



12 May 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: Recommendations to Address Covid-19's Effects on Behavioral Health

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

The National Association for Behavioral Healthcare (NABH) represents healthcare systems that provide a wide range of behavioral healthcare services, including inpatient, residential, partial hospitalization/intensive outpatient, and outpatient care. Our members greatly appreciate the flexibilities and resources that Congress and the federal agencies have developed and implemented quickly to respond to the Covid-19 pandemic. These actions have enabled us to increase greatly telehealth services and establish crucial protocols to protect our patients and staff.

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.ⁱ Recent polls have found that half or more of Americans say the coronavirus pandemic is affecting their mental health with many reporting symptoms of anxiety and depression with high degrees of distress.ⁱⁱ

Behavioral health conditions were already taking an increasing and deadly toll on the U.S. population. The Centers for Disease Control and Prevention (CDC) reported recently that between 1999 and 2018, the rate of suicides in the United States rose by 35%ⁱⁱⁱ to the highest age-adjusted rates since 1941.^{iv} Reports of exponential increases in calls to mental health crisis hotlines at the federal level and in major cities also indicate a looming behavioral health crisis.^v Social distancing and isolation can worsen the feelings of anxiety that the pandemic has generated. In addition, we know economic downturns, such as the one America is experiencing now, are associated with higher rates of suicide.^{vi}

Furthermore, the opioid crisis continues to devastate families and communities nationwide. Although the overall overdose rate declined slightly in 2018, the number of people dying from overdoses of synthetic opioids, cocaine, and psychostimulants continues to increase at an alarming pace.^{vii} The risk of substance use disorders (SUD) increases during stressful times,^{viii} and there are widespread reports of increased alcohol and drug sales during the current pandemic as well as increased opioid overdoses^{ix}

We are concerned about the welfare of our patients and the effect the Covid-19 pandemic is having on healthcare workers and first responders. Recent history has taught us that this type of crisis will have delayed, although lethal, effects. Healthcare providers, particularly emergency room physicians and female physicians, are at heightened risk of suicide.^x First responders, including emergency services personnel, also have increased rates of depression, post-traumatic stress disorder, and suicide.^{xi}

Healthcare workers exposed to Covid-19 in Wuhan, China have experienced heightened symptoms of depression, anxiety, insomnia, and psychological distress particularly among women, nurses, and frontline workers.^{xii} Previous research has also indicated high levels of stress, anxiety, and depression symptoms among healthcare workers following the 2003 SARS outbreak.^{xiii}



Public health crises and natural disasters have particularly harmful effects on those with preexisting mental health or SUDs.^{xiv} These individuals have high smoking rates, which increase the risk of adverse outcomes from Covid-19. They are also more likely to be homeless or experience housing instability, which also could raise their risk of infection. Physical distancing policies increase the already high degree of social isolation, stigma, and loneliness that people with serious mental illness commonly experience. Moreover, the current pandemic's psychological burden will exacerbate any underlying behavioral health condition and quickly elevate to crisis levels among those already challenged with serious mental illness or addiction.

Children and youth are also heavily affected by the pandemic with schools closed and physical distancing policies in place across the United States. A survey of children quarantined during the outbreak in Hubei, China found that more than one-fifth reported symptoms of depression and almost as many reported symptoms of anxiety.^{xv} Suicide rates are already tragically high among U.S. adolescents, for whom suicide is the second leading cause of death.^{xvi}

Key Steps to Address Behavioral Health Effects from Covid-19

We recommend the following actions to ensure continued and improved access to behavioral healthcare before emergency authorities are withdrawn and federal programs and insurers re-impose the usual coverage limitations and restrictive policies.

1. Maintain and Improve Expansions of Tele-Behavioral Health

- a. Require private health plans and insurance issuers to cover mental health and addiction treatment delivered via telehealth to the same degree and with the same policies and reimbursement rates as coverage for these services when delivered in-person.** Most states have enacted laws that require private health insurers to cover telehealth services. However, the degree to which those laws require parity with coverage of in-person services varies.
- b. Enact legislation that preserves the expanded Medicare coverage of behavioral healthcare via telehealth that CMS has established during this pandemic.**
- c. Enact legislation that preserves the expanded coverage of behavioral healthcare via telehealth in Tricare.**
- d. Provide incentives to states to maintain and expand coverage of behavioral healthcare provided via telehealth in their Medicaid programs.**
- e. Ensure the rates paid for behavioral healthcare via telehealth services include reimbursement for overhead costs and the cost of professional services.** These changes will be critical for improving access to behavioral healthcare services during and following the pandemic for Medicare and Medicaid beneficiaries who disproportionately struggle with mental illness and addiction.
- f. Include coverage of services provided solely via telephone.** Many individuals with serious mental illness or addiction do not have access to smart phones or other means of communicating with video. Moreover, broadband service is not universally available particularly in rural areas where availability of care through telehealth is more critical due to the shortage of behavioral healthcare providers in those areas. At the very least, audio-only behavioral healthcare services



should be covered in rural areas and mental health professional shortage areas designated by HHS' Health Resources and Services Administration. Some of our older patients and others may not be comfortable using video services or may not be able to do so even if they have access to that technology. These are often patients with more significant needs and an audio-only visit can provide access to crucially needed care.

- g. Provide targeted funding to behavioral healthcare providers for the purchase and implementation of electronic health information systems and telehealth technology.** 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 and other healthcare technologies.

2. Maintain Other Coverage Expansions Critical to Improving Access to Behavioral Healthcare

- a. Maintain permanently the Medicare policy allowing clinicians to provide all treatment allowed under their state's licensure standards.** This flexibility, authorized during the Covid-19 pandemic, expands the capacity of staff in our treatment settings to provide behavioral healthcare. This is particularly important because there are such significant shortages of behavioral healthcare providers in many parts of the country, and we expect these shortages to increase significantly in the coming months and years. Almost 120 million people currently live in mental health professional shortage areas.^{xvii} About half of U.S. counties and 80 percent of rural counties have no practicing psychiatrists, and over 60 percent of psychiatrists are nearing retirement.^{xviii}
- b. Continue and expand the accelerated and advanced payment programs in Medicare and allow retainer payments in Medicaid.** These bundled payments give providers more flexibility to focus on the needs of patients. Medicare and Medicaid programs should lead the way in improving how behavioral healthcare services are reimbursed to improve access to mental health and addiction services.
- c. Promote support programs and provide targeted funding to healthcare provider organizations and state and local governments to improve access to behavioral healthcare services for healthcare workers and first responders.** As discussed above, healthcare workers and first responders are already at higher risk for mental health and substance use disorder conditions that often go unaddressed. The Covid-19 pandemic will greatly increase the need to ensure they have access to behavioral health supports tailored to their needs.
- d. Enact the *Parity Compliance Act* (S. 1737/HR. 3165) provisions that the Senate HELP Committee passed and negotiated with the House Energy and Commerce Committee.** Federal parity law offers an important tool for improving access to behavioral healthcare. However, ensuring compliance with the law continues to be a challenge. For example, research has shown that behavioral professionals are not reimbursed at rates comparable to other providers.^{xix} The federal parity regulations specifically address this type of disparity as a non-quantitative treatment limit.
- e. Require managed care companies (MCOs) to implement clinical management policies and practices that are based on generally accepted standards of professional practice.** These



standards should be based on robust clinical research and published in clinical specialty organization consensus statements. MCOs 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.^{xx}

3. Improve Access to Addiction Services

- a. Direct the Substance Abuse and Mental Health Services Administration (SAMHSA) to permit physicians to use real-time telehealth to provide methadone induction for new patients.** This should be permissible when the patient is physically present in the opioid treatment program 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.
- b. Provide targeted funding for opioid treatment programs (OTPs).** The opioid crisis continues, and the need for federal intervention to improve access to treatment has become even more critical as the Covid-19 pandemic aggravates underlying substance use disorders and makes access to treatment providers more limited. In addition, early release of non-violent offenders by jails and prisons increases the need for SUD treatment, including treatment by OTPs. OTPs are also incurring additional costs for take-home medication supplies, personal protective equipment, sick leave, relief worker compensation, and over-time pay. OTPs have only recently become eligible for Medicare reimbursement as of January 2020. Therefore, they have not been able to claim much of the relief distributed to treatment providers based on Medicare reimbursement. They have traditionally served a very low-income population many of whom paid for treatment with cash. With the dramatic economic downturn we are experiencing, these individuals can no longer afford to pay. However, many OTPs are continuing to provide treatment without payment including the multi-day take-home doses of methadone that are currently allowed.
- c. Direct SAMHSA to increase the DATA 2000 patient limit to 500 patients for those practitioners who meet the requirements for the higher patient limit.** This will ensure patients with opioid use disorder can continue to access evidence-based treatment during this crisis and practitioners can meet the demand for new admissions.
- d. 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.**

4. Increase Access to Urgent and Acute Care for Behavioral Health Conditions

- a. Enact legislation establishing a national toll-free crisis hotline (H.R. 4194/S. 2661).** This bill would require the Federal Communications Commission (FCC) to designate 9–8–8 as the universal telephone number for a national suicide prevention and mental-health crisis hotline.
- b. Fund a new grant program to encourage broad development of crisis stabilization and urgent care facilities and services by well-established behavioral healthcare providers.**



Many of the callers to crisis hotlines require a rapid assessment to determine whether they need behavioral health treatment and at what level of intensity. Unfortunately, in most areas of the United States this type of urgent crisis assessment and stabilization service is only available in emergency departments in inpatient acute care hospitals. In general, but particularly during an infectious disease outbreak such as Covid-19, it is paramount that we develop alternatives to emergency departments for people experiencing behavioral health crises. Behavioral healthcare systems and providers offering many levels of care including most of the members of NABH are well-situated to develop urgent behavioral health crisis stabilization centers including mobile crisis units that coordinate with law enforcement and other first responders. They are well-known within their communities, including among first responders, as providers of high-quality behavioral healthcare. However, insurance and federal healthcare programs do not cover the upfront implementation and infrastructure development costs of establishing these types of services.

c. Increase access to acute care for mental health conditions by lifting the IMD Exclusion

President Trump's Fiscal Year (FY) 2021 Budget includes a proposal to create a Medicaid state option to cover services in Institutions for Mental Diseases (IMDs) paired with state actions to improve the broader continuum of care for beneficiaries with serious mental illness. We urge you pass that legislative proposal.

d. Eliminate the 190-day lifetime limit on care in psychiatric hospitals for Medicare beneficiaries.

This limit in Medicare and the IMD exclusion in Medicaid are arbitrary and outdated federal limits that conflict with the principles of parity that apply to other forms of healthcare coverage. They also create unnecessary barriers to critical inpatient care for individuals struggling with the most serious forms of mental illness and/or addiction.

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

a. 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.

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. 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.

b. Maintain Medicaid coverage for children and youth in residential treatment 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. President Trump's FY 2021 Budget proposes a legislative fix to make QRTPs exempt from the IMD exclusion. We urge Congress to pass this legislative proposal.

National Association for Behavioral Healthcare



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Thank you for considering our concerns and recommendations. If you have questions, please contact NABH President and CEO Shawn Coughlin 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,
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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 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 in nearly all 50 states. The association was founded in 1933.

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