Mental Health Policy in the Era of COVID-19

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The response to the global COVID-19 pandemic has important ramifications for mental health systems and the patients they serve. This article describes significant changes in mental health policy prompted by the COVID-19 crisis across five major areas: legislation, regulation, financing, accountability, and workforce development. Special considerations for mental health policy are discussed, including social determinants of health, innovative technologies, and research and evaluation. These extraordinary advances provide an unprecedented opportunity to evaluate the effects of mental health policies that may be adopted in the post–COVID-19 era in the United States.

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The response to the global COVID-19 pandemic has important ramifications for our mental health systems and the patients they serve (1, 2). The disruptive nature of the public health measures implemented to reduce the spread of this novel coronavirus has required dramatic changes in the ways in which usual health care is delivered. This ultra-rapid and widespread transformation of clinical practice was enabled by policies enacted at the local, state, and federal levels in record time.

This article describes changes in mental health policy—which influence services for people with mental disorders as well as substance use disorders—prompted by the COVID-19 crisis. Although policies have been enacted at every level of government, with crucial leadership from state and local authorities, we focus primarily on federal policies that have had far-reaching impacts. We believe this is a critical time to recognize these extraordinary advances in policy making because it provides an unprecedented opportunity to evaluate the effects of mental health policies that may be adopted in the post–COVID-19 era in the United States.

MENTAL HEALTH POLICY RESPONSES TO THE COVID-19 CRISIS

To facilitate major changes to clinical practice without exacerbating existing disparities across populations, policy makers have addressed a range of legal, regulatory, financial, and technological issues. The following framework describes some of the key domains of mental health policy—levers that directly influence the delivery of mental health care. While not exhaustive, this framework outlines significant ways in which federal policy levers have been used to promote and enable changes in mental health care delivery in the face of the COVID-19 crisis. These policies are current as of early April 2020, and some details have yet to be finalized as the broader health care landscape continues to evolve.

Legislation

Policies at the federal, state, and local levels may present obstacles or opportunities that could be addressed with legislative changes. Although procedures for passing bills, ordinances, and other legislative mechanisms differ depending on the locality, elected representative bodies typically must approve proposed legislation that is then signed into law by the leader of the executive branch. Types of laws include appropriations of funds for new and existing programs, authorizations for new agencies and programs and reorganizations of existing ones, and mandates for reporting and oversight activities.

The COVID-19 crisis has catalyzed a surge in legislative activity. The U.S. Congress has passed three major relief packages as of March 2020, with more on the horizon. The examples of legislation provided here include a range of measures relevant to mental health policy.

Families First Coronavirus Response Act. The Families First Coronavirus Response Act (H.R. 6201) includes provisions for paid sick leave effective April 2020 for people who have COVID-19 symptoms, need to quarantine, or are caring for children or ill family—all of which can be used by the mental health workforce who are exposed on the front lines (3).

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Coronavirus Aid, Relief, and Economic Security Act. The Coronavirus Aid, Relief, and Economic Security (CARES) Act (H.R. 748) is a $2 trillion stimulus package with multiple important provisions of relevance to mental health providers (4). It includes $425 million of appropriations to the Substance Abuse and Mental Health Services Administration (SAMHSA) to respond to the pandemic, with $250 million going to new funding for Certified Community Behavioral Health Clinic (CCBHC) Expansion grants, $100 million for emergency response activities, and $50 million for suicide prevention (Division B, Title VIII). The stimulus package further expands the CCBHC Medicaid demonstration to include two additional states in addition to the eight states currently involved, with an extension of the program to December 2020 (sec 3814). The CARES Act also aligns rules about sharing substance use disorder treatment information (commonly referred to as "42 CFR part 2") with the more familiar rules of the Health Insurance Portability and Accountability Act (HIPAA) (sec 3221).

Additional measures of this stimulus package are not specific to mental health but will have important financial implications for provider organizations. First, $349 billion is earmarked for the newly created Paycheck Protection Program, which provides loans of up to $10 million to small businesses and eligible nonprofit organizations toward job retention and certain other expenses, with the possibility that the loans will be forgiven (sec 1102). Second, $10 billion goes toward the Small Business Administration's Economic Injury Disaster Loan program, which provides small businesses and eligible nonprofits with an advance of up to $10,000 (does not need to be paid back), as well as capital loans of up to $2 million to help overcome the temporary loss of revenue that they are experiencing (sec 1110). Third, $100 billion is appropriated to the U.S. Department of Health and Human Services (DHHS) to be allocated to health care organizations that are providing diagnosis or treatment of COVID-19 and have had demonstrable reduction in services or uncompensated expenses as a result of COVID-19 (Division B, Title VIII). Fourth, $200 million is provided to the Federal Communications Commission to create the COVID-19 Telehealth Program to help eligible health care providers purchase telecommunications services, information services, and necessary devices (Division B, Title V) (5). Fifth, the legislation temporarily suspends Medicare sequestration through the end of 2020, which will increase payments to hospitals and other providers during the COVID-19 outbreak by delaying previously planned 2% reductions in fee-for-service Medicare payments (sec 3709).

Regulation

Although legislation dictates the official legal code, many details are often determined by specified departments, agencies, and other entities that are responsible for implementing the enacted statute. These agencies are also charged with responding to executive orders issued by the President, governors, and mayors. These determinations are issued in the form of regulations that have significant influence over how policies function in practice. Important types of regulations include reimbursement rules, patient eligibility criteria for programs, rules regarding what types of services are permitted in certain settings, accreditation requirements, and more.

A wide range of regulations has been issued in response to the COVID-19 crisis, most of which aim to reduce requirements for face-to-face contact between patients and providers so as to minimize viral transmission. One example is an exception issued by SAMHSA regarding maximum take-home methadone doses for patients with opioid use disorder enrolled in opioid treatment programs (28 days of take-home doses for stable patients and 14 days for less stable patients), as well as a temporary exemption of the requirement for in-person evaluations for new prescriptions of buprenorphine in the treatment of opioid use disorders (6). Another example is an easing of rules related for clozapine blood monitoring. The Food and Drug Administration and the Clozapine Risk Evaluation and Mitigation Strategy Program will not prevent pharmacies from dispensing clozapine for patients not meeting absolute neutrophil count reporting requirements established to monitor for onset of agranulocytosis (7), given that the risk of becoming severely ill with COVID-19 may be higher than the rare risk of complication of agranulocytosis for this patient population (8). Another example is Medicare's temporary relaxation of telehealth rules, permitting payments and waiving copays for services rendered "to beneficiaries in all areas of the country in all settings," including their homes, and regardless of whether an established clinical relationship existed (9). Finally, the DHHS Office of Civil Rights issued a temporary exemption to allow providers to deliver telehealth by using technology platforms that are not HIPAA compliant so as to reduce barriers to care (10).

Financing

Financing is a critical focus of health policy. Although funding mechanisms are most often controlled by governmental legislative and regulatory activities via direct appropriations, federal block grants, or public payers (namely, Medicare and Medicaid), organizations such as private insurance companies (including managed care plans), philanthropic organizations, and foundations are also affected by changes in mental health policy. Sustaining mental health programs typically relies on a combination of reimbursements for clinical services, including public funding, private contracts and grants, and other sources of revenue.

Health care financing has shifted substantially in the context of COVID-19. As many people who are under- or uninsured seek care, rising unemployment precipitates losses in employer-based health insurance, with few alternatives for enrollment in public insurance exchanges, and health care systems face major reductions in revenue as they limit care to essential services (11). In addition to the appropriations described above, regulatory changes have been made to help mental health providers remain financially viable during the COVID-19 crisis. For example, the Centers for Medicare and Medicaid Services (CMS) issued an 1135 "blanket waiver" to allow for greater flexibility in Medicare and Medicaid reimbursements, reduce prior authorizations, and allow for easier transfer of patients between facilities—all of which will support the delivery of mental health care during the pandemic. The provision regarding patient transfers is particularly relevant to hospitalized psychiatric patients, who may need to be safely transferred from facilities overwhelmed by COVID-19. Multiple states (34 as of this writing) have been approved for participation in this 1135 waiver opportunity (12).

CMS has approved reimbursements for telehealth appointments that are equivalent to reimbursements for in-person appointments for most service codes for Medicare-financed services (13). These equivalent reimbursements have also been approved by multiple private payers, as tracked by the American Psychiatric Association's Practice Guidance for COVID-19 (14), and many states (27 as of this writing) have also made changes to state Medicaid plans regarding reimbursements for telehealth (15).

Accountability

Oversight of health services is an important role of government and a target for policy change. A range of strategies is in place to hold providers, programs, and payers accountable for high-quality care by using quality measurement and reporting mechanisms. Incentives linked to high-quality care are realized through value-based payment strategies and alternative payment models. Although these accountability mechanisms are essential, collecting and reporting metrics according to strict guidelines can also be burdensome.

In the context of COVID-19, given that so much has changed in the health care system, the early response has been to ease the administrative burden on health systems. CMS has delayed quality reporting requirements for programs requiring quality reporting, such as the Merit-based Incentive Payment System, which includes mental health providers (16). Although the current crisis response justifies this relaxing of reporting requirements, evaluating the effects of the COVID-19 crisis on the quality and value of mental health outcomes will be important to inform policy responses in future crises.

Workforce Development

Fostering an adequate workforce to meet the service needs of a population can be influenced by legislation, regulation, and judicial case law. Common issues include professional credentialing and licensure, scope of practice, training and technical assistance, and incentives, such as loan repayment programs.

Measures aimed at strengthening the workforce in the face of COVID-19 have primarily focused on maximizing access to mental health providers while reducing administrative burden. With coordination by the Federation of State Medical Boards, many states have temporarily waived state licensing and renewal requirements and allowed for greater reciprocity across the United States (17). CMS has temporarily exempted requirements for physician supervision of nurse practitioners and physician assistants to expand access to care (13). Under the 1135 blanket waiver authorities described above, CMS has also fast-tracked provider enrollment and relaxed requirements that physicians and other health care professionals be licensed in the state in which they are providing services (12). The Drug Enforcement Agency waived the requirement to register in new states to prescribe controlled substances (18).

Additional measures that may be considered include hazard pay and special loan repayment opportunities for COVID-19 responders. Although the high rates of infection among frontline health care workers have raised alarm (19), we are not aware of specific policies aimed at protecting health care workers who treat patients at high risk of contracting COVID-19, such as adults with serious mental illness (1).

SPECIAL CONSIDERATIONS FOR MENTAL HEALTH POLICY IN THE CONTEXT OF COVID-19

The major areas of mental health policy described above—legislation, regulation, financing, accountability, and workforce development—encompass a large range of stakeholders, each of whom have unique perspectives and incentives. Engaging a diverse coalition of partners can help ensure the success of a policy, regardless of the lever involved. Some key domains of mental health policy that maintain broad support include social determinants of health, innovative technologies, and research and evaluation.

Social Determinants of Health

As clinicians and leaders work overtime to adjust to the new realities of COVID-19, justified concern exists for the vulnerable populations served in safety-net settings who already have a higher burden of poverty and social disadvantage. The COVID-19 crisis is likely to exacerbate existing disparities in mental and physical health and health care (1). These are "acute on chronic" disparities: higher rates of comorbid medical conditions (20) and smoking status (21) that put people with mental illness at higher risk of serious morbidity due to COVID-19 (22, 23); barriers to care seeking because of immigration status (24); poor access to essential care for incarcerated and homeless populations, despite increased exposure (25); and more. Compounding these

disparities, publicly funded systems that serve these patient populations tend to have fewer resources. As a result, COVID-19 testing may be less available and take longer, and shortages of personal protective equipment, intensive care unit beds, and ventilators may be more severe (26, 27). The burden of these disparities also weighs heavily on clinicians delivering care in these settings.

Every one of the aforementioned policy levers must take into consideration the effect of policies on vulnerable and underserved populations. Although mental health care delivery may be bolstered by increased funding and a larger and more empowered workforce, policies should also consider how long-entrenched disparities can be addressed with expansion of programs, coordination across social services agencies (e.g., housing, employment, schools, and criminal justice system), and targeted outreach to vulnerable populations (e.g., homeless, immigrant, and incarcerated) to prevent viral spread and facilitate access to care from first episode through recovery. Furthermore, given existing disparities in preventive health care, such as influenza vaccinations, among people with serious mental illness (28, 29), a concerted effort will be needed to ensure equitable access to an eventual COVID-19 vaccine.

Innovative Technologies

Another important opportunity for influencing policy involves the private and public entities sprinting to develop innovative health care technologies (e.g., mobile apps, tablet-based platforms, and Web portals). Identifying obstacles to and opportunities for promoting high-functioning mental health programs that can readily adapt to crises such as the ongoing pandemic can have important implications for improving clinical management and uptake.

In response to the major disruptions in conventional care that have been precipitated by the COVID-19 crisis and facilitated by changes in the regulatory environment, technology solutions have been ubiquitous. Most prominent has been the rapid expansion of tele–mental health platforms for remote visits, a change that many hope will last beyond the current crisis (30). In light of the social determinants described above, monitoring for inequities in engagement with new technologies across groups with limited access to smartphones or the Internet will be essential as mental health delivery systems adapt to this new clinical environment.

Research and Evaluation

Finally, the role of research and evaluation is central to informing mental health service delivery and policy. Funding for research is often motivated by gaps in the literature that can have meaningful impacts on clinical practice. An additional consideration for funders and researchers is how findings could be used to directly inform evidence-based policy making.

Given the transformations in clinical practice that have resulted from COVID-19, there is an urgent need for rigorous evaluation of new programs and patient outcomes. Research opportunities should take advantage of natural experiments that have resulted from responses to the COVID-19 crisis, such as quasi-experimental studies of mental health outcomes based on state-level changes in use of telehealth. In addition, the impact of COVID-19 on the mental health of patients and health care workers will be a major issue that requires long-term attention (31). To adequately conduct research in these areas, novel approaches are needed to facilitate large-scale data collection using common registries and interoperable electronic records. Only by collecting, analyzing, and disseminating these findings will our field be able to identify beneficial or harmful interventions that can inform future evidence-based policy making.

CONCLUSIONS

The domains of mental health policy described in this article, while not a comprehensive list, are important levers that can be influenced by researchers, advocates, clinicians, and individuals with lived experience and their families. Seldom in recent history have so many policies evolved so quickly as in this period of COVID-19 crisis response. These circumstances raise a critically important question: What evidence for new policies and approaches has been born from the COVID-19 crisis that should—or should not—be sustained in the future?

As we continue to move through the unique challenges presented by this global pandemic, we can and should be opportunistic when it serves the public interest and the well-being of people with mental illness. Mental health practices for which there is expansive evidence are often stymied because of policy barriers—important examples include telepsychiatry, integrated care, clozapine prescribing, and medication-assisted treatment. All these models stand to benefit from sustaining the policy changes that have been catalyzed by the COVID-19 crisis. Surely there are lessons to be learned from the present to improve mental health services in the future.

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