Chapter 4:

Encouraging Health Information Technology Adoption in Behavioral Health: Recommendations for Action

Encouraging Health Information Technology Adoption in Behavioral Health: Recommendations for Action

Recommendations

4.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Office of the National Coordinator for Health Information Technology to develop joint guidance on how states can use Medicaid authorities and other federal resources to promote behavioral health information technology adoption and interoperability.

4.2 The Secretary of the U.S. Department of Health and Human Services should direct the Substance Abuse and Mental Health Services Administration and the Office of the National Coordinator for Health Information Technology to jointly develop a voluntary certification for behavioral health information technology.

Key Points

- Delivery systems for physical and behavioral health are often fragmented. This impedes access to care and results in inappropriate or limited use of services, poor health status, and increased costs for persons with behavioral health conditions.
- Adoption of certified health information technology (IT) is one strategy to promote integration. Health IT can improve communication between providers and allow them to electronically retrieve and transfer patient information in real-time.
- Behavioral health providers have adopted IT at lower rates compared with other providers because they were not eligible for federal incentive payments. Current barriers to adoption include the costs of technology and training, challenges related to sharing information about substance use disorder (SUD), and the lack of industry guidelines for behavioral health IT.
- Medicaid programs play a critical role in financing behavioral health services and are increasingly focusing on ways to provide behavioral health in more integrated settings.
- Additional subregulatory guidance is needed on how Medicaid and State Children's Health Insurance Program (CHIP) authorities can be used to encourage health IT adoption for behavioral health providers.
- At the federal level, the Office of the National Coordinator for Health IT (ONC) is charged with providing health IT guidance by developing informational resources that guide providers and developers when implementing health IT for specific settings of care and medical specialties.
- To help providers in the purchase of health IT and to move the market toward better products for behavioral health practice settings, the Substance Abuse and Mental Health Services Administration and ONC should jointly develop a voluntary certification for IT used in behavioral health and integrated care settings to support ongoing integration efforts.

CHAPTER 4: Encouraging Health Information Technology Adoption in Behavioral Health: Recommendations for Action

Over the years, the Commission has discussed at length the need to improve integration of care for Medicaid beneficiaries with behavioral health conditions (MACPAC 2021a, 2018, 2017, 2016). The delivery systems for physical and behavioral health care, which encompass practitioners who treat substance use disorder (SUD), mental health conditions, or both, are not integrated with each other. Furthermore, delivery systems for mental health and SUD are also fragmented. In addition, behavioral health treatment is not well coordinated or integrated with treatment for other physical health conditions (MACPAC 2018). This fragmentation impedes access to care and may result in inappropriate or limited use of services, poor health status, and increased health care costs, particularly for persons with behavioral health and chronic health conditions.

Integrating care potentially can improve overall care and reduce spending. Integrating care is of particular concern to the Medicaid program given that its beneficiaries have higher rates of SUD and mental health conditions and have higher rates of other chronic conditions than their privately insured peers (MACPAC 2021a and 2021b). Medicaid is the largest payer of behavioral health services in the United States due to the population it covers and the services it finances.

State Medicaid agencies can play an important role in supporting the integration of care for individuals with behavioral health needs. In our June 2021 report, we focused on one barrier to integration: the relatively low rates of electronic health records (EHR) and information technology (IT) use among behavioral health providers. The report showed most behavioral health providers were ineligible for federal incentives for EHR adoption under the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH, P.L. 111-5) and documented the low rates of use of these tools among behavioral health providers, particularly relative to the sharp uptick in EHR use among other providers as a result of HITECH (Wolf et al. 2012).

This year, the Commission focused on policy options to strengthen Medicaid's role in encouraging behavioral health providers to adopt health IT. We considered a range of strategies and sought feedback on their merits from state and federal officials, providers, IT vendors, and other experts in the field. In this chapter, we make two recommendations to promote greater use of health IT, which should improve integration of care:

- The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Office of the National Coordinator for Health IT to develop joint guidance on how states can use Medicaid authorities and other federal resources to promote behavioral health IT adoption and interoperability.
- The Secretary of the U.S. Department of Health and Human Services should direct the Substance Abuse and Mental Health Services Administration and the Office of the National Coordinator for Health IT to jointly develop a voluntary certification for behavioral health IT.

Guidance on how to deploy existing authorities and federal funding opportunities would help states identify approaches for advancing the adoption and use of health IT for behavioral health providers, furthering integrated care efforts among state Medicaid agencies. In addition, the development of a voluntary certification for IT appropriate for behavioral health and integrated

care practice settings could provide a path toward comprehensive adoption of high-quality behavioral health IT tools, ensuring real-time data sharing and collaboration between behavioral health providers and virtually all hospitals and physicians.

This chapter begins by reviewing the implications of poorly integrated care for behavioral health and outlining how health IT can foster more integrated care through patient data sharing. Next, the major barriers to EHR adoption in behavioral health are described. The chapter concludes with recommendations to address Medicaid's role in supporting health IT adoption and state care integration efforts, noting that Medicaid authorities could be used to promote behavioral health IT adoption and could be deployed more effectively with improved guidance and instructions from the Centers for Medicare & Medicaid Services (CMS). We also note the need for federal actions to provide clarity regarding health IT standards and functions in EHRs to facilitate behavioral health integration (Box 4-1).

Benefits of Clinical Integration and Health Information Technology

As noted above, Medicaid beneficiaries have higher rates of mental health conditions and SUD and experience other chronic conditions at higher rates than their privately insured peers (MACPAC 2021a and 2021b).[1] Individuals with mental illness have worse health outcomes and die 32 years earlier when compared to the general population (Roberts et al. 2017, NASMHPD 2012). The COVID-19 public health emergency has underscored these vulnerabilities, as persons with mental health conditions and SUD face even greater mortality and morbidity risks due to COVID-19 (Fond et al. 2021, Das Munshi et al. 2021, Wang et al. 2020). Additionally, MACPAC has found there are significant disparities in unmet need for behavioral health services; beneficiaries with a mental illness who identify as Black, Hispanic, or Asian American receive treatment at lower rates compared to those that identify as white (MACPAC 2021b).

Greater sharing of clinical information between behavioral and physical health providers can improve care among adults with mental illness. (Gilmer et al. 2016, NASEM 2020, PCC 2022). For example, when providers are unable to share information about their patients, gaps in knowledge may lead to conflicting treatments, such as prescribing medications with potentially dangerous or even deadly interactions with other medications (MACPAC 2018).

EHRs can foster clinical integration through data sharing, care coordination, and referral to treatment across the continuum of care (MACPAC 2021a). They can promote coordinated care by allowing clinicians to readily update patient health information and distribute that information to authorized providers working in other settings (Falconer et al. 2018). While EHRs on their own do not integrate patient care, the ability to share information among providers and between providers and patients is an important step toward this goal.

Increased provider adoption of certified health IT and certified EHR technology is one strategy to improve integration of care.[2] Certified health IT improves communication between providers and allows them to electronically retrieve and transfer patient information, often in real-time. However, the costs associated with certified EHR technology and the unique needs of behavioral health providers represent significant barriers to adoption with only 6 percent of mental health facilities and 29 percent of substance use treatment centers using an EHR, compared to more than 80 percent of hospitals (MACPAC 2021a, ONC 2017, Henry et al. 2016). Behavioral health providers are thus less likely to send and receive patient information with those providing other health services and many continue to rely on phone, paper, or fax. This can lead to missed opportunities to provide integrated services and improve quality of care for Medicaid beneficiaries.

The Commission previously has noted the benefits of certified EHR technology adoption in behavioral health integration efforts, and the extent to which health IT addresses other issues of concern. Namely, certified EHR technology facilitates:

- connections to state health information exchanges (HIE);
- participation in value-based arrangements; and
- provider data submissions that are necessary for the state to calculate quality measures in the Medicaid Adult and Child Core Sets (MACPAC 2021a, MACPAC 2020c).

Barriers to Certified Health IT Adoption Among Behavioral Health Providers

The barriers to certified health IT and certified EHR technology adoption are multifaceted but mainly fall into three areas, including the significant cost implications of EHR adoption, the unique challenge associated with SUD privacy protection outlined under 42 CFR Part 2 (Part 2), and the lack of clear guidelines to ensure that health IT tools can meet the needs required in behavioral health practice settings.[3]

BOX 4-1. Key Health Information Technology (IT) Terms

Standards: The common language and common set of expectations that enable different systems to interact with each other. Standards permit clinicians, labs, facilities, and patients to share data regardless of the application or market supplier (HIMMS 2022). The Office of the National Coordinator for Health Information Technology (ONC) is responsible for updating standards and specifications to support interoperability and different health information exchange scenarios. These standards are outlined in the Interoperable Standards Advisory (ISA) (ONC 2019a).

Function: Specific capabilities that an electronic health record (EHR) or an IT system should possess to document and share patient care. Examples include providing immediate access to health information and data; giving patients access to their health records; data storage that is amenable to federal, state, and private reporting; and clinical decision support tools (IOM 2003).

Interoperability: The ability of different information systems, devices, and applications to access, exchange, integrate, and cooperatively use data in a coordinated manner, within and across organizational and geographic boundaries, to provide timely and seamless portability of information and improve the health of individuals and populations (HIMMS 2022).

The 21st Century Cures Act (Cures Act, P.L. 114-255) also created a statutory definition for interoperability that states that health IT is interoperable when it:

- enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user;
- allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable state or federal law; and
- does not constitute information blocking.

Costs

Behavioral health providers report that the cost of purchasing, installing, and training staff is the principal barrier to certified health IT uptake (NASMHPD 2018).[4] Such costs are significant, especially for solo practitioners and those in small practices as well as for state behavioral health agencies with limited budgets (NASMHPD 2018).[5] Many hospitals and physicians received federal incentive payments for EHR adoption under the HITECH Act, and could be eligible for almost $64,000 over a six-year period per individual eligible provider, and almost $15 million over a four-year period for eligible hospitals.[6] Behavioral health providers and facilities, with the exception of physicians and some nurse practitioners, were not included in this effort.[7]

Due to narrow operating margins, behavioral health providers often have little capital available to invest in the expensive hardware, software, and training needed to use EHRs (MACPAC 2016). The COVID-19 pandemic has further strained provider finances despite increased demand for services. Furthermore, a national crisis hotline will be implemented in 2022, which may further increase demand for behavioral health services across the care continuum (NAMI 2021, Eder 2022, MACPAC 2021b). The National Council for Mental Wellbeing's April 2021 survey found that 40 percent of behavioral health organizations only can maintain their operations for a year due to financial issues (NCMW 2021).[8]

In addition to the costs of the technology itself, there are significant costs associated with training providers to meaningfully use an EHR and high demand for technical assistance. For many behavioral health providers, sharing information electronically will require major shifts in how they operate, for example, adopting new practice workflows that integrate technology (AmeriHealth Caritas 2021, Covered California 2021, NYeC 2021). Addressing the privacy-related concerns related to sharing information about SUD data protected by Part 2 also may create additional costs, as providers may need to establish how to share these records and hire legal counsel to update privacy practice notifications and disclosure and redisclosure consent documentation (OHA 2021).[9]

SUD patient information

Another key challenge for providers is segmenting, or restricting access to SUD information, while sharing the rest of the patient record. Federal health IT certification requirements were designed to support compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) and its implementing regulations (45 CFR Part 160 and Part 164, subparts A and E), which govern the use and disclosure of individually identifiable health information (i.e., information related to all health conditions, health care services, or payment) (Box 4-2).[10] HIPAA generally allows information to be shared without patient consent among providers and payers for payment, treatment, and health care operational purposes.[11] Certified health IT provides assurances that the product supports compliance with HIPAA and allows for the seamless sharing of patient records.

In contrast, SUD treatment information created, received, or acquired by Part 2-covered providers is subject to additional requirements that affect information sharing among providers. Specifically, Part 2 does not allow for the disclosure or redisclosure of protected SUD information for treatment purposes from Part 2-covered providers without written consent from the patient. This protection overrides the HIPAA information sharing provision. As such, Part 2-covered providers must obtain patient consent to disclose and redisclose such records, including for care coordination and case management.[12] To support compliance with Part 2, health IT must be able to segment Part 2-protected SUD treatment information from the rest of a patient's health record.[13] While data tagging and segmentation capabilities have been developed, they have not been widely incorporated into certified EHR technology used by many Medicaid-enrolled providers.[14]

Changes in federal privacy laws may make it easier for providers to share this information. The

Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136) aligned the statutory basis for Part 2 more closely with HIPAA. Among other things, it permits providers to obtain a single patient consent for all future disclosures of SUD records for treatment, payment, and health care operations. The CARES Act allows Part 2-covered entities and business associates that receive Part 2 records to redisclose it in accordance with HIPAA. Under HIPAA and Part 2, patients have the right to request a restriction on the use of SUD records for treatment, payment, or health care operations, and the CARES Act requires Part 2-covered providers to make every reasonable effort to comply with a patient's request.[15]

Although the CARES Act takes steps to advance data sharing among SUD treatment providers, EHRs and connected information exchanges used by behavioral health providers will continue to require data segmentation capabilities because individuals still can request restrictions on use of their treatment records. Moreover, in addition to being subject to HIPAA, other sensitive health data (e.g., related to HIV/AIDS, mental health, substance use, reproductive health, and domestic violence) also may be subject to state laws or other federal laws mandating heightened disclosure or redisclosure protections (OCR 2017). For this reason, it is essential for IT in settings where behavioral health services are provided to have standards that support consent management, security labeling, and segmentation for access, exchange and use of health information at a document, section, or data element level.

Lack of clear guidelines for behavioral health IT

The HITECH Medicaid EHR adoption incentives spurred a large and active vendor market, especially for office-based practices (Gold 2016).[16] This allowed providers to choose an EHR that was affordable and met their specific clinical needs. However, there were drawbacks. Due to the extensive choice of products available, it took an informed provider to purchase the right EHR for a specific practice. In some cases, providers chose EHRs that met their initial needs but later turned out to be insufficient for subsequent reporting needs (Gold 2016). To partially address this, the 21st Century Cures Act (Cures Act, P.L. 114-255) was passed in 2016 to give the U.S. Department of Health and Human Services (HHS) more authority in limiting the spread of EHRs and health IT that block information sharing (Lye et al. 2018).

Currently, voluntary certifications for IT exist for other practice settings (e.g., pediatric practices), but not for behavioral health. Based on a set of specifically appropriate criteria, a voluntary certification from ONC would help behavioral health providers understand what to look for in an EHR and also send a signal to the market that certain features are desirable for behavioral health practice settings (Box 4-2). As noted above, behavioral health providers need different privacy and clinical tools within their EHR compared to physical health providers, functions that may not be supported by many EHRs certified based on the current ONC health IT certification criteria. For example, these include Part 2-related segmentation capabilities and capturing standardized information about plans of care, encounter notes, or patient-directed goals. Although some currently available behavioral health IT may have some of these functions, they may not capture this information in a way that promotes interoperability and supports clinical decision making (Partnership for HITPS 2021).

Voluntary certification for behavioral health also would be useful for primary care providers, particularly as Medicaid agencies encourage integration of primary care, mental health care, and SUD treatment (NAMD 2021). Primary care providers should have some of these behavioral health functions in their EHR because of their own need to integrate and communicate effectively with behavioral health providers (Partnership for HITPS 2021). Voluntary certification would help primary care providers know how to upgrade their systems to support integrated care models.

BOX 4-2. Office of the National Coordinator for Health Information Technology (ONC) Certification Program, Voluntary Certification for Practice Settings, and Interoperability Standards Advisory (ISA)

The ONC Certification Program and ONC Interoperability Standards Advisory (ISA) includes health information technology (IT) standards and functions that support behavioral health care delivery, including those for capturing and tagging care plans and health data. Having these standards in an electronic health record (EHR) can provide patients with access to their information and make them available to transfer between providers during a transition of care.

The ONC Certification Program defines the requirements for health IT and the process by which health IT may be evaluated, tested, and certified (ONC 2022). Though providers are allowed to use any EHR they want, the Centers for Medicare & Medicaid Services (CMS) required the use of certified health IT as part of the EHR incentive payment programs under Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH, P.L. 111-5). By 2019, more than 90 percent of hospitals and clinicians eligible for EHR incentive payments used certified technology (ONC 2019b).

The ONC ISA provides the health IT industry with a single public list of standards and implementation specifications that can be used to address healthcare interoperability needs. ISA also is meant to reflect industry discussions about emerging standards and their limitations in addressing specific functions or interoperability needs (ONC 2019a).

ONC also develops implementation resources and recommends functions and standards for a voluntary certification for IT used in specific practice settings (ONC 2020e). This approach does not constitute a separate certification program for the practice setting, meaning that ONC does not review IT products and assess whether they meet voluntary certification's requirements. The ONC approach for doing so consists of three parts:

- ONC analyzes adopted and proposed certification criteria in the ONC Health IT Certification Program to ensure these standards are broadly applicable to multiple medical specialties and sites of service;
- ONC evaluates standards to determine applicability to medical specialties and sites of service as well as to the broader care continuum, including the evaluation of such standards for inclusion in the ISA; and
- ONC works in collaboration with stakeholders to support the development of resources for medical specialties and sites of service for which there is an identified need to advance effective implementation of certified health IT (ONC 2020e).

It is important to note that voluntary certification is not considered a seal of approval or endorsement from ONC. Rather, it provides a framework to help developers and providers understand expectations for high-quality tools.

Encouraging Behavioral Health Information Technology

There are a number of ways that federal Medicaid policies could address barriers to EHR adoption among behavioral health providers, including playing a larger role in financing certified EHR technology adoption and training and providing additional guidance on health IT suitability.

Medicaid authorities that can support behavioral health IT adoption and interoperability

States currently have the authority to fund EHR adoption through multiple mechanisms but lack explicit guidance from CMS on how to do so. Further guidance from CMS would help states deploy these authorities to promote EHR adoption and information sharing among behavioral health providers and with other providers.

Section 1115 demonstrations. States may be able to use Section 1115 demonstration authority to use federal funding for EHR adoption, but additional guidance is needed from CMS. For example, in describing Section 1115 demonstration opportunities to improve systems of care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED), CMS explains how states can use these authorities to support integration efforts and requires a health IT plan that supports behavioral health data sharing (CMS 2018, CMS 2017a, CMS 2017b).[17] But given that many behavioral health providers lack an interoperable EHR and the equipment necessary to exchange electronic health information, it is unclear how states can fulfill these goals (MACPAC 2021a).[18]

The second area where more clarity is needed relates to the use of demonstration authority to provide incentive payments for provider infrastructure improvements. Under the delivery system reform incentive payment (DSRIP) demonstrations, states could encourage provider investment in technology so long as it supported clinical and population health improvements over time (MACPAC 2020, MACPAC 2021b). Although CMS does not plan to approve new demonstrations of this type, states are still using Section 1115 demonstrations for delivery system reform initiatives. It would be useful for CMS to clarify the parameters for support of technology infrastructure improvements for providers who were previously ineligible for Medicaid EHR incentive payments under Section 1115 authority (WAHCA 2021).

Directed payments. CMS guidance on state directed payments within managed care notes that EHR incentive payments for providers that were ineligible for incentives through HITECH is an allowable use of directed payments (CMS 2016). In a recent review of directed payment programs, MACPAC found that only one state was using directed payments to support EHR adoption as part of its larger quality strategy for behavioral health beneficiaries (MACPAC 2022). States could benefit from further information from CMS on how states can use directed payments in Medicaid managed care for EHR adoption. Refer to *Chapter 2: Oversight of Directed Payments in Managed Care* in this report for more on state directed payments.

Medicaid Information Technology Architecture (MITA). MITA 3.0 is the current standard that states must meet to receive enhanced federal match for health IT improvements, including new initiatives to support care integration and behavioral health IT.[19, 20] CMS guidance notes that states may obtain an enhanced administrative match for the development of health technologies that can be used by Medicaid providers to coordinate care for beneficiaries with serious mental illness.[21] However, this MITA guidance, created by the Substance Abuse and Mental Health Services Administration (SAMHSA) and CMS to facilitate coordination, cooperation, and interoperability among state Medicaid and behavioral health agencies, is outdated. The

behavioral health planning tools and processes were written in 2008 when most state-run HIEs were still in development. The tools have not been updated to reflect changes in how Medicaid supports behavioral health integration efforts or the CMS and ONC interoperability and information blocking rules (MACPAC 2021b, CMS 2020, ONC 2020a, CMS 2008). States would benefit from clearer guidance on how the different federal match rates under MITA could support greater data sharing among providers.

Federal funding to support technical assistance. States may need to identify additional sources of funding to finance technical assistance for providers, since the use of Medicaid may be limited to costs associated with the purchasing of technology. As noted above, other expensive activities associated with EHR adoption include education and training, EHR developer selection and financial consultations, workflow redesign, and support for connections to an HIE. In recognition of these additional costs, Congress appropriated funds under HITECH for regional extension centers (REC) to support Medicaid and Medicare providers participating in the EHR incentive programs with technical assistance around workflow redesign and EHR developer selection. The REC program was administered by ONC. Providers that received support from RECs were more likely to meet and exceed the programs' quality benchmarks.[22] However, Medicaid funding for these centers ended when HITECH sunset at the end of fiscal year 2021.

Stakeholders have noted the importance of the SAMHSA-administered Certified Community Behavioral Health Clinic (CCBHC) expansion grants in convening working groups that shared information on EHR developers and workflow design (Hammond et al. 2021, SAMHSA 2022).[23] Guidance from CMS, ONC, and SAMHSA would be useful to states trying to blend sources of funding for technical assistance with those permissible under Medicaid.

Center for Medicare and Medicaid Innovation (CMMI) models. The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) authorized CMMI to test incentive payments for behavioral health providers who accept Medicaid for the adoption and use of certified EHR technology. However, CMMI has no public plans to test such a demonstration. Although there is interest from states in exploring this opportunity, states are unclear on how to apply to use CMMI's authority in this way (NASMHPD 2018). States could benefit from information from CMS on how to apply to test EHR incentive payments under CMMI authority.

Providers need guidance on behavioral health IT products

In interviews with provider groups and IT experts, we heard that the purchase of a behavioral health EHR, particularly one that offers integrated physical and behavioral health functions, may be difficult and risky for providers, given that there are no industry guidelines (Partnership for HITPS). A voluntary certification outlining IT standards that support behavioral health clinical functions and care settings would help providers distinguish among products to find one that meets their needs.[24]

To help identify what stakeholders consider critical behavioral health clinical priorities, the associated health IT functions, and how they may align with existing standards and capabilities found in certified health IT products, we reviewed public comments on SAMHSA's proposed rule on Part 2 (SAMHSA 2020), CMS' interoperability rule (CMS 2020), and ONC's information blocking rule (ONC 2020a). Below are the findings.

Guidance on IT standards relevant for specific practice settings. One challenge for behavioral health providers is they are often unclear about which health IT products meet the needs of their practice. Other practice settings have had similar challenges. Under the 21st Century Cures Act (Cures Act, P.L. 114-255), ONC was required to recommend a series of standards and EHR functions relevant for pediatric health IT because of concerns that EHR usability jeopardized the

safety of pediatric patients (Pew 2019). Like behavioral health, pediatric health has specific privacy needs (e.g., disclosure of sexual history) as well as specific clinical functions (e.g., weight-based dosage).[25]

Through a collaborative working group process with EHR developers and pediatricians, ONC developed criteria for voluntary certification of health IT for pediatric care without having to create an entirely separate certification program for pediatric care and practice settings.[26] ONC also identified relevant certification program criteria and interoperability standards that supported pediatric practices. In addition, ONC developed information resources to support the implementation of health IT products that meet the voluntary certification's recommended criteria (ONC 2020a). A similar process could be used to develop guidance for IT used in behavioral health and integrated care practice settings.

Guidance on data segmentation standards. Another significant challenge faced by behavioral health providers when using health IT is keeping SUD information private while sharing the rest of the patient record. Many EHR systems cannot easily identify which portions of the record contain Part 2 information, and instead identify patients as receiving SUD services, which restricts access to functionally all of that patient's data (ECRI 2019, Hammond et al. 2021, MACPAC 2018, Partnership to Amend 42 CFR Part 2 2021).[27] The experience with pediatric health IT shows that segmentation is feasible. That is, separation of a child's sexual history for pediatric health IT requires a similar permissions structure as the separation of SUD treatment information (ONC 2020d).

ONC and SAMHSA co-developed open-source SUD consent management tools in 2016, however, implementing these segmentation tools can be burdensome, and these open source segmentation tools may need further refinement before they can be used easily among providers who are not familiar with Part 2 privacy requirements (SAMHSA 2020, Netsmart 2019). Creation of a voluntary certification for behavioral health practice settings would help providers and developers understand which IT standards support compliance with Part 2 and which can be readily implemented within behavioral health and integrated care settings.

Moving the field

The Commission considers requiring the use of IT products with Part 2 segmentation capabilities among behavioral health providers to be a long-term goal. However, this goal is not practical in the near term. It would require widespread adoption of EHRs that work for behavioral health providers, and widespread availability of IT tools that support Part 2's SUD privacy protections.

CMS has the discretion to add health IT requirements to its conditions of participation for Medicare and Medicaid participating providers. For example, CMS requires most hospitals to be able to send and receive electronic patient event notifications, which generally requires the use of certified EHR technology (CMS 2020). Similarly, additional data privacy or clinical function that supports beneficiaries with behavioral health needs could be added as condition for participation. When these IT systems are more mature, CMS could consider requiring the use of health IT that meets the voluntary certification benchmark for behavioral health. However, the Commission understands this is not feasible in the near future.

Commission Recommendations

In this report, the Commission recommends that the Secretary of HHS provide states with guidance on how to use Medicaid authority to promote EHR adoption, and that HHS develops a voluntary certification for health IT essential for the delivery of high-quality behavioral health care that also complies with state and federal privacy and security laws.

Recommendation 4.1

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Office of the National Coordinator for Health IT to develop joint guidance on how states can use Medicaid authorities and other federal resources to promote behavioral health IT adoption and interoperability.

Rationale

A variety of Medicaid authorities could be used to support EHR adoption and interoperability; however, states do not have a playbook for how to deploy these resources appropriately (DHCF 2021, DHS 2021, CMS 2018). More explicit instructions to states on how to use different Medicaid authorities to support behavioral health IT would help states advance behavioral health integration efforts.

Our findings suggest that there are multiple mechanisms that can be included in a playbook encouraging health IT adoption for behavioral health. MITA governs the rules for health IT funding, but has not updated its behavioral health guidance since 2008 (CMS 2008, MACPAC 2021a). Directed payments, Section 1115 authority, and CMMI's demonstration authority could be used to promote EHR adoption among behavioral health providers, but states may be unsure how to deploy these authorities to improve provider IT. In addition, other existing sources of federal health IT funding from SAMHSA, and future ONC funding, may need to complement Medicaid spending by funding technical assistance necessary to support EHR adoption, use, implementation and exchange. Additional guidance from CMS, SAMHSA, and ONC could outline how states can combine various funding streams to encourage behavioral health providers adopt health IT.

At a minimum, such guidance should:

- update the MITA rules governing how states can use an enhanced federal match to promote integration of services for beneficiaries with behavioral health needs;
- address how states could use Section 1115 demonstration authority to develop an EHR incentive program, including potential ways for states to meet budget neutrality requirements;
- explain how states can use directed payments via managed care plans to promote EHR adoption for behavioral health providers, including how different types of EHR incentive payments can be classified under medical loss ratio calculations;
- discuss how states could finance the technical assistance necessary for providers to incorporate health IT into their workflows and achieve meaningful use of an EHR;
- address how states can use Medicaid, including the enhanced administrative federal match, to pay costs related to HIE services that support behavioral health data consent management and interoperable data sharing;
- address how states can combine Medicaid with other federal funding streams such as SAMHSA-administered grant opportunities to promote behavioral health EHR adoption and interoperability; and
- explain how states can use the CMMI SUPPORT Act authority to test EHR incentive payments for behavioral health providers enrolled in Medicaid.

Implications

Federal spending. This recommendation would not have a direct effect on federal Medicaid and State Children's Health Insurance Program (CHIP) spending. Depending on how states respond to guidance by encouraging IT adoption or encouraging greater behavioral health use of HIEs and other general connections to state IT systems, costs to the federal government could be affected. The extent to which spending would increase or decrease is difficult to predict.

States. This recommendation would give states the option to advance clinical integration goals through greater uptake of behavioral health IT. Providing guidance to state Medicaid and CHIP officials on these different Medicaid authorities would help remove technological barriers to clinical integration for patients with behavioral health needs. For these states, greater behavioral health IT funding would have other positive implications for other uses as well. This includes greater state capacity to collect data needed for the Adult and Child Core Set and to encourage behavioral health participation in value-based payment (VBP) programs.

Enrollees. To the degree that additional federal guidance supports states' ability to encourage greater use of behavioral health IT, it could enhance integration of behavioral health services by strengthening care coordination and data sharing. Greater information sharing is correlated with better patient health outcomes, which includes lower readmission rates, lower risks of medication discrepancies, reduced redundant testing, and decreased emergency department use (Boockvar et al. 2017, Vest et al. 2015, Yaraghi 2015).

Plans and providers. Providers would benefit from greater funding for EHR adoption and more funding for broader data sharing integration efforts via HIEs and coordination with home- and community-based service providers. Providers would have improved capabilities to integrate care for patients with behavioral health needs. Plans would benefit from guidance that encourage EHR adoption via directed payments because they could receive data from their behavioral health providers. This data could help inform integration efforts, support the development of VBP arrangements for behavioral health, and support submission of data on quality to states.

Recommendation 4.2

The Secretary of the U.S. Department of Health and Human Services should direct the Substance Abuse and Mental Health Services Administration and the Office of the National Coordinator for Health IT to jointly develop a voluntary certification for behavioral health IT.

Rationale

Current behavioral health EHR products are of poor quality primarily because many do not allow for segmentation of data related to SUD protected under Part 2 (ABHW 2021, BHIT 2021, WIDHS 2019). Because such information cannot be disclosed, or redisclosed, without patient consent, behavioral health providers subject to Part 2 would benefit from systems that include Part 2 consent management tools and associated permission structures. Without such systems, behavioral health providers will be unable to electronically segment Part 2 records and share the rest of the patient's record.

This recommendation calls on ONC and SAMHSA, in collaboration with providers and EHR developers, to recommend a set of IT standards, implementation resources, provider manuals, and other resources to address behavioral health clinical and privacy functions.

The Commission discussed a more aggressive approach of requiring all behavioral health providers enrolled in Medicaid to use health IT tools that segment Part 2 protected information and meet other functions important for behavioral health and integrated care settings. The Commission ultimately decided on improving products and encouraging adoption as a first step. Advantages of this approach are that:

- it would help behavioral health providers know which EHR platform meets their needs;
- it would allow for development of robust consent management tools that support Part 2 compliance, allowing providers to keep SUD data private, and share the rest of the patient record; and
- it would not require the use of Part 2 consent management tools by other providers until these are more mature.

A voluntary certification also would provide a non-financial incentive for adoption because providers practicing in integrated care settings would know how to upgrade IT systems to support Part 2 segmentation, but can still send and receive the patient's other health data. Furthermore, a voluntary certification approach could outline a set of standards that support behavioral health provider needs, which would further promote EHR adoption. Recommended standards could support EHR functions for tele-behavioral health visits, mental health screening tools, and connecting to SUD registries or Prescription Drug Monitoring Programs (PDMPs) (Partnership for HITPS 2021).

ONC should replicate the process used when it created its recommendations for voluntary certification for health IT in pediatric care settings, which were released in 2020. Developed in collaboration with providers and EHR developers, ONC recommended a set of standards and functions aligned with ONC's interoperability and certification framework and included implementation resources for providers and EHR developers to support the customization of their EHR platform (ONC 2020b and 2020d).

Given the prevalence of SUD within the Medicaid population, IT that can support Part 2 compliance is urgently needed for all Medicaid providers. However, such tools are still in their infancy and standards that support them may require further development and testing before being considered as a Medicaid requirement. Although a voluntary certification for IT in behavioral health and integrated behavioral health practice settings is a less aggressive approach, it could provide a path to more stringent requirements when those standards are more mature.

Implications

Federal spending. This recommendation would not have a direct effect on federal Medicaid and CHIP spending, although ONC and SAMHSA would incur costs associated with undertaking these activities.

States. This recommendation would create a federal standard to support state efforts. That is, if a Medicaid agency decides to encourage EHR adoption for behavioral health practice settings, it could require providers to adopt an EHR that complies with the behavioral health voluntary certification.

Enrollees. In the near term, patients receiving services from a provider that upgraded their system to meet voluntary certification would benefit from the potential for greater communication regarding their care.

Plans and providers. In the near term, providers would benefit by having guidance on a set of standards and functions that support behavioral health. Behavioral health providers could work with a developer on an IT product that meets the needs of their practice setting. Physical health providers could use implementation resources to upgrade their systems to support SUD privacy protection requirements. Standards outlined under the voluntary certification could support tele-behavioral health services, crisis counseling, and connections to SUD registries and PDMPs. Plans and providers would be in a better position to provide integrated care through greater information sharing. In the long run, as behavioral health IT systems improve and mature, additional federal action could be contemplated to make the behavioral health certification benchmark mandatory. This action would further facilitate care integration efforts, especially for providers who serve patients receiving SUD treatment.

Endnotes

[1] For example, 55 percent of Medicaid beneficiaries have a serious mental illness and a serious physical health condition compared to 46 percent of privately insured patients (MACPAC 2021a). In addition, 36 percent of Medicaid beneficiaries have a serious mental illness and SUD, compared to 27 percent of privately insured patients (MACPAC 2021a).

[2] In order to convey confidence that electronic health information can be easily shared between providers using different IT systems, ONC certifies IT systems to confirm that they meet a set of minimum quality standards. Non-certified health IT may store health records in a non-standardized structure, making it a challenge to transfer data between providers. Because certified IT systems meet minimum standards on core functions and data structures, they are more likely to facilitate interoperability and data exchange when compared to non-certified IT systems.

[3] The regulation at 42 CFR Part 2 established patient protections and set the conditions for disclosure and redisclosure of SUD treatment and prevention records for people receiving treatment from federally assisted programs. These regulations first were promulgated in 1975 and implement statutory requirements intended to encourage individuals to seek treatment for SUDs by addressing the stigma of SUDs and concerns that individuals receiving treatment could be subject to negative consequences from unauthorized disclosure of their patient records. The Coronavirus Aid, Relief, and Economic Security (CARES, P.L. 116-136) Act requires changes to 42 CFR Part 2. Rulemaking on the CARES Act is in progress by SAMHSA and the U.S. Department of Health and Human Services Office of Civil Rights.

[4] Additionally, designing and maintaining systems that comply with Part 2 requirements (including incorporating updates such as those made by the 2017 and 2018 Part 2 regulatory changes) can be costly (MACPAC 2018).

[5] Even if a provider adopts certified EHR technology there are additional costs associated with sharing data with other providers. These may include technical on-boarding into an information exchange, fees charged by a state HIE, and legal counsel for interpreting HIE legal agreements.

[6] Hospitals that were eligible for HITECH's incentive payments were primarily pediatric and short-term acute care hospitals. Psychiatric, long-term acute care, and rehabilitation facilities were ineligible for incentive payments.

[7] Most licensed physicians were eligible for HITECH incentive payments, including psychiatrists and addiction medicine specialists.

[8] The National Council for Mental Wellbeing's survey found that, overall, 67 percent of mental health and addiction treatment organizations had increased demand for services. They found this was also true for 63 percent of youth mental health and addiction treatment services (NCMW 2021).

[9] In addition to 42 CFR Part 2, other privacy laws such as Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) and state behavioral health privacy laws also create additional costs for providers regarding consent around the disclosure and redisclosure of medical records.

[10] Certification of health IT includes privacy and security provisions, which can help a user to comply with HIPAA. To further assess compliance with HIPAA, CMS also requires providers or health care organizations to complete a security risk analysis by the provider or health care organization.

[11] In this report, we use the term HIPAA as a shorthand for both the HIPAA statute and its implementing regulations.

[12] There are many reasons why a patient receiving SUD treatment may not want to disclose their treatment information. A good example is that there remains significant stigma against persons with SUD affecting housing, employment, and education (NASEM 2016). This is one reason why some patients do not want their SUD records shared or want them to be shared with some providers but not others. When patients are unable or unwilling to authorize Part 2 programs to disclose SUD treatment information, inadequate or even dangerous care, such as prescribing medications with dangerous or deadly interactions, may be the result (SAMHSA 2018, Wakeman and Friedman 2017, APA 2016, MHA 2016).

[13] Segmentation capabilities support the sharing of Part 2-protected information within accordance with state and federal law (ONC 2015). Data segmentation includes capabilities to tag health care data and allow certain documents, messages, or individual data elements to be marked as sensitive, without restricting access to the entire EHR. This is typically not automated and is not a common feature within an EHR platform.

[14] For example, ONC and SAMHSA have developed the Data Segmentation for Privacy (DS4P) standard and the Consent2Share software application to manage patient consent preferences and share Part 2-protected information electronically through EHRs and HIEs. The Health Information Technology Standards Committee advising ONC called into question the maturity of the DS4P standard, suggesting that additional testing and refinements are needed (MACPAC 2018).

[15] The CARES Act also requires the Secretary of HHS to update federal regulations to align with statutory changes to SUD confidentiality standards. As of April 2022, HHS is still in the rulemaking process, and this provision has yet to be implemented.

[16] The Medicaid EHR Incentive Program is now called Promoting Interoperability and has gone through many name changes since its inception. Promoting Interoperability is now the umbrella term for most of the EHR incentive payment programs. The Medicaid component of Promoting Interoperability is administered by the states. This name change went into effect in April 2018.

[17] This demonstration opportunity requires states to increase the availability of community-based mental health care, including non-hospital-based and non-residential crisis-stabilization services, in order to receive a federal match for mental health services rendered in institutions for mental diseases.

[18] States must develop a health IT plan that describes the state's ability to leverage health IT, advance HIEs, and ensure health IT interoperability in support of the program goals. These health IT plans must address electronic care plan sharing, care coordination, and integration of behavioral and physical health (CMS 2018).

[19] States can receive an enhanced federal match for certain administrative health IT expenses under Section 1903(a)(3)(A) and (B) of the Social Security Act. This includes a 90 percent federal match for the design, development, and implementation of mechanized claims processing and information retrieval systems and a 75 percent match for maintenance and operations of these systems.

[20] For example, the enhanced federal match could be used for data-sharing capabilities between hospitals and community-based mental health providers such that when a beneficiary is discharged from a hospital, their treatment record could be transferred to a community-based mental health provider, or if the beneficiary was being admitted to a hospital for acute care, the mental health provider could be notified easily. Such funding also can be used to promote data sharing between schools, hospitals, primary care, and specialized mental health providers (CMS 2018).

[21] SMI and SED guidance states that the enhanced federal match used to improve state IT systems could be made available to states to develop data-sharing capabilities among hospitals and community-based mental health providers such that when an SMI diagnosed beneficiary is discharged from a hospital, the treatment record could be transferred to a community-based treatment provider. Another example is if the beneficiary was being admitted to a hospital for acute care, the community-based mental health provider could be notified through an automated electronic messaging service.

[22] Regional Extension Centers (RECs) were organizations that supported provider EHR adoption during the implementation of the Medicaid EHR incentive payment program. The HITECH Act created a grant program through which ONC provided funding to organizations that provide on-the-ground technical assistance for individual and small provider practices that have historically had challenges effectively integrating health IT into provider workflows in ways that strengthen quality of care (Crabtree et al. 2011, Lynch et al. 2014). Providers who received support from RECs were significantly more likely to meet the milestones of the Promoting Interoperability program when compared to providers who did not receive support from RECs (e.g., 68 percent of participants in the REC program achieved Stage 1 meaningful use of EHRs of the incentive program by May 2014, compared to 12 percent of nonparticipants, (AIR 2016)).

[23] SAMHSA's Substance Abuse and Mental Health Block Grant allows states to use funds for EHRs but are limited by statute to five percent of funds for administrative services. States that receive funding through SAMHSA's Community Mental Health Services Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SABG) programs can use funds to support administrative activities including the costs for implementing electronic health records and other health information technology. However,

by statute, states cannot spend more than five percent of their grant on administrative expenses (SAMHSA 2022).

[24] As previously discussed, the use of certified health IT is technically voluntary for providers. However, since providers were required to use certified EHR technology to participate in the EHR incentive payment programs for both Medicare and Medicaid, use of a certified tool became the industry norm. When the Commission discusses voluntary certification for IT used for behavioral health, this means providing a list of standards and EHR functions that support clinical, security, and privacy needs of behavioral health providers.

[25] These recommendations were published in June 2020 and included implementation guidance for pediatric capabilities that developers and providers could use for pediatric-focused IT. For example, ONC recommended that pediatric-focused IT should compute weight-based drug dosages, synchronize immunization histories with registries, and segment access to sensitive information such as a child's sexual history (ONC 2020b). The recommendations also provided guidance that EHR vendors could use to design a pediatric-focused IT systems that also met the requirements of CMS' interoperability rule and ONC's information blocking rule (CMS 2020, ONC 2020a).

[26] ONC's voluntary certification of health IT for pediatric settings of care built on top prior federal efforts to improve pediatric health IT; specifically, it was built on top of the Children's EHR Format. The Children's EHR Format tried to bridge the gap between what was available in most EHRs at the time and what was needed to provider higher quality care for children. The Format was authorized by the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3), and was developed by Agency for Healthcare Research and Quality (AHRQ) in coordination with CMS (AHRQ 2022).

[27] MACPAC made several recommendations regarding clarifying key 42 CFR Part 2 provisions; however, this predates congressional action on SUD privacy requirements. The Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136) aligned the statutory basis for Part 2 more closely with HIPAA. However, some issues related to patient consent and electronic information sharing were not directly addressed by the CARES Act and will instead be addressed through future rulemaking.

References

Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services (HHS). 2022. Children's Electronic Health Record Format. Rockville, MD: AHRQ. https://digital.ahrq.gov/health-it-tools-and-resources/pediatric-resources/childrens-electronic-health-record-ehr-format.

American Institutes for Research (AIR). 2016. Evaluation of the Regional Extension Center Program. Washington, DC: AIR. https://www.healthit.gov/sites/default/files/Evaluation_of_the_Regional_Extension_Center_Program_Final_Report_4_4_16.pdf.

American Academy of Family Physicians (AAFP). 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (June 3, 2019). Washington, DC: AAFP. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1652.

American Psychiatric Association (APA). 2016. Comment letter on proposed rule. Confidentiality of substance use disorder patient records (April 11, 2016). https://www.regulations.gov/document/HHS-OS-2016-0005-0241.

AmeriHealth Caritas. 2021. Comment letter on proposed rule: Medicaid program; Patient Protection and Affordable Care Act; reducing provider and patient burden by improving prior authorization processes, and promoting patients' electronic access to health information for Medicaid managed care plans, state Medicaid agencies, CHIP agencies and CHIP managed care entities, and issuers of qualified health plans on the federally-facilitated exchanges; health information technology standards and implementation specifications (January 4, 2021). https://www.regulations.gov/comment/CMS-2020-0157-0167.

Association for Behavioral Health and Wellness (ABHW). 2021. Comment letter on proposed rule: Medicaid program; patient protection and Affordable Care Act; reducing provider and patient burden by improving prior authorization processes, and promoting patients' electronic access to health information for Medicaid managed care plans, state Medicaid agencies, CHIP agencies and CHIP managed care entities, and issuers of qualified health plans on the federally-facilitated exchanges; health information technology standards and implementation specifications

(January 4, 2021). https://www.regulations.gov/comment/CMS-2020-0157-0065.

Behavioral Health IT Coalition (BHIT). 2021. Comment letter to Senator Bennet and Senator Cornyn: a bold vision for America's mental well-being (October 8, 2021). http://www.bhitcoalition.org/news---events.html.

Bipartisan Policy Center. 2021. *Tackling America's mental health and addiction crisis through primary care integration: task force recommendations.* March 2021. Washington, DC: BPC. https://bipartisanpolicy.org/report/behavioral-health-2021/.

Boockvar, K., W. Ho, J. Pruskowski, et al. 2017. Effect of health information exchange on recognition of medication discrepancies is interrupted when data charges are introduced: results of a cluster-randomized controlled trial. *Journal of the American Medical Informatics Association* 24, no. 6: 1095–1101. https://www.ncbi.nlm.nih.gov/pmc/articles/pmid/28505367/.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). 2020. Medicare and Medicaid programs; patient protection and Affordable Care Act; interoperability and patient access for Medicare Advantage organization and Medicaid managed care plans, state Medicaid agencies, CHIP agencies and CHIP managed care entities, issuers of qualified health plans on the federally-facilitated exchanges, and health care providers. May 2020. Washington, DC: HHS. https://www.federalregister.gov/documents/2020/05/01/2020-05050/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). 2018. State Medicaid Director Letter. "Opportunities to design innovative service delivery systems for adults with a serious mental illness or children with a serious emotional disturbance." Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). 2017a. State Medicaid Director Letter. "Strategies to address the opioid epidemic." Baltimore, MD: CMS. https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd17003.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). 2017b. CMCS Informational Bulletin: Delivery systems and provider payment initiatives under Medicaid managed care contracts. Baltimore, MD: CMS. https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib11022017.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). 2016. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid managed care, CHIP delivered in managed care, and revisions related to third party liability. May 2016. Baltimore, MD: CMS. https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). 2008. Behavioral health MITA: Maturity model document version 2.0. Baltimore, MD: CMS. https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidInfoTechArch/Downloads/BH-MITA-MM.pdf.

Cerner. 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (May 29, 2019). Kansas City, MO: Cerner. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1212.

Covered California. 2021. Comment letter on proposed rule: Medicaid program; Patient Protection and Affordable Care Act; reducing provider and patient burden by improving prior authorization processes, and promoting patients' electronic access to health information for Medicaid managed care plans, state Medicaid agencies, CHIP agencies and CHIP managed care entities, and issuers of qualified health plans on the federally-facilitated exchanges; health information technology standards and implementation specifications (January 4, 2021). https://www.regulations.gov/comment/CMS-2020-0157-0153.

College of American Pathologists (CAP). 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (June 3, 2019). Washington, DC: CAP. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1856.

Crabtree, BF, P.A. Nutting, WL Miller, et al. 2011. Primary care practice transformation is hard work: insights from a 15-year developmental program of research. *Med Care* 49(Suppl): S25-S35. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3043156/pdf/nihms-250809.pdf.

Das-Munshi, J., C.K. Chang, I. Bakolis et al. 2021. All-case and cause-specific mortality in people with mental disorders and intellectual disabilities, before and during the COVID-19 pandemic: cohort study. *The Lancet* 2021. https://www.thelancet.com/journals/lanepe/article/PIIS2666-7762(21)00214-3/fulltext.

Department of Health Care Finance (DHCF), Government of the District of Columbia. 2021. Initial spending plan and narrative for enhanced funding for Medicaid home and community-based services under section 9817 of the American Rescue Plan Act of 2021. Washington, DC: DHCF. https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/page_content/attachments/District%20of%20Columbia%20ARPA%20Initial%20Narrative%20and%20Spending%20Plan.pdf.

ECRI Institute (ECRI). 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (May 20, 2019). https://www.regulations.gov/comment/HHS-ONC-2019-0002-1255.

Eder, S. 2022. As a crisis hotline grows, so do fears it won't be ready. *New York Times* 2022. https://www.nytimes.com/2022/03/13/us/suicide-hotline-mental-health-988.html.

Electronic Health Record Association (EHRA). 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (June 4, 2019). Chicago, IL: EHRA. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1468

Falconer, E., D. Kho, and J. Docherty. 2018. Use of technology for care coordination initiatives for patients with mental health issues: a systematic literature review. *Neuropsychiatric Disease and Treatment* 2018, no. 14: 2337–2349. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6143125/pdf/ndt-14-2337.pdf.

Fond, G., K. Nemani, D. Etchart et al. 2021. Association between mental health disorders and mortality among patients with COVID-19 in 7 countries: a systematic review and meta-analysis. *JAMA Psychiatry.* 2021, no:78(11) 1208-1217. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2782457.

Gilmer, T., B. Henwood, M. Goode, et al. 2016. Implementation of integrated health homes and health outcomes for persons with serious mental illness in Los Angeles County. *Psychiatric Services* 67, no. 10: 1062–1067. https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201500092.

Gold, M., and C. McLauglin. 2016 Assessing HITECH implementation and lessons: 5 years after. *The Milbank Quarterly*. 94(3): 654-687. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5020152/.

Henry, J., Y. Pylypchuk, T. Searcy, and V. Patel. 2016. *Adoption of electronic health record systems among U.S. non-federal acute care hospitals: 2008–2015.* ONC data brief no. 35. Washington, DC: Office of the National Coordinator for Health Information Technology. https://www.healthit.gov/sites/default/files/briefs/2015_hospital_adoption_db_v17.pdf.

Healthcare Information and Management Systems Society (HIMMS). 2022. *Interoperability in healthcare.* Accessed on 4/20/2022. https://www.himss.org/resources/interoperability-healthcare.

Health Level Seven International (HL7 International). 2019. Comment letter on proposed rule: Confidentiality of Substance Use Disorder Patient Records (October 24, 2019). Ann Arbor, MI: HL7. https://www.regulations.gov/comment/HHS-OS-2019-0011-0461.

Institute of Medicine (IOM). 2003. *Key capabilities of an electronic health record system: letter report.* Washington, DC: The National Academies Press. https://nap.nationalacademies.org/catalog/10781/key-capabilities-of-an-electronic-health-record-system-letter-report?onpi_newsdoc073103=.

InterSystems. 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (June 3, 2019). Cambridge, MA: InterSystems. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1694.

John, A., J. McGregor, I. Jones, et al. 2018. Premature mortality among people with severe mental illness – new evidence from linked primary care data. *Schizophrenia Research* 2018, no: 199:154-162. https://www.sciencedirect.com/science/article/pii/S0920996418301981?via%3Dihub.

Lynch, K., M. Kendall, K. Shanks, et al. 2014. The health IT regional extension center program: evolution and lessons for health care transformation. *Health Services Research* 49(1 Pt 2): 421-437. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3925411/pdf/hesr0049-0421.pdf.

Lye, C.T., H. Forman, J. Daniel, et al. 2018. The 21st Century Cures Act and electronic health records one year later: will patients see benefits? J*ournal of the American Medical Informatics Association* September 2018, 25(9):1218-1220. https://academic.oup.com/jamia/article/25/9/1218/5060211.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2022. Chapter 2: Oversight of managed care directed payments. In *Report to Congress on Medicaid and CHIP*. June 2022. Washington, DC: MACPAC. https://www.macpac.gov/publication/oversight-of-managed-care-directed-payments/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021a. Chapter 4: Integrating clinical care through greater use of electronic health records for behavioral health. In *Report to Congress on Medicaid and CHIP.* June 2021. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-4-Integrating-Clinical-Care-through-Greater-Use-of-Electronic-Health-Records-for-Behavioral-Health.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021b. Chapter 2: Access to mental health services for adults covered by Medicaid. In *Report to Congress on Medicaid and CHIP*. June 2021. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-2-Access-to-Mental-Health-Services-for-Adults-Covered-by-Medicaid.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021c. *MACStats: Medicaid and CHIP Data Book*. December 2021. Washington, DC: MACPAC. https://www.macpac.gov/macstats/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020a. Chapter 2: State readiness to report mandatory core set measures. In *Report to Congress on Medicaid and CHIP*. March 2020. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2020/03/State-Readiness-to-Report-Mandatory-Core-Set-Measures.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020b. *Delivery System Reform Incentive Payment (DSRIP) Programs.* April 2020. Washington, DC: MACPAC. https://www.macpac.gov/publication/delivery-system-reform-incentive-payment-programs/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018. Chapter 2: Substance use disorder confidentiality regulations and care integration in Medicaid and CHIP. In *Report to Congress on Medicaid and CHIP.* June 2018. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2018/06/Substance-Use-Disorder-Confidentiality-Regulations-and-Care-Integration-in-Medicaid-and-CHIP.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017. Chapter 2: Medicaid and the opioid epidemic. In *Report to Congress on Medicaid and CHIP.* June 2017. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2017/06/Medicaid-and-the-Opioid-Epidemic.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016. Chapter 4: Integration of behavioral and physical health services in Medicaid. In *Report to Congress on Medicaid and CHIP.* March 2016. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2016/03/Integration-of-Behavioral-and-Physical-Health-Services-in-Medicaid.pdf.

Mental Health American (MHA). 2016. Comment letter on proposed rule: Confidentiality of substance use disorder patient records (April 12, 2016). https://www.regulations.gov/document/HHS-OS-2016-0005-0273.

Momen, N.C., O. Plana-Ripoll, E. Agerbo et al. 2022. Mortality associated with mental disorders and comorbid general medical conditions. *JAMA Psychiatry* 2022 Mar. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2790723.

National Alliance on Mental Illness (NAMI). 2022. *As launch of 988 mental health crisis number looms, NAMI poll finds broad support for the system and fees to fund it, opposition to police response to mental health crises.* Arlington, VA: NAMI. https://www.nami.org/Press-Media/Press-Releases/2021/As-Launch-of-988-Mental-Health-Crisis-Number-Looms-NAMI-Poll-Finds-Broad-Support-for-the-System-and.

National Alliance on Mental Illness (NAMI). 2020. *Mental health care matters.* Arlington, VA: NAMI. https://www.nami.org/NAMI/media/NAMI-Media/Infographics/NAMI_MentalHealthCareMatters_2020_FINAL.pdf.

National Academy of Sciences, Engineering, and Medicine (NASEM). 2020. *Caring for people with mental health and substance use disorders in primary care settings: proceedings of a workshop.* Washington, DC: The National Academies Press. https://doi.org/10.17226/25927.

National Academy of Sciences, Engineering, and Medicine (NASEM). 2016. *Ending discrimination against people with mental and substance use disorders.* Washington, DC: The National Academies Press. https://nap.nationalacademies.org/catalog/23442/ending-discrimination-against-people-with-mental-and-substance-use-disorders.

National Association of Medicaid Directors (NAMD). 2021. Comment letter to U.S. Senate Committee on Finance's request for information on behavioral health care. (November 12, 2021). Washington, DC: NAMD.

National Association of State Mental Health Program Directors (NASMHPD). 2018. Comment letter to Center for Medicare and Medicaid Innovation: Section 6001 of the SUPPORT Act, payment on incentives to behavioral health providers to adopt EHRs (December 10, 2018).

National Association of State Mental Health Program Directors (NASMHPD). 2012. *Reclaiming lost decades: The role of state behavioral health agencies in accelerating the integration of behavioral healthcare and primary care to improve the health of people with serious mental illness.* Alexandria, VA: NASMHPD. https://www.nasmhpd.org/sites/default/files/Reclaiming%20Lost%20Decades%20Full%20Report.pdf.

National Association for Community Health Centers (NACHC). 2021. Health information technology a home run for NACHC. October 2021. Washington, DC: NACHC. https://blog.nachc.org/health-informatics-team-hit-a-home-run-for-nachc/.

National Council for Mental Wellbeing (NCMW). 2021. New report: 40% of mental health and addiction treatment organizations will survive less than a year without additional financial support. March 2021. Washington, DC: NACHC. https://www.thenationalcouncil.org/news/new-report-40-of-mental-health-and-addiction-treatment-organizations-will-survive-less-than-a-year-without-additional-financial-support/.

New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services, State of New Jersey. 2021. *State of New Jersey home and community-based services enhanced FMAP spending plan*. Trenton, NJ: DHS. https://nj.gov/humanservices/assets/slices/NJHCBSspending.pdf.

New York eHealth Collaborative (NYeC). 2021. Comment letter on proposed rule: Medicaid program; Patient Protection and Affordable Care Act; reducing provider and patient burden by improving prior authorization processes, and promoting patients' electronic access to health information for Medicaid managed care plans, state Medicaid agencies, CHIP agencies and CHIP managed care entities, and issuers of qualified health plans on the federally-facilitated exchanges; health information technology standards and implementation specifications (January 4, 2021). https://www.regulations.gov/comment/CMS-2020-0157-0219.

Netsmart. 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (June 3, 2019). Overland Park, KS: Netsmart. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1509.

NextGen Healthcare (NextGen). 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (June 3, 2019). Horsham, PA: NextGen. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1711.

Office of the National Coordinator for Health IT (ONC), U.S. Department of Health and Human Services (HHS). 2022. *ONC Health IT Certification Overview.*

Updated on March 31, 2022. Washington, DC: HHS. https://www.healthit.gov/sites/default/files/PUBLICHealthITCertificationProgramOverview.pdf.

Office of the National Coordinator for Health IT (ONC), U.S. Department of Health and Human Services (HHS). 2020a. *21*st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program. May 2020. Washington, DC: HHS. https://www.federalregister.gov/documents/2020/05/01/2020-07419/21st-century-cures-act-interoperability-information-blocking-and-the-onc-health-it-certification.

Office of the National Coordinator for Health IT (ONC), U.S. Department of Health and Human Services (HHS). 2020b. Pediatric health information technology: Pediatric healthcare provider informational resource. Washington, DC: HHS. https://www.healthit.gov/sites/default/files/page/2020-12/Pediatric_HealthIT_Provider_IR_Print_508.pdf.

Office of the National Coordinator for Health IT (ONC), U.S. Department of Health and Human Services (HHS). 2020c. Strategy on reducing regulatory and administrative burden relating to the use of health IT and EHRs. Feb 2020. Washington, DC: HHS. https://www.healthit.gov/sites/default/files/page/2020-02/BurdenReport_0.pdf.

Office of the National Coordinator for Health IT (ONC), U.S. Department of Health and Human Services (HHS). 2020d. Pediatric health information technology: Developer informational resource. Washington, DC: HHS. https://www.healthit.gov/sites/default/files/page/2020-06/Pediatric-Health-IT-Developer-IR-06102020.pdf.

Office of the National Coordinator for Health IT (ONC), U.S. Department of Health and Human Services (HHS). 2020e. ONC approach and stakeholder opportunities for advancing health IT across the care continuum. Washington, DC: HHS. http://www.healthit.gov/sites/default/files/page/2020-07/Care%20Continuum%20Tipsheet.pdf.

Office of the National Coordinator for Health IT (ONC), U.S. Department of Health and Human Services (HHS). 2019. *Health IT standards*. June 2019. Washington, DC: HHS. https://www.healthit.gov/topic/standards-technology/health-it-standards.

Office of the National Coordinator for Health IT (ONC), U.S. Department of Health and Human Services (HHS). 2019b. 2015 edition market readiness for hospitals and clinicians. March 2019. Washington, DC: HHS. https://www.healthit.gov/data/quickstats/2015-edition-market-readiness-hospitals-and-clinicians.

Office of the National Coordinator for Health IT (ONC), U.S. Department of Health and Human Services (HHS). 2017. Non-federal acute care hospital electronic health record adoption. Health IT Quick-Stat #47. September 2017. Washington, DC: HHS. https://www.healthit.gov/data/quickstats/non-federal-acute-care-hospital-electronic-health-record-adoption.

Office of the National Coordinator for Health Information Technology (ONC), U.S. Department of Health and Human Services. 2015a. Percent of U.S. hospitals with capability to electronically query patient health information from outside their organization or system. Health IT Quick-Stat #25. Washington, DC: ONC. https://www.healthit.gov/data/quickstats/hospital-capability-electronically-query.

Office of the National Coordinator for Health Information Technology (ONC), U.S. Department of Health and Human Services. 2015. 2015 Edition health information technology (Health IT) certification criteria, 2015 Edition Base Electronic Health Record (EHR) definition, and ONC Health IT Certification Program modifications. Final rule. *Federal Register* 80, no. 200 (October 16): 62601–62759. https://www.federalregister.gov/documents/2015/10/16/2015-25597/2015-edition-health-information-technology-health-it-certification-criteria-2015-edition-base.

Office of the National Coordinator for Health Information Technology (ONC), U.S. Department of Health and Human Services. 2013. Certification guidance for EHR technology developers serving health care providers ineligible for Medicare and Medicaid EHR incentive payment. Washington, DC: ONC. https://www.healthit.gov/sites/default/files/generalcertexchangeguidance_final_9-9-13.pdf.

Office for Civil Rights (OCR), U.S. Department of Health and Human Services (HHS). 2017. *Does HIPAA provide extra protections for mental health information compared with other health information.* Washington, DC: HHS. https://www.hhs.gov/hipaa/for-professionals/faq/2088/does-hipaa-provide-extra-protections-mental-health-information-compared-other-health.html.

Oregon Health Authority (OHA). 2021. Health Information Exchange (HIE) Onboarding Program development Q&A. Salem, OR: OHA. https://www.oregon.gov/oha/HPA/OHIT/Pages/HIE-Onboarding-QA.aspx.

Partnership for Health IT Patient Safety (Partnership for HITPS). 2021. Optimizing health IT for safe integration of behavioral health and primary care. https://d84vr99712pyz.cloudfront.net/p/pdf/hit-partnership/partnership_whitepaper_behavioralhealth_v2.pdf.

The Partnership to Amend 42 CFR Part 2. 2021. Comment letter to MACPAC: Considerations related to 42 CFR part 2 (November 3, 2021).

The Pew Charitable Trusts. 2019. *Poor usability of electronic health records can lead to drug errors, jeopardizing pediatric patients: challenges can stem from product design, clinician use, and customization.* Philadelphia, PA: PEW. https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2019/04/poor-usability-of-electronic-health-records-can-lead-to-drug-errors-jeopardizing-pediatric-patients.

Plana-Ripoll, O., P.C.B. Pedersen, P.E. Agerbo et al. 2019. A comprehensive analysis of mortality-related health metrics associated with mental disorders: a nationwide, register-based cohort study. *The Lancet* 2019, no: 394(10211):1827-1835. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)32316-5/fulltext.

Plana-Ripoll, O., K.L. Musliner, S. Dalsgaard et al. 2020. Nature and prevalence of combinations of mental disorders and their association with excess mortality in a population-based cohort study. *World Psychiatry* 2020 Oct, no:19(3):339-349. https://pubmed.ncbi.nlm.nih.gov/32931098/.

Primary care collaborative (PCC). 2022. *Benefits of integration of behavioral health.* https://www.pcpcc.org/content/benefits-integration-behavioral-health.

Roberts, L.W., A.K. Louie, A.P.S. Guerrero, et al. 2017. Premature mortality among people with mental illness: Advocacy in academic psychiatry. *Academic Psychiatry* 2017, no. 41, 441–446. https://link.springer.com/content/pdf/10.1007/s40596-017-0738-9.pdf.

State of Washington Health Care Authority (WAHCA). 2021. Comment letter to MACPAC: Electronic health record incentive payments to behavioral health providers (March 30, 2021).

State of Washington Department of Health (WADOH). 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (2019). Olympia, WA: WADOH. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1680.

State of Wisconsin Department of Health (WIDHS). 2019. Comment letter on proposed rule: 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program (2019). Madison, WI: WIDHS. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1276.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2022. *Substance abuse and mental health block grants.* Rockville, MD: SAMHSA. https://www.samhsa.gov/grants/block-grants.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2021. *Disclosure of substance use disorder patient records: how do I exchange Part 2 data?* Rockville, MD: SAMHSA. https://www.samhsa.gov/sites/default/files/how-do-i-exchange-part2.pdf.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2020. Final Rule: Confidentiality of substance use disorder patient records. Rockville, MD: SAMHSA. F*ederal Register* 85, no. 42986: 42986-43039 https://www.federalregister.gov/documents/2020/07/15/2020-14675/confidentiality-of-substance-use-disorder-patient-records.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2018. SAMHSA listening session transcript, 42 CFR part 2, January 31, 2018, Rockville, MD. https://www.samhsa.gov/sites/default/files/42cfrpart2listeningsession-securitylist.pdf.

U.S. Department of Defense (DoD). 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (June 3, 2019). Washington, DC: DoD. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1924.

Vest, J., L. Kern, M. Silver, et al. 2015. The potential for community-based health information exchange systems

to reduce hospital readmissions. *Journal of the American Medical Informatics Association* 22, no. 2: 435–442. https://pubmed.ncbi.nlm.nih.gov/25100447/.

Virginia Hospital & Healthcare Association (VHHA). 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (June 3, 2019). Richmond, VA: VHHA. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1867.

Wakeman, S. and P. Friedman. 2017 Outdated privacy law limits effective substance use disorder treatment: The case against 42 CFR Part 2. *Health Affairs Blog*, March 1. https://www.healthaffairs.org/do/10.1377/hblog20170301.058969/full/.

Wang, Q., D.C. Kaelber, R. Xu, et al. 2021. COVID-19 risk and outcomes in patients with substance use disorders: analysis from electronic health records in the United States. *Molecular Psychiatry* 2020, no. 26:30-39. https://www.nature.com/articles/s41380-020-00880-7.

WellSky. 2019. Comment letter on proposed rule: 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT Certification Program (June 3, 2019). Kenexa, KS, DC: WellSky. https://www.regulations.gov/comment/HHS-ONC-2019-0002-1650.

Wolf, L., J. Harvell, and A. Jha. 2012. Hospitals ineligible for federal meaningful-use incentives have dismally low rates of adoption of electronic health records. *Health Affairs* 31, no 3: 505-513. https://www.healthaffairs.org/doi/10.1377/hlthaff.2011.0351.

Yaraghi, N. 2015. An empirical analysis of the financial benefits of health information exchange in emergency departments. *Journal of the American Medical Informatics Association* 22(6):1169-72. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7784316/pdf/ocv068.pdf.

Commission Vote on Recommendations

In MACPAC's authorizing language in Section 1900 of the Social Security Act, Congress requires the Commission to review Medicaid and CHIP policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on these recommendations on April 8, 2022.

Encouraging Health Information Technology Adoption in Behavioral Health: Recommendations for Action

4.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Office of the National Coordinator for Health Information Technology to develop joint guidance on how states can use Medicaid authorities and other federal resources to promote behavioral health information technology adoption and interoperability.

4.2 The Secretary of the U.S. Department of Health and Human Services should direct the Substance Abuse and Mental Health Services Administration and the Office of the National Coordinator for Health Information Technology to jointly develop a voluntary certification for behavioral health information technology.

4.1-2 Voting Results	#	Commissioner
Yes	15	Allen, Bella, Brooks, Burwell, Carter, Cerise, Davis, Douglas, Duncan, Gordon, Heaphy, Johnson, Lampkin, Herrera Scott, Weno
Not Present	1	Scanlon