



NABH Recommendations:

Critically Needed Behavioral Healthcare Waivers and Guidance

These recommendations are intended to help ensure behavioral healthcare settings operate at fullest capacity. Implementing these recommendations will prevent placing additional stress on acute-care settings and provide expanded access to behavioral healthcare during the Covid-19 pandemic. “Behavioral healthcare” includes services for individuals with mental and substance use disorders.

BEHAVIORAL HEALTHCARE SPECIALTY SERVICES

Issue

Specialty behavioral healthcare settings can help relieve the strain on general hospitals that are struggling to find beds for all the Covid-19 patients. For this to happen, behavioral healthcare providers need waivers of certain coverage limitations in Medicaid and Medicare. Although CMS has issued a blanket section 1135 waiver allowing general hospitals to convert psychiatric unit beds to acute care beds for Covid-19 patients, the agency has not provided guidance regarding how patients who require effective psychiatric care will continue to receive it. Many of them will still require inpatient care. As hospitals face a dramatic influx of patients during the pandemic, it seems unlikely there will be extra acute care beds available to transfer these patients. Most freestanding psychiatric hospitals have excess capacity to accept displaced patients immediately; however, Medicare and Medicaid coverage limitations in freestanding psychiatric settings present significant barriers to providing care for beneficiaries in those settings.

Recommendations

Medicaid:

- We urge CMS to issue a blanket waiver under the section 1135 authority to allow states and Managed Care Organizations (MCOs) to pay for services provided in inpatient and residential settings that qualify as Institutions for Mental Diseases (IMDs) for both managed care patients and fee-for-service patients during this emergency period. This blanket waiver would allow states to begin paying immediately for services to patients transferred from general hospital settings to IMDs without requiring individual states to submit formal waivers. This waiver would give states access to the additional capacity more quickly, and, consequently, improve access to treatment in specialty psychiatric and substance use disorder (SUD) treatment settings for Medicaid beneficiaries. This blanket waiver would be particularly helpful in those states that do not have an approved section 1115 demonstration allowing coverage of services in IMDs primarily for treatment of mental illness or SUD.
- We recommend CMS lift all caps on length of stay in IMDs during this emergency period.



Medicare:

- We urge CMS to waive the Medicare 190-day lifetime limit for freestanding psychiatric hospital stays to enable Medicare beneficiaries to receive care in these settings. This will be critical for Medicare beneficiaries being transferred out of a psychiatric unit of a general hospital. A waiver of the 190-day lifetime limit would also prevent Medicare beneficiaries who are currently receiving care in freestanding psychiatric settings from losing coverage once they reach the lifetime limit. There will most likely be nowhere else for these patients to receive inpatient psychiatric care because the beds in psychiatric units in general hospitals will most likely be needed for Covid-19 patients.
- CMS should also issue behavioral healthcare specific guidance on allowing intensive outpatient and partial hospitalization program (PHP) providers to provide services on-site in nursing homes because patients are currently not allowed to leave the premises and have limited visitation.

PAYMENT AND UTILIZATION POLICIES

Issue

Many substance use treatment and mental healthcare providers are concerned about disruptions to revenue, as well as other billing issues, due to Covid-19. Opioid treatment programs (OTPs) are especially at risk for revenue reductions because SAMHSA prohibits the use of telemedicine to maintain new patient intake levels and address the acceleration of expected intakes. At the same time, office-based opioid treatment (OBOT) programs and OTPs are losing physician capacity. Approximately 40% of physicians in NABH OTPs are 60 years of age or older and many are self-quarantined. This is expected to accelerate. The Covid-19 pandemic has greatly affected psychiatric hospitals. NABH is concerned that the recent CMS Medicare guidance on accelerated payments has provisions that would exclude OTPs and other behavioral healthcare providers. However, as an essential healthcare service, OTPs and other addiction treatment, as well as mental healthcare services, should be included.

Recommendations

- We recommend CMS encourage states to implement, on an emergency basis, bundled or case-rate payments in Medicaid to reduce administrative burden on providers. Massachusetts, New Jersey, and North Carolina have good model policies.
- CMS should clarify that OTPs and other behavioral healthcare providers are included under the recent CMS guidance on advance/accelerated Medicare payments. In addition, we urge CMS to waive the requirement that the provider/supplier must have billed Medicare for claims within 180 days immediately prior to the date on the provider's/supplier's request form. This is particularly important for OTPs because the OTP Part B benefit only began in January 2020. We also recommend that OTPs be able to request up to 125% of their payment for a six-month period, as they do not have the margins to maintain services and federal policies will result in reduced patient admissions.



- Our OTP and other levels-of-care programs have multi-state businesses. Some of these programs and providers are working with more than 100 MCOs. We recommend CMS encourage all MCOs that participate in Medicare or Medicaid align similar payment and utilization management policies to reduce administrative burden and prevent potential errors that could result in reduced payment for services rendered.

TELEHEALTH

Issue

Some patients do not have or are not able to use devices with both audio and video capabilities for telehealth services (e.g., many patients with serious mental illness, homeless individuals, and geriatric patients). Some patients do not have Internet access or other platforms that support telehealth services that include both audio and video components. Consequently, behavioral healthcare providers need flexibility to provide services via telephonic-only telehealth. Intensive outpatient services and PHPs are critical levels of behavioral healthcare that can greatly reduce the need for inpatient and/or emergency services among individuals with more serious behavioral health conditions. However, these forms of therapy have not generally been provided via telehealth before now. Behavioral healthcare providers need guidance on how to provide these services via telehealth and how they will be paid for providing them. In general, providers are struggling with varied policies and frequent denials of coverage for services provided via telehealth by payors that could be violations of parity requirements. They are very concerned they will not be reimbursed for services provided via telehealth.

Recommendations

- We urge CMS to provide mental health- and SUD-specific guidance to allow coverage of audio-only telehealth in Medicare.
- We recommend CMS encourage states to follow Medicare policy in Medicaid and in private insurance regulation to ensure consistency in telehealth services coverage.
- We ask CMS to offer guidance on how providers should maintain intensive outpatient and PHP services, including guidance on how to provide more intensive and group services, via telehealth and how group telehealth services will be reimbursed. These changes will provide much-needed support for individuals with more serious behavioral conditions in their communities as an alternative to inpatient or emergency care settings.
- We recommend CMS specifically approve reimbursement for services provided and billed with the code 90853 (group therapy). Until now, CMS has not included 90853 on the list of approved codes.
- We urge CMS to reassure providers they will be reimbursed for telehealth services by offering specific guidance to states, MCOs, and other entities on billing and payment for behavioral healthcare services provided via telehealth. As the need for telehealth services increases during the Covid-19 pandemic, providers need to be assured payment will flow and be consistent with payment for services in person.



- We encourage CMS to issue a statement highlighting that mental health and SUD parity requirements still apply during this emergency, and that behavioral healthcare services must be covered and paid for in the same manner as covered medical-surgical services including with regard to behavioral health care services provided via telehealth.
- We urge CMS to clarify that mental health and SUD treatment services are essential, not elective, healthcare services, and encourage states to treat these services as essential.

STAFFING

Issue

Behavioral healthcare providers are crucial to keeping hospitals and other settings fully functional. In addition, behavioral healthcare providers are managing many of the same problems as medical-surgical providers, including staffing shortages and the need for revised policies and protocols related to new or modified services, including private rooms, telemedicine, Covid-19 testing, and employee and visitor screening.

Recommendations

- CMS should provide a blanket waiver from Conditions of Participation, including waiver of rules to allow staff to practice to the top of their respective license. For example, this change would allow advanced practice nurses, rather than physicians, to do rounds with hospital patients.
- We urge CMS to relax staffing-ratio requirements on an emergency basis as providers are managing staff infected with Covid-19, quarantines, and employees' childcare issues.
- CMS should provide waivers and guidance regarding intensive outpatient and PHP and other programming for elderly or disabled individuals or individuals with opioid use disorder (who are often homeless, in shelters, or in recovery residences), establishing flexibility to allow services to be provided in alternative settings as patients are displaced by Covid-19 containment practices.
- CMS should urge state Medicaid programs and MCOs to relax minimum counseling requirements for individuals receiving medication assisted treatment.

ADDICTION

Issue

Addiction treatment services at all levels of care are essential health services. However, they are not identified in many CMS and state Covid-19 policies offering flexibilities in service delivery and healthcare payment (e.g., the Medicare Telemedicine Health Care Provider Fact Sheet). This is due partly to overlooking addiction providers as a specialty and to varying definitions of behavioral healthcare at the federal and state level. It is not always clear whether a policy applies to SUD treatment.

Recommendations

- We encourage CMS to be clear in public communication when mental health and SUD providers are included. This will ensure that substance use treatment providers, such as state-level certified addiction counselors and mental healthcare providers, are included in flexibilities being provided to other healthcare workers.



- Critical OTP staff, assistants, and patients are required to travel to OTPs despite lockdowns and curfews. To help ensure these providers and patients can travel to OTPs unimpeded, CMS should explicitly refer to and treat substance use and mental health services as essential health services and encourage states to do so as well. CMS and/or states should provide a template of an Essential Health Services Employee Memo and Essential Health Services Patient Memo that employees and patients can use to verify that they should be permitted to travel to their healthcare delivery sites. North Carolina provides a good example.

Issue

Some states have requirements for patient urine screens in OTPs that are above the SAMHSA requirement of eight in one year. This policy is not necessary as a blanket policy for all patients; it increases burden on the healthcare system and requires patients to engage in social interactions at a time when they should be observing social-distancing policies.

Recommendation

- CMS should encourage states to reduce urine screen requirements by urging states to make urine screen determinations based on patient need and ability during Covid-19.

Issue

Some states require pharmacists to prepour methadone and deliver it to OTPs. Currently, a pharmacist comes to the clinic daily or several days a week to prepour the medication, per a physician order. This burdens the pharmacists, does not support social distancing policies, and does not take advantage of the ability for technicians and assistants in OTPs to perform these function and work to the top of their license.

Recommendation

- CMS should encourage states to permit flexibility for technicians and assistants in OTPs to take over these functions. It is consistent with CMS' intention to ease health care and administrative burden.

EMTALA

Issue

Many of our members do not have the expertise or medical equipment to treat people with serious cases of COVID-19, although some do have patients and staff who have tested positive for the virus. They are concerned about how they can ensure the health of their patient population and staff while also complying with the *Emergency Medical Treatment and Labor Act* (EMTALA). In addition, they are seeking assistance as they respond to pressure from general hospitals to accept patients with psychiatric conditions who also have contracted the virus, even though they are not equipped to care for serious cases of Covid-19.

Recommendations

- We urge CMS to issue guidance allowing flexibility regarding EMTALA requirements for behavioral healthcare providers who do not have the capacity to stabilize individuals with serious cases of Covid-19.
- We encourage CMS to issue guidance allowing behavioral healthcare providers to refer patients with Covid-19 to alternative treatment settings.



About NABH

The National Association for Behavioral Healthcare (NABH) advocates for behavioral healthcare and represents provider systems that treat children, adolescents, adults, and older adults with mental health and substance use disorders in more than 1,800 inpatient behavioral healthcare hospitals and units, residential treatment facilities, partial hospitalization and intensive outpatient programs, medication assisted treatment centers, specialty behavioral healthcare programs, and recovery support services. The association was founded in 1933.