



9 April 2020

Vice President Mike Pence
Senate Majority Leader Mitch McConnell
Senate Minority Leader Chuck Schumer
House Speaker Nancy Pelosi
House Minority Leader Kevin McCarthy

Re: Critical Behavioral Healthcare Recommendations During Covid-19

Dear Vice President Pence, Senate Majority Leader McConnell, Senate Minority Leader Schumer, House Speaker Pelosi, and House Minority Leader McCarthy:

It has been well-documented that epidemics, even those of lesser magnitude than the Covid-19 pandemic, cause significant detrimental effects on mental health and substance use among affected populations often for years following an outbreak.¹ There is every reason to believe that the current pandemic will cause widespread stress on the behavioral health of people across the United States. These types of public health crises have particularly harmful effects on those with preexisting mental health or substance use disorders.² According to the World Health Organization, “Mental health is crucial to the overall social and economic recovery of individuals, societies, and countries after emergencies . . . [and] “Many countries have capitalized on emergency situations to build better mental health systems after crises.”³

Our members include the largest providers of inpatient and outpatient mental health and substance use disorder treatment, including programs and facilities spread across every state in the country. They are struggling to adapt to the current crisis as quickly as possible so they can continue caring for their patients during this dangerous time.

Despite growing recognition among the public that the Covid-19 crisis will generate dramatically increased need for behavioral healthcare services, Congress and the federal agencies have not yet addressed these critical needs. We provide some recommendations below on how the federal government should improve access to behavioral healthcare, given the strain the current public health emergency has already imposed on behavioral healthcare providers and the wave of increased need for behavioral healthcare that we anticipate in the future.

Ensure Access to Inpatient Psychiatric Care for Medicare and Medicaid Beneficiaries

We continue to hear from our members that inpatient hospital beds are being converted from psychiatric care to address other needs, including treatment for Covid-19. We are concerned that alternative settings for inpatient psychiatric care will not be available for some of our most vulnerable citizens—those enrolled in Medicare and Medicaid—due to statutory limitations on coverage of inpatient care. These limitations include the exclusion from Medicaid coverage of services provided in Institutions for Mental Diseases

¹ Laura Hawryluck, Wayne L. Gold, Susan Robinson, “SARS Control and Psychological Effects of Quarantine, Toronto, Canada”, *Emerg Infect Dis*, July 2004, vol.10 no.7, 1206–1212; Sara Reardon, “Ebola’s mental-health wounds linger in Africa: health-care workers struggle to help people who have been traumatized by the epidemic”, *Nature*, vol. 519, no. 7541, 2015, p. 13.

² Benjamin Druss, “Addressing the Covid-19 Pandemic in Populations with Serious Mental Illness” *JAMA Psychiatry*, published [online](#) April 3, 2020; Hao Yao, Jian-Hua Chen, Yi-Feng Xu, Patients with mental health disorders in the COVID-19 epidemic, *Lancet Psychiatry*, April 2020; Vol 7: e21.

³ World Health Organization, Fact Sheet on Mental Health in Emergencies, June 2019, available [online](#).



(IMDs), and the 190-day lifetime limit in Medicare on coverage of services in free-standing psychiatric facilities.

Moreover, the Centers for Medicare and Medicaid Services (CMS) has issued a blanket section 1135 waiver allowing general hospitals to convert psychiatric unit beds to acute care beds for Covid-19 patients. However, the agency has not seriously addressed the effect this change will have on access to inpatient psychiatric care. The CMS guidance refers to moving patients in inpatient psychiatric beds to other acute care beds. As many hospitals face a dramatic influx of patients with Covid-19, it seems unlikely there will be extra acute care beds available for psychiatric care.

Specialty behavioral healthcare settings can help relieve the pressure on general hospitals that are struggling to find beds for all the Covid-19 patients. Most freestanding psychiatric hospitals have excess capacity to accept displaced patients immediately. However, the Medicaid IMD exclusion and Medicare 190-day limit present significant barriers to accessing available capacity for treatment in those settings.

We urge Congress to consider and pass the proposal in President Trump's FY 2021 Budget to create a Medicaid state option to cover services in IMDs paired with state actions to improve the broader continuum of care for beneficiaries with serious mental illness. We also urge Congress to pass legislation to eliminate the 190-day lifetime limit on care in psychiatric hospitals for Medicare beneficiaries. An alternative would be to lift the IMD exclusion and 190-day limit limited to the time period of the current public health emergency. However, we know that the effects on behavioral healthcare will last far beyond the end of the immediate Covid-19 pandemic, and a longer-term solution is required.

Lessen the Burden of Covid-19 on Behavioral Healthcare Providers

Our members continue to provide mental health and addiction treatment during this pandemic despite the risks, knowing that many of their patients need support and care now more than usual. Similar to general acute-care providers, our members also face shortages in personal protective equipment (PPE). Behavioral healthcare providers have not traditionally used PPE as much as providers in other healthcare settings; consequently, many of our members did not have large stores of this equipment when the Covid-19 pandemic began, and many do not have well-established supply chains to rely on during this time of short supply.

Our providers are also incurring significant financial losses as they have acted quickly to address the rapid spread of Covid-19. Some examples of activities that have caused increased, unexpected costs due to the Covid-19 are listed below:

- Staff, patient, and visitor screenings: primarily the cost of supplies and staff for screening,
- Additional staffing and pay for overtime/incentive pay and added staff to fill vacancies,
- Setting-up, equipping (e.g., additional PPE, negative air pressure machines), and staffing isolation rooms and units for Covid-19 infected patients,
- Remote staffing needs, including software licenses and hardware purchases, and
- Lost revenue from not being able to provide certain services (group therapy services and education services) and decreased patient volumes due to infection concerns and school closures affecting referrals.

Psychiatric hospitals and other behavioral healthcare providers are in dire need of continued cash flow to maintain staffing and general operations and protect their staff and patients. We urge you to clarify that psychiatric hospitals and other mental health and addiction treatment providers are eligible for accelerated and advanced payments in Medicare as Part A and Part B providers. In addition, we urge you



to provided dedicated funding, including funding for PPE, for behavioral healthcare providers through the Department of Health and Human Services' (HHS) Public Health and Social Services Emergency Fund.

Require Private Insurance Companies to Modify Usual Practices During this Pandemic

Hospitals and other behavioral healthcare providers will be dealing with staff reductions and crises that draw staff away from usual operations. Health plans should not be permitted to deny reimbursement for care for which providers were unable to complete prior authorization or other utilization management functions during this pandemic. We urge Congress to require health plans to ease utilization management requirements during this emergency period. In addition, a requirement that health plans provide presumptive authorization would help ensure our members are able to provide behavioral healthcare to individuals in need in a timely manner. While one private insurance plan has recently announced it will provide accelerated payments, so far, this support from commercial insurers, including Medicare Advantage plans, has not been widespread. We urge Congress to enact legislation to require health plans to provide accelerated or interim payments during this public health emergency period. Legislation to address these concerns would help ensure there are not bottlenecks and unnecessary delays in care.

Help Behavioral Healthcare Providers Catch Up on Implementation of Health Information Technology and Telehealth

Most behavioral healthcare providers, including psychologists, clinical social workers, psychiatric hospitals, residential treatment centers, and addiction treatment programs, were not eligible for federal funding provided through the *Health Information Technology for Economic Clinical Health (HITECH) Act* (Pub.L.111-5) to implement electronic health information systems. As a result, behavioral healthcare providers have lagged far behind other provider types in implementing the systems that enable electronic exchange of health information to improve quality and care coordination.

To address the increased demand for behavioral healthcare during this pandemic and for years to come, it is crucial that Congress provide targeted funding for the purchase and implementation of electronic health information systems and telehealth technology to providers of mental health and addiction treatment services.

Improve Coverage of Behavioral Healthcare via Telehealth Technology

It is also critical to ensure that coverage of services provided via telehealth is comparable to coverage of in-person services and consistent across the various payors. We urge Congress to enact telehealth parity requirements ensuring all ERISA-regulated plans, Medicare, Medicaid, and Tricare cover mental health and addiction treatment services provided via telehealth in the same way as in-person treatment in terms of services covered and provider reimbursement rates. Coverage should include all levels of intensity of mental health and addiction treatment, including outpatient care, intensive outpatient, partial hospitalization care, residential treatment, and inpatient including screening, assessment, treatment, and after-care. We also urge you to require health plans and programs to cover behavioral healthcare services provided via audio-only technology to ensure access in areas with poor Internet connectivity and among populations that lack video conference ability, including senior citizens, homeless individuals, and many individuals with serious mental illness or addiction. In addition, it will be important to require health plans and programs temporarily to cover out-of-network providers via telehealth during this public health emergency. This legislation should also provide support for data collection and research to leverage the recent emergency expansion of telehealth services to assess the effect on access to care and outcomes.

Improve Parity Compliance

In light of increasing needs for behavioral healthcare as a result of the Covid-19 pandemic, now more than ever, Congress should act quickly to enact existing legislative language to improve compliance with the federal mental health and addiction treatment parity law that the Senate HELP and House Energy and



Commerce Committees passed with bipartisan support. We have heard from numerous behavioral healthcare providers that they are facing denials for treatment provided via telehealth that may not apply to medical/surgical care provided via telehealth.

Increase Access to Medication Treatment for Opioid Use Disorder

Office-based buprenorphine providers and opioid treatment programs (OTPs) anticipate an increase in new admissions as opioid use increases and incarcerated individuals are released from jails and prisons. This comes at a time when the behavioral healthcare workforce is strained. Forty-three percent of physicians in OTPs who are members of NABH are over the age of 60 and at high risk for contracting Covid-19 and are self-quarantining. The Substance Abuse and Mental Health Services Administration (SAMHSA) does not permit OTP physicians to use telehealth for new patients' induction on methadone, and limits the patient caseload of buprenorphine providers. To address this increased need and preserve the health of the physician workforce, we urge Congress to pass legislation that includes the following provisions.

- Direct SAMHSA to permit physicians to use real-time telehealth to provide methadone induction for new patients when the patient is physically present in the OTP and another qualified health provider is with the patient and providing evaluation assistance to the physician. In this scenario, patients new to treatment will continue the usual protocol of daily dosing (except if the clinic is closed on Sunday) for at least the first 30 days. This will reduce diversion risks and preserve patient and physician safety as well as broader public health.
- Direct CMS to delay implementation of the Medicare OTP *partial* bundle payment methodology and other Year Two changes for an additional year. Implementation of new requirements will reduce OTP revenue and impose new clinical and business processes that will distract managers from assuring continuity of essential program functions.
- Direct the Drug Enforcement Administration to immediately implement "mobile methadone" regulations issued on February 26, 2020 entitled *Registration Requirements for Narcotic Treatment Programs with Mobile Components* and reinstitute the public comment period after the Covid-19 public health emergency designation has been removed.
- Direct SAMHSA to increase the DATA 2000 patient limit to 500 patients for those practitioners who meet the requirements. This will ensure patients with opioid use disorder (OUD) can continue to access evidence-based treatment during this crisis and practitioners can meet the demand for new admissions.
- Direct SAMHSA to expedite approvals for DATA 2000 waiver applications for emergency patient limit increases and reduce the paperwork burden for these applications. Many clinicians who currently hold a waiver to prescribe buprenorphine up to 100 patients have submitted applications to temporarily increase their patient limit to 275 under the national public health emergency provisions.

Improve Access to Care and Education for Youth with Serious Behavioral Health Conditions

Covid-19 is significantly affecting children and adolescents with serious behavioral or emotional conditions receiving care in residential treatment settings. Their routines have been disrupted and visitation has been limited to protect them from infection. The education services and supports these settings provide are critical for maintaining structure, stability, and positive reinforcement for these youth



and ultimately for helping them transition back into their homes and communities. During the current crisis, the principals, teachers, and support staff in these settings continue to provide crucially needed education services for these children even while regular schools across the United States have been closed.

In most instances, the residential treatment settings employ the principals, teachers, and support staff to provide educational services, because state and local education agencies often do not provide sufficient funding to support the education of children in these settings. These residential treatment settings are incurring additional costs for technology, infection control, curriculum materials, and other safety measures. These facilities need additional support to continue serving some of our most vulnerable children and adolescents. We urge Congress to provide dedicated funding through the Department of Education for educational services and supports for children and youth with behavioral and/or emotional disorders receiving care in residential settings.

The Family First Prevention Services Act (Pub.L. 115-123) designated qualified residential treatment programs (QRTPs), a new type of facility for the care of children with serious emotional or behavioral conditions in less clinically focused settings. These programs must meet certain quality standards and other requirements, including a requirement to provide trauma-informed care. Unfortunately, these settings may qualify as IMDs, which means Medicaid would not cover on- and off-site services for children residing in these programs. The President's Budget for FY 2021 proposes a legislative fix to make QRTPs exempt from the IMD exclusion. We urge Congress to pass this legislative proposal.

Address these Additional Emergency Funding Needs

Below are additional proposals to address increased demand for mental health and substance use disorder services during the Covid-19 pandemic:

- Fund emergency SAMHSA grants to mental health and addiction treatment providers to develop innovative models for increasing access to timely professional mental health and addiction treatment, e.g., urgent care for behavioral healthcare needs;
- Target funding to address the behavioral healthcare needs of healthcare workers, first responders, and others at risk due to their employment;
- Provide funding to the Department of Justice for reentry services and supports including naloxone and warm hand-offs to community-based mental health and addiction treatment providers for incarcerated populations leaving jails and prisons;

Expand existing program providing grants to states to increase mental health and addiction treatment provider participation in Medicaid under section 1003 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. These grants provide funding to state Medicaid agencies for activities aimed at increasing SUD treatment provider enrollment in Medicaid including by reexamining Medicaid reimbursement rates; and

- Address social determinants of health with grants to providers to support implementation of programs that improve social circumstances and factors that greatly influence behavioral health status, particularly evidence-based supported employment and education and supportive housing programs. In addition, ensure Medicaid coverage of the critical components of such programs.

National Association for Behavioral Healthcare



Access. Care. Recovery.

Thank you for your attention to these proposals addressing concerns of mental health and addiction treatment providers across the US. If you have questions, please contact me directly at shawn@nabh.org or 202-875-4272, or contact NABH Director of Policy and Regulatory Affairs Kirsten Beronio at kirsten@nabh.org or 202-680-3095.

Sincerely,

A handwritten signature in black ink, appearing to read 'Shawn Coughlin'. The signature is fluid and cursive, with a large initial 'S' and 'C'.

Shawn Coughlin, President and CEO

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.