

# Supporting State Behavioral Health Systems During COVID-19 Response and Recovery

## Background

The COVID-19 pandemic is having immediate and long-term impacts on behavioral health (i.e. mental health and substance use disorder) systems in all states. Governors and their senior health and human services advisors play an essential role in incorporating a behavioral health strategy into the state COVID-19 response and recovery approach. Previous public health and financial crises are associated with well-documented exacerbations in mental illness and substance misuse, and the current array of crises related to COVID-19 are expected to follow suit. For example, in August the Centers for Disease Control and Prevention found that during the pandemic self-reported rates for adverse mental health conditions, substance use, and suicidal ideation were significantly [elevated](#) - 40% reported at least one mental or behavioral health condition (e.g. anxiety, depression, trauma and stress) and 11% reported seriously considering suicide within the last 30 days. Additionally, the impact on state-supported programs (e.g., Medicaid and state behavioral and public health systems) will be significant, and thoughtful, coordinated approaches to supporting best practices in a time of constrained budgets is paramount. This paper identifies for Governors the key issues that are currently challenging state behavioral health systems, along with actions that state agencies may consider to support and sustain behavioral health services. Many of the issues identified below are still emerging and state and federal actions will require ongoing follow up to determine outcomes.

## States are challenged to meet existing demand, and demand will grow.

State behavioral health and Medicaid agencies are challenged to meet both existing needs, as well as an increase in demand, due to the pandemic and its associated economic stressors. Prior to the pandemic, access to behavioral health services varied by state, and regionally within states, based on a number of factors including insurance coverage, access to providers and needed social supports, and transportation challenges. Pre-pandemic capacity and operations of the behavioral health system are increasingly strained as the direct care workforce is negatively impacted (due to illness, job loss, etc.), resulting in even greater variability and less

access to treatment and services. Compounding the issue is that as the pandemic and related physical, social, and economic effects continue for an unknown period of time, demand for behavioral health services will increase, through exacerbation of existing illness and an anticipated large number of individuals who have not previously accessed treatment.

## Core Roles of State Agencies to Meet Demand for Behavioral Health Treatment and Services

The role of Governors and state health and human services leads in sustaining the behavioral health system during the pandemic falls into three main areas:

- Maintaining access to treatment and services;
- Flexibility of policies, program rules, and regulations; and
- Availability and administration of state and federal resources.

### Maintaining Access to Treatment and Services

Most behavioral health agencies across the country suspended site-based services (e.g. day programs, outpatient counseling) for publicly and privately funded clients early in the pandemic, and agencies struggled to maintain staffing while in-person supports are limited. In addition, residential programs that provide up to 24-hour onsite coverage experienced staff coverage challenges. To maintain access to critical services, such as case management, Assertive Community Treatment (ACT), or in-home services, some agencies are paying direct care staff enhanced hourly rates and offering incentives like increased vacation time. Direct service workers also need immediate access to Personal Protective Equipment (PPE) which providers are struggling to secure due to supply and funding issues.

Additionally, crisis hotlines are experiencing increased call volume for adults and children and as of September congress passed the [National Suicide Hotline Designation Act](#) which designates 988 as the national number for seeking assistance for a suicide or mental health crisis. Many crisis hotline calls will require mobile response from trained crisis counselors (i.e. a type of first responder) to make determinations on need for hospitalization or referral to community services such as behavioral health providers or primary care providers. Opportunities for crisis text lines, such as [Ohio's Department of Mental Health and Addiction Services crisis line](#), can offer immediate assistance to those in need and also supply states with data to understand mental health trends. States may consider the need to add mobile crisis team capacity in order to meet demand over the next six to twelve months, otherwise these crisis responses will default to law enforcement. SAMHSA's [National Guidelines](#)

[for Behavioral Health Crisis Care](#) provides a framework for the core services that every local crisis system should have.

When natural disasters occur, disaster mental health counselors often respond to provide psychological first aid. The scale of this pandemic is likely to result in significant [psychological stress](#) across a large segment of the population requiring increased capacity in the disaster mental health workforce and helplines. SAMHSA has a [Disaster Distress Helpline](#) that states may share as a resource. States may also consider opening helplines specifically to deal with the psychological stress of this disaster. New Jersey [established](#) the Disaster and Terrorism Branch in the Division of Mental Health and Addiction Services after 9/11 to ensure capacity of a disaster mental health workforce to provide psychological first aid and ongoing support following disasters. Other states have developed similar programs to support individuals following hurricanes, tornados, and forest fires. States may consider activating these teams and crisis lines and consider providing training to develop additional capacity to meet anticipated need.

While the capacity to provide critical face-to-face services remains necessary during this time, providers have also augmented these services by utilizing telehealth to engage and provide behavioral health support to individuals. Telehealth is an emerging tool in behavioral health, especially in rural areas, but its use among providers has been limited due to restrictive regulations and reimbursement policies, privacy concerns, questions about clinical efficacy, lack of staff training, internet connectivity issues, and insufficient funds for technology. Crisis-related flexibilities on federal and state level have created [additional opportunities](#) during the pandemic, though behavioral health providers may need technical assistance on these issues, as well as support to secure equipment for clinicians and service recipients in order to provide telehealth services (e.g., smartphones, tablets, Wi-Fi jetpacks).

Primary care providers will need increased support which can be offered through teleconsultation services, such as the [Behavioral Health and Addiction ECHO program](#) that makes available specialized consultation from licensed behavioral health professionals. These programs have been instrumental in supplementing major workforce shortages before the pandemic, especially in pediatric psychiatry. For example, through the [Massachusetts Child Psychiatric Access Program](#), access to child behavioral health services improved through integrated primary care models. States may consider augmenting these opportunities, especially in underserved areas.

## Flexibility of Policies, Program Rules, and Regulations

State behavioral health and Medicaid agencies have taken advantage of allowable flexibilities during the public health emergency in order to empower providers to be responsive in the current circumstances. State Medicaid agencies have pursued federal waivers for provider qualifications, telehealth coverage, prior authorization requirements, and where services can be delivered. The Secretary of HHS issued a blanket waiver, meaning states do not need to separately apply for permission, allowing reimbursement for out of state providers in Medicare and Medicaid programs. States have also reviewed such blanket waivers approved at the federal level to ensure consistency at the state level and minimize confusion of burdensome requirements for providers. For more information on waivers from the Centers for Medicare and Medicaid services, please see NGA's memo [here](#).

As noted, telehealth has emerged as an important tool to replace or augment face-to-face behavioral health services, particularly in underserved areas, and federal and state agencies are implementing flexible policies in order to respond to the pandemic. For more information and resources see NGA's memo on [Gubernatorial Strategies for Telehealth](#), [The National Telehealth Policy Resource Center](#) and [The National Consortium of Telehealth Resource Centers](#). For specific information on Medication Assisted Treatment specifically, see [below](#).

Several state behavioral health and Medicaid agencies are providing guidance, training, support, and resources (e.g., purchasing Zoom licenses and equipment) for behavioral health providers. The scope of potential telehealth strategies is very broad, and states may consider assigning staff to focus on this issue specifically. On the behavioral health side, providers have long been under resourced, so additional state support for technical assistance, training, and general capacity building support is needed for the behavioral health provider community. Providers have indicated that additional information on telehealth waivers, flexibility, and guidance is needed from state and federal agencies. This may be due to a flood of telehealth resources being sent electronically from various sources. In addition, states will need to communicate clearly if any such flexibilities are rolled back at the end of the public health emergency. States could proactively distill this information directly to their providers through concise guidance and bulletins or technical assistance webinars.

The National Association of Insurance Commissioners (NAIC) has [compiled](#) a list of state actions related to health insurance coverage that may benefit behavioral health consumers and providers. State departments of insurance may work with private insurers to encourage flexibilities similar to their publicly funded programs so that barriers to accessing behavioral health services are minimized for privately insured individuals if, and when, they seek services.

## Availability and Administration of Federal and State Resources

Budgets for community-based behavioral health agencies are generally tight, and any revenue reductions can threaten overall agency operations. During periods of economic stress, such as the recession in 2009-2011, funding for behavioral health services was reduced by states to offset declining revenues. While FMAP for Medicaid was boosted during this period, states were forced to limit eligibility and services in order to manage budgets. In addition, many services for mental health and substance use disorders that were funded primarily by state general funds experienced direct reductions and lost capacity. In order to meet current and anticipated needs, states budgets may leverage state and federal resources to meet demand.

### Leveraging Federal Resources

States should examine federal resources that are available through the CARES Act, Families First Coronavirus Response Act (FFCRA), the Paycheck Protection Program and Health Care Enhancement Act (PPHCA), and future relief bills. Funds coming through agencies such as the Substance Abuse and Mental Health Service Administration (SAMHSA), the Health Resources Service Administration (HRSA), Centers for Medicare and Medicaid Services (CMS), the Department of Housing and Urban Development (HUD), the Department of Labor (DOL), and the Federal Emergency Management Agency (FEMA) may flow through state agencies or directly to providers to pay for direct care staff to meet existing needs, crisis counselors to meet new demand, telehealth equipment, payroll protection, and PPE. States can partner with provider agencies to develop crisis action plans to ensure that state and federal resources that flow to agencies are tied to plans to ensure continued access to core services, consider increased demand in the coming year, and minimize duplication.

**SAMHSA was allocated \$425 million in the CARES Act to support the behavioral health system response to COVID-19.** This includes \$250 million available for all community behavioral health organizations; \$50 million for suicide prevention programs; \$100 million for SAMHSA programs, and \$15 million for tribes. Full details on how the funds will be distributed are not yet available. In April, SAMHSA began [releasing](#) the \$110 million in grant funds to successful applicants in states, territories, and tribes to develop comprehensive systems to address the needs of individuals with serious mental illness, individuals with substance use disorders, and/or individuals with co-occurring serious mental illness and substance use disorders. SAMHSA anticipates making 60 grants available for up to \$2 million per state, territory, or tribe.

**Section 3814 of the Cares Act extended the Medicaid Community Mental Health Services demonstration**, known as Certified Community Behavioral Health Clinics, that provides coordinated care to patients with mental health and substance use disorders, through November 30, 2020. It would also expand the demonstration to two additional states.

The CARES Act also included numerous provisions not specifically pertaining to behavioral health, but that could benefit providers and consumers. Below are several provisions that should be explored for the behavioral health system:

The **Paycheck Protection Program** (authorized and funded in CARES and PPPHCA) is a very important program designed to get funding quickly to small businesses and non-profits, such as behavioral health providers, to offset revenue losses in order to retain employees and maintain operations. A significant number of behavioral health providers have applied for and been approved to receive these forgivable loans.

**Public Health and Social Services Emergency Fund:** \$100 billion in direct aid to health care institutions on the front line of the crisis. \$75 billion was added to this fund in PPPHCA. It is unclear who these may be directed to. Some activities that funds can be used for include leasing of properties, medical supplies and equipment including personal protective equipment and testing supplies, increased workforce and trainings, emergency operation centers, retrofitting facilities, and surge capacity. Payments can be made as pre-payment, prospective payment, or retrospective payment, as determined appropriate by the Secretary.

**Distance Learning, Telemedicine, and Broadband Program:** \$25 million to improve distance learning and telemedicine in rural America. Includes additional \$100 million funds to increase broadband access.

**Section 3212. Telehealth network and telehealth resource centers grant programs.**

Reauthorizes Health Resources and Services Administration (HRSA) grant programs that promote the use of telehealth technologies for health care delivery, education, and health information services. Telehealth offers flexibility for patients with, or at risk of contracting, COVID-19 to access screening or monitoring care while avoiding exposure to others.

**SAMHSA revised the Confidentiality of Substance Use Disorder Patient Records regulation, 42 CFR Part 2.** The adoption of this revised rule advances the integration of healthcare for persons with SUD by allowing the sharing of medical information (with patient consent) among providers with the goal of improving the quality of care, patient safety, claims management, and program integrity.

**Section 3213. Rural health care services outreach, rural health network development, and small health care provider quality improvement grant programs.**

Reauthorizes HRSA grant programs to strengthen rural community health by focusing on quality improvement, increasing health care access, coordination of care, and integration of services. Rural residents are disproportionately older and more likely to have a chronic disease, which could increase their risk for more severe illness if they contract COVID-19.

**Section 3214. United States Public Health Service Modernization.**

Establishes a Ready Reserve Corps to ensure we have enough trained doctors and nurses to respond to COVID-19 and other public health emergencies.

**Sec. 3720. Providing State Access to Enhanced Medicaid FMAP**

This section would amend a section of the Families First Coronavirus Response Act of 2020 (Public Law 116-127) to ensure that states are able to receive the Medicaid 6.2 percent FMAP increase.

**Section 3811. Extension of Money Follows the Person Demonstration Program**

This section would extend the Medicaid Money Follows the Person demonstration that helps patients transition from the nursing home to the home setting through November 30, 2020.

**Lifeline Program**

Another resource example that already existed is the national Lifeline program. The [Lifeline Program](#) provides a discount on phone service for qualifying low-income consumers to ensure that all Americans have the opportunities and security that phone service brings, including being able to connect to jobs, family, and emergency services. Lifeline is part of the Universal Service Fund. The Lifeline program is available to eligible low-income consumers in every state, territory, commonwealth, and on Tribal lands. Many providers and consumers are not familiar with this program, and states should share this resource. States could also have conversations with MCOs about ways to leverage the Lifeline program to improve access for consumers. Several plans across the country (Molina, Aetna, Magellan, Omnicare, and others) are leveraging the Lifeline program and making phones, tablets, and plans available.

**Medicaid Strategies**

*Medicaid Authorities*

States have taken advantage of federal flexibilities tied to the public health emergency, including waivers, to help providers offset revenue reductions that

threaten agencies. States submitted emergency [Section 1135 waivers](#), [Section 1115 demonstration waivers](#), [Section 1915\(c\) Appendix K waivers](#) and [State Plan Amendments](#) to CMS that may increase flexibilities that benefit behavioral health providers. Generally, states used these authorities to:

- suspend premiums and other cost sharing
- substitute types of providers eligible to provide some services
- suspend prior authorizations for some services
- make advanced or supplemental payments to certain providers
- increase payment rates for some services
- allow early or extended refills without prior authorization for some medications
- add or modify benefits and services for certain populations

A scan of these authorities for several states found that state efforts were not specific to behavioral health, although they may include behavioral health providers and services. For example, Florida's Agency for Health Care Administration [waived prior authorization requirements and service limits](#) on frequency and duration for behavioral health services. The North Carolina Department of Health and Human Services [also waived](#) prior authorizations, length of services, certain staff training requirements, supervision requirements, and requirements for face to face services for certain behavioral health services.

All states are currently operating with at least one approved Section 1135 waiver that increases flexibility for state Medicaid programs during the period of the emergency. States have commonly used these waivers to modify provider enrollment requirements, lift prior authorization requirements, reimburse for care in alternative settings, and add additional flexibility to home and community-based services (HCBS) programs. Washington state is the only state with an approved emergency Section 1115 waiver, but the waiver is primarily related to long term services and supports (LTSS) and home and community-based services and not specific to behavioral health.

Similarly, Section 1915(c) Appendix K waivers generally do not directly affect the behavioral health system, though there are exceptions. Connecticut's Section 1915(c) Appendix K waiver allows the state to use additional staff to provide services to persons with mental health conditions coming out of nursing facilities. [Thirty six states](#) have temporarily increased provider payment rates<sup>1</sup> and thirty nine are now temporarily using retainer payments to address emergency related issues using

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<sup>1</sup> AK, AL, AR, AZ, CO, CT, DC, DE, GA, HI, ID, IL, IN, KY, LA, MA, MD, ME, MI, MN, MS, MT, ND, NE, NJ, NM, NY, OH, OR, PA, RI, TN, TX, WA, WI, WY



Appendix K authority.<sup>2</sup> Thirty four states are also using State Plan Amendment or other administrative action to increase Medicaid State Plan reimbursement rates for providers.<sup>3</sup>

### *Managed Care Strategies*

States and managed care organizations (MCOs) have used prospective payments and advanced cash flow to assist providers in paying employees and maintaining access to services. States are undertaking efforts to allow prospective provider payments following Centers for Medicare and Medicaid Services (CMS) [guidance](#) noting that states can request authority for advance payments and a [CMCS Informational Bulletin](#) that provided information on capitation rates and directed payments to temporarily enhance provider payments. The approach would provide funds immediately to providers, but providers would need to repay the Medicaid agency for payments in excess of billable claims. States also incentivized their managed care plans to increase payments to providers with declining utilization. States may also encourage plans to develop strategies to support providers by providing managed care plans with additional funding for providers. CMS allows states to make [incentive payments](#) to MCOs (up to 5 percent above the actuarially sound capitation rates) and/or could increase capitation rates by 1.5% to assist with underwriting payments to providers.

- [New Hampshire](#) has sent a directive to their managed care plans, emphasizing that they share accountability and responsibility for ensuring stability of their provider networks. The state has asked their plans to reallocate 1.5% of capitation dollars for provider rate enhancements for certain providers. They have also removed managed care withhold requirements, thus freeing up funds for emergency payments to their providers.
- [Washington](#) has developed joint State/MCO [messaging](#) regarding the importance of sustaining behavioral health providers. This includes sharing information with their MCOs on providers most at-risk of closing. They have developed customized funding strategies for at-risk providers (e.g. advanced payments, capitated contracts). The state has also directed to have the MCOs pay all outstanding claims immediately.

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<sup>2</sup> AK, AL, AZ, CA, CO, CT, DC, DE, FL, GA, HI, IA, IL, KS, KY, LA, MA, MD, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OK, OR, PA, RI, SC, SD, UT, TN, VA, WA, WI, WV

<sup>3</sup> AL, AR, WA, LA, RI, CA, IA, WV, NM

One example is [Premera Blue Cross](#) which works in Washington and Alaska. Premera is advancing \$100 million in payments to various providers, including behavioral health providers.

- [North Carolina](#) has [developed guidance](#) to their Local Management Entities (regional behavioral health MCOs) in an effort to stabilize their provider networks to deliver services and supports and to reduce the need for any hospitalization or avoidable readmissions from state psychiatric hospitals. Specifically, North Carolina has provided that they use up to 15% from their current risk-reserves for supporting providers who are accepting referrals, maintaining consumers in their existing residential placements, utilizing telehealth capabilities to the maximum extent possible, and providing services that keep consumers from needing access to emergency departments and inpatient services.
- [Massachusetts](#) is [distributing](#) over \$800 million in critical stabilization funding to the Commonwealth's vital providers through MassHealth. Over \$100m is for behavioral health. For dates of service from April 1, 2020, through July 31, 2020, payment for certain MassHealth-covered mental health and substance abuse services will be increased by 10% above current rates.

### Maximizing State Resources

States can also leverage their purchasing power to support community-based provider needs. For example, the Washington Health Care Authority is [paying](#) for Zoom licenses for providers to ensure access to telehealth services. States may also consider community-based providers in rationing of PPE to protect frontline direct service workers, such as extending the usage rate, or using reusable PPE options such as cloth face masks or face shields.

### Leveraging Philanthropy

States may explore public - private partnerships to identify resources that can be used to support providers to maintain operations or purchase PPE, telehealth, or other needed equipment. Hawaii's Behavioral Health and Homelessness Statewide Unified Response Group (BHHSURG) [created](#) a public-private partnership aimed at getting PPE donated to community-based providers. The Melville Charitable Trust is advancing funds to grantees to support operations. Other foundations, such as the [Rhode Island Foundation](#) and the [Blue Cross Blue Shield Foundation](#) (MA), are also making funds available to support behavioral health providers in responding to the pandemic.

## Special Considerations

### Institutional and Residential Care

Most people in the behavioral health system are served in community-based settings. However, each state has many individuals with mental illness and/or substance use disorders who are served in state – and privately-run facility-based settings, such as state psychiatric hospitals, inpatient units, nursing facilities, and other residential programs. Employees and service recipients are at increased risk of contracting COVID-19, and service recipients may be at heightened risk of complications due to underlying health conditions.

Also at issue is whether it is advisable to discharge patients or residents to community-based settings. Transitions often require significant planning to ensure that housing and services are in place for the resident, and providers may be reluctant to discharge a person to the community if there are concerns about workforce availability. However, many facility-based settings are experiencing spikes in COVID-19 cases for staff and service recipients, raising concerns regarding resident safety. Additionally, as individuals have the right to be served in the least restrictive possible setting under the Americans with Disabilities Act, states must take civil rights considerations into account when making these decisions as well. The [Bazelon Center for Mental Health Law](#) has issued a call to action for states to proactively discharge individuals who do not need an institutional level of care to community-based settings. Bazelon is also recommending federal and state rental subsidies be made available to individuals, as well as vacant hotel rooms, college dorms, and trailers (e.g. including those provided by FEMA), as needed.

Several states have halted or slowed discharges from state psychiatric hospitals and nursing homes, while others continue to facilitate discharges. An interview with one state revealed that housing search teams continue to look for apartments for discharge ready individuals, and they are developing a process to do additional screens to prevent unnecessary admissions.

States agencies, including those with oversight responsibility for long-term care settings and community behavioral health providers, can work together to determine health and safety precautions and policies and procedures regarding discharges to community-based settings during this period. Several states that experienced clusters in state psychiatric hospitals (e.g. Washington, New Jersey, Louisiana). States and privately run facilities should increase testing for staff and residents, ensure continued access to PPE, increase social distancing to the extent possible, allow non-essential hospital employees to work from home, and establish specific units to treat patients with COVID-19.

## Medication Assisted Treatment

Individuals receiving medications for opioid use disorder (OUD) are at increased risk for morbidity and mortality caused by interruptions in their pharmacotherapy. As the landmark report [Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health](#) notes, SUD providers have an obligation to prepare for disasters and other large scale emergencies that could jeopardize access to services, including MAT. States have a unique opportunity to avoid preventable injury and death caused by serious withdrawal symptoms, relapse, and overdose, by protecting access to MAT throughout the pandemic.

There have been numerous federal and state policy changes, such as:

- [Relaxation](#) of the longstanding Ryan Haight Online Act requirements.
- Buprenorphine [prescribing](#) via telephone.
- Blanket [exceptions](#) for all stable patients in an opioid treatment program (OTP) to receive 28 days of take-home doses, and to request up to 14 days of take-home doses for patients who are less stable.

In addition to developing targeted take-home policies and the use of telehealth, states can take additional steps to support OTPs to promote social distancing provided they comport with applicable chain of study protocols, such as:

- Providing flexibility for OTPs to alter their operating hours and stagger services;
- Encouraging the implementation of car-based dosing or separate dosing areas for patients who are high-risk or COVID-19 symptomatic yet present too great a risk for take-home medications;
- Supporting observed dosing approaches (e.g. delivering methadone in a lockable container to a doorstep and observing patients taking the medication through a window);
- Supporting the use of [secure medication dispensers](#) with timing and tamper-proof capacities;
- Supporting the use of [drug tests](#) that can be performed remotely in lieu of in-person drug testing;
- Removing barriers to the provision of extended-release formulations of buprenorphine as clinically appropriate; and
- Ensuring OTPs can dispense and be reimbursed for naloxone and fentanyl test strips.

For additional information on practical state strategies to help SUD providers keep their doors open, reduce financial and regulatory burdens, and maintain access

during the pandemic, please see NGAs memo on [State Strategies To Support Access To Substance Use Disorder Treatment Services Through The COVID-19 Pandemic](#).

## Treatment Rationing for Persons with Disabilities

An analysis of state policies by the Center for Public Integrity found [significant concerns](#) regarding the impact of treatment rationing on persons with disabilities. States can review their treatment rationing policies to ensure compliance with civil rights laws and to avoid complaints and law suits. Formal complaints have been filed with the U.S. Department of Health and Human Services' Office of Civil Rights against at least five states (Washington, Alabama, Pennsylvania, Tennessee, and Utah) concerning the discriminatory impact of treatment rationing against persons with disabilities in those states. Such policies are in violation of federal disability rights laws, including the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act (Section 504), and Section 1557 of the Affordable Care Act (ACA). OCR reached a resolution with [Alabama](#) on April 8, 2020 and [Pennsylvania](#) on April 16, 2020.

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