

## How Legal Changes in Response to COVID-19 Can Improve Access to Community Behavioral Health

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# Contents

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## 3 Executive Summary

## 5 Background: California's Behavioral Health System

## 6 The Pandemic's Impact on Governments, Providers, and Patients

- State and County Governments

- Community Behavioral Health Care Providers

- Californians with Behavioral Health Needs

## 10 Overview of Pandemic Response Measures Affecting Community Behavioral Health Providers

## 12 Assessment of High-Impact Legal Changes and Candidates for Permanent Reform

- Increased Access to Telehealth

- Changes to Medi-Cal Reimbursement Methodologies

- Controlled Substances and Prescription Drugs

- Provider Licensure and Operating Standards

## 21 Conclusion

## 22 Appendix

- A. Glossary of Abbreviations and Key Terms

- B. Interviewees

## 25 Endnotes

## Executive Summary

The COVID-19 pandemic has created immense challenges for California’s community-based behavioral health care system and the people it serves. Traditional in-person service models for mental health and substance use disorders (SUDs) presented a risk of contagion as the pandemic took hold. At the same time, deferring care for weeks or months created grave risks for individual health and welfare, particularly as pandemic-related stressors drove an increase in the prevalence and severity of behavioral health conditions. Recognizing these challenges, both the federal and California state governments implemented numerous legal reforms aimed at supporting providers’ efforts to slow the spread of the coronavirus while preserving access to needed services in a time of social distancing and economic crisis.

This report discusses the impact of those legal reforms on outpatient and residential behavioral health services in California. The authors focus on legal changes that were adopted and implemented during the early months of the COVID-19 pandemic (January to July 2020), and also identify opportunities for long-term reform. Although focused primarily on Medi-Cal (California’s Medicaid program), the report also addresses legal changes that affected the Medicare program and commercial health plans. Because this report focuses specifically on outpatient and residential care — commonly referred to as “community behavioral health care” — it does not address acute behavioral health services furnished in the hospital emergency department or inpatient settings.

The authors undertook two primary tasks in preparing this report. First, they prepared a compendium of the relevant legal actions adopted in response to the COVID-19 pandemic through California and federal laws, regulations, waivers, or other regulatory guidance (the “[Legal Compendium](#)”). Second, they conducted interviews with four stakeholders who collectively possess a deep and diverse set of experiences in California’s behavioral health system. (See Appendix B for additional details.) The authors provided the Legal Compendium to these interviewees and asked them to consider which legal changes had the greatest impact on the delivery of behavioral health care in California during the pandemic and which changes should be preserved — or expanded upon — after the pandemic subsides.

In Table 1 (page 4), the authors outline both the temporary response measures that were most important in supporting access to high-quality community behavioral health services and those that are the most promising opportunities for long-term reform. Many of these policies have long been supported by advocates in pursuit of a more accessible and efficient community behavioral health system. They fall into four general categories:

1. Coverage for telehealth services
2. Medi-Cal’s cost-based reimbursement system
3. Controlled substances and prescription drugs
4. Provider licensure and operating standards

**Table 1. COVID-19 Behavioral Health Care Legal Changes**

HIGH-IMPACT PANDEMIC RESPONSE MEASURES	OPPORTUNITIES FOR LONG-TERM REFORM
<b>Coverage for Telehealth Services</b>	
<ul style="list-style-type: none"> <li>▶ Expanded coverage for telehealth services under Medi-Cal, Medicare, and commercial health plans</li> <li>▶ Permitted additional types of “originating” and “distant” sites</li> <li>▶ Granted flexibility on telehealth technology and privacy rules, including by expanding the types of permissible telehealth platforms</li> </ul>	<ul style="list-style-type: none"> <li>▶ Enhance coverage across all payers for established telehealth modalities (video and telephone) in clinically appropriate circumstances</li> <li>▶ Evaluate additional remote modalities, such as texting-based services</li> <li>▶ Establish telehealth reimbursement policies that promote patient choice and incentivize the right care at the right place at the right time</li> <li>▶ Eliminate unnecessary administrative barriers to telehealth access, such as restrictions on originating and distant sites or requirements for written consent</li> <li>▶ Develop an expedited licensure pathway for out-of-state psychiatrists seeking to deliver telepsychiatry services to California residents</li> </ul>
<b>Medi-Cal’s Cost-Based Reimbursement System</b>	
<ul style="list-style-type: none"> <li>▶ Allowed counties to pay providers a fixed amount each month, subject to subsequent reconciliation based on actual volume and costs</li> <li>▶ Added new types of reimbursable costs and raised the cap on administrative costs</li> <li>▶ Substantially increased reimbursement rates for certain behavioral health services</li> </ul>	<ul style="list-style-type: none"> <li>▶ Move away from a cost-based system toward a more flexible system that minimizes administrative burden, incentivizes value-based care, and supports financial stability for counties and providers in times of crisis</li> </ul>
<b>Controlled Substances and Prescription Drugs</b>	
<ul style="list-style-type: none"> <li>▶ Enhanced flexibility for treatment of opioid use disorder, including Narcotic Treatment Programs (NTPs), with respect to telehealth assessments and counseling, take-home dosing, and hand delivery of medications</li> <li>▶ For non-opioid controlled substances (including certain psychotropic drugs), created new flexibility for practitioners to prescribe drugs based on telehealth evaluations</li> <li>▶ Relaxed dispensing limits and prior authorization procedures for prescription drugs under Medi-Cal and Medicare</li> </ul>	<ul style="list-style-type: none"> <li>▶ Evaluate policies to decrease the number of required in-person interactions in NTPs, such as increased use of telehealth and take-home dosing in appropriate circumstances</li> </ul>
<b>Provider Licensure and Operating Standards</b>	
<ul style="list-style-type: none"> <li>▶ Granted flexibility for providers to modify hours of service</li> <li>▶ Streamlined procedures for provider enrollment in Medi-Cal and Medicare</li> <li>▶ Delayed on-site provider inspections and offered the option of virtual inspections</li> <li>▶ Suspended requirements for practitioner license renewals and continuing education</li> <li>▶ Extended the time for trainees to complete their qualifying exams and other licensure requirements</li> </ul>	<ul style="list-style-type: none"> <li>▶ Reconsider California’s documentation requirements for behavioral health services, particularly with respect to patient signature requirements, treatment plans, and progress notes</li> <li>▶ Streamline the procedures for Medi-Cal provider certification</li> <li>▶ Align Medi-Cal’s provider certification and service delivery standards across mental health and substance use disorder (SUD) services</li> <li>▶ Increase the use of desk reviews and virtual inspections in lieu of on-site provider surveys, when appropriate</li> </ul>

## Background: California's Behavioral Health System

The COVID-19 pandemic has had a devastating impact in California. In the pandemic's early months — from January to July 2020 — the new coronavirus infected more than 500,000 Californians and caused more than 9,300 deaths.<sup>1</sup> The spread of this dangerous and highly infectious new pathogen fundamentally transformed everyday activities in all facets of life, including the operation of California's community behavioral health system. Traditional in-person service models for mental health and SUDs presented a risk of contagion. At the same time, deferring care for weeks or months created grave risks for individual health and welfare, particularly as pandemic-related stressors drove an increase in the prevalence and severity of behavioral health conditions. To help providers navigate between these competing concerns, government officials implemented a bevy of policy changes aimed at preventing and mitigating the spread of the virus while preserving access to crucial behavioral health services.

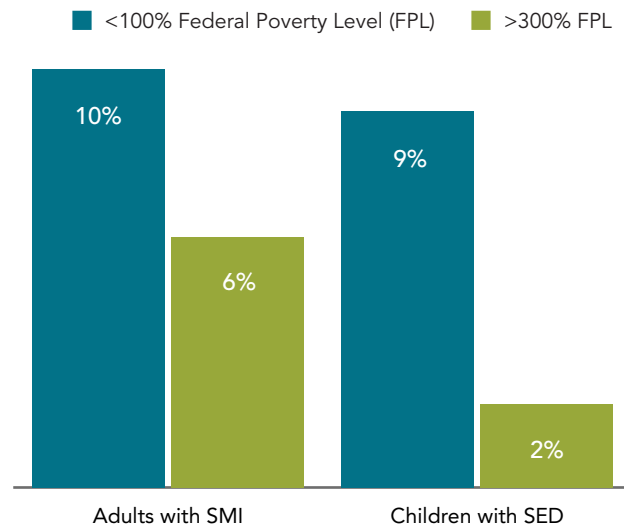
This section reviews the landscape of behavioral health needs in California and then provides a brief overview of Medi-Cal's coverage of behavioral health services, which has historically been more robust than the coverage available under either Medicare or commercial insurance plans.

Each year, approximately one in six California adults experiences a mental health condition; among adults and adolescents, one in 12 meets the criteria for a SUD.<sup>2</sup> Behavioral health conditions are both more prevalent and more acute among the 13 million low-income Californians served by the Medi-Cal program, which covers one-third of the state's total population (see Figure 1).<sup>3</sup> In addition to the immediate suffering caused by mental health and SUD conditions, people with behavioral health problems are more likely to experience chronic physical conditions, poor social outcomes, and early mortality.<sup>4</sup>

The Medi-Cal program, which is administered by the California Department of Health Care Services (DHCS), provides a broad array of services related to behavioral health, physical health, and long-term care. However, the state relies on disparate funding streams and a decentralized structure in which each county holds significant responsibility for managing and delivering these services. Although this structure allows for county-level flexibility and innovation, it can also produce a fragmented experience of care for Medi-Cal enrollees.<sup>5</sup> Not only do coverage policies vary across county lines, but an individual with physical and behavioral health needs may have to interface with three different types of Medi-Cal plans:

- ▶ **Managed care plans (MCPs).** These plans contract with the state to manage all physical health and mental health services for individuals with mild to moderate mental health needs.<sup>6</sup> MCPs must comply with DHCS policies regarding the Medi-Cal program, and most MCPs are also subject to regulations issued by the California Department of Managed Health Care (DMHC), which regulates both Medi-Cal MCPs and commercial health plans.

**Figure 1. Prevalence of Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED), by Income Level, California 2014**



Source: *Mental Health in California: For Too Many, Care Not There*, CHCF, March 2018.

- ▶ **County mental health plans.** These plans contract with the state to manage specialty mental health services for adults and children who have been diagnosed with a serious mental health condition in addition to meeting certain criteria for impairment and intervention.
- ▶ **County alcohol and drug programs.** Under the Drug Medi-Cal Organized Delivery System (DMC-ODS), most counties provide a full continuum of SUD services modeled on the American Society of Addiction Medicine (ASAM) criteria (see Table 2).<sup>7</sup> The DMC-ODS program was established in 2015 after the federal government approved California’s request to broaden Medi-Cal coverage of SUD services using an innovative waiver under Section 1115 of the Social Security Act. All of California’s largest counties have opted into DMC-ODS, with the result that 96% of Medi-Cal enrollees have access to the full continuum of SUD services.<sup>8</sup> In the 21 counties

that have *not* opted into DMC-ODS, a more limited range of SUD services is available through the pre-waiver Drug Medi-Cal program.

## The Pandemic’s Impact on Governments, Providers, and Patients

COVID-19 ushered in twin crises in public health and the economy, driving an increase in social needs while simultaneously disrupting the very health care and governmental systems that would normally help address those needs. This section reviews the pandemic’s impact on three sets of stakeholders in California’s community behavioral health system: states and counties, providers, and individual Californians with behavioral health needs.

### State and County Governments

#### The Two-Sided Budget Squeeze

The pandemic created budget crises around the country as state and local governments found their finances squeezed from two directions at once.<sup>9</sup> California faced an unexpected \$54 billion dollar deficit in spring 2020, as the economic slowdown sharply reduced tax-based revenues while increasing the demands on — and the costs of — publicly funded safety-net programs related to cash assistance, nutrition support, and health care.<sup>10</sup> Administrative capacity has been stretched thin as state and local officials endeavored to do more with less, seeking to maintain existing public programs and address areas of rising need while implementing new policies on remote work, physical distancing, and other infection control measures.

*“Counties need to deliver a broad suite of services to a growing population of recipients at a time when funding sources have shrunk. It is a real challenge.”*

— Kelly Pfeifer  
deputy director of behavioral health, DHCS

**Table 2. Services Provided Through Drug Medi-Cal and DMC-ODS**

#### DRUG MEDI-CAL

- ▶ Outpatient drug-free treatment
- ▶ Intensive outpatient treatment
- ▶ Naltrexone treatment
- ▶ Residential SUD services  
(only for perinatal women, and only in facilities with ≤16 beds)
- ▶ Narcotic Treatment Programs  
(methadone only)

#### DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

- ▶ Outpatient drug-free treatment
- ▶ Intensive outpatient treatment
- ▶ Naltrexone treatment
- ▶ Multiple levels of residential SUD treatment  
(additional populations, larger facilities)
- ▶ Narcotic Treatment Programs  
(methadone, plus buprenorphine, disulfiram, and naloxone)
- ▶ Withdrawal management  
(at least one American Society of Addiction Medicine [ASAM] level)
- ▶ Recovery services
- ▶ Case management
- ▶ Physician consultation
- ▶ Partial hospitalization (*optional*)
- ▶ Additional medication-assisted treatment (*optional*)

## The Impact on Community Behavioral Health Care

Among other consequences, these budgetary pressures have affected California’s behavioral health system in two fundamental ways:

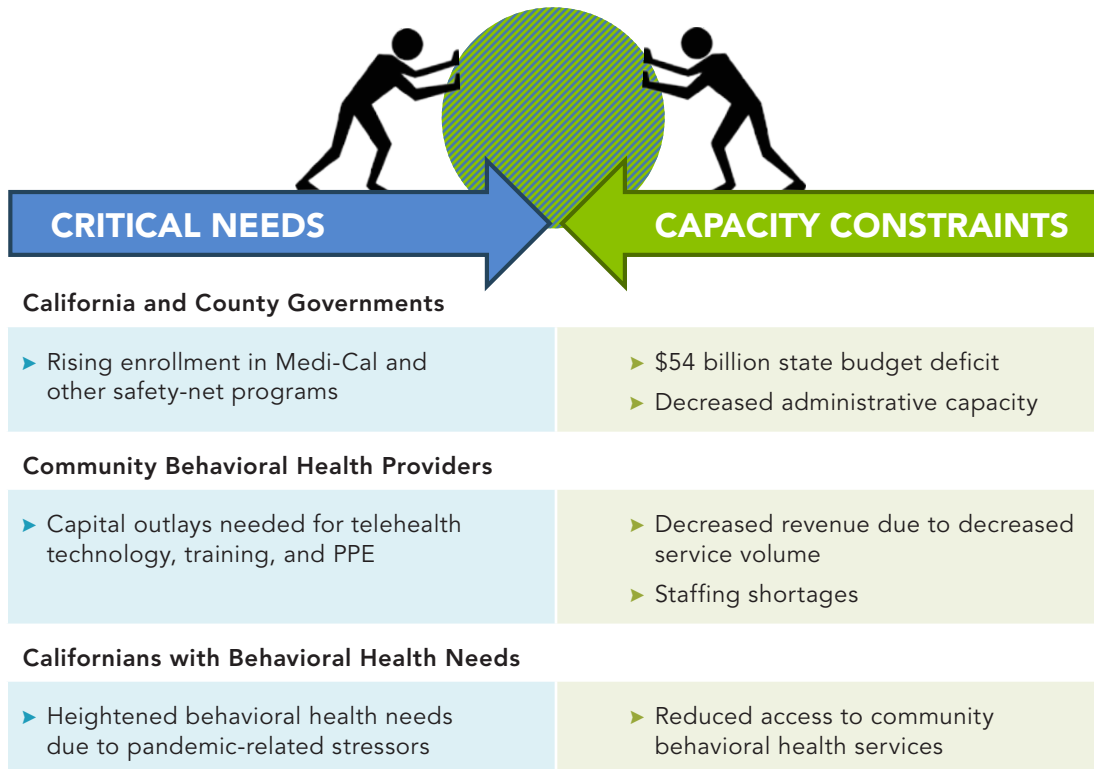
- ▶ **Increasing fragmentation across county lines.** The pandemic’s health and economic impacts varied by county, and each county made its own choices when it came to certain pandemic response protocols and COVID-19 testing initiatives. Counties also differed in their decisions about whether and how to implement regulatory flexibilities that were authorized at the federal or state level with respect to, for example, telehealth or physical signature requirements.
- ▶ **Prioritizing immediate needs over longer-term reform.** Before the pandemic, DHCS was beginning a multiyear Medi-Cal redesign initiative known as “CalAIM” (which stands for “California Advancing and Innovating Medi-Cal”). Among other goals, CalAIM sought to support an integrated “whole

person” approach by aligning administrative and financing policies across physical and behavioral care and, within behavioral health care, across mental health and SUD services. CalAIM was put on hold, however, as DHCS and other health care stakeholders focused on the immediate needs presented by the public health emergency.<sup>11</sup> DHCS has recently announced plans to move forward with CalAIM pending federal approval.<sup>12</sup>

## Community Behavioral Health Care Providers

Like state and county governments, community behavioral health providers experienced increased costs and declining revenues as a result of the pandemic. These financial impacts were felt most acutely by smaller providers, as well as by larger safety-net providers without substantial cash reserves. Moreover, community behavioral health care providers largely have been excluded from the \$175 billion Provider Relief Fund that the US Congress created to compensate

Figure 2. Pandemic-Related Needs and Capacity Constraints for Governments, Providers, and Patients





providers for revenue losses and to finance pandemic response measures.<sup>13</sup> (As used in this report, the term “community behavioral health providers” refers to providers of outpatient and residential behavioral health services, including providers operated by a county government or other public agency.)

### Capacity Constraints

The pandemic imposed a number of limitations on the ability of community behavioral health care providers to deliver services, as described below.

**The challenges of physical distancing in behavioral health care.** Behavioral health providers have traditionally relied on service delivery models that involve close in-person contact, including congregate living in residential programs, group therapy meetings, and individual counseling sessions conducted face to face in small offices. With the arrival of the pandemic, many providers were unable to achieve proper physical distancing without substantially reducing capacity or undertaking major facility renovations.

**Pandemic-related staffing shortages.** Providers had difficulty maintaining adequate staffing levels. Staff members with caregiving responsibilities were often unable to work due to school closures (affecting staff with school-aged children) and reduced availability of home and community-based services (affecting staff who care for elderly or disabled family members). There were, in addition, health-related absences among staff who were recovering from COVID-19, quarantining after an exposure, or “self-furloughing” because they or their family members were at heightened risk for severe COVID-19 complications.

**Costly pandemic response measures.** Although many problems created by the pandemic were theoretically solvable, and although many providers demonstrated incredible resilience in the face of immense challenges, cash-strapped community providers faced financial barriers to implementing needed changes. Telehealth provides an alternative to in-person services, for example, but it costs time and money to acquire telehealth technology and train staff on its use.<sup>14</sup> Similarly, as compared to medical providers, behavioral health

care providers had lower baseline familiarity with infection control measures, requiring comprehensive staff training and a sudden need for bulk acquisitions of personal protective equipment (PPE).

*“Between the loss of staff and the difficulty getting PPE, residential SUD programs were in crisis mode during the early weeks of the pandemic.”*

— Vitka Eisen, CEO of HealthRIGHT 360

**Inadequate access to COVID-19 testing for patients and staff.** Testing and contact tracing are essential components of infection prevention and control. Behavioral health providers were hindered, however, by an inability to ensure consistent access to testing supplies, insufficient capacity at community testing sites, uneven coverage for surveillance testing (for individuals who lacked symptoms or known exposures), and slow turnaround times on test results. These testing limitations — which affected both patients and staff — were particularly challenging for residential programs. Not only do such models depend on in-person contact, but facilities with COVID-19 outbreaks were required to suspend new admissions and implement surveillance testing until certain criteria were met; without reliable access to testing with rapid turnaround times, however, facilities were often left at substantially reduced capacity due to an inability to demonstrate compliance with reopening criteria.

### Revenue Losses

The capacity constraints highlighted above, together with other barriers to patient access, produced a precipitous decline in behavioral health care utilization in the pandemic’s early months. With respect to low-income children enrolled in Medicaid and the Children’s Health Insurance Program (CHIP), for example, nationwide utilization of outpatient mental health services for March through May 2020 was down 44% compared to the same period in 2019, even after accounting for the substantial rise in telehealth visits.<sup>15</sup>



California has historically relied on a system of cost-based reimbursement, under which counties and providers submit claims based on their documented cost of providing services, subject to certain limits such as a cap on the amount of administrative costs. Under this system, a sharp decline in service volume automatically produces a sharp decline in revenues. Pandemic-related revenue losses not only made it more difficult for providers to implement needed pandemic response measures but also threatened provider solvency and, thus, the stability of the community behavioral health system. As shown in Table 3, an April 2020 survey found that more than 60% of community behavioral health providers had closed at least one program; a similar percentage of providers indicated that, if conditions persisted, they would likely shut down entirely within three months.<sup>16</sup>

**Table 3. Economic Hardship Indicators for Community Behavioral Health Organizations**

Percentage of community behavioral health organizations that...	
Anticipated a shortage of PPE within 2 months	83%
Closed at least one program (due to COVID-19)	62%
Expected to close within 3 months	62%
Planned to lay off or furlough employees (due to COVID-19)	47%

Source: COVID-19 Economic Impact on Behavioral Health Organizations, ndp analytics and National Council for Behavioral Health, April 15, 2020.

## Californians with Behavioral Health Needs

### Increased Behavioral Health Needs

Every Californian has been touched by COVID-19, including those who have not personally contracted the coronavirus. The illness or death of a loved one, the loss of a job, the sudden social isolation, the fear of potential exposure inherent in everyday activities — these and other stressors — have produced a substantial increase in the number of people reporting

mental health and SUD symptoms.<sup>17</sup> In October 2020, almost 30% of Californians reported that their mental health had gotten worse since the start of the pandemic; among low-income Californians, the proportion climbs to 36%.<sup>18</sup> Nationwide, COVID-19 brought rising levels of alcohol sales, drug test positivity rates, and suspected overdoses.<sup>19</sup>

The pandemic hit hardest on vulnerable groups that are disproportionately served by the Medi-Cal program. People of color, in particular, have experienced higher rates of COVID-19 deaths than the population overall, and have also grappled with the psychological distress associated with highly publicized instances of racial injustice and police brutality.<sup>20</sup> Adding yet another source of stress, wildfires raged across the state all through the summer of 2020, consuming a record-breaking 4 million acres by early October.<sup>21</sup>

### Reduced Access to Community Behavioral Health Services

As described previously, the pandemic sharply limited community behavioral health providers' ability to serve their patients, particularly through in-person care delivery models. Due in part to these supply constraints, the behavioral health system was unable to meet demand: an August 2020 survey found that, among Californian adults who wanted to see a health care professional about a mental health problem during the pandemic, fewer than 60% received any mental health services.<sup>22</sup>

For Medi-Cal enrollees, these capacity constraints exacerbated existing access barriers arising out of the fragmentation of behavioral health services across counties and lines of service. The pandemic also disrupted Medi-Cal's ongoing efforts to promote "field-based" services in schools and other community settings, which reduced providers' ability to proactively identify and treat potential behavioral health issues. It has been challenging, however, to quantify the pandemic's effects on behavioral health access and outcomes due to preexisting issues related to service fragmentation and data collection.<sup>23</sup>

*“In Medi-Cal, access to behavioral health services is a big question mark. Where are services being provided? What kinds of services? How much? How does this year compare to last year? These are data points we should be able to assess.”*

— Kimberly Lewis, managing attorney  
National Health Law Program (NHeLP)

Taken together, the increased stress of the pandemic and the decreased service capacity of providers have created a behavioral health crisis for many Californians. To put things in perspective, 91 San Franciscans died of COVID-19 in the five-month period between April and August 2020; in that same time period, more than 300 people died of drug overdoses.<sup>24</sup>

## Overview of Pandemic Response Measures Affecting Community Behavioral Health Providers

In response to the pandemic, federal and state governments implemented dozens of legal reforms aimed at supporting providers’ efforts to mitigate the spread of COVID-19 infections while preserving access to needed health care services in a time of physical distancing. Table 4 provides a high-level overview of the legal changes that directly affected coverage for, and delivery of, community behavioral health care services in California between January and July 2020. Many of these changes applied equally across all types of health care services (such as an expansion in the types of permissible telehealth technologies), while others specifically targeted behavioral health services (such as relaxed restrictions on NTPs).

**Table 4. Pandemic Response Measures that Affected California’s Community Behavioral Health Care System**

LEGAL CHANGE?  
Federal California

	Federal	California
<b>Telehealth</b>		
Expanded coverage for telehealth services under Medi-Cal, Medicare, and commercial plans, including coverage for both video and telephone service modalities	✓	✓
Enhanced use of telehealth for dispensing controlled substances, including at Narcotic Treatment Programs (NTPs)	✓	✓
<b>Data Privacy and Security</b>		
Expansion in the types of permissible telehealth platforms, including common technologies (e.g., Zoom, Apple FaceTime) that do not comply with security standards under the Health Insurance Portability and Accountability Act (HIPAA)	✓	
Relaxed requirements regarding consent for telehealth services and inadvertent disclosures of protected information during telehealth communications	✓	✓
Revisions to the federal rules that govern SUD-related information held by certain types of providers (commonly referred to as the “Part 2” rules because they are codified at 42 C.F.R. Part 2)	✓	
Waivers of federal confidentiality laws with respect to community-based testing sites and other public health activities	✓	
State waivers of certain consent and signature requirements		✓

As indicated previously, the Legal Compendium captures these legal changes in greater detail and provides citations to applicable federal and state

legislation, agency regulations, emergency waivers, and subregulatory guidance.

**Table 4. Pandemic Response Measures that Affected California’s Community Behavioral Health Care System, *continued***

LEGAL CHANGE  
Federal California

	Federal	California
<b>Professional Licensing and Certification</b>		
Authorized in-state practice by professionals holding out-of-state licenses	✓	✓
Relaxed supervision requirements for advanced practice clinicians, such as nurse practitioners (NPs) and physician assistants (PAs)	✓	✓
Modified standards and procedures for initial licensure and certification, as well as renewals		✓
Relaxed certain standards regarding health care student trainee education and supervision		✓
<b>Prescription Ordering and Dispensing</b>		
Relaxed prior authorization procedures and dispensing limits for prescription drugs under Medi-Cal and Medicare	✓	✓
Enhanced flexibility around prescribing and dispensing controlled substances, including in NTPs	✓	✓
<b>Other Behavioral Health Services</b>		
Enhanced Medi-Cal coverage and reimbursement of behavioral health services		✓
Granted flexibilities that apply automatically, or upon request, to specific behavioral health provider types, including various residential and outpatient programs for mental health and SUDs, as well as primary care clinics, federally qualified health centers (FQHCs), and rural health clinics (RHCs)		✓
Provided flexibility to California counties as they administer and fund behavioral health services		✓
<b>COVID-19 Testing and Treatment</b>		
Enhanced coverage for COVID-19 testing and treatment under Medi-Cal, Medicare, and commercial insurance	✓	✓
Authorized pharmacists to order and administer COVID-19 tests	✓	✓
<b>Other Legal Changes of General Applicability</b>		
Modified Medi-Cal and Medicare procedures concerning provider enrollment, beneficiary appeals, and prior authorization	✓	✓
Prevent states from restricting Medicaid enrollment or benefits during the public health emergency, as described under the Families First and Coronavirus Response Act (FFCRA)	✓	
Granted flexibility to consumers with respect to enrollment in commercial coverage and payment of premiums		✓

# Assessment of High-Impact Legal Changes and Candidates for Permanent Reform

Federal and state policymakers released a torrent of new laws and emergency waivers during the early months of the pandemic, as summarized in the preceding section and the Legal Compendium. Legislators and executive branch officials sought to react quickly in an environment characterized by a limited and rapidly changing evidence base about COVID-19's epidemiology and effects. This section reviews the legal changes that appear to have been most crucial during the early stage of the pandemic in stabilizing providers' finances and promoting patients' access to behavioral health services. These changes related to:

- ▶ Telehealth
- ▶ Medi-Cal reimbursement methodologies
- ▶ Controlled substances and prescription drugs
- ▶ Provider licensure and operating standards

Because so many rules changed so quickly, the pandemic created an opportunity to test policy changes that advocates have long pursued. The vast majority of these changes were implemented on a temporary basis, with sunset dates linked to either the federal Public Health Emergency declared by the US Department of Health and Human Services, effective January 27, 2020, or the State of Emergency declared by the California Governor on March 4, 2020.<sup>25</sup> (As of this report's publication date, both emergency declarations remain in effect.) Longer-term changes may require policy revisions that reflect a rebalancing among competing priorities, given that emergency response measures typically prioritize flexibility, access, and harm reduction over considerations related to oversight, quality measurement, and cost control. In each section, we identify potential areas of data collection and analysis that may help to assess the impacts of suggested policy reforms.

In addition to the policies discussed below, DHCS's CalAIM proposal includes numerous high-value reforms that would, among other things, support an integrated behavioral health benefit that improves coordination across mental health and SUD services, in addition to enhancements to overall Medi-Cal data collection and accountability.<sup>26</sup> CalAIM's implementation was put on hold due to the pandemic and is resuming this year pending federal approval.

*“Through CalAIM, we were working toward a more integrated ‘whole person’ approach to care. We’re still committed to that goal, but are starting a year later.”*

— Kelly Pfeifer  
deputy director of behavioral health, DHCS

## Increased Access to Telehealth

As it became clear that the novel coronavirus was both highly contagious and exceptionally dangerous, policymakers and providers turned to telehealth as a means of maintaining patient access while minimizing the contagion risks inherent in face-to-face interactions. Rapid increases in telehealth coverage, patient demand, and provider motivation drove an explosive growth in telehealth utilization. In Medicaid and CHIP, for example, enrollees nationwide received more than 34.5 million telehealth services between March and June 2020, representing an *increase of more than 2,600%* compared with the prior year.<sup>27</sup> Although these telehealth visits did not fully offset the decreased volume of in-person services, they nonetheless played a substantial role in preserving patients' access to services and preserving providers' ability to generate revenue. Advocates and policymakers generally agree that COVID-19 represents a permanent tipping point for telehealth, but it remains to be seen how longer-term policy reforms will balance concerns about access, quality, cost, and fraud.

*“The pandemic caused a nationwide public health emergency, which has allowed us to accelerate change in telehealth for Californians. We have learned a lot in the process.”*

— Kelly Pfeifer  
deputy director of behavioral health, DHCS

Although decisions about Medicare coverage are made at the federal level by Congress and the Centers for Medicare & Medicaid Services (CMS), California has broad authority to reshape telehealth coverage policies for the Medi-Cal program and for commercial health plans offered on Covered California, the state’s insurance marketplace that was established under the Affordable Care Act.

### Key Legal Changes During the Pandemic

**Expanded telehealth coverage.** All major health care payers took a big step toward parity of coverage and parity of reimbursement for telehealth services, including both video telehealth and telephone (or “telephonic”) services.

- ▶ In the Medi-Cal program, DHCS implemented a broad policy of telehealth parity, allowing any covered service to be furnished via a video or telephone modality if deemed clinically acceptable by the treating practitioner, subject to certain limitations. Telehealth services receive the same rate of reimbursement as the equivalent in-person service. Although Medi-Cal had previously permitted certain tele-behavioral health services (including telephonic services), there was wide county-level variation in telehealth coverage, and many community behavioral health providers had not invested in developing their telehealth capabilities.

- ▶ California required commercial plans to cover clinically appropriate telehealth services and provide parity of reimbursement during the pandemic, mirroring the parity policies implemented in the Medi-Cal program.
- ▶ With respect to Medicare, CMS did not implement full parity, but did substantially expand coverage for video telehealth (including for psychological evaluation services), while authorizing coverage for a more limited set of telephone and other virtual services at a lower rate of reimbursement.

*“Telehealth flexibility has been the most important policy change in response to the pandemic. In the Medi-Cal program, there’s not much more you could ask for, except to allow even more modalities like text-based counseling.”*

— Kimberly Lewis  
managing attorney, NHeLP

**Permitting additional types of originating and distant sites.** During the pandemic, all payers allowed telehealth services to be furnished at any originating site (where the patient is located) and also expanded the range of eligible distant sites (where the provider is located). In many cases, telehealth encounters might involve a patient and a rendering provider who are each located in their own homes. Pre-pandemic, Medicare had particularly strict limitations on eligible originating sites: Telehealth services were available only to patients in rural regions who traveled to a health care facility that met certain originating-site requirements.

**Flexibility on telehealth technology and confidentiality rules.** Federal and state regulators permitted providers to:

- ▶ Use a broader range of telehealth platforms that employ less stringent data security standards, including commonly used technologies, such as Zoom or Apple FaceTime.
- ▶ Obtain verbal patient consent to receive services by telehealth (forgoing the pre-pandemic requirement for written consent).

*“These flexibilities allowed for a much faster switch to telehealth than we could otherwise have achieved. Later on, we adopted telehealth platforms that comply with all security standards. That’s the right thing to do for our consumers.”*

— Ryan Quist, behavioral health director  
Sacramento County Dept. of Health Services

### Key Policy Considerations

Telehealth has played a crucial role in supporting both patient access and provider financial stability during the pandemic. It is not a panacea, however, and a vigorous conversation has already begun about when and how telehealth modalities should be permitted in lieu of, or in addition to, in-person services, both during and after the pandemic.<sup>28</sup> As part of that discussion, policymakers will need to weigh the following policy tradeoffs and considerations.

**Telehealth reduces many barriers to access.** There is no doubt that broad telehealth coverage increases access for many people. Telehealth may be especially valuable for individuals who face barriers, such as:

- ▶ Inflexible work or childcare arrangements
- ▶ Strong preference for a linguistically or culturally matched practitioner
- ▶ Lack of reliable access to transportation

- ▶ Residence in a health professional shortage area
- ▶ Elevated risk for severe complications from COVID-19

All of these barriers are especially prevalent among low-income people and people of color, which may explain why these groups were more likely than others to rely on telehealth service modalities during the pandemic.<sup>29</sup>

### Telehealth reveals new types of access barriers.

Telehealth services — like in-person services — are not equally accessible to all. In addition to general technological literacy issues, individuals may lack access to compatible hardware or to a fast and reliable internet or data connection. These barriers are likely most pressing with respect to video telehealth and may be most prevalent among individuals who are older, rural, or lower-income. A recent study, for example, found that almost 40% of adults over 65 were “unready” for video telehealth (primarily due to inexperience with technology), while 20% were unready for telephonic services (due to difficulty hearing, difficulty communicating, or dementia).<sup>30</sup> These potential access concerns demonstrate that telehealth will not serve as a perfect substitute for in-person services for all people in all circumstances. The government could help “bridge the digital divide” by, for example, supporting access to high-speed internet.<sup>31</sup> And even without such actions, more expansive telehealth coverage gives many individuals an option they did not have before.

**Privacy can be an issue.** Confidentiality may be a concern for patients who receive telehealth services in a home they share with other people. These concerns may be particularly acute with respect to stigmatized conditions like mental health and SUD, and are most likely to manifest in lower-income urban areas (where overcrowding is most common) and during periods of strict physical distancing (when people spend most of their time at home). The inability to guarantee privacy may prevent some patients from being fully candid during their health care visits or may prevent them from accessing services at all.

### Efficacy may vary across service modalities.

Telehealth modalities are not equally appropriate for all services in all circumstances. During the height of the pandemic, when slowing the spread of the virus was a top priority, broad telehealth coverage made sense under a philosophy of “harm reduction”: better for patients to receive services by telehealth than to receive no services at all. Moving forward, policymakers may seek to balance the access issues discussed above against the goal of incentivizing the right care at the right place at the right time.

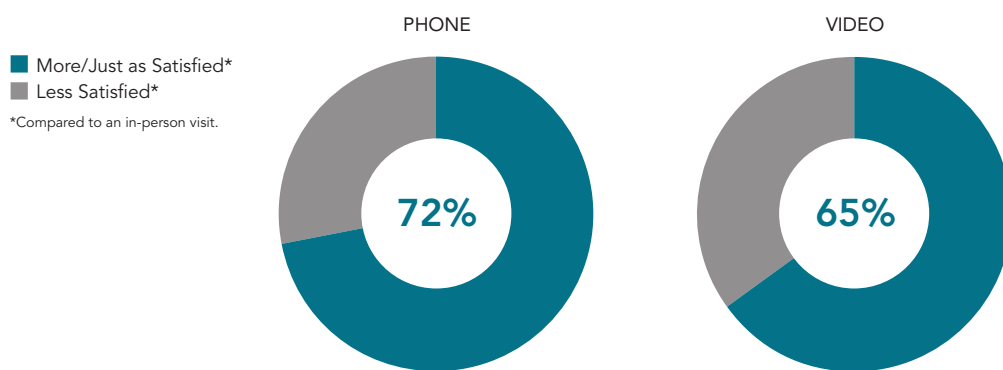
- ▶ The evidence suggests that certain services — including psychotherapy — translate well to the virtual environment.<sup>32</sup> Even so, clinicians and patients may vary in their preferences and comfort levels with different service modalities, as shown in Figure 3.
- ▶ A minimum level of in-person interaction is inherent in residential SUD treatment programs and certain other services. Telehealth has a more limited role to play in these settings. Meanwhile, anecdotal evidence suggests that telehealth modalities may create new types of challenges for certain services, such as group therapy sessions. Further research is needed to identify the circumstances in which telehealth may not be a perfect substitute for in-person services and to determine whether those efficacy gaps could be mitigated by adjustments in technology or provider approach.

*“Some individuals need in-person contact to feel fully supported. Other individuals love telehealth because they don’t have to worry about finding transportation and arranging childcare each time they have an appointment.”*

— Ryan Quist, behavioral health director  
Sacramento County Dept. of Health Services

- ▶ A growing evidence base supports the use of “hybrid” models that combine in-person and telehealth services. A hybrid approach may be particularly appropriate in rural areas and other regions that lack a sufficient supply of specialized health care personnel.<sup>33</sup>
- ▶ Certain emerging telehealth modalities are generating interest, but do not yet have as robust an evidence base as video and telephone modalities. For example, texting or asynchronous virtual communications could facilitate convenient, low-intensity interactions between patients and clinicians (perhaps mediated through health apps) and can perhaps delay — but not fully replace—the need for higher-intensity services that require real-time communication.<sup>34</sup>

**Figure 3. Satisfaction with Telephone and Video Telehealth Compared to In-Person Visits**



Note: Based on a survey of California residents age 18 to 64 between June and August 2020.

Source: *Listening to Californians with Low Incomes*, CHCF, October 2020.



**Telehealth may change utilization patterns.** The evidence suggests that increased coverage for telehealth services increases telehealth utilization through two distinct pathways: Some telehealth encounters replace care that would otherwise have been provided in person, while other telehealth encounters represent visits that, but for the availability of telehealth, would not have happened at all, or at least not until much later on.<sup>35</sup> Policymakers are keen to understand these dynamics so that they may incentivize high-value telehealth services without opening the door to convenient but low-value care. Moreover, concerns have been expressed that broad telehealth access without sufficient accountability measures may create opportunities for fraud and abuse by unscrupulous providers.<sup>36</sup>

*“Providers and regulators have some concerns about telehealth fraud, but there are controls we can put in place to ensure that billed telehealth encounters are actually happening and that they’re medically necessary.”*

— Vitka Eisen, CEO of HealthRIGHT 360

### Opportunities for Long-Term Reform

#### Support telehealth coverage in Medi-Cal, Medicare, and the commercial market.

- ▶ Provide broad coverage for video and telephone telehealth modalities in clinically appropriate circumstances
- ▶ Consider expanding telehealth coverage to include additional remote modalities, like texting-based services, remote patient monitoring (e.g., through personal health apps), asynchronous virtual communications, and e-consult collaborative care codes
- ▶ Establish reimbursement policies that sufficiently incentivize providers to offer telehealth while acknowledging that telehealth modalities are not always a perfect substitute for

in-person services, and that there may be material differences among telehealth modalities. Full reimbursement parity may be justified in some circumstances; in others, it may be more appropriate for a remote modality to carry a lower reimbursement rate or additional utilization management requirements.

- ▶ Collect data and analyze the effects of telehealth coverage and reimbursement policies on health care utilization, cost, and quality
- ▶ Consider the role of value-based payment models in promoting patient-centered and cost-conscious decisionmaking with respect to service modalities.<sup>37</sup>

#### Eliminate unnecessary administrative barriers to telehealth access.

- ▶ Lift unnecessary restrictions on eligible “originating” and “distant” sites so that patients and practitioners may participate in telehealth encounters from home (when clinically appropriate)
- ▶ Allow patients to consent verbally to the receipt of telehealth services during the telehealth encounter (rather than providing written consent in advance, as was previously required)
- ▶ Develop an expedited licensure pathway for out-of-state psychiatrists seeking to deliver telepsychiatry services to California residents. During the pandemic, California provided limited flexibility for out-of-state practitioners to seek temporary authorization for in-state practice. After the pandemic, it may be valuable to explore a narrower but longer-term solution for cross-border psychiatry practice in light of a long-standing shortage in the supply of psychiatric services. As of September 2020, nearly 9.4 million Californians lived in counties designated as mental health professional shortage areas.<sup>38</sup> Flexibility on licensure for out-of-state psychiatrists would go hand-in-hand with the other telehealth-related reforms discussed in this section.

## Data Collection and Analysis

To assess the pace and the impacts of telehealth adoption, regulators and researchers may wish to collect data and publish analyses addressing issues such as:

- ▶ Trends in the utilization rates of different service modalities (in-person, video, telephone, remote patient monitoring, etc.), including segmentation by type of service, patient characteristics, and provider type
- ▶ The extent to which telehealth services operate as a substitute for, or a supplement to, in-person visits
- ▶ The relationship between telehealth utilization and outcomes such as timely access to health care services, use of preventive versus acute care, cost-effectiveness of chronic disease management, and patient health outcomes
- ▶ Self-reported satisfaction — for both patients and providers — with telehealth versus in-person visits for various types of services

## Changes to Medi-Cal Reimbursement Methodologies

Under Medi-Cal's cost-based reimbursement system for specialty behavioral health services, decreased service volume means decreased revenue. As utilization fell during the early months of the pandemic, the resulting revenue losses created immediate challenges for providers that needed to quickly develop their telehealth capacity and acquire PPE, in addition to presenting a longer-term existential threat to provider solvency and the stability of the community behavioral health system, as discussed above. To support counties and providers, DHCS made several changes to Medi-Cal's reimbursement policies. Before the pandemic, moreover, planning had begun under CalAIM to replace Medi-Cal's cost-based reimbursement system with a more flexible, less burdensome model.

## Key Legal Changes During the Pandemic

- ▶ To support short-term stability, the state allowed counties to pay providers a fixed amount each month, subject to later reconciliation based on actual volume and costs. Counties, in turn, could adjust their own rates with the state to cover these fixed monthly payments to providers.
- ▶ When service volume is low, fixed overhead costs will represent a higher proportion of overall costs. To address that issue, DHCS allowed additional types of reimbursable costs and raised the cap on administrative costs.
- ▶ Reimbursement rates for certain behavioral health services were temporarily increased by as much as 100%.

*“These rate flexibilities for providers were crucial in light of shifting utilization patterns and fluctuating costs, including hazard pay and PPE.”*

— Vitka Eisen, CEO of HealthRIGHT 360

## Opportunities for Long-Term Reform

Before the pandemic, DHCS's CalAIM initiative already included a proposal to move away from cost-based reimbursement. DHCS recognized that, in addition to creating significant administrative burdens for providers, counties, and the state, the current reimbursement model focuses exclusively on the cost of providing services and so does not take into account measures of access or quality. COVID-19 has reaffirmed these rationales for abandoning a cost-based system and has also demonstrated the risks inherent in a system in which revenue is tightly linked to service volume. California's community behavioral health system would be better served by a value-based reimbursement model designed to promote reliable access, high-quality care, and long-term provider solvency.<sup>39</sup>

## Data Collection and Analysis

To assess the comparative merits of the current cost-based reimbursement system and potential alternative financing models, state and county policymakers might consider gathering data on the administrative burdens associated with billing and cost reporting for both counties and health care providers, as well as data on the higher-level implications for county and provider solvency and financial planning.

## Controlled Substances and Prescription Drugs

Prescription drugs are an essential tool for treating acute behavioral health problems and managing chronic conditions. To prevent misuse, however, laws and payer coverage policies impose constraints on drug prescribing and dispensing. These constraints are particularly strict with respect to controlled substances, which carry special restrictions because of their greater potential for addiction or other harmful consequences if prescribed or used inappropriately. The lists (“schedules”) of controlled substances include two of the key drugs prescribed for opioid use disorder (methadone and buprenorphine), as well as certain classes of psychiatric medications: benzodiazepines (such as Xanax), hypnotics (such as Ambien), and stimulants (such as Adderall).<sup>40</sup> Among other rules, practitioners are generally required to perform an *in-person* physical examination before prescribing controlled substances.

During the pandemic, many of these drug-related constraints were relaxed to support continued access to pharmaceutical treatments while minimizing the number of in-person interactions. Similar flexibilities could help to promote access even after the end of the public health emergency.

The rules on prescription drug dispensing are generally set at the state level, although the Medicare program is also subject to CMS regulations. Controlled substances are tightly regulated at the federal level, and so any policy changes with respect to NTPs would need to involve some combination of Congress, the federal Drug Enforcement Administration (DEA), and

the Substance Abuse and Mental Health Services Administration (SAMHSA).

## Key Legal Changes During the Pandemic

### Treatment for opioid use disorder.

- ▶ Buprenorphine may be prescribed to new and existing patients after a telehealth encounter (video or telephonic).
- ▶ With respect to methadone prescriptions within an NTP, the initial physical exam must be conducted in person, but follow-up exams may be conducted via telehealth.
- ▶ NTP medications may be hand-delivered to a patient’s home.
- ▶ With DHCS approval, NTPs may dispense take-home doses up to a 28-day supply, establish off-site locations to deliver take-home doses, and grant exceptions to certain urinalysis and counseling requirements.

*“Concerns about eligibility and potential misuse need to be addressed whether we’re talking about services delivered in person or remotely. These NTP flexibilities make it easier for people to access the right services at the right place and the right time.”*

— Ryan Quist, behavioral health director  
Sacramento County Dept. of Health Services

**Other controlled substances.** Outside the context of NTPs, controlled substances may be prescribed based on a medical examination conducted via video telehealth (in lieu of an in-person exam).

**Prescription drugs.** Across Medi-Cal, Medicare, and the commercial market, regulators sought to reduce barriers to prescription drugs through policies, such as the following:

- ▶ Allowing prescriptions up to a 90-day supply in most cases (and, for Medi-Cal, a 100-day supply)
- ▶ Permitting early refills
- ▶ Waiving or reducing prior authorization and other utilization management requirements
- ▶ Waiving the requirement for a physical signature to confirm receipt of mail-order prescriptions

### Opportunities for Long-Term Reform

The temporary flexibilities regarding buprenorphine and NTPs include changes that have long been sought by advocates seeking to minimize the burdens associated with recovery from opioid addiction. By reducing the number and frequency of required in-person interactions, policies such as telehealth assessments, telehealth counseling, and take-home dosing could help to increase enrollment in, and adherence to, medication-assisted treatment. Reforms along these lines would benefit many individuals suffering from opioid use disorder, but should, at a minimum, be adopted for the following:

- ▶ Individuals in the early stages of recovery who are enrolled in a residential treatment program. Frequent trips for assessments, counseling, and medication dispensing can be disruptive for an unstable individual suffering the effects of detoxification and adjusting to an intensive treatment protocol. These in-person visits also impose burdens on the program staff members who accompany the individual to and from the NTP. Meanwhile, the supervision provided by the residential program minimizes the risk of improper medication usage.
- ▶ Stable individuals with an established recovery trajectory. These individuals present a lower risk of improper medication usage, and may no longer require the same level of counseling from the NTP. As these individuals seek to reintegrate and establish a healthy routine, a requirement for frequent in-person visits to the NTP can present challenges for maintaining a work schedule and keeping up with other obligations.

### Data Collection and Analysis

As in the discussion of telehealth above, policymakers will need to consider — and perhaps generate — evidence about the impacts of various NTP models on access, efficacy, and safety, an especially important concern in light of the dangers associated with improper use or diversion of medications, such as methadone and buprenorphine. As policymakers and providers seek to strike the appropriate balance, it may be helpful to assess metrics, such as rates of NTP intake, treatment adherence, and adverse events relating to misuse use of NTP medications. These types of analyses could play a role in establishing guidelines around the appropriate scheduling of assessments, the use of telehealth modalities, and the flexibility for take-home dosing. As discussed previously, these questions may yield different answers for different patient populations.

### Provider Licensure and Operating Standards

California suspended various requirements related to provider licensure and operations in an effort to increase provider flexibility and reduce administrative burdens. These legal changes included suspensions of certain reasonable patient safeguards that should be reinstated once it is safe and appropriate to do so. Some areas of provider regulation, however, may be ripe for permanent change.

### Key Legal Changes During the Pandemic

High-impact emergency flexibilities for providers included the following, all of which were enacted under state law except as noted below:

- ▶ The ability to modify hours of service
- ▶ Streamlined procedures for provider enrollment in Medi-Cal and Medicare (*These changes required federal action from CMS.*)
- ▶ A delay of on-site provider inspections, as well as certain flexibilities for virtual inspections (*Certain changes to the schedule of inspections required federal action from CMS.*)

- ▶ Suspended requirements for practitioner license renewals and continuing education
- ▶ Extensions of time for trainees to complete their qualifying exams and other licensure requirements

Certain provider flexibilities, by contrast, did not live up to their promise of reducing provider burden and expanding access to services, typically because the emergency measure provided incomplete regulatory relief. For example, residential behavioral health providers could seek waivers to expand capacity, but remained obligated to maintain a valid fire clearance, which presented a major hurdle to any attempts at short-term capacity expansions.

### Opportunities for Long-Term Reform

The pandemic has forced health care stakeholders to examine every element of health care administration and service delivery in pursuit of strategies to minimize in-person interactions and reduce provider burdens. This provides an opportunity to identify provider standards that create administrative burdens without providing commensurate value in terms of access, safety, or quality. Any such low-value requirements could be scaled back or modified to streamline operations and reduce costs for both providers and regulators.

*“During the pandemic, providers could document verbal consent for receipt of telehealth services, for treatment plans, for medication regimens, and so on. This was a game changer. Normally, each step requires a physical signature, which can disrupt the flow of services. This is also a parity issue: behavioral health services come with more signature requirements than other health services.”*

— Ryan Quist, behavioral health director  
Sacramento County Dept. of Health Services

Candidates for reform include the following:

- ▶ Evaluate documentation requirements for behavioral health services, including policies at the state and county levels. These requirements are generally more prescriptive and more burdensome than the equivalent requirements for physical health services, particularly with respect to the need to secure a separate physical signature for various types of services and at various treatment milestones, as well as the strict standards that govern the timing and format for treatment plans and progress notes.
- ▶ Streamline Medi-Cal’s provider certification and enrollment procedures. Certain unduly burdensome procedures could be pared back without harming consumers, such as Drug Medi-Cal’s certification process for newly enrolling providers of residential services.
- ▶ Promote integration across Medi-Cal’s mental health and SUD benefits, building on the proposals already included in CalAIM. Potential areas for alignment include provider certification and contracting, patient assessments, consent forms, data reporting, and audits.
- ▶ Eliminate or relax the federal laws prohibiting Medicaid reimbursement for most services rendered in an “institution of mental diseases,” defined as a facility with more than 16 beds that primarily provides psychiatric services. This policy drives up the cost of operating larger psychiatric hospitals and residential treatment programs. At the same time, public officials should continue to support measures that promote access to behavioral health services in home and community settings.
- ▶ Increase the use of desk reviews and virtual inspections in lieu of on-site provider inspections in appropriate circumstances, especially for providers with an established history of compliance.

*“We need to move away from having separate requirements for mental health and SUD. An integrated approach to behavioral health would be so much better for behavioral health providers and the consumers they serve.”*

— Ryan Quist, behavioral health director  
Sacramento County Dept. of Health Services

### Data Collection and Analysis

In addition to critically assessing the benefits of various provider standards and procedures, it may be helpful to gather information on the administrative burdens associated with certain compliance practices, including the staff time and other costs incurred by regulators as well as providers. After filling in both sides of the cost/benefit ledger, policymakers will be well situated to identify high-value reforms.

## Conclusion

The early months of the pandemic forced a reckoning as policymakers, providers, and patients sought to preserve access to needed services while slowing the spread of the novel coronavirus. Although the pandemic is far from over, it has lasted long enough for us to be able to take stock of the emergency response measures that have been enacted to date and assess the impact on California’s community behavioral health care system. Similarly, it is not too early to begin planning for a post-pandemic world. The flurry of regulatory activity in the spring and summer of 2020 provided critical support in the midst of a crisis and also created an opportunity to test policies that have long been supported by behavioral health advocates. Although these policies were implemented on a temporary basis, many of them would continue to benefit patients and providers even after the pandemic subsides.

It goes without saying that the pandemic has been, and remains, a tragedy that has killed many and irrevocably harmed many more. Californians — and their providers — will be grappling for years with the psychological aftereffects of mourning, social isolation, and financial hardship. These emerging needs underscore the importance of seizing this moment to reflect on lessons learned and potential next steps toward a more sustainable, more flexible, and more patient-focused behavioral health system.



## Appendix A. Glossary of Abbreviations and Key Terms

**1135 Waiver** An emergency waiver issued by the US Department of Health and Human Services (HHS) or the Centers for Medicare & Medicaid Services (CMS) pursuant to Section 1135 of the Social Security Act (42 U.S.C. § 1320b5). CMS has issued dozens of “blanket” (i.e., nationwide) waivers (PDF), as well as 1135 waivers specific to Medi-Cal (on [March 23](#) and [May 8](#), 2020).

**AOD Facility or Counselor** An Alcohol and Other Drug facility or counselor

**ASAM** The American Society of Addiction Medicine, which releases guidance concerning placement, transfer, or discharge of patients with addiction and co-occurring conditions

**BH** Behavioral health

**CARES Act** The Coronavirus Aid, Relief, and Economic Security Act, [Public Law No. 116-136](#), enacted March 27, 2020

**CDI** The California Department of Insurance, which regulates insurance issuers

**CDPH** The California Department of Public Health

**CMS** The Centers for Medicare & Medicaid Services, a federal agency within HHS

**CNW** Certified nurse-midwife

**DCA** The California Department of Consumer Affairs, which oversees professional licensure

**DEA** The US Drug Enforcement Administration, which establishes federal limits on prescribing and dispensing controlled substances

**DHCS** The California Department of Health Care Services, which oversees the Medi-Cal program

**DMC** Drug Medi-Cal, the program through which Medi-Cal SUD services are furnished in counties that have not opted into the newer DMC-ODC 1115 demonstration project

**DMC-ODS** The Drug Medi-Cal Organized Delivery System, the Medi-Cal 1115 demonstration project through which certain counties provide Medi-Cal SUD treatment. (Counties that have not opted into DMC-ODS continue to provide SUD services under DMC.)

**DMHC** The California Department of Managed Care, which regulates: all health maintenance organization plans, some preferred provider organization and exclusive provider organization products, as well as dental and vision plans. DMHC oversees some large group plans, most small group plans, most Medi-Cal managed care plans, and many individual and family products.

**DR SPA** A temporary “disaster relief” State Plan Amendment in the Medicaid program. California’s [DR SPA 20-0024](#) (PDF) was approved, effective March 1, 2020.

**FDA** The US Food and Drug Administration, a federal agency within HHS

**FFCRA** The Families First Coronavirus Response Act, [Public Law No. 116-127](#), enacted March 18, 2020

**FFS** Fee-for-service



<b>FQHC</b>	Federally Qualified Health Center
<b>IFR</b>	Interim final rules with comment period. During the time period discussed in this report, CMS issued two relevant rules with effective dates of <a href="#">March 31</a> and <a href="#">May 8, 2020</a> .
<b>HIPAA</b>	The federal Health Insurance Portability and Accountability Act of 1996
<b>HHS</b>	The US Department of Health and Human Services
<b>HHS OCR</b>	The HHS Office for Civil Rights, which enforces HIPAA
<b>HHS OIG</b>	The HHS Office of the Inspector General, which investigates fraud and abuse in federal health care programs
<b>LCSW</b>	Licensed clinical social worker
<b>MAO</b>	Medicare Advantage Organization
<b>MCP</b>	Medi-Cal managed care plan
<b>NP</b>	Nurse practitioner
<b>NTP</b>	Narcotic Treatment Program, referred to under federal law as an Opioid Treatment Program (OTP)
<b>PA</b>	Physician assistant
<b>PHE</b>	The federal <a href="#">COVID-19 Public Health Emergency declared by HHS</a> , effective January 27, 2020, and any renewals thereof, pursuant to Section 319 of the Public Health Service Act (42 U.S.C. § 247d)
<b>RHC</b>	Rural Health Clinic
<b>SAMHSA</b>	The federal Substance Abuse and Mental Health Services Administration, which sits within HHS, and which regulates certain aspects of SUD programs
<b>SMHS</b>	The Medi-Cal Specialty Mental Health Services program
<b>State of Emergency</b>	The <a href="#">State of Emergency declared by California Governor Gavin Newsom</a> (PDF) on March 4, 2020
<b>SUD</b>	Substance use disorder

## Appendix B. Interviewees

The authors thank the following individuals for sharing their knowledge of California's behavioral health system and sharing their perspective on the impact of COVID-19 and related legal changes:

Vitka Eisen, MSW, EdD

President and chief executive officer  
HealthRIGHT 360

Kimberly Lewis, JD

Managing attorney for Los Angeles  
National Health Law Program

Kelly Pfeifer, MD

Deputy director of behavioral health  
California Department of Health Care Services

Ryan Quist, PhD

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Sacramento County Department of Health Services

## Endnotes

1. Evan Webeck, [“Coronavirus: July Was California’s Worst Month of the Pandemic,”](#) *Mercury News*, July 31, 2020.
2. [Mental Health in California: For Too Many, Care Not There](#) (PDF), in California Health Care Almanac, California Health Care Foundation (CHCF), March 2018; [Substance Use in California: A Look at Addiction and Treatment](#) (PDF), in California Health Care Almanac, CHCF, October 2018.
3. Peter J. Cunningham, [“Income Disparities in the Prevalence, Severity, and Costs of Co-Occurring Chronic and Behavioral Health Conditions,”](#) Commonwealth Fund, February 26, 2018; see also [“Medi-Cal Monthly Enrollment Recent Trends,”](#) California Department of Health Care Services (DHCS), September 2020.
4. [Behavioral Health in the Medicaid Program — People, Use, and Expenditures](#) (PDF), in Report to Congress on Medicaid and CHIP Payment and Access Commission, June 2015; Benjamin Druss and Elizabeth Reisinger Walker, [“Mental Disorders and Medical Comorbidity,”](#) Robert Wood Johnson Foundation, February 1, 2011.
5. For additional discussion of fragmentation issues in California’s behavioral health system, see Kimberly Lewis et al., [Pre-Convening Paper: Overview of Medi-Cal’s Behavioral Health System & Necessary Safeguards for an Integrated System](#) (PDF), National Health Law Program (NHeLP), October 10, 2019.
6. Medi-Cal deploys six different managed care models throughout the state, as described in the [Medi-Cal Managed Care Program Fact Sheet — Managed Care Models](#) (PDF), DHCS, January 2, 2020.
7. [“County Plans & Contracts: Counties Participating in DMC-ODS,”](#) DHCS, last updated January 23, 2020. For more detail on the ASAM criteria, see [“About the ASAM Criteria,”](#) ASAM.
8. Allison Valentine et al., [How Medi-Cal Expanded Substance Use Treatment and Access to Care: A Close Look at Drug Medi-Cal Organized Delivery System Pilots](#) (PDF), CHCF, August 2020.
9. [“Coronavirus \(COVID-19\): Revised State Revenue Projections,”](#) National Conference of State Legislatures, September 10, 2020.
10. Gabriel Petek, [The 2020–21 Budget: Overview of the California Spending Plan](#) (PDF), California Legislative Analyst’s Office, October 7, 2020.
11. [“California Advancing and Innovating Medi-Cal,”](#) DHCS, last modified January 27, 2021.
12. [California Advancing & Innovating Medi-Cal \(CalAIM\) Proposal](#) (PDF), DHCS, January 8, 2021.
13. Cindy Mann and Gayle Mauser, [“COVID-19 Relief Needed to Keep Medicaid Community-Based Providers Afloat,”](#) Commonwealth Fund, October 2, 2020.
14. June-Ho Kim et al., [“How the Rapid Shift to Telehealth Leaves Many Community Health Centers Behind During the COVID-19 Pandemic,”](#) *Health Affairs Blog*, June 2, 2020.
15. [Service Use Among Medicaid & CHIP Beneficiaries Age 18 and Under During COVID-19: Preliminary Medicaid & CHIP Data Snapshot](#) (PDF), Centers for Medicare & Medicaid Services (CMS), September 2020.
16. [COVID-19 Economic Impact on Behavioral Health Organizations](#) (PDF), ndp analytics and National Council for Behavioral Health, April 15, 2020.
17. Jen Joynt, [Listening to Californians with Low Incomes: Health Care Access, Experiences, and Concerns Since the COVID-19 Pandemic](#) (PDF), CHCF, October 2020; Nirmita Panchal, [“The Implications of COVID-19 for Mental Health and Substance Use,”](#) Kaiser Family Foundation, August 21, 2020; Stacy Weiner, [“COVID-19 and the Opioid Crisis: When a Pandemic and an Epidemic Collide,”](#) American Association of Medical Colleges, July 27, 2020; [COVID-19, Economic Pressure and Americans’ Mental Health](#) (PDF), Joint Economic Committee, US Congress, October 2020.
18. Joynt, *Listening to Californians with Low Incomes*.
19. Weiner, [“COVID-19 and the Opioid Crisis.”](#)
20. Azza Altiraifi and Nicole Rapfogel, [“Mental Health Care Was Severely Inequitable, Then Came the Coronavirus Crisis,”](#) Center for American Progress, September 10, 2020.
21. Alex Wigglesworth, [“California Wildfires on the Cusp of Burning 4 Million Acres so Far this Year,”](#) *Los Angeles Times*, October 3, 2020.
22. Joynt, *Listening to Californians with Low Incomes*.
23. Lewis et al., Pre-Convening Paper; Katrina Connolly et al., [Quantifying Integrated Physical and Behavioral Health Care in Medi-Cal](#) (PDF), CHCF, July 2019.
24. [“COVID-19 Cases and Deaths,”](#) City of San Francisco; [Report on Accidental Overdose Deaths — January to August, 2020](#) (PDF), Office of the Chief Medical Examiner, City of San Francisco, October 9, 2020.
25. [“Determination that a Public Health Emergency Exists,”](#) US Department of Health and Human Services (HHS), January 31, 2020; [Proclamation of a State of Emergency](#) (PDF), Executive Department of the State of California, March 4, 2020.
26. *CalAIM Proposal*, DHCS.
27. [Services Delivered via Telehealth Among Medicaid & CHIP Beneficiaries During COVID-19: Preliminary Medicaid & CHIP Data Snapshot of Services Through June 30, 2020](#) (PDF), CMS.
28. For additional discussion of these issues, see Shantanu Agrawal and Tejal Gandhi, [“Telehealth Should Be Expanded — If It Can Address Today’s Health Care Challenges,”](#) *Health Affairs Blog*, September 23, 2020; Ateev Mehrotra et al., [“Telemedicine: What Should the Post-Pandemic Regulatory](#)

and Payment Landscape Look Like?," Commonwealth Fund, August 5, 2020; Elizabeth Morrison and Elizabeth Horevitz, "Clinicians Call for Making COVID-19 Emergency Telehealth Benefits Permanent," CHCF, August 21, 2020; *Creating a Framework to Support Measure Development for Telehealth* (PDF), National Quality Forum, August 31, 2017.

29. Joynt, *Listening to Californians with Low Incomes*.
30. Kenneth Lam et al., "Assessing Telemedicine Unreadiness Among Older Adults in the United States During the COVID-19 Pandemic," *JAMA Internal Medicine*, Research Letter, August 3, 2020.
31. Fabiola Carrión, *California Policy Needs During COVID and Beyond: Telehealth* (PDF), NHeLP, November 4, 2020.
32. Brittany Lazur et al., *Telebehavioral Health: An Effective Alternative to In-Person Care* (PDF), Milbank Memorial Fund, October 2020; Erin Shigekawa et al., "The Current State Of Telehealth Evidence: A Rapid Review," *Health Affairs* 37, no. 12 (December 2018); *Telehealth for Acute and Chronic Care Consultations* (PDF), Comparative Effectiveness Review No. 216, Agency for Healthcare Research and Quality, April 2019.
33. See, e.g., M. Courtney Hughes et al., "Increasing Access to Rural Mental Health Care Using Hybrid Care that Includes Telepsychiatry," *Journal of Rural Mental Health* 43, no. 1 (2019): 30–37.
34. See, e.g., Dror Ben-Zeev et al., "Augmenting Evidence-Based Care With a Texting Mobile Interventionist: A Pilot Randomized Controlled Trial," *Psychiatric Services*, July 7, 2020; Kathleen Myers, "Advances in Asynchronous Telehealth Technologies to Improve Access and Quality of Mental Health Care for Children and Adolescents," *Journal of Technology in Behavioral Science* 3, (2018): 87–106.
35. Agrawal and Gandhi, "Telehealth Should Be Expanded"; Mehrotra et al., "Telemedicine: Post-Pandemic Regulatory and Payment Landscape."
36. Fred Schulte, "Coronavirus Fuels Explosive Growth in Telehealth — And Concern About Fraud," *Kaiser Health News*, April 22, 2020.
37. Robert Belfort and Adam Striar, *Paying for Value in Behavioral Health: What California Can Learn from Other States' Medicaid Programs* (PDF), CHCF, February 14, 2020.
38. "Mental Health Care Health Professional Shortage Areas (HPSAs)," Kaiser Family Foundation, last updated September 30, 2020.
39. For additional discussion for value-based reimbursement models for Medicaid-covered behavioral health services, see Belfort and Striar, *Paying for Value in Behavioral Health*.
40. The federal schedules of controlled substances are available at "Drug Scheduling," US Drug Enforcement Administration.