CLASP
Policy solutions that work for low-income people

Policy Brief
April 2020 | Isha Weerasinghe

Mental and Behavioral Health System Fixes During the COVID-19 Crisis, and Beyond

Introduction

The coronavirus (COVID-19) pandemic is testing our mental health and wellbeing, shaking our stability, and bringing uncertainty to what we could previously depend upon. Devastating job losses, school and child care instability, lack of housing, and increased tensions in strained families living in close quarters, all weigh on an individual's mental health. For those with substance use concerns, restrictions created by the pandemic limit options to practice safe harm reduction and create barriers to treatments. Even before the current public health crisis, mental and behavioral health supports often did not meet the need, particularly for people living in households with low incomes. Now, the gaps are widening, especially for people of color. As inequities increase, gaps in services will follow.

Medicaid is the largest payer of mental health services in the United States. However, gaps exist in the types of mental and behavioral health services that are accessible for populations with low-incomes, with and without insurance. Even those with Medicaid experience barriers because of **limited provider networks and unaffordable out-of-pocket costs**, particularly in states that contract with managed care organizations rather than fee-for-service programs. Additionally, **we already had a shortage of mental and behavioral health providers**, including those needed professionals **who can best serve in a culturally and linguistically responsive manner**, e.g., peer support specialists, social workers, and recovery coaches.

People are feeling increased stress because of limited public assistance and the uncertainty the pandemic is bringing to so many dimensions of life, for example paying rent, qualifying for SNAP, having to forego "social distancing" by taking public transportation, etc. Because mental and behavioral health are strongly tied to people's basic needs (e.g., food, housing, education, quality of life), many states are considering their authority to **use the Coronavirus Aid, Relief, and. Economic Security (CARES) Act funding to address these needs**.

Additionally, fear and stress due to racism and xenophobia are on the rise during this pandemic. This impacts specific communities of color—namely **Asian Americans and Pacific Islanders because COVID-19 has been misrepresented as a "Chinese virus,"** and this has created misconceptions about Asian Americans being more likely to contract the virus and that Black people/people from the African diaspora are not. We are seeing **incredibly high rates of morbidity and mortality among Black people** from COVID-19. This will adversely impact people of color living in low-income communities with higher law enforcement and Black and Brown communities that already experience implicit bias within the health system. We are hearing stories of mental health professionals being stopped by the police on their way to/from work, mothers who have not received adequate or effective delivery of care because of implicit bias, and providers experiencing the stress of COVID-19. Some of these stories are not new because of the crisis. However, with tensions so high, we have to put in place appropriate measures to protect providers and patients to curb stress levels.

Federal and state governments can seize the opportunity to make lasting changes by overhauling the mental and behavioral health systems and proving that what is working now could work in the long term. Beyond the federal stimulus packages, we know that states have taken advantage of the national public health emergency declared by the president to move forward a number of emergency Medicaid waivers.

CLASP offers recommendations for some immediate and longer-term policy strategies for how our mental and behavioral health systems can respond to the pandemic. If states and territories are not able to meet the needs of their residents, mental and behavioral health outcomes will worsen and health inequities for communities of color will widen.

The following recommendations are not meant to be comprehensive but offer advice on how federal and state policymakers can use policy guidance and implementation to fill in gaps to better serve people with low incomes, and the providers who serve them:

Federal recommendations

Frontline staff

Funds allocated through the stimulus packages do not go far enough in supporting staff. We recommend that the next stimulus package include the following provisions, all of which should continue to be implemented beyond the public health emergency.

Institute mandatory funding to provide mental health supports for frontline workers, from health care staff to bus drivers to delivery workers. The pandemic is incredibly stressful for everyone, particularly those who are risking their lives and working under intense conditions.

Provide federal funding to the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), and the Department of Labor (DOL) to provide grants to agencies in order to hire more mental and behavioral health professionals for agencies that need them (e.g., Federally Qualified Health Centers, workforce agencies, etc.).

Ensure that health professionals such as community health workers, doulas, peer support professionals, recovery specialists, harm-reduction counselors, and other caregivers **get the protective gear they need**. Although we are facing a nationwide shortage of gear, policymakers must ensure that these professionals are protected too—for their safety and those they serve.

Provide reimbursements for providers outside the definition of "qualified provider" by statute, including peer support professionals and doulas. This expanded set of qualified providers should also be reimbursed for their visits when consulting with other providers (e.g. social workers, psychologists, counselors). In the short term, a state can apply for these modifications using Medicaid's 1915(c) Appendix K.

Quarantine centers

Federal and state entities also need to consider how families are affected by the close quarters created by "social distancing" requirements. Policymakers should use CARES Act or Medicaid funding to create quarantine centers for victims of intimate partner violence.

Step therapy/ "Fail first" policies

Federal administrators should waive these policies for behavioral health at this time of dire need. This will allow providers to prescribe the medications they feel would be best suited for their patients *first*, rather than having to prescribe the least expensive drug.

Telemental health/telemedicine

We have seen how the expanded use of telemental health/medicine regulations during the COVID-19 crisis is reaching communities that may have had difficulty accessing care before, such as people with disabilities or who live in rural communities. However, policymakers still need to address concerns about safety, applicability, and reimbursement. In addition, they should consider relaxing regulations to allow the use of phone apps and other tools that work for young people and parents, such as therapy by text. To ensure that people are not using the limited minutes on their cell phone plans for health visits, cellular providers should make exemptions for health visits, or states should have money allocated for disposable mobile phones for telemental health. This could be done through ***private-public partnerships***.

Indian Health Service

Although Native populations received $8 billion through the last coronavirus stimulus package and the Indian Health Service (IHS) has expanded its **telehealth services**, Tribal Nations **need more federal funding** for substance use and mental health services. This includes **funding to reimburse qualified providers, both within urban Indian programs and outside of IHS and tribal facilities**.

State recommendations

Pre-authorization and cost-sharing

Provide services and medications to meet the needs of families living in low-income households without cost-sharing and without pre-authorization requirements. When states have limited provider networks in their Medicaid managed care organizations and varied definitions of what is covered under Medicaid plans, people have difficulty getting the care they need. New York and other states have filed waivers under section 1135 of the Social Security Act (which governs Medicaid) to waive requirements for signatures and face-to-face contact for pre-authorizations, but not all of these requests have been approved by the Centers for Medicare and Medicaid Services (CMS).

Medical necessity

People also have tremendous difficulty accessing care because of the complex and varied medical necessity definitions across states and the applicability of definitions. A state's 1135 waiver can temporarily expand medical necessity criteria definitions. This is important particularly as people feel more helpless and stressed and need mental and behavioral health supports.

Presumptive eligibility

People who qualify for Medicaid and need immediate mental and substance use services can be covered under presumptive eligibility. More information about this can be found **here**.

Treatment for opioid addiction

States must allow providers discretion to prescribe methadone to be taken at home and to extend buprenorphine prescriptions. **SAMHSA has released guidance** related to take-home medications and authorization to prescribe via telehealth. States that have declared an emergency can request an exemption, and Opioid Treatment Programs in states that have not declared an emergency can ask the state's opioid treatment authority for an exemption.

We also recommend these critical immediate steps to support long-term approaches to transform our mental and behavioral health care systems for communities of color and people with low incomes.

Mental, behavioral, and physical health services need to be co-located. While federal funding for Certified Community Behavioral Health Clinics is an important step, federal policymakers need **to incentivize states to co-locate services to reduce patient burden of visiting two locations and to help providers create health homes to coordinate care.**

Despite the passage of the Mental Health Parity Act and Mental Health Parity and Addiction Equity Act, the United States has a long way to go to ensure that mental health services are provided equitably. **Enforcing parity implementation is an important step to ensure mental and behavioral health services are covered at the same levels as physical health.**

As mentioned above, medical necessity definitions vary greatly by state and are often the rate-limiting factor to providing that care. We need **a non-partisan body to review medical necessity criteria for consistency and fair applicability.**

Many of these recommendations can be accomplished through seeking Medicaid waivers through Section 1135, applying for a State Plan Amendment, or amending a state/territory's 1915(c) plan through an Appendix K application. Find out more about Medicaid in the context of COVID-19 **here**. To see which states and territories have applied for waivers, check out Kaiser Family Foundation's tracker **here**. For more information about what applies under each waiver, see the **National Health Law Program's guidance**, **Kaiser Family Foundation's guidance**, or **CMS's guidance**.

Conclusion

The current pandemic is creating cultural trauma. Without an adequate response now, we are sure to see adverse mental health outcomes as a result of the COVID-19 pandemic, and historical trauma as time passes. Immediate interventions need to be in place now to ensure that the trauma does not last for years, let alone decades. We need mental and behavioral health system and policy changes to help all communities thrive—now and beyond this public health crisis.

*Thank you to the following individuals for their expertise in informing this brief: Dr. Kimá Taylor and Clelie Choute, **CLASP Mental Health Advisory Board Members**; Andre Johnson, **Founder and President of the Detroit Recovery Project**; Dr. Nira Singh, **Director of Behavioral Health** for Asian Americans for Community Involvement; and Sebastian Hickey, **Emerson Hunger Fellow***

If you or your organization need support, check out **Mental Health America's** and the **Centers for Disease Control and Prevention's** great lists of resources.