MACPAC

Promoting Behavioral and Physical Clinical Integration Through EHRs

Medicaid and CHIP Payment and Access Commission

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Overview

- Background
- Components of clinical integration and co-occurring conditions among beneficiaries
- Health information technology's value in promoting clinical integration
- Barriers to EHR adoption among behavioral health providers
- Next steps

Background

- Our June report chapter will help set the stage for discussions of policy options in the fall
- The Commission has commented extensively on the fragmented delivery system for mental health and substance use disorder (SUD) services
- The Commission has recognized that Medicaid should play a role in promoting greater clinical integration of behavioral and physical health services
- Certified electronic health record (EHR) technology (CEHRT) adoption could help behavioral health providers integrate with the rest of the health system
- Behavioral health providers were left out of the Medicaid EHR incentive payment program, authorized under the Health Information Technology for Economic and Clinical Health Act (HITECH)

Components of Clinical Integration

- Care coordination or care management
- Co-location
- Data sharing
- Formal or informal agreements with external partners
- Screening and referral to treatment
- Provider education and training

Lifetime Rates of Co-Occurring Conditions Among Adults with Past Year Mental Illness, 2018

Categorical mental illness indicator	Percentage of adults age 18–64	Percentage of adults age 18–64		
		Medicaid	Private coverage	Uninsured
Any mental illness	44.1%	48.2%	40.6%*	37.5%*
Mild or moderate mental illness	42.1	45.1	39.0*	35.8*
Serious mental illness	49.9	55.3	46.0*	41.8*

Notes: Co-occurring condition include HIV or AIDS, heart conditions, diabetes, chronic bronchitis, cirrhosis of the liver, Hepatitis B or C, kidney disease, asthma, cancer, high blood pressure, and sexually transmitted diseases. Estimates for any mental illness, mild to moderate mental illness, and serious mental illness are based on a statistical model of a clinical diagnosis and responses to questions in the main National Survey on Drug Use and Health (NSDUH) interview on: distress, using the Kessler-6 scale; impairment, which is assessed through an abbreviated version of the World Health Organization Disability Assessment Schedule; past year major depressive episode; past year suicidal thoughts; and age. Mental illnesses in this category can vary in severity, ranging from no impairment, to mild or moderate, or even severe impairment. Within the 2018 NSDUH survey, a diagnosable mental, behavioral, or emotional disorder is defined based on the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* and excludes developmental and substance use disorders (SAMHSA 2019). We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid, other, or uninsured. Coverage source is defined as of the time of the most recent survey interview.

*Difference from Medicaid is statistically significant at the 0.05 level.
- Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC 2020.

Beneficiary Use of the Specialty Behavioral Health System

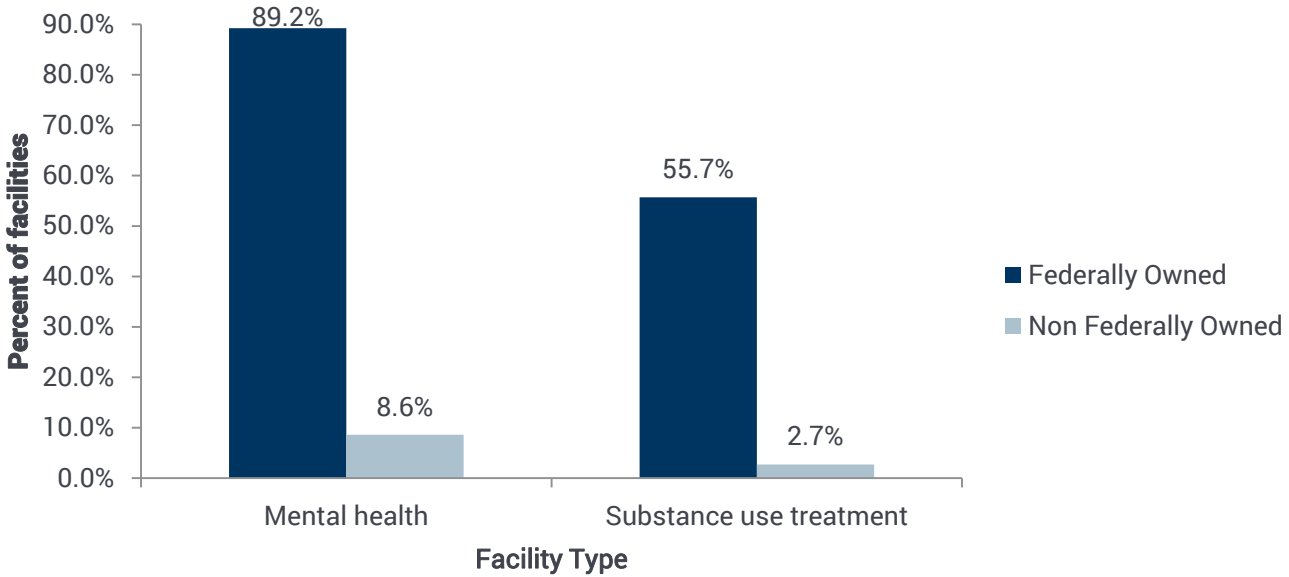
- Historically, services for behavioral health and physical health have been financed and delivered under separate systems
- Beneficiaries often receive care in specialty behavioral health facilities that interact on a limited basis with other parts of the health care system
- Specialty mental health facilities facilities rarely offer fully integrated care
  - Roughly half of facilities also offer co-occurring SUD treatment
  - Only one in four facilities offer integrated primary care
- When providers are unable to share information about their patients, gaps in knowledge may lead to conflicting treatment

Health IT can Strengthen Clinical Integration

- CEHRT can:
  - Facilitate behavioral health access to state health information exchanges
  - Enable behavioral health provider participation in value-based payment arrangements
  - Improve state quality reporting (e.g., Child and Adult Core Set Measures)

- But CEHRT adoption remains low among behavioral health providers

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

Barriers to CEHRT Adoption Among Behavioral Health Providers

- Lack capital to invest in expensive hardware, software, and training
- Federal standards were designed to comply with the Health Insurance Portability and Accountability Act (HIPAA), but not with 42 CFR Part 2
- Behavioral health providers require extensive guidance on EHR suitability

Next Steps

- Evaluate mechanisms to promote CEHRT adoption among specialty behavioral health providers:
  - Incentive payments for CEHRT adoption
  - Section 1115 behavioral health demonstrations
  - Enhanced federal match for behavioral health IT
  - Substance Use-Disorder Prevention that Promotes Opioid Recover and Treatment for Patients and Communities Act of 2018 (SUPPORT Act, P.L. 115-271) authorities to promote EHR adoption

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