Case Study of Massachusetts COVID-19 Emergency Policy Reforms to Support Community-based Behavioral Health and Reduce Mortality of People with Serious Mental Illness

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Highlights:

1. People with serious mental illness and the community-based behavioral health organizations where they seek and receive care across the nation are both at extreme risk for catastrophic outcomes in the current COVID-19 pandemic.
2. The State of Massachusetts has rapidly responded to this crisis by rapidly implementing a variety of policy, regulatory, and payment reforms designed to enhance remote telehealth delivery of care, access to needed medications and residential care staff, and support the financial livelihood of community-based behavioral health services at a time of dramatic declines in revenues and a diminished workforce.

3. If shown to improve access and mitigate adverse outcomes, rapid state and federal policy reforms implemented during this health care crisis such as flexible coverage for telehealth and population-based payments should be considered as the "new normal" for the future health and welfare of people with serious mental illness and community-based behavioral health organizations.

Abstract

People with serious mental illness (SMI) are at disproportionate risk for COVID-19 morbidity and mortality due to high rates risk factors that directly parallel those related to poor coronavirus outcomes. In addition to high rates of smoking, COPD, cardiovascular disease, and diabetes; SMI is associated with greater likelihood of housing instability, homelessness, food insecurity, and poverty. Community-based behavioral health organizations across the nation are experiencing unprecedented challenges related to COVID-19. Policy, financing, and service delivery challenges are identified with corresponding emergency reforms implemented in the state of Massachusetts as an example of key components of a coordinated state emergency response.

People with serious mental illnesses (SMI) including schizophrenia, schizoaffective disorder, bipolar disorder, and severe depression make up over 3-4% of the US population with intersecting psychological, medical, and social vulnerabilities that place them at disproportionate risk for COVID-19 acquisition, morbidity, and mortality. People with SMI historically experience one of our nation's greatest and underrecognized health disparities with a reduced life expectancy of at least 10 years, explained in part by high rates of tobacco use and multiple chronic health conditions.[1,2] Of direct relevance to the current pandemic, the prevalence of cigarette smoking, COPD, cardiovascular disease, and diabetes among people with SMI are each about 2-3 times higher than in the general population[3], directly corresponding to age-independent risk factors associated with higher rates of COVID-19 mortality.[4] Compounding these risks are psychological, cognitive, and socioeconomic challenges experienced by people with SMI that potentially lead to difficulties with medication adherence, self-care, living skills, and following health-related recommendations. SMI is also associated with numerous social vulnerabilities that are likely to contribute to poor COVID-19 outcomes [5], including poverty, homelessness, poor nutrition, and difficulty accessing needed medications, as well as increased risk of viral transmission associated with residing in congregate group homes, emergency shelters, transitional housing programs, long-term care facilities, and psychiatric hospitals. At the nexus of the COVID-19 crisis for people with SMI are state-supported community-behavioral health organizations that have experienced profound challenges in striving to rapidly transform and scale new services in the absence of essential capacity and capability, along with direct adverse impacts on staff and related physical and fiscal health.

An example of adverse impact of COVID-19 on community-based behavioral health services is illustrated by a survey of 32 California non-profit Community Behavioral Health agencies.[6] One-third of the agencies indicated that they have service recipients who are too sick to engage in treatment and do not know if this is due to COVID-19, a worsening of psychiatric or medical illness, or both. The vast majority of agencies (87%) reported lacking vital equipment to adequately conduct telehealth, and agencies lacked access to any personal protective equipment for front line staff. Over half (58%) reported decreasing delivery of needed behavioral health services, with most (81%) experiencing reduced capacity due to staff health issues or lack of child care. Due to declines in revenue, 10% of the agencies have furloughed staff, 13% terminated positions, and an additional one third reported that they will furlough or terminate positions in the absence of financial relief.

Massachusetts Example of State-wide COVID-19 Behavioral Health Policy Reforms

The Massachusetts Department of Mental Health provides services to approximately 30,000 people with SMI annually. As the COVID-19 pandemic developed, community-based providers collaborated with the Executive Office of Health and Human Services to rapidly develop changes in guidance, regulations, and funding to provide flexibility in supporting behavioral and physical health services as the coronavirus pandemic spread.[7] In Figure 1, we identify critical challenges and corresponding health care delivery and policy measures implemented in the State of Massachusetts as an example of a coordinated statewide response to challenges associated with the COVID-19 pandemic. Among the most high-impact regulatory relief

measures being enacted at the level of clinicians and patients are state Medicaid, third-party, and federal Medicare and HIPPAA waivers allowing extensive use of provider-to-person home and community-based telehealth assessments and treatments.[8] At the patient level, Massachusetts instituted a temporary policy preventing termination of individual-level Medicaid coverage during the national emergency. Other critical measures include allowing pharmacies to distribute larger amounts of prescribed medications and refills to individual patients, along with waivers on the amount of medication stored on-site in group homes, helping to ensure an uninterrupted supply of critical psychiatric and medical medications to patients at significant risk of relapse with the increased stress and isolation associated with the COVID-19 pandemic. The special challenges associated with distributing Clozapine that requires in-person blood draws and labs before filling prescriptions (so called "no blood no drug" policy) were addressed by academic-community partnerships with input from the state. For example, Massachusetts General Hospital, McLean Hospital and the North Suffolk Mental Health Association set up a clozapine working group to formulate guidance about how to proactively manage clozapine dispensation for our large clozapine cohort during COVID-19, consistent with national REMS guidance and an international consensus paper.[9] The Massachusetts Department of Mental Health explicitly endorsed the recommendations which removed uncertainty for clinicians and pharmacies. Additional regulatory relief included relaxing criteria for group home staff to be recently recertified to administer medications, and providing increased "combat pay" for frontline residential care workers. In an effort to provide additional physician workforce capacity, Massachusetts also approved temporary 3-month medical licenses for early graduating medical students and recently retired physicians.

At the organization-level, examples of critical financial life-lines being enacted by Massachusetts to behavioral health providers providing temporary continued distribution of a portion of historically billed Medicaid payments untethered from fee-for-service direct visits. Critical financial stabilization funds announced by Massachusetts Governor Baker coordinated by the Executive Office of Health and Human Services include $23 Million of in immediate cash relief in March followed by a commitment of $104 Million including monthly interim payments from April to July 2020 equaling 50% of providers historical behavioral health revenue and a 10% increase to clinical support services, acute treatment services, residential support services, children's behavioral health services, and opioid treatment services.[7]

Focused efforts have also been engaged to help reduce the devastating impact of COVID-19 on the most vulnerable subgroups of people with serious mental such as those who are homeless. In partnership with city and state agencies and other community stakeholders, Boston Health Care for the Homeless Program (BHCHP) rapidly deployed a comprehensive COVID-19 response strategy that included front-door symptom screening at local shelters, expedited COVID-19 testing, isolation of homeless persons under investigation for COVID-19 in alternate care settings, and dedicated COVID-19 care units for people experiencing homelessness. Across each segment of this response, BHCHP mental health clinicians have been able to provide virtual care to patients with psychiatric and addictive disorders via telehealth-based approaches. Additional long-term support is available for basic housing and food support through the Massachusetts Medicaid 1115 Waiver Delivery System Reform Incentive (DSRIP) program and

Medicaid Accountable Care Organizations for a "Flexible Services Program" dedicated to health-related nutrition and housing supports that will be deployed.

Summary: During natural disasters and states of emergency, existing inadequacies in our current health care delivery system are brought into bold relief. Rapidly implementing measures at state and local levels may not only contribute to mitigating the disproportionate morbidity, mortality, and spread of COVID-19 for people with serious mental illness, but may have substantial implications for reducing the impact of this pandemic for the broader population of vulnerable adults with complex physical, social, and psychological needs and disabilities. The State of Massachusetts provides one example of a coordinated response aimed at providing flexibility and relief at the level recipients of care, clinicians, staff, and organizations. Some of these transformations have accelerated previously existing trends such as increasing the use of provider-to-patient telehealth and use bundled capitated payment approaches. Additional potential measures could include leveraging mobile health and automated telehealth providing medical and psychiatric illness self-management support and remote monitoring [10], supplemented by automated delivery of COVID-19 patient education and symptom tracking. At the individual-level in the critical domain of social support, family members, certified peer support specialists, and relevant federally supported state agencies could be widely engaged through the National Alliance for Mental Illness and the Substance Abuse and Mental Health Administration to virtually reinforce social distancing, handwashing, and stress reduction practices while helping to minimize the adverse psychological effects of social isolation, such as increased risk of depression, substance use, psychiatric relapse, and

suicide. These and other adopted measures could subsequently translate to downstream reforms in how we care for these populations during more ordinary times. Once we make it through this crisis and reflect on the lessons learned in implementing these innovations and reforms, we should not waste this potentially transformative opportunity by returning to business as usual.

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Figure 1:

Behavioral Health Regulatory and Financing Challenges and Massachusetts COVID-19 Responses

Behavioral Health Regulatory & Financing Challenges	Emergency Policy & Financing Initiatives
In-Person Individual and Group Treatment Requirements In-person individual and group clinical encounters required for reimbursement presenting barriers to safe, scalable, and effective psychiatric and medical telehealth services.	**Cover and Resource Psychiatric and Medical Telehealth** Medicaid and third-party payer reimbursement allowed for provider-to-person telehealth in conjunction with implementation of Medicare and HIPPAA waivers to reduce telehealth restrictions.
Risk of Losing Medicaid Eligibility Due to changes in employment status, income, residential address, homelessness, or routine eligibility review, people	**Protection of Medicaid Coverage During COVID-19** Guarantee of coverage for all individuals with MassHealth as of March 18, 2020 and for all individuals approved for

with SMI are potentially at risk to lose eligibility for Medicaid.	coverage during the COVID-19 national emergency, and for one month after the emergency period ends.
Psychiatric/Medical Medication Regulatory Restrictions -30 day limited prescriptions and number of refills -Limited on-site store of medications in congregate settings -Staff certification deadlines for administering medications - FDA-required labs for clozapine: “no blood, no drug”.	**Enact Flexible State and Federal Regulations** 90-day prescriptions allowed with increased automatic refills, greater storage of medications in congregate settings, prior authorizations reduced.
Inadequate Psychiatric Clinician Workforce Existing shortfall of psychiatrists, psychologists, psychiatric nurse practitioners/RNs, and psychiatric social workers will be further exacerbated by quarantines and redeployments.	**Deploy Untapped Professional Reinforcements** Temporary licenses allowed for early medical school graduates and recently retired psychiatric clinicians, honor licenses from less affected regions for cross-state telehealth.
Financially Fragile Behavioral Health Provider System Low rates of Medicaid, Medicare, and third-party behavioral health reimbursement translate into minimal cash reserves for payroll if routinely provided units of service decline.	**Bundled Temporary Payments Based on Historical Billings** Temporary capacity to continue salary support for essential residential, outpatient, and institution-based behavioral health providers by providing bundled payments based on historical Medicaid and related aggregate billings.
Unstable Housing, Employment, Nutrition, Finances Greater health-related social needs: housing instability, unemployment, food/financial insecurity, poverty.	**Engage/Optimize Safety Net and Basic Support Services** Proactively engage social services, housing and food assistance by leveraging Massachusetts DSRIP 1115 waiver flexible support services program.
Unmet Needs for Highly Vulnerable Subgroups Homeless, older adults, children, co-occurring substance use disorders/developmental disabilities, incarcerated jail and prison populations, nursing homes, and congregate settings.	**Target/Tailor Services for Highly Vulnerable Subgroups** Implement integrated behavioral and medical health care services tailored to special populations and settings supported by specialty on-site and remote consultation.