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Response to Request for Information
Centers for Medicare & Medicaid Services: Innovation Center New Direction

We thank CMS for sharing its vision for a new direction for the Innovation Center, and for embracing stakeholder input and ideas as a key part of the Center’s evolving focus.

Netsmart provides electronic health records (EHRs) and associated health information exchange (HIE) and analytics solutions that are powerful, intuitive and easy-to-use. Our platform provides accurate, up-to-date information which is easily accessible to care team members in behavioral health, social services and post-acute care. We make the complex simple and personalized so our clients can concentrate on what they do best: provide much needed services and treatment that support whole-person care.

We urge the Innovation Center to implement a pilot program to award health IT incentives to behavioral health, substance use treatment and post-acute providers for the adoption of interoperable EHR technology that enable them to share clinical data with hospitals and primary care physicians, and more significantly, to use that technology to improve the quality and coordination of care.

Focus on At-Risk Populations
Such a program could enhance interventions and provide additional resources to providers directly engaged in improving the lives of those impacted by the disorders mentioned in the RFI Potential Model #7, Mental and Behavioral Health Models…mental illness, opioid and other substance use disorders, and the growing number of persons with dementia.

These populations have significantly higher rates of comorbidity and mortality than the general population as discussed further below.

Mental Illness
Persons with severe mental illness experience extremely high rates of mortality and morbidity; in fact, comorbidity between mental and medical conditions is the rule rather than the exception. People with schizophrenia or bipolar disorder are up to three times more likely to have three or more chronic medical/surgical conditions compared with persons without those mental disorders. In the Medicaid/Medicare context, it’s estimated that fully one-third of the 9 million dually-eligible beneficiaries have a primary diagnosis of severe mental illness.
An earlier study published in a Centers for Disease Control and Prevention (CDC) publication, *Preventing Chronic Disease*, found that patients/consumers served by state mental health systems die 25 years sooner than other Americans, while experiencing elevated levels of morbidity.1 In context, the available data show that people in the U.S. with mental illnesses such as schizophrenia and bipolar have average life expectancy similar to the citizens of sub-Saharan African nations, who lack access to clean water and vaccinations against preventable communicable diseases.

**Opioid and Other Substance Use Disorders**

Drug overdose deaths and opioid-involved deaths continue to increase in the U.S. Deaths from drug overdose are up among both men and women, all races, and adults of nearly all ages. More than three out of five drug overdose deaths involve an opioid.2

Overall, people with substance use disorders die as much as 20 years earlier than others of the same age from cancer, cardiovascular disorders, HIV/AIDS and STDs, injuries, and many other illnesses.3 More than 100,000 people in the U.S. die annually of alcohol or drug related causes, making it the fourth leading cause of preventable death, according to the CDC.4 Medically ill inpatients who also have alcohol or drug disorders have a greater increased risk of rapid re-hospitalization after discharge, and higher healthcare use and costs.5 Patients with illnesses such as diabetes or cardiovascular disorders who also have a substance use disorder use healthcare services 2-3 times more often than their peers with just diabetes or heart problems … and the cost of care is similarly much higher.6 Untreated alcohol or drug use during pregnancy dramatically increases risk of poor birth outcomes, neonatal intensive care use and greater infant and maternal healthcare use.

**Alzheimer’s Disease/Dementia**7

Alzheimer’s Disease is the sixth leading cause of death in the U.S. More than 5 million Americans are living with Alzheimer’s, and by 2050 this number could rise to as high as 16

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7 2017 Alzheimer’s Disease Facts and Figures. Alzheimer’s Association
million. Every 66 seconds, someone in the U.S. will develop the disease. Alzheimer’s kills more people than breast cancer and prostate cancer combined. Since 2000, deaths from heart disease have decreased by 14 percent, while deaths from Alzheimer’s disease have increased by 89 percent. In 2017, Alzheimer’s and other dementias will cost the nation $259 billion. By 2050, these costs could rise to as high as $1 trillion. Fifteen million Americans provide unpaid care for people with Alzheimer’s or other dementias. In 2016, these caregivers provided an estimated 18.2 billion hours of care valued at more than $230 billion.

**Interoperability and Coordinated Care**

We applaud CMS for including the language in the RFI: “…improving mental healthcare provider participation in Medicare, Medicaid, and CHIP through models that enhance care integration and/or utilize episode payment.” (emphasis added).

The optimal way to treat mental illness and substance use disorders is to couple it with primary care services – treating the “whole person” with comprehensive, multidisciplinary services systematically combined to provide the best outcomes. Information technology provides the vital link in this process by facilitating the exchange of authorized health data between care providers. This provides clinicians with a complete picture of the person’s health, enabling them to make fully-informed treatment decisions.

Providing coordinated, integrated care to these high-risk populations can enhance outcomes, improve efficiency and lower costs across the entire healthcare spectrum. Netsmart provides the nation’s largest national health information exchange connecting behavioral health, social services and post-acute providers with their health systems and community provider partners. The network allows more than 560,000 providers across 25,000 organizations to share information with each other, enabling whole-person care for more than 25 million individuals. The Netsmart network leverages open application program interface (API), including Fast Healthcare Interoperability Resources (FHIR) to promote safe, secure, quick integration.

Here are examples of providers utilizing this network for integrated care despite using disparate EHR systems:

--A regional behavioral health center and a hospital system in south Florida use a secure, integrated electronic referral process for persons seeking treatment in the emergency department for mental health issues. This has resulted in more timely referrals and faster transition from the emergency room to appropriate care; and $2 million in cost savings from the average two-hour reduction in patients’ time spent in the emergency room.

--A Federally Qualified Health Center (FQHC) and a behavioral health provider in Oregon exchange Continuity of Care Documents (CCDs) to facilitate a “no wrong door” access model for every encounter, regardless of where the patient presents. This process keeps both systems in sync on patients’ behavioral health and primary care diagnoses and treatments. As a result, clinicians from both provider organizations can view up-to-date information and collaborate on care, enabling them to provide better continuity of care and more coordinated care.
--Implementation of an electronic referral system between an inpatient mental health facility, outpatient mental health provider, 211 information hotline and regional hospital in western Florida resulted a faster process for patient care; real-time referrals and status visibility; improved workflows and efficiencies for all agencies; and inclusion of a major community resource (211 system) to embrace more persons needing services.

--Integrated workflow enables a New York county-based home health provider to send patient information from the point of care to a Regional Health Information Organization (RHIO). This furnishes multiple providers with a complete, longitudinal view of patients’ health records for whole-person care.

--A continuing care retirement community (CCRC) in Pennsylvania connects to a health system and HIE network for continuity of care, automating key phases of the referral process and improving transitions of care.

**Significant Funding Deficiencies vs. Acute Care**
Despite the growing body of data supporting the need for increased services and coordinated care, human services and post-acute providers have for decades received significantly lower levels of funding and reimbursement rates than their primary/acute care counterparts. This lack of parity is exacerbated by the substantial increase in demand for services, largely driven by the broad-based impact of the nationwide opioid crisis.

Community-based behavioral health providers, substance use disorder treatment facilities, psychiatric hospitals and post-acute providers (home health, hospice, skilled nursing facilities and continuing care retirement communities) must be able to adopt health information technology at roughly the same rate as hospitals and doctors nationwide. Otherwise, care coordination across the spectrum of human services, primary care and long-term post-acute care will rapidly become impossible. This compromises quality of care and further increases cost of care for some of healthcare’s most at-risk, expensive populations.

**Recommendation**
In alignment with Potential Model #7, *Mental and Behavioral Health Models*, Netsmart recommends that the Innovation Center implement a pilot mental health and behavioral health payment model with incentives for the adoption of EHR technology, and use of that technology to improve quality and coordination of care through the electronic exchange of health information. The resulting care coordination, streamlined processes and workflow would also align with the Innovation Center’s goal of reducing Medicare and Medicaid spending.

Two bipartisan bills have been introduced in Congress recommending the creation of such a pilot program by the Innovation Center. Cong. Lynn Jenkins (R-KS) and Cong. Doris Matsui (D-CA) introduced H.R. 3331 in the House; and Sen. Rob Portman (R-OH) and Sen. Sheldon Whitehouse (D-RI) introduced the Improving Access to Behavioral Health Information Technology Act (S. 1732), the Senate counterpart to H.R. 3331.
We also recommend that any new ONC or CMS behavioral health or post-acute EHR certification standards be linked to availability of the health IT incentives associated with the Innovation Center pilot program above. This provision would further facilitate connectivity and integration of behavioral health and post-acute providers for coordinated care.

Thank you for the opportunity to provide input and comment on the Innovation Center’s new direction.

Sincerely,

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