share data with other providers

# Non-federally Owned Behavioral Health Facilities Use Electronic Means for Basic Clinical Functions at Much Lower Rates Compared to Federally Owned Facilities



**Notes:** Only includes facilities that accept Medicaid patients. Measure looks at whether a facility uses only electronic means for different clinical functions, such as storing and maintaining health records, assessing a client, or creating a treatment plan. If a facility does not execute a specific clinical function, then they were dropped from the composite measure. **Source:** MACPAC 2020 analysis of SAMHSA 2017-2018

# Non-federally Owned Behavioral Health Facilities Electronically Share Patient Information at Lower Rates Compared to Federally Owned Behavioral Health Facilities



**Notes:** Chart shows percent of facilities that only use electronic means to share client data. Only includes facilities that accept Medicaid patients. Question on interoperability changed in 2017 and therefore is not comparable in future years **Source:** MACPAC 2020 analysis of SAMHSA 2015-2016

# Existing Authorities to Support EHRs With Medicaid Funding

- States have limited authority to offset CEHRT costs with Medicaid funding
- States can apply to CMS and use HITECH administrative funds to provide payments to facilities to share data with other providers
  - Funding cannot be used to incentivize CEHRT adoption or to supplement existing CEHRT
- Substance Use-Disorder Prevention that Promotes Opioid Recover and Treatment for Patients and Communities Act of 2018 (SUPPORT Act, P.L. 115-271) authorized Center for Medicare and Medicaid Innovation to administer Medicaid demonstrations that target EHR incentive payments to behavioral health providers and facilities
  - No funding was allocated under the SUPPORT Act and the authority has yet to be used in any innovation models

# Next Steps

- Gauge Commissioner interest in doing more work on this topic
- Staff could develop policy options which builds on HITECH by expanding EHR incentive payments to behavioral health providers



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