National Association
for Behavioral Healthcare
Access. Care. Recovery.

2025 ADVOCACY PRIORITIES

National Association for Behavioral Healthcare

NABH's advocacy priorities for the 119th Congress reflect the organization's mission to advance responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental health (MH) and substance use disorders (SUD).

Demand for our services across all age groups nationwide has never been higher, as the country continues to face intense access challenges for both MH and SUD patients.

Looking ahead, behavioral healthcare providers are armed with new telehealth tools that were expanded during the national response to the COVID-19 pandemic, which optimize access to care and the reach of the often-limited behavioral healthcare workforce that continued to decrease during the crisis. Securing continued telehealth services is an important NABH goal.

In 2025, behavioral healthcare providers continue to face perennial challenges that we discuss below. NABH has resumed advocating these ongoing priorities, such as the repealing the Medicaid program's IMD exclusion and Medicare's 190-day limit, among others. We will also continue to prioritize securing sufficient funding to expand the behavioral healthcare information technology (BHIT) infrastructure. We discuss these and other top NABH issues below.

Mental Health

Securing the Promise of Parity

The promise of parity remains unfulfilled. Although the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* became law more than 16 years ago, Americans have yet to see full parity between behavioral and physical healthcare. As one example, Medicare Advantage plans are exempted from this vital parity law. NABH will continue to support policies that support true parity in benefits, access and payment.

NABH Advocacy 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. Department of Labor to improve enforcing parity requirements.

NABH advocates for Medicare to provide coverage of all levels of care for individuals with SUD.

Behavioral Healthcare Workforce

The existing demand for behavioral healthcare continues to greatly exceed 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 MH crisis or drug overdose face life-threatening conditions that can be treated with appropriate behavioral healthcare; however, in many parts of the United States, treatment professionals are not available to provide that care.

NABH Advocacy 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 would 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.

The Centers for Medicare & Medicaid Services (CMS) should reexamine and require states to improve their Medicaid rates for behavioral healthcare providers to encourage greater participation in Medicaid.

In addition, we appreciate the steps Congress and relevant federal agencies took recently to expand the MH and SUD workforce by authorizing new behavioral healthcare practitioner types to bill Medicare. We support additional steps in the future to increase the behavioral healthcare workforce,

including adding medical school physician training slots earmarked for students pursuing behavioral healthcare positions, additional loan repayment support, and similar efforts.

Behavioral Health Information Technology

The behavioral healthcare field's information technology (IT) continues to lag a generation behind the IT capacity of its physical healthcare peers. This gap is largely due to behavioral healthcare providers' exclusion from *The Health Information Technology for Economic and Clinical Health Act* (HITECH), which offered financial incentives to other healthcare providers for demonstrating "meaningful use" of electronic health records (EHR). Unfortunately, today our field has much lower EHR adoption rates and a lack of EHR developers creating IT systems for the behavioral healthcare patient population.

This overdue investment would materially advance the goals of parity, improve overall quality and transitions of care across settings, and help provide greater safety for patients suffering under the nation's MH crisis.

NABH Advocacy Steps

NABH will push for legislation to fund BHIT in the same manner and under the same regulatory framework established for providers under the HITECH Act, providing financial incentives for the adoption of interoperable electronic health records.

The Addiction and Overdose Crisis

The nation's addiction and overdose crises continue to escalate on multiple fronts, affecting tens of thousands of individuals and families with loss and grief, as well as posing difficult challenges to public health and the U.S. healthcare system. In 2023, 48.5 million people aged 12 or older – 17.1% of this age group – are estimated to have had a SUD in the past year.[1] Among this population, 85.4% did not receive treatment in the past year. Further, the Centers for Disease Control and Prevention predicts that more than 96,000 people in the U.S. will have died from an overdose in the 12-month period ending in June 2024.[2]

Overdose deaths involving fentanyl and stimulants grew 60-fold between 2010 and 2021.[3] In addition, there is a growing cohort of individuals who are overdosing on stimulants alone, without the concurrent use of opioids.

Equally important for policymakers to address is the more pervasive but under-acknowledged problem of the number of deaths from excessive alcohol use that is responsible for about 178,000 deaths per year.[4]

Consequently, America's addiction crisis reflects the lethality of synthetic opioids such as fentanyl, as well as the use of cocaine, methamphetamine, other drugs, and alcohol.

NABH Advocacy Steps

NABH advocates for reimbursement and policy solutions to increase SUD treatment, including:

- Improving Medicare and other coverage for substance use residential treatment programs and other intermediate levels of care.
- Permitting the use of federal funds for all types of evidence-based SUD treatment.
- Permitting the use of federal workforce, treatment, and harm-reduction funds by for-profit treatment programs.
- Broadening the use of evidence-based contingency management protocols for individuals with stimulant, opioid, and other SUDs.
- Permitting the use of federal funds for evidence-based levels of contingency management incentives.
- Allowing telehealth treatment through state reciprocity and other measures.
- Increasing rural treatment capacity.

[1] https://www.samhsa.gov/data/sites/default/files/reports/rpt47095/National%20Report/National%20Report/2023-nsduh-annual-national.pdf
[2] *12 Month-Ending Provisional Number and Percent of Change of Drug Overdose Deaths* https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm
[3] *Friedman, J, Shover, C. medRxiv preprint. Doi.or/10.1101/2022.11.04.2228. Nov 5, 2022.*
[4] https://www.cdc.gov/alcohol/facts-stats/index.html

Opioid Treatment Programs

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

NABH Advocacy Steps

NABH will advocate for OTPs to remain the source of methadone treatment and support legislation that increases access to treatment while maintaining patient safety. Further, we appreciate the Substance Abuse and Mental Health Services Administration revising 42 CFR 8 to provide OTPs with additional flexibility to tailor treatment for each patient's unique needs. NABH will also urge CMS to offer payment rates that provide adequate and appropriate reimbursement for OTP services, including:

- Assuring rates are competitive by using hospital market basket rates for the non-drug bundle.
- Creating rates and billing protocols for contingency management.
- Establishing a 17% add-on for rural services in high overdose areas.
- Permitting admissions and treatment without a physician referral and preauthorization under Medicare Advantage.

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.

NABH Advocacy Steps

NABH continues to advocate for Congress to repeal the IMD exclusion. NABH also is pursuing both legislative and regulatory solutions to reduce the burden of the IMD exclusion. These include:

- Supporting legislation to waive the IMD exclusion for beneficiaries enrolled in Medicaid managed care plans.
- Supporting legislation to allow state Medicaid programs to cover services in IMDs for MH and SUD treatment. We support legislation to authorize state plan amendments to permanently waive the federal IMD exclusion for Serious Mental Illness (SMI) services, similar to those enacted for SUD services in the 118th Congress.
- Supporting legislation and regulatory action to exempt qualified residential treatment programs from the IMD exclusion.
- Educating key Members of Congress and their staff about the urgent need to expand this under-resourced segment of the behavioral healthcare continuum.

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 this policy 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 most other healthcare coverage programs.

The expert clinical judgment of a treating physician, not an arbitrary policy, should be the primary basis for determining the scope of services a patient needs. Eliminating this cap would help behavioral healthcare patients access the right care, in the right place, at the right time.

NABH Advocacy Steps

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

Maintain Telehealth Coverage

Expanded coverage of MH and SUD services via telehealth technology during and following the COVID-19 pandemic has been critical for preserving access to treatment during these extremely challenging times.

This expanded coverage enabled behavioral healthcare providers to demonstrate how effectively telehealth is augmenting in-person care, as we report with Manatt in the issue brief *Telehealth is Effectively Augmenting Partial Hospitalization and Intensive Outpatient Programs.*

NABH Advocacy Steps

NABH advocates to build upon and extend the telehealth flexibilities that Congress and the U.S. Department of Health and Human Services (HHS) made permanent during the COVID-19 pandemic. Coverage expansions are warranted from Medicare, Medicaid, and commercial insurance plans for MH and SUD treatment, 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 technical literacy and without broadband services; access to transportation; and other vulnerable populations.

NABH also advocates that reimbursement rates for behavioral healthcare services via telehealth 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 recognizes the true costs associated with providing telehealth services, we will lose the opportunity to maintain behavioral healthcare access now and expand access to this treatment in the future.

Telehealth for Controlled Substances

Since the COVID-19 pandemic, regulatory flexibilities have exempted providers from the general requirement to conduct an initial in-person medical evaluation prior to prescribing controlled substances. Recently, the Drug Enforcement Administration (DEA) and HHS issued a final rule to enable providers to prescribe buprenorphine for opioid use disorder via telehealth for six months prior to conducting an in-person medical evaluation, and DEA proposed a rule that would allow this practice to continue for all schedule II-V controlled substances indefinitely, with significant limitations.

These flexibilities have facilitated clinically indicated controlled substance prescribing during and after the pandemic, which has helped mitigate pervasive behavioral health workforce shortages, limited availability of in-network providers, and other access barriers.

NABH Advocacy Steps

NABH will continue to work with policymakers to ensure that providers can prescribe schedule II-V controlled substances via telehealth with appropriate guardrails that maximize care quality and minimize undue burden on providers and patients.

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 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 from the Medicare and Medicaid programs and widespread lack of coverage in commercial insurance plans.

NABH Advocacy Steps

NABH supports improving 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. NABH will advocate for legislation that would make certain that intensive outpatient programs (IOPs) and PHPs are effectively covered for individuals with a primary diagnosis of an SUD, consistent with the American Society of Addiction Medicine levels of care criteria.

NABH supports eliminating the requirement that the treating physician must determine the need for both IOPs and PHPs more frequently than monthly.

Crisis Care

In most areas of the United States, this type of urgent crisis assessment and stabilization service is not available. Consequently, people experiencing a serious MH or SUD crisis land in emergency departments, where they are unlikely to receive appropriate care, or are taken into custody of law enforcement.

NABH supports federal funding and guidance to help states establish or improve crisis systems that integrate crisis response with a full continuum of MH and SUD 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.

Quality and Outcome Measures

NABH and its members continue to work closely with CMS, accrediting agencies, consumers, and other stakeholders to develop and support reliable performance metrics. NABH was one of the original organizations that helped develop new measures for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) program.

NABH Advocacy Steps

Through our Quality Committee, NABH works to develop key quality measures with policymakers, along with timely recommendations for improvements.

NABH participates in technical panels and collaborates with CMS, the Academy of Medicine, and other partners to develop and improve quality measures for opioid and other SUD 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.

NABH Advocacy 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.

Modernize Psychiatric Hospital Regulations

CMS regulations define conditions of participation (COP) applicable to all hospitals, including psychiatric facilities. However, psychiatric hospitals and units are also currently subject to an additional series of COP, 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.

NABH Advocacy Steps

NABH's report *The High Cost of Compliance: Assessing the Regulatory Burden on Inpatient Psychiatric Facilities* 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.

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 members have lower rates of illicit drug use, they show a higher prevalence for using prescription drugs (mostly opioid pain relievers) and alcohol.

NABH Advocacy 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 MH and SUD treatment.

Please visit www.nabh.org to learn more about NABH.

For questions or comments about NABH's 2025 advocacy priorities, please contact us at nabh@nabh.org.