National Association
for Behavioral Healthcare

Access. Care. Recovery.

NABH 2019

LEGISLATIVE AND REGULATORY PRIORITIES

190-day Lifetime Limit

Medicare beneficiaries are limited to only 190 days of inpatient care in a psychiatric hospital in their lifetime. No other lifetime limits exist in Medicare for any other type of inpatient care. Eliminating the Medicare 190-day lifetime limit for psychiatric hospitals would expand beneficiary choice, increase access for the most seriously ill, improve continuity of care, create a more cost-effective Medicare program, and align Medicare with parity, the standard required for all other insurance plans.

NABH Action

NABH is working with Rep. Paul Tonko's (D-N.Y.) office to re-introduce the *Medicare Mental Health Inpatient Equity Act*, which would repeal Medicare's 190-day lifetime limit permanently.

IMD Exclusion

The Medicaid program's Institutions for Mental Diseases (IMD) exclusion prevents adult Medicaid beneficiaries (ages 21-64) from accessing short-term, acute behavioral healthcare in psychiatric hospitals and other residential treatment facilities with more than 16 beds. Eliminating the IMD exclusion would give states flexibility and allow Medicaid beneficiaries to receive cost-effective, efficient, and high-quality treatment.

NABH Action

NABH is pursuing legislative and regulatory solutions to reduce the burden of the IMD exclusion, such as making changes to the Medicaid managed care rule and expediting 1115 waivers.

Parity

The *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* (MHPAEA) became law a decade ago, but full parity still does not exist. A 2017 report from Milliman found that, on average, 31.6 percent of outpatient behavioral healthcare services were provided out of network, while only 5.5 percent of outpatient medical/surgical services were provided out of network. At the same time, the rate for out-of-network office visits was 18.7 percent for behavioral healthcare and 3.7 percent for medical/surgical care.

NABH Action

NABH is working through its new Managed Care Committee to identify challenges that NABH members experience with utilization management procedures from health plans; discuss problems they face providing care that their patients' need; and develop practical recommendations to solve this persistent problem. NABH is also working on legislative efforts to increase the U.S. Labor Department's parity-enforcement authority and allow the department to levy monetary penalties for non-compliant health plans.

Partial Hospitalization

Nearly 45 percent of NABH members offer psychiatric partial hospitalization (PHP) services as either a transition from a hospital program or as an alternative to inpatient care. The current PHP payment structure from CMS does not cover the cost of providing transportation, nutritional services, or vocational counseling to Medicare beneficiaries.

NABH Action

NABH and Rep. Alcee Hastings (D-Fla.) are advocating for Congress to pass Rep. Hastings's *Outpatient Mental Health Modernization Act*, which would require Medicare to reimburse PHPs for providing transportation, food and nutritional services, and vocational counseling.

Opioid Crisis

The nation's opioid crisis is one of the worst behavioral healthcare challenges the United States has faced. More Americans died in a single year by drug overdoses than the total number of Americans killed during the Vietnam War.

NABH Action

NABH is pursuing legislative and regulatory solutions to the crisis, including removing reimbursement and policy barriers to substance use disorder (SUD) treatment, increasing parity enforcement, and expanding medication-assisted treatment (MAT).

42 CFR Part 2

Federal regulations dating from the 1970s—commonly referred to as 42 CFR Part 2 or "Part 2"—currently govern the confidentiality of patient records in substance use treatment programs. Part 2 provisions are more demanding than those in the *Health Insurance Portability and Accountability Act* (HIPAA). In today's digital environment, these regulations prevent healthcare integration and risk endangering patients.

NABH Action

NABH supports legislative and executive branch efforts to reform Part 2 and improve information sharing in a way that protects individuals from using medical records in criminal, civil, and administrative prosecution and discrimination.

Quality and Outcome Measures

NABH and its member organizations have worked closely with the Centers for Medicare & Medicaid Services (CMS), accrediting agencies, consumers, and other stakeholders to develop and support innovative performance metrics. NABH was one of the original organizations that spent more than 10 years helping to develop the Hospital-Based Inpatient Psychiatric Services (HBIPS) measures that were among the first CMS performance measures in the Inpatient Psychiatric Facility Quality Reporting (IPFQR) program.

NABH Action

NABH continues to engage with partners and CMS to ensure all performance measurement and outcomes data-collection are used to improve the effectiveness and efficiency of patient care; focus on indicators that provide the most useful clinical and operational data possible; focus on indicators that support actionable steps that fall within the scope of responsibility and accountability of the organization being measured; provide value in the data generated that is in proportion to the intensity of the data-collection effort; and have the potential for being used to measurably improve the processes, outcomes, efficiency, and patient experiences of the care being delivered.

Special Conditions of Participation or "B-tags"

CMS regulations define conditions of participation (COPs) applicable to all hospitals (the "A tags"), as well as a set of COPs specific to psychiatric facilities (the "B-tags"). As a matter of law, the B-tag regulations define general standards for psychiatric evaluations, medical records, and staffing. CMS' interpretive guidance is extremely detailed, however, articulating requirements with a level of granularity that far surpasses the A-tags.

NABH Action

NABH has commissioned a study on compliance costs associated with regulations.

Ligature Risk

Limiting the risk of suicide is a top priority for every hospital that treats patients with mental health conditions. Hospitals apply best practices and the latest technologies and data to ensure patient safety. However, CMS' new approach to surveying for ligature risks denying access to critically need treatment because it is unclear, unrealistic, and unscientific.

NABH Action

NABH has commissioned a study on compliance costs associated with regulations.

EMTALA

The *Emergency Medical Treatment and Labor Act* (EMTALA) is a federal law that requires patients in emergency departments must receive a medical screening from a qualified medical professional (QMP). If a provider identifies an emergency condition in the patient, then the patient may not be discharged or transferred until the emergency condition is stabilized. Recent actions by the CMS and the Office of Inspector General (OIG) suggest a new interpretation of EMTALA in the behavioral healthcare context.

NABH Action

NABH has commissioned a study on compliance costs associated with regulations.

Alternative Payment Models (APMs)

Various stakeholders, including the CMS, are exploring the idea of value-based payment (VBP) arrangements for Medicaid behavioral healthcare services. The goal is to shift from systems that pay for volume of services to a model that rewards high-quality, cost-effective care.

NABH Action

NABH is engaged in the national conversation about VBPs and APMs in behavioral healthcare settings and has developed a list of challenges, guidelines, and next steps for CMS to consider as the agency begins to develop these models.

Behavioral Healthcare Workforce

The existing demand for behavioral healthcare treatment exceeds the supply of qualified treatment professionals. Federal projections show the behavioral healthcare workforce will need up to 253,000 workers by the year 2025. People experiencing a mental health crisis or drug overdose face life-threatening conditions. Their conditions can be treated with the appropriate behavioral healthcare. But in many parts of the United States, treatment professionals are not available to provide that care.

NABH Action

NABH encourages Congress to create a streamlined approach to enhancing and expanding the mental health and SUD workforce. This new model should include the full spectrum of treatment professionals, non-professionals, and peer workers along the entire behavioral healthcare continuum so that behavioral healthcare access, treatment, and recovery is within reach for all Americans.

The Family First Prevention Services Act (FFPSA)

The *Family First Prevention Services Act* (FFPSA) was signed into law in February 2018. A provision in the legislation that established qualified residential treatment programs (QRTPs) could lead to more young Americans in the juvenile justice system, more adults in prison, a larger homeless population, and potentially more suicides.

NABH Action

NABH is working within the legislative and regulatory process to reduce the impact of the QRTP provision. Partnering with association members and outside organization, NABH has pushed for CMS to include QRTPs in the "psych under 21 benefit" and therefore make them eligible for Medicaid reimbursement.

Behavioral Health Information Technology

EHRs can improve the quality and efficiency of care substantially. The *Health Information Technology for Economic and Clinical Health Act* of 2009 (HITECH), was designed to stimulate EHR adoption by offering providers financial incentives for demonstrating "meaningful use" of EHRs. The law accomplished that goal, but behavioral healthcare providers were not included in the incentive program. This has resulted in lower EHR adoption rates and fewer EHR developers creating systems that apply to behavioral healthcare and are interoperable with general healthcare.

NABH Action

NABH is pushing Congress and the administration to extend incentives to behavioral healthcare organizations. NABH has also encouraged the CMS Innovation Center to test models that provide incentive payments to behavioral healthcare providers who adopt EHR technology.

Veteran and Military Healthcare

According to a report from the National Academies of Sciences, Engineering, and Medicine, about 1.7 million veterans from the wars in Afghanistan and Iraq and the Global War on Terrorism have a mental health need, but more than half of them are not receiving any mental health services. Meanwhile, veterans make up less than 9 percent of the U.S. population but account for 18 percent of all suicides. And while active military have lower rates of illicit drug use, they show a higher prevalence for using prescription drugs (mostly opioid pain relievers) and alcohol.

NABH Action

NABH is working to develop a national strategy to address the mental health and SUDs among our nation's veterans. NABH is focused on redesigning the current VA Choice program to increase patient access to care, include veterans' family members in treatment plans, forge greater public/private community partnerships, and increase reimbursement rates for behavioral health services to align with actual costs in certain specialty areas such as mental health and SUD treatment.

Tele-behavioral Health

Telehealth is widely accepted as a mechanism that can address provider shortages in some geographic areas. There is significant potential for using tele-behavioral healthcare to address unmet psychiatric and substance use needs. However, outdated laws and regulatory structures have slowed the use of tele-behavioral healthcare and other support services to help people with serious mental illness and SUDs.

NABH Action

NABH is working to update rules that inhibit tele-behavioral healthcare services and revise reimbursement policies to allow behavioral healthcare treatment via tele-behavioral health.

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