American Hospital Association

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April 9, 2020

The Honorable Alex M. Azar
Secretary
U.S. Department of Health and Human Service
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including nearly 1,600 psychiatric and substance use disorder provider members, the American Hospital Association (AHA) asks Health and Human Services (HHS) to provide additional guidance and flexibility for providers caring for patients with behavioral health disorders. These patients have unique needs that merit special consideration during the novel coronavirus (COVID-19) outbreak, and our members need help balancing safe public health measures with appropriate clinical protocols for these vulnerable patients.

Many of the requests we made in our recent letters (on waivers of certain regulations and additional requests for flexibility) would benefit providers of psychiatric care; in today's letter, we detail additional, specific concerns our members have raised to us and adjustments we believe HHS can offer. In general, these concerns fall into two categories: special treatment considerations for patients with behavioral health disorders and logistical barriers for psychiatric care providers.

Special Treatment Considerations. Treating patients with behavioral health disorders requires different clinical protocols from general acute care. For example, when treating a patient in crisis — like a patient in an acute psychotic episode — it is difficult to gauge history of exposure to COVID-19 and to minimize various forms of contact, as has been recommended by guidelines issued by the U.S. Centers for Disease Control and Prevention (CDC). Similarly, in the inpatient psychiatric facility setting, providers have difficulty applying some guidance to their patients: The CDC states that patients should be asked to wear a surgical mask and be evaluated in a private room with the door closed. This guidance may pose safety risks for both the patient and the staff, as many patients with mental illness feel uncomfortable in limited physical

spaces and may be unwilling to wear a mask — in fact, the masks themselves may be considered a ligature risk for patients demonstrating suicidal ideation.

In addition, many clinical treatment protocols for behavioral health disorders include group therapy. These formal sessions offer significant benefits to patients, and can maximize the reach of specialized clinicians who can work with multiple patients at a time. In addition, patients often receive treatment through intensive outpatient or partial hospitalization programs, where the patient visits the treatment center several days per week instead of being admitted as an inpatient. These programs frequently involve group as well as individual psychotherapy. However, in an attempt to control the spread of COVID-19, the Centers for Medicare & Medicaid Services (CMS) issued guidance to nursing homes that would cancel all group activities including therapy. If such guidance were applied to psychiatric facilities, it would cause serious harm and threaten recovery. In addition, many of our members have voiced confusion about what adjustments they should make to their outpatient treatment programs so as to both continue providing recovery support for their patients while limiting exposure to COVID-19.

In another recent letter, we urged HHS to take additional action to expand telehealth services, which would have particular benefit for patients receiving behavioral health care treatment. In particular, facilities (like hospital outpatient departments, or HOPDs) that provide outpatient psychotherapy services need to be able to provide these services via telehealth technology, including group therapy, and the facilities that provide these treatments must be appropriately remunerated to ensure they can continue to serve patients.

CDC should work with the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop guidance for providers who treat patients with behavioral health disorders on how to adjust general guidelines around COVID-19 for this unique patient population. Such guidance should include specific instructions on protocols for patients admitted to psychiatric facilities who test positive for COVID-19 and reasonable group therapy management practices or alternatives, like remote sessions. In addition, **CMS should ensure that behavioral health services, including group therapy offered through HOPDs, are appropriately reimbursed.**

Logistical Barriers. A surge of COVID-19 patients causes severe shortages of staff, physical space and supplies for all types of health care facilities. These shortages are even more severe in the field of behavioral health care, which already demonstrates a lack of clinicians and beds. In a facility that is already at capacity, it is unrealistic to move patients or shift group therapy or other activities commonly performed in communal spaces into private rooms, as has been suggested by CMS guidance. Not only could this pose safety issues as noted above, but it would require significantly more staff to oversee (in other words, one staff member may be able to lead a group therapy session of 10 patients, but shifting that session into 10 individual sessions

would not be feasible for that single practitioner). In addition to the guidance requested above on how psychiatric facilities should apply CDC and CMS guidance to their patient population, **we also recommend that CDC and CMS issue unique guidance for psychiatric facilities that takes these concerns into account.**

Staffing poses a particularly dire challenge in behavioral health care, which will face a shortage of 250,000 professionals by 2025, according to a 2016 HHS report. While there are several complex factors contributing to this issue, shortages are often exacerbated by regulatory directives. For example, psychiatric facilities have to abide by strict staff-to-patient ratios and only practitioners with certain qualifications and degrees may perform specific tasks. While some of these restrictions are appropriate, some are not — for example, under the Emergency Medical Treatment & Labor Act (EMTALA), only designated medical personnel may perform a definitive medical screening examination, even though the tasks included that examination are well within the scope of practice and licensure of other medical staff. Our members also struggle with the administrative burden and time lag associated with credentialing and licensure, which are always a significant barrier to increase staffing capacity but are particularly problematic during an emergency when time is scarce. With these myriad issues in mind, **we encourage HHS to relax staffing ratio requirements, loosen some restrictions on what levels of practitioners may perform certain tasks, and allow and issue guidance on providing additional services (like medication management) and use of telehealth modalities for behavioral health (including telephonic and store-and-forward as opposed to only two-way audio/video).**

In addition, many inpatient behavioral health treatment programs — particularly those for children and adolescents — include home visit passes, where patients may temporarily leave the residential facility and return to their communities to spend time with their families. These programs also often include family therapy sessions, where family members join patients at the psychiatric facility. While these programs are important to recovery, they also increase the risk of bringing community-acquired viruses back to the facility. **We encourage HHS to issue short-term waivers to limit these visits.**

In addition, clinicians treating behavioral health disorders have voiced concerns about the lack of safeguards as they meet with patients inside small counseling rooms without masks or other protective equipment, which has been diverted to general acute care facilities. **HHS should ensure that clinicians and professionals who treat behavioral health disorders are included in priority testing and are also able to receive emergency medical supplies.**

Finally, while our members are working tirelessly to treat COVID-19 patients on the front lines, they are also preparing for what we believe is an inevitable surge in behavioral health patients with symptoms brought on by this incredibly stressful time. Many hospitals have reduced their inpatient psychiatry census in response to the

pandemic, but these unoccupied beds are unlikely to stay empty for long. An influx of behavioral health patients will include those experiencing exacerbation of depressive, psychotic and substance use disorders due to isolation or lack of easy access to care, incidences of domestic violence and suicide, and even post-traumatic stress events for patients and the health care workforce. We thank the administration for the resources made available through SAMHSA, the Department of Veterans Affairs and CDC on coping with and managing stress and emotional health in this context. **However, we believe that it is essential that the Administration preemptively plan for the surge of behavioral health patients that is likely to arise in the next few months by determining how to use expanded capacity originally intended to treat COVID-19 patients to address behavioral health patients, identifying additional funding opportunities for psychiatric providers (including expanded waivers of the Institutions for Mental Disease Exclusion, which would allow Medicaid to pay for care provided in these facilities), and enhancing the behavioral health workforce to triage emergency department backlogs.**

We appreciate your leadership and the ongoing work of the White House Coronavirus Task Force. We look forward to continuing to work with you during this critical time to protect the health of our nation and our most vulnerable patients.

Sincerely,

/s/

Richard. J. Pollack
President and Chief Executive Officer