National Association
for Behavioral Healthcare

Access. Care. Recovery.

NABH

Priorities for the 117th Congress

IMD Exclusion

The Medicaid program's Institutions for Mental Diseases (IMD) exclusion discriminates against adult Medicaid beneficiaries by denying them access to specialized acute behavioral healthcare in psychiatric hospitals and residential treatment facilities. This provision is inconsistent with the principles of parity, hinders care, and contributes to the criminalization of mental illness.

Rising rates of suicide and overdoses highlight the need for improved access to acute mental health and addiction treatment that is provided in psychiatric hospitals and residential treatment facilities. Eliminating the IMD exclusion would give states flexibility to fund a full continuum of care for Medicaid beneficiaries struggling with serious mental illnesses and/or addiction.

Next Steps

NABH is pursuing full repeal of the IMD exclusion. At the same time, NABH is pursuing legislative and regulatory solutions to reduce the burden of the IMD exclusion, for example:

- NABH supports legislation to waive the IMD exclusion for beneficiaries enrolled in Medicaid managed care plans;
- NABH supports enactment of legislation to allow state Medicaid programs to cover services in IMDs for mental health treatment as part of a statewide initiative to provide a full continuum of care, including crisis stabilization services; and
- NABH supports legislation and regulatory action to exempt qualified residential treatment programs from the IMD exclusion. These types of programs recently designated in the *Family First Prevention Services Act* (FFPSA) are required to include staff trained to address the needs of children and adolescents with serious emotional disturbances through trauma-informed care.

190-day Lifetime Limit

Medicare beneficiaries are limited to 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 those with more serious behavioral health conditions, improve continuity of care, create a more cost-effective Medicare program, and align Medicare with parity, the standard required for practically all other healthcare coverage programs.

Next Steps

NABH supports legislation to permanently repeal Medicare's 190-day lifetime limit.

Mental Health and Addiction Treatment Parity Enforcement

The *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* (MHPAEA) became law more than a decade ago, but full parity still does not exist. For example, a 2019 report from Milliman found that inpatient out-of-network use for behavioral healthcare was greater than five times more likely than for medical/surgical services.

Next Steps

NABH's Managed Care Committee is harnessing the nationwide footprint of NABH's membership to identify the scope of parity challenges, detail how the lack of true parity harms those most in need of treatment and develop practical solutions to remedy this unjustifiable crisis.

NABH supports legislation to provide civil monetary penalty authority and increased appropriations to the U.S. Labor Department to improve enforcement of parity requirements.

Parity 2.0 - Basic Consumer Protections to Improve Access to Mental Health and Addiction Treatment

The *Wit v. United Behavioral Health* decision established an important new policy to require mental health and addiction treatment medical necessity determinations and other utilization management practices to be based on generally accepted standards of care developed and widely used by mental health and addiction treatment experts.

Next Steps

NABH supports state and federal legislation to ensure broader application of this new policy as well as regulatory actions (e.g., federal Medicaid guidance regarding managed care contracts) to apply these standards in commercial insurance plans as well as Medicaid and Medicare managed care arrangements.

Opioid and Addiction Crisis

The nation's opioid and addiction crises remain some of its most serious healthcare challenges. More than 81,000 Americans died between June 2019 and May 2020 from drug overdoses, the largest number ever recorded in a 12-month period. While the rates accelerated during the Covid-19 pandemic, deaths were already increasing before the public health emergency. This epidemic of addiction reflects the growing use of synthetic opioids and concurrent use of cocaine, methamphetamine, other illicit drugs, and alcohol.

Next Steps

NABH is pursuing legislative and regulatory solutions to the addiction crisis by advocating for removing reimbursement and policy barriers to substance use disorder (SUD) treatment, including:

- permitting the use of federal funds for treatment of all types of drug and alcohol addiction;
- expanding availability of medication-assisted treatment;
- removing preauthorization for medication-assisted management;
- allowing telehealth treatment;
- broadening the use of contingency for new and existing patients at in-person rates; and
- increasing rural treatment capacity.

Medicare Payment Bundle for Opioid Treatment Programs

Opioid Treatment Programs (OTPs) offer a range of services, including methadone, the most widely researched FDA- approved medication to effectively treat opioid use disorder. In addition, OTPs offer counseling, vocational, recovery support, and other services. OTP services are now funded through Medicare Part B, improving access to services for Medicare beneficiaries.

Next Steps

NABH will continue collaborating with the Centers for Medicare & Medicaid Services (CMS) to ensure the weekly bundled payment rate provides adequate and appropriate reimbursement for the range of treatment services to help individuals with opioid use and other co-occurring disorders achieve and maintain long-term recovery.

NABH encourages CMS to collaborate with the Substance Abuse and Mental Health Services Administration (SAMHSA) to make permanent the flexibilities provided during the public health emergency related to take-home medication and telehealth.

We also encourage SAMHSA to conduct pilot studies to determine the safety and efficacy of performing methadone induction via telehealth in OTPs.

Maintain Coverage of Tele-Behavioral Healthcare

Expanded coverage of mental health and addiction treatment services via telehealth technology during the Covid-19 pandemic has been critical for preserving access to treatment during these extremely challenging times. This expanded coverage has also enabled behavioral healthcare providers to demonstrate how effectively they can use this type of technology to provide care.

Next Steps

NABH advocates for continued coverage in Medicare, Medicaid, and commercial insurance plans of mental health and addiction treatment via telehealth, including partial hospitalization and intensive outpatient programs and medication assisted treatment.

This coverage should also include behavioral healthcare delivered via audio-only technology, which is critical for supporting treatment for people living in professional shortage areas, with limited access to transportation, or without access to video technology, as well as other vulnerable populations.

NABH also calls for reimbursement rates for behavioral healthcare services via telehealth to be maintained at comparable levels with rates for in-person treatment. In addition to clinical services, providing care via telehealth requires assistance from administrative staff and other overhead costs. Without assurance of continued reimbursement that factors in all the costs associated with providing this type of care, we will lose this opportunity to maintain and, in the long run, expand access to behavioral healthcare via telehealth.

Behavioral Health Information Technology

Electronic Health Records (EHRs) can improve the quality and efficiency of care substantially. The *Health Information Technology for Economic and Clinical Health Act* of 2009 (HITECH), has offered financial incentives to certain healthcare providers for demonstrating "meaningful use" of EHRs. Unfortunately, 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.

Next Steps

NABH urges Congress and the Biden administration to extend incentives to behavioral healthcare organizations. NABH also encourages the CMS Innovation Center and the U.S. Health and Human Services Department's (HHS) Office of the National Coordinator to test and fully fund models that provide incentive payments to behavioral healthcare providers for adoption of EHR technology.

Increase Crisis Stabilization Services for 988 Hotline Calls

Designation of 988 as a universal, toll-free crisis hotline creates a tremendous opportunity to prevent tragic outcomes and increase access to mental health and addiction treatment.

Many of the callers to crisis hotlines require a rapid assessment to determine whether they need mental health and/or addiction treatment and at what level of intensity, as well as assistance finding behavioral healthcare providers. Unfortunately, in most areas of the United States, this type of urgent crisis assessment and stabilization service is not available. As a result, people experiencing a serious mental health crisis or addiction wind up in emergency departments where they are unlikely to receive appropriate care or they are taken into custody of law enforcement.

Next Steps

NABH supports federal funding for and guidance to help states establish or improve crisis systems that effectively integrate crisis response with a full continuum of treatment services including mobile crisis, short-term crisis stabilization, and inpatient and outpatient care. Research shows that such systems improve treatment outcomes and can reduce interaction with law enforcement and emergency department utilization.

This federal guidance and funding should encourage states to identify a high-level 988 coordinator to work with local behavioral healthcare providers as well as police, emergency departments, and 911 operators to develop crisis stabilization systems that address the needs of 988 callers.

Behavioral Healthcare Workforce

The existing demand for behavioral healthcare exceeds the supply of qualified treatment professionals. Federal projections show the behavioral healthcare workforce will require millions of additional workers to meet current needs. People experiencing a mental health crisis or drug overdose face life-threatening conditions that can be treated with appropriate behavioral healthcare, but in many parts of the United States, treatment professionals are not available to provide that care.

Next Steps

NABH calls for legislation to require increased Medicare reimbursement rates for behavioral healthcare providers to levels that are more consistent with their education and credentialing, comparable with how reimbursement rates are set for general medical providers. This will encourage more behavioral healthcare providers to participate in the program. Moreover, because Medicare rates tend to be key benchmarks for reimbursement in commercial insurance, improvements in Medicare reimbursement should lead to better reimbursement in commercial plans and potentially Medicaid programs as well.

CMS should also incentivize states to reexamine and improve their Medicaid rates for behavioral healthcare providers to encourage greater participation in Medicaid. One step would be for Congress to expand the Demonstration to Increase Substance Use Provider Capacity in Medicaid (authorized by Sec. 1003 of the *SUPPORT* Act).

In addition, we urge Congress and relevant federal agencies to take additional actions to expand the mental health and SUD workforce addressing the full spectrum of treatment professionals, non-professionals, and peer workers along the entire behavioral healthcare continuum including through loan repayment and grant programs.

Partial Hospitalization

Nearly 45% of NABH members offer psychiatric partial hospitalization programs (PHP) as either a transition from a hospital program or as an alternative to inpatient care. These programs can help prevent unnecessary hospitalization among individuals with more serious behavioral health conditions and also provide a transitional level of care for those discharged from inpatient care. Unfortunately, these types of programs are not available in many regions of the United States. This undoubtedly results from inadequate reimbursement in the Medicare and Medicaid programs and widespread lack of coverage in commercial insurance plans.

Next Steps

NABH supports legislation to improve Medicare reimbursement for PHPs, including reimbursement for providing transportation, food and nutritional services, and vocational counseling. Improved Medicare reimbursement can provide an influential example for both Medicaid and commercial insurance plans.

Quality and Outcome Measures

NABH and its member organizations have worked closely with CMS, accrediting agencies, consumers, and other stakeholders to develop and support innovative performance metrics. NABH was one of the original organizations that helped develop the Hospital-Based Inpatient Psychiatric Services (HBIPS) measures that were used in the Inpatient Psychiatric Facility Quality Reporting (IPFQR) program.

Next Steps

NABH participates in technical panels and collaborates with CMS, the National Quality Forum, the National Academy of Medicine, and other partners to develop and improve quality measures for opioid and other substance use disorder treatment.

NABH advocates for all data-collection for performance and outcomes measurement to be used to measurably improve the processes, outcomes, efficiency, effectiveness, and patient experiences of the care being delivered; focus on indicators that provide the most useful clinical and operational data possible; support actionable steps that fall within the scope of responsibility and accountability of the organization being measured; and provide value in the data generated proportionate to the intensity of the data-collection effort.

Alternative Payment Models (APMs)

Various stakeholders, including CMS, are exploring 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.

Next Steps

NABH is engaged in the national conversation about VBPs and APMs in behavioral healthcare settings and will continue working with CMS as the agency continues to develop these models.

42 CFR Part 2

Federal regulations known as 42 CFR Part 2, or "Part 2," have been modified to align with the *Health Insurance Portability and Accountability Act* (HIPAA). Changes to the law and its regulations will require education of consumers and providers to assure that patients are appropriately protected.

Next Steps

NABH supports funding for federal agencies to provide training to all stakeholders, including consumers, providers, and the legal community, on the changes to the law and the appropriate best practices to assure compliance and patient protection.

Excessive Regulation of Psychiatric Hospitals

CMS regulations define conditions of participation (COPs) applicable to all hospitals, including psychiatric facilities. However, psychiatric hospitals and units are also currently subject to an additional series of COPs, the majority of which have not been updated since the 1980s. These outdated regulations impose large costs on providers without increasing treatment quality or patient safety.

Next Steps

NABH's 2019 report *The High Cost of Compliance: Assessing the Regulatory Burden on Inpatient Psychiatric Facilities*[i] recommends a series of revisions to the psychiatric hospital requirements and calls on CMS to convene a commission to gather professional input on how best to update them. We continue to urge CMS to update these regulations and interpretive guidance.

EMTALA

The *Emergency Medical Treatment and Labor Act* (EMTALA) is a federal law that requires patients in emergency departments to 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.

Next Steps

NABH's report on *The High Cost of Compliance: Assessing the Regulatory Burden on Inpatient Psychiatric Facilities*[i] includes a series of recommendations to improve EMTALA's enforcement based on adherence to the law's purpose. NABH is working to promote CMS implementation of the report's recommendations.

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' approach to surveying for ligature risk potentially denies access to critically needed treatment because it is unclear, unrealistic, and unscientific.

Next Steps

The High Cost of Compliance: Assessing the Regulatory Burden on Inpatient Psychiatric Facilities[i] proposes a series of reforms to ligature-risk enforcement, including issuing guidance, allowing greater flexibility in areas under constant supervision, providing advanced notice of required new technology, and permitting at least a three-year safe harbor for any feature deemed ligature resistant.

Veteran and Military Healthcare

Veterans make up less than 8% of the U.S. population, but account for 14% of all suicides. 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.

Next Steps

NABH recommends reforms to the VA Choice program to increase patient access to care, include coverage for 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.

For questions or comments about NABH's legislative and regulatory priorities for the 117th Congress, please contact us at nabh@nabh.org

[i] *The High Cost of Compliance: Assessing the Regulatory Burden on Inpatient Psychiatric Facilities*, available online at www.nabh.org/access-to-care