National Association for Behavioral Healthcare

Access. Care. Recovery.

15 January 2021

Re: Administrative Actions to Improve Access to Mental Health and Addiction Treatment

Dear Biden-Harris Transition Team Members:

The National Association for Behavioral Healthcare (NABH) represents behavioral healthcare systems that provide mental health and/or addiction treatment in inpatient, residential treatment, partial hospitalization, and intensive outpatient programs, as well as medication assisted treatment centers and other facility-based outpatient programs for children, adolescents, adults, and older adults in almost every state. On behalf of NABH, I write to recommend the administrative actions and policies to improve access to mental health and addiction treatment services described below.

Background

Increased Need for Mental Health and Addiction Treatment

Ensuring access to mental health and addiction treatment could not be more urgent and important. A recent report by the Centers for Disease Control and Prevention (CDC) revealed that symptoms of anxiety disorder were approximately three times higher and prevalence of depression about four times higher among adults during the second quarter of 2020 compared with the same time last year.[i] Moreover, twice as many people reported serious consideration of suicide in the prior 30 days with 18-24 years-old individuals reporting the highest rate at more than 25%.[ii]

Suicide rates have continued to increase, up 35% between 1999 and 2018,[iii] with early indications of additional increases in suicides recently. Meanwhile, overdoses have spiked during the Covid-19 pandemic with more than 40 states reporting increased opioid-related deaths this fall,[iv] and an overall 18-percent increase in overdoses between May of 2019 and 2020.[v]

The pandemic is also having a significant negative effect on the behavioral health of children and adolescents. According to another recent CDC report, the proportion of children's visits to emergency departments for mental health reasons increased dramatically starting in April 2020 and continuing through October 2020.[vi]

Covid-19 is singularly intertwined with behavioral health conditions. Research has found that substance use disorders constitute a risk factor for Covid-19. [vii] In addition, recent findings point to increased risk of mental health conditions (anxiety and depression, in particular) among those who contract Covid-19, as well as an increased risk of contracting Covid-19 among those with preexisting mental health conditions that appears not to be a result of the high rates of co-occurring chronic physical health conditions in this group.[viii]

Elevated levels of mental health and substance use disorders are expected to linger long after the Covid-19 pandemic ends. Large-scale disasters such as the current pandemic are known to have widespread and long-lasting detrimental effects on mental health and substance use.[ix] Moreover, studies of past disasters have shown the mental health distress and suicidality often do not peak until years after the disaster has ended.[x]

Challenges for Mental Health and Addiction Treatment Providers

Since the onset of the pandemic, our members have implemented many new practices and protocols to meet increased demand for behavioral healthcare while they established methods to prevent the spread of the coronavirus. They have created and developed new screening and infection control measures. Unfortunately, some of these measures reduce their capacity to provide care, including reducing the number of patients in group therapy sessions, allowing additional time between appointments, and designating precautionary units where

patients can stay while awaiting a Covid-19 test.

In addition, staff availability at mental health and addiction treatment facilities has declined for a number of reasons. Addiction treatment programs, for example, have reported reduced capacity because staff members are concerned about working in contagious environments, are quarantined themselves, older than 60 years of age and in a high-risk group, or living with family members who have compromising health conditions, among other reasons. These factors have reduced the capacity of addiction treatment providers to offer desperately needed services.

Furthermore, these providers have faced significant shortages of personal protective equipment (PPE). Unlike providers in general medical settings, behavioral healthcare providers have not been accustomed to using PPE to the extent now required; consequently, they did not have large stores of these supplies to access. Moreover, they generally do not have prioritized access to PPE through well-established supply chains. Consequently, they have had to work harder to find these supplies and pay higher prices.

Recommendations

Ensure Access to Covid-19 Vaccines for Mental Health and Addiction Treatment Providers
It is critical that we preserve and even increase access to behavioral healthcare as a key component of responding to Covid-19. To maintain access to care, mental health and addiction treatment providers should be recognized as essential healthcare workers and included among the priority groups for receiving the Covid-19 vaccines.

Maintain Coverage of Telehealth Including Audio-Only
Telehealth is particularly effective in behavioral healthcare delivery, particularly psychiatric and psychological services.[xi] In addition, telehealth has been found to increase retention in SUD treatment, including medication treatment, especially when treatments are not otherwise available or require lengthy travel to treatment.[xii]
The experience of our members in delivering behavioral healthcare during this pandemic is consistent with these research findings. Expanded coverage of telehealth has enabled our members to continue providing treatment in some cases beyond the levels provided before the pandemic. They have seen improved engagement in treatment, as their patients missed far fewer appointments and reported high levels of patient satisfaction. Our members also report greatly increased capability to serve individuals in rural areas and those without access to reliable transportation.

The convenience and immediacy of accessing behavioral healthcare services via telehealth make this service particularly important for supporting emergency and frontline healthcare providers. These providers are at heightened risk for mental health and substance use disorders particularly now under the ongoing strain from the Covid-19 pandemic. Even before this crisis, healthcare providers, especially emergency room physicians and female physicians, were at heightened risk of suicide.[xiii] First responders, including emergency services personnel, have increased rates of depression, post-traumatic stress disorder, and suicide.[xiv] They work long hours and face other systemic barriers, including stigma[xv] and discriminatory practices that discourage them from accessing behavioral healthcare. Accessing treatment for mental health and substance use disorders via telehealth addresses many of these barriers.

Continued coverage of telehealth via audio-only technology will be crucial to support improved access to care in rural areas and among vulnerable populations. Coverage of audio-only telehealth services enables access to behavioral healthcare in areas where broadband service is often not available to support video interactions. In addition, availability of care through audio-only telehealth is even more important in rural areas due to the shortage of behavioral healthcare providers in those areas. Availability of behavioral health services via audio-only technology is also necessary for vulnerable populations who do not have the access or ability to use video-technology, including those with cognitive impairments and many older individuals.

Continue Increased Reimbursement Rates for Mental Health and Addiction Treatment via Telehealth
Mental health and addiction treatment providers have incurred significant unexpected costs in purchasing hardware and software as well as training to support ongoing telehealth treatment. Moreover, these types of providers receive far lower reimbursement rates overall than other clinicians. In the future, behavioral healthcare providers will be unable to offer telehealth services if reimbursement is substantially below in-person rates.
In general, behavioral healthcare providers operate with very low margins, partly because reimbursement rates for services are often much lower than they are for other specialty care providers. Reimbursement for mental health and addiction treatment via telehealth should account for the overhead and administrative costs of providing these services in office settings, as well as the cost of purchasing technology and staff training. We urge the Centers for Medicare & Medicaid Services (CMS) to maintain in Medicare full reimbursement for telehealth services comparable to in-person rates to take advantage of this opportunity to improve access to behavioral healthcare that the growth in telehealth created.

Moreover, we recommend that CMS review Medicare reimbursement levels and strategies for mental health and addiction treatment services in general (for telehealth and non-telehealth services alike) to bring reimbursement for behavioral healthcare providers to levels that are more consistent with their education and credentialing, as they are for their peers in general medicine.

Cover Telehealth Partial Hospitalization and Intensive Outpatient Programs Including Facility Fees
We urge you to continue Medicare coverage of services and facility fees for intensive outpatient programs (IOPs) and partial hospitalization programs (PHPs) provided via telehealth. PHPs and IOPs provide a critical level of care for people with serious behavioral health conditions who need support while transitioning back into their communities from acute care to avoid relapse and readmission.[xvi] PHPs and IOPs can also serve as alternatives to inpatient care or residential treatment. These programs are more efficient options for those who need intensive behavioral health treatment, but do not necessarily need to reside in a facility while receiving that treatment. These programs also enable individuals with serious behavioral health conditions to stay more connected with their communities. However, these types of programs are not widely available in all communities, particularly in rural areas. Many of our members have long-standing experience operating PHPs and IOPs.
Currently, NABH members support an average of almost 700 PHP admissions per year, ranging from an average of 500 admissions to an average of almost 850 admissions per year, depending on the size of the facility.[xvii] During the Covid-19 pandemic, our members have been able to continue and even increase access to IOP and PHP programs by providing these services via telehealth. This expanded telehealth benefit in Medicare has included facility fees that cover the support services necessary to provide these programs.

Maintain and Improve Access to Medication Assisted Treatment via Telehealth
As the opioid crisis continues to cause unprecedented overdose deaths, we urge you to continue to allow access to medication assisted treatment (MAT) for opioid use disorder via telehealth for existing and new patients. The Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) regulations should be revised permanently to allow qualified providers to engage existing and new patients in methadone and buprenorphine MAT via audio-visual telehealth. Section 3232 of the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act*, authorizes this action in directing the Attorney General, in consultation with the Health and Human Services (HHS) secretary, to promulgate final regulations specifying the circumstances under which a special registration for telehealth may be issued that would authorize the use of a telehealth exam in lieu of an in-person exam for the purpose of issuing an electronic prescription of controlled substances for MAT.

In addition, we urge SAMHSA to continue authorization of an expanded provision of take-home medications by opioid treatment programs and treatment models in which physicians can provide methadone induction via telehealth as long as there is a qualified health professional in the room with the patient.

Regulations should also be revised to permit the dispensing of buprenorphine for opioid use disorder to hospital inpatients. Specifically, 21 CFR 1306.07(d) should be revised to permit registered hospitals, clinics, and pharmacies located in hospitals to dispense Schedule III, IV, or V medications. This will allow immediate initiation of medication treatment, improve retention in care, and reduce overdose deaths after discharge.

We also recommend that HHS remove the buprenorphine provider patient limit to increase access to buprenorphine medication assisted treatment. Most physicians with DATA 2000 waivers practice far below the permitted patient limits. Office-based treatment facilities who meet the definition of 'qualified practice setting' and serve up to 275 patients, provide most buprenorphine services in the country. These facilities employ highly specialized and trained providers, and are staffed, organized, and well-positioned to bring treatment to a larger scale and provide services to more communities and many vulnerable populations, especially communities of color.

To avoid disincentivizing qualified practitioners from providing buprenorphine, the DEA should standardize the oversight and auditing of buprenorphine practices across the country, such that practitioners in all states have common expectations and experiences similar to other medical providers that are subject to oversight by independent parties. The DEA should collaborate with stakeholders to develop oversight practices.

In addition, NABH recommends the elimination of prior authorization for medications to treat opioid use disorder. Furthermore, the Justice Department should assure that individuals with a substance use disorder have access to all forms of medication assisted treatment while in jail and prison.

Waive the IMD Exclusion in Covid-19 Hotspot Areas

As you know, hospitals in many communities across the United States are struggling to care for dramatically increasing numbers of patients with Covid-19. 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. Reductions in availability of inpatient and residential care have been reported in the news as well.[xviii]

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 inpatient treatment coverage. These limitations include the exclusion from Medicaid coverage of services provided in Institutions for Mental Diseases (IMD) regulation, and the 190-day lifetime limit in Medicare for coverage of services in free-standing psychiatric facilities.

Last year CMS 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 has had 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.

Behavioral healthcare settings can help relieve the pressure on general hospitals that are struggling to find beds for Covid-19 patients. However, the Medicaid IMD exclusion and Medicare 190-day limit present significant barriers to accessing available treatment capacity in those settings. We urge you to waive the IMD exclusion in Medicaid and 190-day limit in Medicare in Covid-19 hotspot areas to make available inpatient beds in acute care hospitals where additional capacity is needed for Covid-19 patients.

This waiver would also ensure that individuals with serious mental illness or substance use disorders, who may not otherwise be eligible for treatment in freestanding psychiatric hospitals or residential treatment centers, are able to

receive care in those settings that are equipped to provide the intensive mental health care and addiction treatment they need.

Continue Flexibilities Regarding Hospital Conditions of Participation

We also request that CMS continue to provide flexibility regarding the following general conditions of participation (CoPs) after the Covid-19 public health emergency has ended. Many of these requirements and restrictions prevent psychiatric facilities from being able to use their staff fully to offer care because of unnecessary requirements that force them to shift away from patient care to administrative tasks.

- **Care of patients,** 42 CFR §482.12(c)(1), (2), and (4). The flexibility regarding these regulations during the pandemic has allowed hospitals to employ nurse practitioners and other mid-level providers to the fullest extent that their licensure and state scope of practice laws allow. This change has expanded the capacity of staff to provide behavioral healthcare. Continuing this policy 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 in the coming months and years. Almost 120 million people currently reside in mental health professional shortage areas.[xix] About half of U.S. counties and 80% of rural counties have no practicing psychiatrists, and over 60 percent of psychiatrists are nearing retirement.[xx]

- **Nursing care plan requirements**, 42 CFR §482.23(b)(4). The specifications for these plans are overly burdensome and should be streamlined.

- **Authentication of verbal orders**, 42 CFR §482.23(c)(i-iii). The additional flexibility allowed during the pandemic should be maintained where read-back verification is required, but authentication may occur later than 48 hours.

- **Utilization Review**, 42 CFR §482.30. This section includes a long list of specific requirements for a utilization review committee, the scope and frequency of reviews, determinations regarding admissions or continued stays, and extended stay review. These specifications are overly prescriptive.

- **Discharge planning requirement to provide a list of post care facilities, financial disclosure, quality data, and information on managed care requirements**, 42 CFR §482.43(a)(8) and 482.43(c)(1-3). The types of post-acute care settings that must be incorporated into discharge planning under these regulations are not focused on addressing mental health conditions or addiction. Moreover, obtaining the required data on these other settings is burdensome. Furthermore, it is counterproductive to provide information on treatment settings which do not address the needs of the patient or to which a patient may not be accepted or have the means to access.

Delay Implementation of Broad New Regulatory Initiatives

Although our members have been working hard to comply with the new price transparency requirements[xxi] that became effective on Jan. 1, 2021, they have had to manage Covid-19-related challenges that have added to the difficulty of implementing these complex new rules.

Behavioral healthcare providers of all types have moved quickly to implement virtual treatment platforms and resources. Psychiatric inpatient settings, outpatient programs, and individual providers have initiated and expanded telehealth treatment capabilities and are now providing virtual patient rounding for physicians and physician assistants, medication management, individual therapy, group therapy including intensive outpatient services, and partial hospitalization day programs all via telehealth. This rapid shift in practice and new technology implementation has required significant resources and greater staff attention and management.

Another unique feature of inpatient psychiatric care that further complicates compliance with the price transparency rules and particularly the requirement to post negotiated rates is the fact that inpatient psychiatric treatment is often covered through carve-out arrangements with specialized managed behavioral healthcare organizations (MBHO).

Psychiatric hospitals face the additional challenge of working with technological vendors who are accustomed to working with acute care hospitals and unfamiliar working with psychiatric facilities. Accordingly, these vendors will need more lead time to develop the technology to help psychiatric hospitals and units determine and post their gross charges, negotiated rates for each payor, de-identified minimum and maximum rates, and discounted prices for those consumers paying out-of-pocket. This difference in readiness between psychiatric hospitals and acute care hospitals is likely a result of the fact that psychiatric hospitals were excluded from the subsidies for electronic health record (EHR) implementation provided through the *Health Information Technology for Economic and Clinical Health Act* (*HITECH*) of 2009. Research studies have shown that psychiatric hospitals have lagged other hospitals in implementation of EHRs as a result.[xxii]

Reduce Reporting Requirements for Psychiatric Inpatient Settings on Covid-19 and Other Issues
During the Covid-19 pandemic, our members have ensured their patients continue to have access to the services they need while these providers have navigated and adjusted to a new world filled with uncertainty, additional requirements, and complex challenges. They have developed new telehealth services and programs with significant new costs for technology and training. In addition, they have incurred added costs related to PPE and screening as well as costs related to additional cleaning and infection control measures. These provider organizations follow both the CDC and state guidelines regarding Covid-19 prevention and infection control to provide the safest care to their patients.

The hospital reporting requirements regarding Covid-19 have significantly added to the regulatory burden psychiatric inpatient settings already must meet due to the Special Conditions of Participation that apply to these settings. Furthermore, unlike inpatient and other hospitals, psychiatric hospitals are unlikely to see any benefit from this additional reporting. They do not provide treatment specifically for Covid-19 and are unlikely to be prioritized for distributions of PPE or testing supplies over the other hospitals in their communities where Covid-19 patients must go to access treatment for that condition.

Improve Coverage of Mental Health and Addiction Treatment with Parity 2
The *Wit v. United Behavioral Health* case highlighted the discriminatory and unlawful practices many managed care plans continue to use to restrict access to critically needed mental health and addiction treatment services. Despite the enactment of the federal *Mental Health and Addiction Equity Act* (MHPAEA) and promulgation of detailed rules and many rounds of guidance, mental health and addiction treatment providers continue to expend countless resources battling with Medicaid, Medicare, and commercial health plans to try to ensure critically ill patients have access to the care they need.

To improve coverage in Medicare, Medicaid, and the Qualified Health Plans, we urge the Biden-Harris Administration to implement a “Parity 2.0” initiative that incorporates the principles of the *Wit v. United Behavioral Health* decision. One element of this initiative would be to issue guidance encouraging state Medicaid agencies to include in their contracts with managed care plans a requirement that medical necessity determinations and utilization management policies and practices be based on generally accepted standards of care developed by clinical expert associations. These same principles should also be incorporated into federal regulations for mental health and addiction treatment benefits covered in Medicare Advantage plans as well as Qualified Health Plans operating in the health insurance marketplaces.

Encourage Participation of Mental Health and Addiction Treatment Providers in Medicaid, Medicare, and Other Federal Healthcare Coverage Programs
We urge you to ensure that Medicaid, Medicare, and Qualified Health Plans include sufficient mental health and addiction treatment providers at all the critical levels of intensity of care to meet the needs of individuals with serious

behavioral health conditions. In the *SUPPORT Act,* Congress authorized a demonstration project to increase the availability of SUD treatment for Medicaid beneficiaries. CMS awarded planning grants for this purpose to 15 states in the fall of 2019. These states received a total of $50 million to conduct in-depth assessments of the providers available in their states and develop incentives to encourage more providers to participate in Medicaid including by reassessing the reimbursement rates for these services. We encourage you to study the findings from this demonstration and develop guidance for states on how to improve the participation of mental health and addiction treatment providers in their states' Medicaid programs as well as other federal healthcare coverage programs including Medicare and Qualified Health Plans.

In addition, CMS should review Medicaid managed care contracts to improve alignment of coverage and reporting procedures. The current system is complex and burdensome for multi-state providers and unnecessarily impedes coverage, treatment, and referral.

Extend Medicaid Coverage of Pregnant Women to One Year Postpartum

CMS should encourage states to propose section 1115 demonstrations extending Medicaid coverage for pregnant women to twelve months postpartum. Mental health conditions and overdoses are among the top causes of pregnancy-related deaths[xxiii] that have been increasing in the United States while decreasing in other developed countries in recent years.[xxiv] The opioid crisis is a significant factor with the prevalence of opioid use disorder (OUD) quadrupling among pregnant women between 1999 and 2014.[xxv]

A number of states have issued reports confirming that substance use, including opioid abuse, is a major factor in pregnancy-associated deaths.[xxvi] More than one half of pregnancy-related deaths occur after the birth of the infant.[xxvii] Recent research has shown that the postpartum period is the time when more women relapse compared with during pregnancy,[xxviii] and women with OUD experience high rates of overdose and mortality, particularly in the postpartum period.[xxix] Legislation to extend Medicaid coverage for pregnant women to one year postpartum was passed by the House this fall and was proposed in the President's Budget for FY 2021 and 2020. Administratively, CMS could issue guidance on policies and procedures to facilitate approval of state section 1115 demonstrations extending Medicaid coverage of pregnant women to one year postpartum.

Increase Availability of Behavioral Healthcare for Children and Adolescents

The global Covid-19 pandemic has affected children and adolescents severely with schools closed and physical distancing policies in place across the United States. This is especially difficult for children and adolescents with emotional or behavioral disorders.[xxx] Uncertainty and restrictions can aggravate symptoms among these children with special needs. Following the closure of their special schools and day care centers, these children lack the support they need to continue developing social and behavioral skills and participating successfully in distance-learning programs. These difficult changes can cause conflicts with parents who lack the professional expertise to resolve these challenges.

According to a recent CDC report, the proportion of children's visits to emergency departments for mental health reasons increased dramatically starting in April 2020 and continuing through October 2020, with increases of 24% for children aged 5-11 and 31% for adolescents aged 12-17 years old.[xxxi] Similarly, 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.[xxxii]

Even before the global Covid-19 pandemic, the incidence of serious mental illness had increased significantly from 2018 to 2019, especially among those aged 18 to 25 years old.[xxxiii] Major depressive episodes increased most dramatically for adolescents and young adults, and suicidal thoughts, plans, and attempts also increased at an alarming rate during this period.[xxxiv] Suicide rates were already tragically high among U.S. children and adolescents, for whom suicide is the second leading cause of death.[xxxv] Emergency visits and hospital stays for children who thought about or attempted suicide had also recently doubled.[xxxvi]

Social-isolation policies and concerns about entering healthcare facilities have prevented child and adolescent behavioral healthcare providers from identifying the need for behavioral healthcare among children and adolescents as early as they would have before the pandemic. As a result, these providers have found that when children and adolescents access services, the severity of their conditions is higher than usual.

Some residential treatment providers have experienced an increased demand for residential treatment and other intensive levels of care during the Covid-19 pandemic. Behavioral healthcare providers also note that patient stays in inpatient, acute-care settings for behavioral health conditions are less available because of increased demand for inpatient beds due to Covid-19; consequently, this has increased the need for residential treatment as a step-down or alternative level of care.

The following actions would help improve access to mental health and substance use disorder treatment for children and adolescents with significant and serious behavioral health conditions:

- Increase support for schools to implement a continuum of mental health and substance use disorder services, including primary prevention activities as well as access to treatment services in schools with funding for establishing relationships and care coordination connections with outside specialized service providers (examples of these types of programs include Positive Behavioral Interventions and Supports and Interconnected Systems Frameworks);

- Increase availability of specialized, evidence-based interventions (e.g., Coordinated Specialty Care for first episode psychosis, Multisystemic Therapy for justice-involved adolescents and families) by requiring coverage of these interventions by public and private payors;

- Ensure children with serious behavioral health conditions can receive intensive treatment in their local communities instead of being sent far away for needed care by providing increased funding to existing behavioral healthcare systems to cover capital and start-up costs for establishing additional treatment facilities specializing in MH and SUD treatment for children and adolescents with serious conditions;

- Clarify that Qualified Residential Treatment Programs are exempt from the IMD exclusion in Medicaid as was intended by Congress when those types of settings were designated as appropriate childcare institutions under Title IV-E for children and adolescents with serious emotional disturbances who need specialized support from qualified professionals; and

- Increase targeted state and federal funding for educational services and supports in residential treatment settings providing specialized treatment for children and adolescents with serious behavioral health conditions.

Support the Use of Contingency Management Strategies

The HHS Office of the Inspector General (OIG) should permit and promote the use of contingency management for the treatment for stimulant use and provide clear guardrails to prevent fraud and abuse. Currently, there is no medication to treat stimulant use disorders, yet stimulant-involved deaths have increased 33% since May 2019.[xxxvii] Fortunately, extensive research has proven both the clinical effectiveness and cost effectiveness of motivation interviewing/contingency management treatment interventions for individuals with these stimulant use disorders.[xxxviii] This evidence-based treatment practice provides tangible rewards to patients to reinforce specific positive behaviors, such as providing a prize or a voucher for a clean urine sample or attending weekly counseling sessions. These interventions have been proven to increase retention in treatment and promote abstinence from drugs. We recommend that the OIG permit the use of contingency management that is based on individually tailored treatment planning, not used in advertising or marketing of the program, and consistent with training curricula and other

materials that the National Institute on Drug Abuse and SAMHSA have developed.

Ensure Broad and Swift Implementation of the 988 Hotline and Crisis Stabilization Services

Designation of 988 as a universal, toll-free crisis hotline creates a tremendous opportunity to prevent tragic outcomes and increase access to mental health and addiction treatment. Upfront infrastructure and implementation funding are needed to build the network capacity and connections necessary to ensure that all callers to the hotline are immediately connected to well-trained staff who are knowledgeable about and in contact with behavioral healthcare providers in that caller's community.

These connections are critical for enabling this hotline to connect callers with the appropriate type of care, whether they need a mobile crisis unit or transport to a crisis stabilization setting. The recent omnibus appropriations and Covid-19 relief package includes some funding for SAMHSA to strengthen the 988 hotline capacity for connecting people throughout the United States with behavioral healthcare that is so critical at this time. In addition, additional funding was provided for states through an increase in SAMHSA's Community Mental Health Services Block Grant (MHBG) to support evidence-based crisis systems.

Many of the callers to crisis hotlines require a rapid assessment to determine whether they need mental health and/or addiction 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 general, but particularly during an infectious disease outbreak such as Covid-19, it is paramount that we develop crisis stabilization alternatives to emergency departments for people experiencing behavioral health crises. Behavioral healthcare systems 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. These health systems are well-known within their communities, including among first responders, as providers of high-quality behavioral healthcare.

We urge SAMHSA to issue guidance advising states that they may use MHBG funding to develop crisis care hubs with sophisticated referral systems as well as mobile crisis units and crisis stabilization centers to help divert individuals struggling with a mental health or substance use disorder crisis from unnecessary involvement with police and emergency room utilization.

States should also be directed to identify a high-level 988 coordinator for their state with oversight over all programs that are involved in addressing individuals experiencing behavioral health crises including police departments, hospital system emergency departments, and agencies that oversee 911 operations, as well as mental health and substance use disorder agencies. Local behavioral healthcare providers should also be engaged in development of the crisis stabilization systems that are needed to address the needs of 988 callers.

The 988 hotline should be perceived and treated as a resource for all. Accordingly, a broad range of funding sources should contribute to supporting this critical network including Medicare, Medicaid, and commercial insurers. Criminal justice programs should also contribute to this effort as they may experience decreased involvement and costs associated with individuals struggling with a behavioral health crisis. Moreover, their financial engagement should help ensure continued awareness of and coordination with the crisis stabilization systems that develop in the wake of 988 designation.

It will be important to ensure that payors and stakeholders understand that 988 is not only a suicide prevention hotline, but also a way to improve connections and access to mental health and addiction treatment particularly for those experiencing a behavioral health crisis. We urge your administration to develop a robust marketing campaign to increase awareness about 988 and its potential to improve connections to mental health and addiction treatment.

In addition, CMS should issue guidance to state Medicaid agencies on the new 988 universal crisis hotline and the various ways that Medicaid can support development of call centers and crisis stabilization services to improve

treatment for individuals experiencing behavioral health. CMS touched on this topic in a State Medicaid Director Letter addressing serious mental illness in November of 2018, but additional guidance would be helpful.

It will also be important to issue Medicare guidance (e.g., a Medicare Learning Network brief) about the new 988 hotline, as well as guidance on Medicare coverage of services in crisis-stabilization settings. We urge you to explore whether a National Coverage Determination could help clarify coverage for services crisis stabilization settings.

Furthermore, we encourage you to incorporate the designation and implementation of the 988 hotline and related efforts to improve availability of crisis stabilization services into the Center for Medicare and Medicaid Innovation's Emergency Triage, Treat, and Transport model.

Improve Connections to Mental Health and Addiction Treatment Providers for Inmates Prior to Release
Many people involved in the criminal justice system have significant mental health and/or substance use disorders. About 65% of the U.S. prison population has an active substance use disorder and another 20% were under the influence of alcohol or drugs at the time of their crime;[xxxix] however, most jails and prisons offer little or no treatment for these conditions.

HHS should immediately implement section 5032 of the *SUPPORT Act,* which required, by October 2019, convening of a best practices stakeholder group to inform the development of policy guidance on continuity of care for the justice-involved population. Specifically, CMS was directed to issue a state Medicaid director letter clarifying availability of section 1115 demonstration authority to allow Medicaid coverage of services 30 days prior to release from jail or prison. This guidance should clarify that section 1115 demonstration authority can be used to cover services by providers in the inmates' community including via telehealth prior to their release from jail or prison.

Allowing community-based providers to offer treatment to incarcerated individuals before their release would facilitate the transition to receiving services from that provider once those individuals are released.

Thank you for considering our concerns and recommendations. If you have any questions, please contact me directly at shawn@nabh.org or 202-393-6700, ext. 100, or contact NABH Director of Policy and Regulatory Affairs, Kirsten Beronio at kirsten@nabh.org or 202-393-6700, ext. 115.

Sincerely,

Shawn Coughlin
President and CEO

About NABH
The National Association for Behavioral Healthcare (NABH) 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 outpatient behavioral healthcare programs, and recovery support services in nearly all 50 states. The association was founded in 1933.

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