



NABH 2020 **ADVOCACY PRIORITIES**

NABH's top three advocacy priorities for 2020 each advance a common goal of expanding access to care for mental health and substance use disorder treatment. This resource provides background information on NABH's 2020 advocacy priorities:

1. Enforce parity in managed care coverage;
2. Repeal Medicare's 190-day lifetime limit; and
3. Reform Medicare's B-tag requirements.

1. ENFORCE PARITY IN MANAGED CARE COVERAGE

Fair and appropriate coverage for behavioral healthcare services must ensure, not solely offer, access to the entire behavioral healthcare continuum. In the present environment, managed care organizations (MCOs) in all markets nationwide use a variety of rationing practices that too often restrict patient access to medically necessary care, thereby violating the spirit of parity. Consequently, these practices compromise patient safety and recovery; worsen disease prognosis; and increase total healthcare costs.

MCOs frequently limit coverage to crisis stabilization or short-term, acute-care services for all levels of care because they often use internally developed, and/or proprietary and non-transparent, medical-necessity criteria that do not reflect generally accepted standards of behavioral healthcare professional practices. These denials are issued regularly without regard for comorbidities, chronicity, or pervasiveness, which result in the briefest of interventions that do not support long-term, meaningful recovery.

These unfair practices relate primarily to a) illegal and/or non-evidenced-based utilization-management practices, and b) inadequate provider networks, such as:

Utilization Management:

- Applying proprietary, non-transparent, medical-necessity criteria to steer coverage determinations that are not consistent with generally accepted standards of care for mental health and substance use disorders;
- Substituting the clinical judgement of treating providers with that of peer reviewers who have never met, interviewed, or personally assessed the patients whose care is being rationed;
- Requiring preauthorization for services that are retrospectively denied;
- Requiring frequent concurrent reviews that inflict administrative burdens and distract providers from direct patient care—even when treatment at non-hospital levels of care is sought;
- Requiring peer reviews without offering providers sufficient time and the opportunity to engage in them, and thereafter denying coverage for medically necessary care based on inadequate clinical information;
- Delaying pre-service coverage determinations beyond legally permissible timeframes, forcing patients to prematurely discharge, seek emergency care, forego treatment, and/or die by suicide or overdose;
- Arbitrarily excluding or disregarding medically necessary levels of care (i.e., intermediate services such as intensive outpatient, partial hospitalization, and residential treatment), instead of covering the continuum of care that has proven to be the most effective treatment for long-term recovery from mental health and substance use disorders;
- Modifying initial coverage requests to coerce acceptance and avoid requirements to identify denials and/or provide due process;
- Failing to cover early intervention services that could avert crises, life-threatening events, and/or morph into chronic disorders; and
- Changing internal policies and procedures without notifying providers of substantive changes and then denying coverage based on concealed changes.

Provider Networks:

- Intentionally failing to develop sufficient networks across the continuum of care that can meaningfully respond to patient demand for services;
- Failing to maintain provider networks that are accessible within reasonable geographic and timeliness standards;
- Creating phantom networks of providers who do not exist, are not accepting new patients, have moved away, died, or are otherwise not available to provide care;

- Routinely denying qualified providers network admission by relying on inaccurate provider information, falsely claiming that networks are full and/or adequate for patient demand;
- Failing to automatically authorize single case agreements due to network deficiencies, thereby forcing patients to forego care altogether or to incur higher cost-sharing for out-of-network care;
- Denying, interrupting, and delaying ongoing care when networks fail to cover the full continuum of care;
- Reimbursing mental health and substance use services at arbitrarily reduced and consistently lower than market rates; and
- Reimbursing mental health and substance use services based on disparate and more stringent methodologies than for medical care.

NABH believes fresh approaches are needed to ensure true parity. We recommend that federal lawmakers begin the long overdue process of conducting oversight hearings to examine the work of the nation's insurers and regulators related to parity implementation.

NABH urges Congress to pass H.R. 2848, *The Parity Enforcement Act*, which would amend the *Employee Retirement Income Security Act* and give the U.S. Labor Department (DOL) authority to levy civil monetary penalties against health insurers and plan sponsors for parity violations. This would give the DOL a critical tool to ensure health plan compliance with the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* of 2008. NABH also urges the Senate to introduce and pass companion legislation.

2. REPEAL MEDICARE'S 190-DAY LIFETIME LIMIT

The Medicare program limits beneficiaries 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 Medicare's 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.

Senators Susan Collins (R-Maine) and Tina Smith (D-Minn.) and Representatives Paul Tonko (D-N.Y.) and Bill Huizenga (R-Mich.) are expected to introduce the *Medicare Mental Health Inpatient Equity Act* in the Senate and House, respectively. This legislation would permanently repeal Medicare's 190-day lifetime limit.

3. REFORM MEDICARE'S B-TAG REQUIREMENTS

The Centers for Medicare & Medicaid Services' (CMS) regulations define mandatory Conditions of Participation (CoPs) for all providers who participate in the Medicare program. Inpatient psychiatric facilities must satisfy the CoPs that apply to all general hospitals, as well as additional CoPs that address psychiatric patient evaluations, medical records, and staffing, known as B-tag requirements.

CMS issued the CoPs in 1966 and the interpretative guidance in the 1980s; neither the rules nor the guidance for psychiatric patient evaluations, medical records, and staffing have been meaningfully updated since their issuance.

As enforced today, the B-tags produce frequent citations and impose large costs on providers, mostly through low-value documentation requirements.

Nationwide, the B-tags impose an estimated \$622 million in compliance costs each year. Many in the industry believe that these requirements are no longer appropriate in today's environment of care, and should be eliminated wholesale.

We recommend that CMS convene a commission (with representation from inpatient psychiatric providers) to determine whether these psychiatric hospital CoPs remain relevant, and whether some—or all—of them should be revised or discarded.

In NABH's 2019 report *The High Cost of Compliance*, we highlight examples of B-tags that merit revision, including:

- Providers must comply with detailed requirements for comprehensive “treatment plans” and “progress notes” (Tags B104 through B132). These requirements not only constrain clinician’s professional judgment, but also impose immense documentation burdens that add little value. CMS should revise these requirements to be less prescriptive;
- CMS should also direct surveyors to limit their review to whether a provider has adopted a reasonable approach to compliance; surveyors should not select and enforce a particular approach among a set of reasonable alternatives;
- Inpatient psychiatric facilities must appoint a director of nursing services (Tag B147). Some surveyors enforce a rigid academic requirement, demanding that all nursing directors have a master’s degree in psychiatric or mental health nursing, irrespective of alternative training or real-world experience;
- CMS should underscore to surveyors that, consistent with the CMS rule, a nursing director may be designated based on competence in lieu of a specialized master’s degree;
- Upon admission, each patient must receive a psychiatric evaluation (Tag B110). Some surveyors require that this evaluation be conducted by a psychiatrist, even if the evaluation falls within the scope of practice for an advanced practice clinician (APC), such as a nurse practitioner (NP) or physician assistant;
- CMS should clarify to surveyors that each facility may designate clinicians to perform patient psychiatric evaluations, subject to applicable state licensure laws that define clinical scope of practice.

NABH recommends that U.S. representatives and senators urge CMS to repeal or substantially revise the B-tag requirements.



To learn more about NABH and its legislative and regulatory priorities, please visit www.NABH.org. Also, please follow us on Twitter @NABHBehavioral and on LinkedIn at the National Association for Behavioral Healthcare.

