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The Impact of COVID-19 on Financing of Psychiatric Services



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KEYWORDS

• COVID • Financing • Waiver • Telehealth • Psychiatric services • Lessons learned

KEY POINTS

- The financial impacts owing to the COVID-19 crisis have varied based on 3 major variables: time since the onset of the epidemic, payment methodology and financing, and type of psychiatric service.
- Initial impact was severe service and revenue loss. Subsequent service and revenue recovery was surprisingly swift but has not yet been restored to prepandemic levels.
- Lasting benefits will be expansion of and payments for virtual services
- Epidemic exposed the weakness and lack of flexibility in fee-for-service payment methodologies
- Swift governmental intervention can have a significant impact on the financial viability of clinical sites

INTRODUCTION

The onset of the COVID-19 pandemic in early 2020 had a significant impact on the delivery of behavioral health services which, in turn, has had significant short-term and long-range consequences. Intertwined with the delivery of services has been the

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Abbreviations

AMA	American Medical Association
CARES	Coronavirus Aid, Relief, and Economic Security Act
CMS	Centers for Medicare and Medicaid Services
PACE	Program for All-Inclusive Care for the Elderly
PHE	public health emergency

financial ramifications of the pandemic which have varied based on 3 major variables: time phases since the onset of the epidemic, payment methodology and financing, and type of psychiatric service.

DISCUSSION***Time Since the Onset of the Pandemic***

For any particular location the impact on financing and access to services has fallen into 3 broad phases.

First, the initial closure of services and subsequent loss of revenue occurred mostly during late February and throughout March 2020. Between March 12 and April 6, all US states and territories issued advisory or mandatory stay-at-home orders, with the exception of Iowa.¹ This resulted in the cessation of the majority of nonemergency psychiatric services. In this early phase, even the majority of virtual services were curtailed because, in most cases, the originating site had to be in a clinic setting and not in the community to be billable.

The second phase was the 60- to 90-day lag between the closure of services and the implementation of waivers that allowed billing for virtual services, including federal COVID-19 relief measures, various Medicaid and state interim payment arrangements, and commercial payer flexibilities. The federal actions to allow expanded and alternate payments occurred promptly. However, providers required time to reorganize service delivery and put in place the virtual service delivery infrastructure. States implemented changes to Medicaid plans through the use of 1115 and 1135 waivers (**Box 1**).

Authorization was given for hardship or supplemental payments to incentivize, stabilize, and retain clinicians who were experiencing disruptions to their revenue streams (North Carolina, Oregon, and Washington); states waived requirements that tied payment to a minimum number of hours or contacts to address limitations owing to social distancing mandates (California and New York). Commercial plans expanded in a patchwork way; and some like Anthem made a national decision, whereas others like Centene varied plan by plan.

Box 1**Federal Medicaid waivers**

The i115 Waivers give the Secretary of Health and Human Services the authority to approve multiyear pilot or demonstration projects requested by the states that are likely to promote the objectives of the Medicaid program.

The 1135 Waivers may be granted once a public health emergency has been declared by the Secretary of Health and Human Services. It enables the secretary to temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure necessary services are available during the period of the emergency and to allow clinicians providing care in good faith to be paid for services and exempt from sanctions (absent a determination of fraud or abuse).

- Medicare expanded telehealth coverage to all beneficiaries regardless of location on March 6 and on March 17 specifically included mental health counseling and outpatient visits.
- On March 24, Medicare announced it would not prevent health insurance companies from making policy changes to increase telehealth coverage, including decreases in cost-sharing requirements for telehealth to ensure access to care.
- On March 30, the Centers for Medicare and Medicaid Services (CMS) added an additional 85 services to the list of Medicare telehealth services and expanded coverage of specific services by audio only.²

Individual state Medicaid programs and commercial insurers showed wide variation in how promptly they allowed expanded billing for virtual care. By June, most payers were reimbursing for virtual services by video or audio only at the same rates they had previously reimbursed for in-person services. The implementation of alternative payment methodologies was not widely or promptly done and varied based on type of service. Habilitation and personal care services were paid based on historic prospective payment amounts, mitigating the impact of any service interruptions. Some states authorized an interim payment based on historic payments for other services that was then subject to reconciliation and repayment if the service volume was not maintained. Other states implemented retroactive rate changes to help practices stay afloat.

The National Council for Behavioral Health, representing more than 3200 providers of treatment for addiction and mental illness, conducted an online survey of 880 behavioral health organizations across the country in April 2020 to quantify the impact of COVID-19 on patients, employment, safety, and financial viability. At that time,

- 62.1% of behavioral health organizations reported that they could only survive financially for 3 months or less under the COVID-19 conditions in place at that time;
- Only 9.4% of organizations reported they could survive 1 year or more;
- 46.7% of behavioral health organizations had to, or planned to, lay off or furlough employees as a result of COVID-19;
- Organizations canceled, rescheduled, or turned away 31.0% of patients;
- 61.8% closed at least 1 program; and
- Nearly all (92.6%) had reduced their operations.

The financial impact was more severe for smaller organizations (serving 2000 patients or less annually) who canceled, rescheduled, or turned away 36.1% of patients (National Council Behavioral Health, April 2020).³ Congress, through legislative action, authorized a number of mechanisms (**Table 1**) to provide financial support to clinicians and entities providing mental health and substance use disorder services.

Although the Paycheck Protection Program was initiated as part of the Coronavirus Aid, Relief, and Economic Security Act (CARES), allocating \$349 billion in forgivable loans for businesses to maintain employment at pre-COVID levels, a second online survey done in early June by the National Council for Behavioral Health found that:

- 31% of behavioral health organizations had not received any relief funding and among those who did receive funding, 39% got less than \$50,000;
- On average, behavioral health organizations reported having lost 24.3% of their revenue during COVID-19; and
- 71% reported having to cancel, reschedule, or turn away patients over the previous 3 months.⁴

Table 1
Breakdown of COVID supplemental bills, 2020 to 2021

	CARES Act, March 2020	COVID Supplemental, December 2020	FY2021 SAMHSA appropriations	American Rescue Plan, March 2021
SAPT block grant	—	\$1.65 billion	\$1.858 billion	\$1.5 billion
Mental health block grant	—	\$1.65 billion (half to providers)	\$757 million (5% crisis set aside)	\$1.5 billion
CCBHC expansion grants	\$250 million	\$600 million	\$250 million	\$420 million
Project AWARE	—	\$50 million	\$107 million	\$30 million
Suicide prevention	\$50 million	\$50 million	\$66 million (multiple programs)	\$20 million (youth suicide)

Adapted from Parks, J. Impact of COVID on Demand for and Access to Behavioral Healthcare. National Council for Behavioral Health. 2020, with permission

The third phase, since mid-2020, has seen the stabilization of operations with a new mix of virtual services and payments in an environment of ongoing uncertainty regarding how long the expanded billable services for virtual care would remain in place. A third National Council for Behavioral Health poll of 343 members conducted during the last 2 weeks of August found that:

- 26% of organizations had laid off employees, 24% had furloughed employees, and 43% had decreased the hours for staff;
- On average, organizations lost 22.6% of their revenue over the past 3 months during COVID-19;
- 39% believed they could only survive 6 months or less;
- Although 52% of organizations reported an increased demand for services, 62% reported that they had to cancel, reschedule, or turn away patients over the past 3 months;
- 48% of organizations reported telehealth services were providing an equal amount of revenue as previously received for in-person services. However, of those (52%) who said telehealth was not providing the same revenue on average as in-person services, they reported a 28% decrease in revenue; and
- 32% reported not receiving any funding from the CARES Act, with smaller organizations more often reporting they did not receive any stimulus funding or provider relief funds.⁵

As reflected in **Fig. 1** (changes in clinical practice), international respondents of the Global Clinical Practice Network reported changes in the number of services provided within their clinical practice. Slightly less than one-half of the respondents were providing less frequent diagnostic, psychological assessments, or psychotherapy services since the pandemic began, although only 37% of the respondents indicated they were providing psychopharmacology less frequently than before the pandemic.

Payment Methodology and Financial Impact

Overall, the predominant fee-for-service payment methodology has proven the least resilient and adaptive payment methodology during the pandemic. Limiting payment

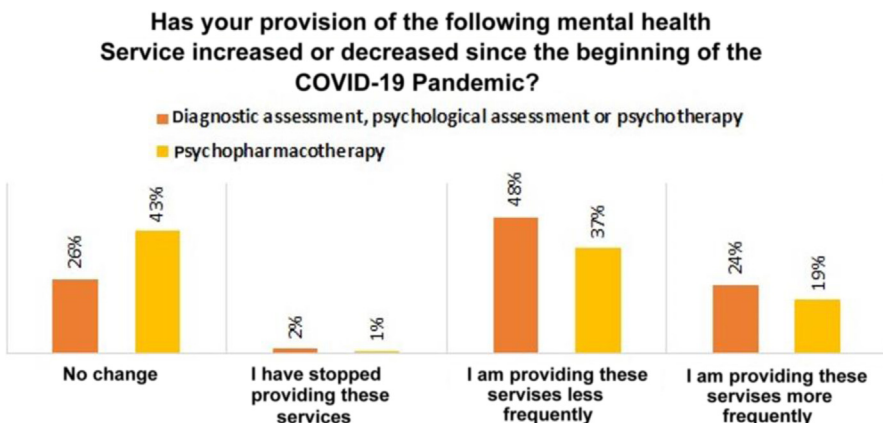


Fig. 1. Changes in the provision of mental health services. (From Parks J. Impact of COVID on Demand for and Access to Behavioral Healthcare. National Council for Behavioral Health. 2020)

to a narrow list of individual services with specific requirements often involving face-to-face care has required many more administrative changes, including a rapid transition to telehealth and limited rapid innovation to the new pandemic conditions. In general, those operating under a capitated or prospective payment system fared better given the existing flexibilities inherent in the structure of the payment. Adjusting rates applied to individual services or expanding coverage as in a fee-for-service environment is much more administratively complex.

The best performing payment methodologies have been in full capitation arrangements providing that the payment adjustment flows through the administrative bodies to the direct service providers and in grant-based funding, where agencies receive a periodic lump sum of money for a broadly defined set of services to a defined population. These payments were immediately adaptable at the provider level in response to the pandemic. Prospective payment methodologies such as those used for funding certified community behavioral health centers and federally qualified health centers, afforded immediate operational adaptability and provider financial resilience. CMS telehealth flexibilities enabled these entities to continue to provide services while receiving the same historic payment amounts.

Medicare, Medicaid, and the Children's Health Insurance Program were hampered by not having the same statutory authority for behavioral health clinicians as they do in the case of community habilitation services to persons with developmental disabilities to issue an 1135 waiver allowing interim alternative payments based on prior historic payments for all behavioral health services. As a result, community habilitation and personal care services were able to maintain their revenue stream owing to the stability in the payment methodology. In a number of cases, states instead resorted to temporary rate increases to avoid providers going out of business and programs closing. In some cases, the rate increases were done retroactively.

The pandemic significantly impacted physician livelihood and outlook. A survey conducted in April 2020 of 842 physicians revealed that 21% had recently been furloughed or experienced a pay cut, 14% planned to change practice settings as a result of COVID-19, and 18% planned to retire, temporarily close their practices, or opt out of patient care.⁶ According to a yearly report published in October 2020, average physician compensation seemed to increase by 1.5%, but this was lower than increases in previous years and, when taking account the rate of inflation, actually represented a decrease in real income.⁷ A similar pattern held for psychiatrists—a survey published in May 2021 had 22% reporting some decrease in compensation over the year prior.⁸ The same group, however, was optimistic, with 83% expecting an eventual return to pre-COVID-19 income levels. Because labor costs typically make up the highest portion of practice expenses, it follows that pandemic-related decreases in patient volume, and thus revenue, led practices to reevaluate employee contracts accordingly.

A recent American Medical Association (AMA) analysis of Medicare Physician Fee Schedule^a spending (spending is the allowed Medicare charge and includes both what Medicare pays and beneficiary deductible) for all physicians reflects a decrease in payments from Medicare during the first months of the pandemic, before rebounding and leveling off in the fall of 2020 (Fig. 2). The AMA found that overall spending

^a *Reflects Medicare Physician Fee Schedule spending, which is one component of the category classified as Part B spending which also includes outpatient hospital, DME, lab, ambulance; Part A (inpatient services) spending is not included.

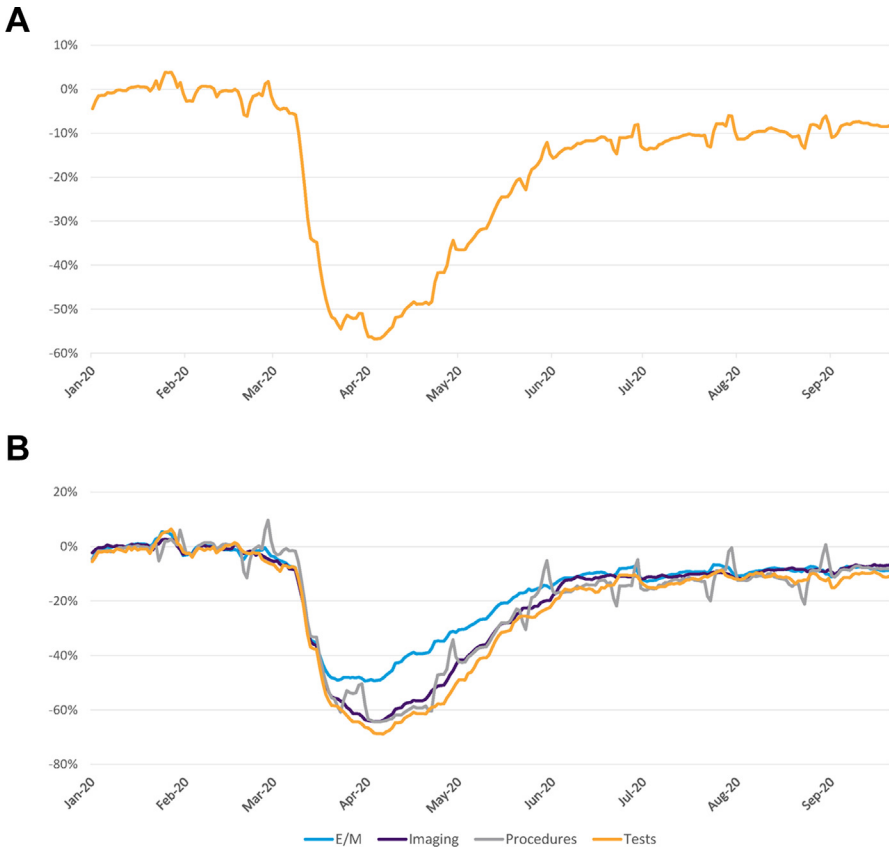


Fig. 2. A) Overall Medicare physician fee schedule spending January to September 2020 as compared with expected spending. (B) Medicare physician fee schedule spending by place of service as compared with expected spending. Evaluation/Management (E/M). (From Economic and Health Policy Research, American Medical Association with permission.)

decreased by 57% before leveling off at a roughly 8% below expected spending September 2020. The AMA estimates that the cumulative reduction for all clinicians during the first 9 months of 2020 is \$11.5 billion.

The AMA estimates that the cumulative decrease in Medicare physician fee schedule spending from January to September 2020 for psychiatry was 9%, \$702 million in spending down from the expected \$773 million. Psychologists spending was down by 11% (\$549 million, down from \$614 million), and social workers spending was down by 9% (\$447 million, down from \$494 million). The decrease in payments to mental health clinicians was less than for some of the other medical specialties, in part because of the ability to provide care via telehealth.

Type of Psychiatric Service

Financial impact by type of psychiatric service varied depending on the payment methodology in place, but a review of the publicly available data reflects that payments for services overall were less in 2020.

Preliminary data from CMS about Medicaid, the largest payer for mental health and substance use disorder services, and the Children's Health Insurance Program shows a significant decrease in services provided to the Medicaid population over the course of the public health emergency (PHE) for all sites of service. As reflected in the tables, services for children under 19 years of age decreased by 34% between March 2020 and October 2020 when compared with the same period in 2019; mental health services for adults decreased by 22% during the same timeframe; and services for patients with substance use disorders declined by 13% when compared with services provided in 2019. As reflected in [Fig. 3](#), services continue to remain below levels in 2018 and 2019.⁹

Outpatient and office-based services

Disruptions in care occurred in the outpatient office setting during the initial months of the PHE as clinicians shifted from seeing patients in person to providing care virtually. A survey of members of the American Psychiatric Association found that 64% of respondents were not using telehealth as a mode of care at all before the implementation of the PHE; 2 months into the PHE, this number shifted dramatically to 85% of respondents seeing more than three-fourths or all of their patients via telehealth.

Some behavioral health clinicians and organizations have reported an increase in revenue for these services owing to a decrease in the rate of patients not keeping appointments for virtual care compared with in-person care. There is continued uncertainty and concern that commercial payers will decrease rates for virtual care at some point in the future or discontinue coverage for audio-only services.

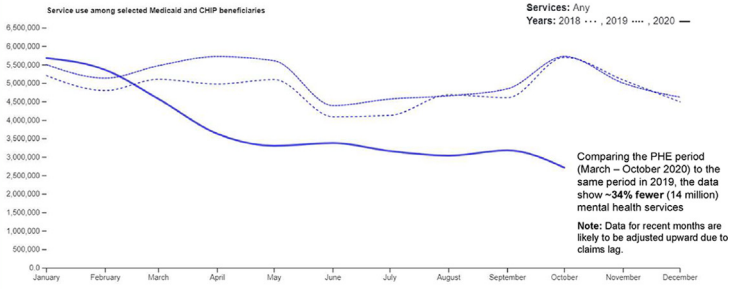
Inpatient and residential care

Inpatient and residential treatment programs continue to operate at substantial losses unless they are paid through alternative interim payment methodologies such as temporary rate increases (see case example in [Box 2](#)). Social distancing and masking have required them to operate at reduced census while maintaining the pre-COVID level of staffing requirements, maintenance of clinical services such as group therapy (reduction in group size but not frequency) as well as one-to-one observation standards. Many have reported having to intermittently further limit capacity owing to shortages of personal protective equipment. Unexpected expenditures for personal protective equipment, testing kits, and technology used to implement telemedicine have likely had an impact on the traditionally thin margins under which psychiatric inpatient units operate.¹⁰

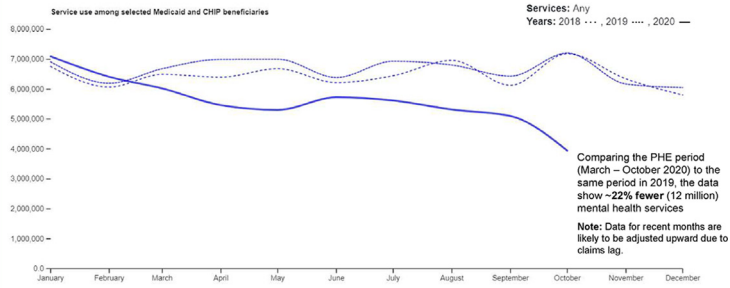
Partial hospitalization programs and intensive outpatient programs

Initially partial hospitalization and intensive outpatient programs were decreased or closed as facilities, including community mental health centers, adapted care during the COVID-19 PHE. The closure of services resulted in a loss of revenue that was primarily dependent on the transition time needed to implement telepsychiatry. The CMS eventually extended emergency waivers, retroactive to March 1, 2020, allowing community mental health centers and other facilities to provide certain partial hospitalization services in temporary expansion locations (ie, patient's homes) through the use of telehealth.¹¹ CMS also waived the requirement that a community mental health center provide at least 40% of its services to patients who are not eligible for Medicare benefits, enabling the provision of services to proceed without regard to payer.¹² Private payers followed suit and began to provide coverage to patients from their homes via telehealth. A recent study indicated that patient satisfaction was as high with telehealth partial hospital treatment as with in-person treatment in a general adult program.¹³ However, some specialized PHPs or IOPs faced specific monitoring

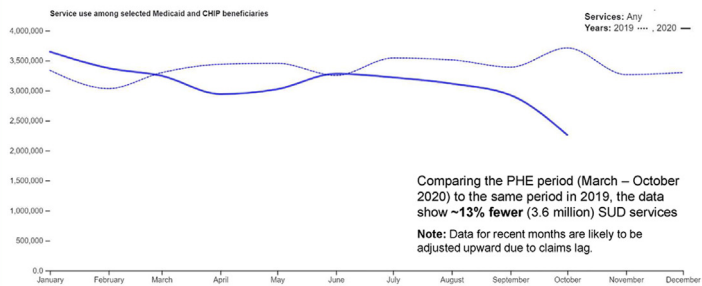
A



B



C



challenges like obtaining weights or blood pressures in patients enrolled in eating disorders programming. As the PHE has continued, some programs have shifted to a hybrid model of care that includes group sessions that includes patients joining the sessions either virtually or in person (see [Box 2](#)).

Long-term care

A 2020 World Health Organization survey described disruptions in mental health services for children and adolescents, older adults and peripartum women in 130 countries. More than 60% of respondents reported disruptions in counseling and psychotherapy, harm reduction services and opioid agonist therapy. More than one-third of countries reported disruptions in emergency services for mental health crises. Closer to home, disruptions in mental health services were reported in all levels of behavioral health care, as outlined elsewhere in this article.¹⁶



Fig. 3. A) Mental health services for children under age 19 during COVID-19. Preliminary 202 data show that mental health services for children under age 19 decreased starting in March and continue to be substantially below prior years' levels through October. Mental health services among children under 19 years decreased from 145 per 1000 in February to a low of 72 per 1000 beneficiaries in October 2020. *Note:* These data are preliminary Data are sourced from the T-MSIS Analytic Files v4 in AREMAC, using final action claims. They are based on December T-MSIS submissions with services through the end of November. Recent dates of service have very little time for claims runout and we expect large changes in the results after each monthly update. Because data for November are incomplete, results are only presented through October 31, 2020. (B) Mental health services for adults during COVID-19. Preliminary 2020 data show mental health services for adults ages 19 to 64 decreased through May and have not rebounded to prior years' levels through October. Mental health services among adults ages 19 to 64 decreased from 176 per 1000 beneficiaries in February 2020 to a low of 100 per 1000 beneficiaries in October 2020. *Notes:* These data are preliminary. Data are sourced from the T-MSIS Analytic Files v4 in AREMAC, using final action claims. They are based on December T-MSIS submissions with services through the end of November. Recent dates of service have very little time for claims runout and we expect large changes in the results after each monthly update. Because data for November are incomplete, results are only presented through October 31, 2020. (C) Substance use disorder services for adults during COVID-19. Preliminary 2020 data show SUD services for adults age 19 to 64 decreased starting in March, increased in June, and are still below 2019 levels through October. *Notes:* These data are preliminary. Data are sourced from the T-MSIS Analytic Files v4 in AREMAC, using final action claims. They are based on December T-MSIS submissions with services through the end of November. Recent dates of service have very little time for claims runout and we expect large changes in the results after each monthly update. Because data for November are incomplete, results are only presented through October 31, 2020. We compare SUD service use in 2020 with 2019 only. Coverage of SUD treatment services has increased dramatically over the past 3 years with the implementation of several 1115 demonstrations. As a result, we do not compare treatment rates in 2020 to treatment rates in 2018 and 2017, when coverage of services was generally lower. Additionally, as of January 1, 2020, Medicare Part B pays Opioid Treatment Programs through bundled payments for opioid use disorder. This change in coverage may impact results for dually eligible beneficiaries. SUD services for adults ages 19 to 64 decreased from about 92 per 1000 beneficiaries in February 2020 to a low of 57 per 1000 beneficiaries in October 2020. (*Data from CMS, Medicaid & CHIP and the COVID-19 to 19 Public Health Emergency: Preliminary Medicaid & CHIP Data Snapshot, Services through October 31, 2020.* 2021. Available at: DOI: <https://www.medicaid.gov/state-resource-center/downloads/COVID-19-19-medicaid-data-snapshot.pdf>. Published May 14, 2021. Accessed May 15, 2021.)

Box 2**Case example: University of North Carolina Hospitals emergency department and inpatient**

At the most basic level, the physician coding is a factor of the volume multiplied by relative value units, so to maximize billing physicians would desire maximum volume at the highest relative value units (highly acute patients moving quickly through the emergency department/inpatient areas). In March of 2020, at the beginning of the COVID-19 epidemic in the United States, most emergency rooms across the United States initially saw a marked decrease in the total number of emergency department visits. The decrease in volume has been theorized to be a reaction to the stay-at-home order and the public's attempt to delay care to minimize exposure to coronavirus infection. A recent study highlighted the overall decrease in total number of emergency room encounters in 2020 as compared with 2019. However, that same study indicated the total number of visits for mental health conditions, suicide attempts, and drug and opioid overdose all increased in the study time period (weeks 1–41 of 2020) as compared with the same time period in 2019.¹⁴ The University of North Carolina saw an initial decrease in overall psychiatric visits in March 2020 (40% decrease) and April 2020 (49% decrease) before returning to expected prepandemic levels by late summer (September 2020).

At the University of North Carolina Hospitals, the coronavirus exacerbated inpatient psychiatry services by several factors that contributed to reduced inpatient capacity during the pandemic. First, following infection prevention guidance, the total number of inpatient psychiatric beds at the Chapel Hill campus was decreased by necessity to convert semiprivate rooms to private rooms to allow for appropriate physical distancing between beds. Second, several nurses either retired or resigned early in the year as the stress of the pandemic hit. This factor impacted the ability to fully staff inpatient units and operate at full volume. Finally, the need to have a designated inpatient psychiatric COVID-positive unit decreased inpatient capacity. The University of North Carolina hospital converted a subsection of a unit to a 3-bed COVID-positive unit for patients in need of inpatient psychiatric care, but medically asymptomatic or mildly symptomatic. Patients who tested positive in the emergency room or converted to positive on the inpatient psychiatric units would be transferred to these beds. Although this action was necessary to meet the needs of the greater system, it frequently was empty and never reached full capacity, leaving unfilled beds. The impact of these changes was increasing the length of stay for psychiatric patients boarding in the emergency room.

During the height of the COVID-19 pandemic, the number of main campus inpatient beds decreased from 76 (before COVID) to 52 (during COVID). At the same time, some of the traditional dispositions for discharging patients (housing shelters, group homes, state psychiatric hospitals, and long-term care facilities) greatly tightened admission criteria or delayed referrals altogether. A recent article described a range of discharge delays between 7 and 47 days owing to reluctance of congregate care facilities to accept COVID-19 patients back into the community.¹⁵ The 2 inpatient units most impacted by these restrictions were the geropsychiatry unit and the psychotic disorders unit. The crisis stabilization unit, child and adolescent units, and eating disorder units all experienced relatively minor increases in their average length of stays (ALOS) and total number of discharges but were less disrupted than the geropsychiatry and psychotic disorders units.

- In the pre-COVID year (March 2019 to February 2020), the ALOS on the psychotic disorder unit ([Fig. 4](#)) was 15.2 days and the total number of discharges was 400.
- During COVID (March 2020 to February 2021), the ALOS was 20.8 days and the total number of discharges 238 for that psychotic disorder unit (see [Fig. 4](#); [Figs. 5](#) and [6](#)).
- In the pre-COVID year (March 2019 to February 2020), the ALOS was 17.7 days and the total number of discharges was 163 on the geropsychiatry unit.
- During COVID (March 2020 to February 2021), the ALOS was 30.6 days and the total number of discharges 78 for that geropsychiatry unit (see [Figs. 4](#) and [5](#)).
- The overall financial impact on the psychotic disorders unit was a 14% decrease in physician charges from March 1, 2020, to February 28, 2021, as compared with March 1, 2019, to February 28, 2019.

- The overall financial impact on the geropsychiatry unit was a 37% decrease in physician charges from March 1, 2020, to February 28, 2021, as compared with March 1, 2019, to February 28, 2019.
- Inpatient units were operating at a decreased volume and patient discharges were delayed, decreasing relative value units (volume and level), which decreased overall physician charges.

What cannot be adequately depicted in charts and graphs is the emotional toll and burnout that decimated staff in the emergency departments and inpatient psychiatric units. The time and mental energy that was spent in contingency planning was unfathomable: (a) infection prevention (screening, rescreening, personal protective equipment distribution, and disinfection), (b) restrictions of visitors and minimization of overcrowding, (c) staff workforce planning and redeployment, (d) operational adjustments (telepsychiatry protocols, revising admission criteria, and designing a COVID-positive unit), and (e) group therapy changes (limiting number of participants, practicing physical distancing). Although the height of the pandemic looks to have past most for emergency and inpatient facilities, the emotional impact remains ever present.

Older individuals with behavioral health conditions confront the risk of COVID-19 on 3 key fronts. First, estimates of mental health condition prevalence in older adults is more than 20%, and near 50% in long-term care settings.^{17,18} Second, individuals with behavioral health conditions experience a higher prevalence of high risk chronic conditions associated with high COVID-19 morbidity and mortality.^{19,20} Third, individuals with behavioral health conditions often reside in settings with elevated risk of COVID-19 exposure, such as shared or congregant housing settings, including long-term care facilities such as assisted living facilities and skilled nursing facilities that house frail and elderly adults in need of 24/7 supervision and progressive levels of skilled needs.^{21,22} Finally, the November 20, 2020, Morbidity Mortality Weekly Report noted:

As of October 15, 2020, an average of one death occurred among every five Assisted Living Facility residents with COVID-19, compared with one death

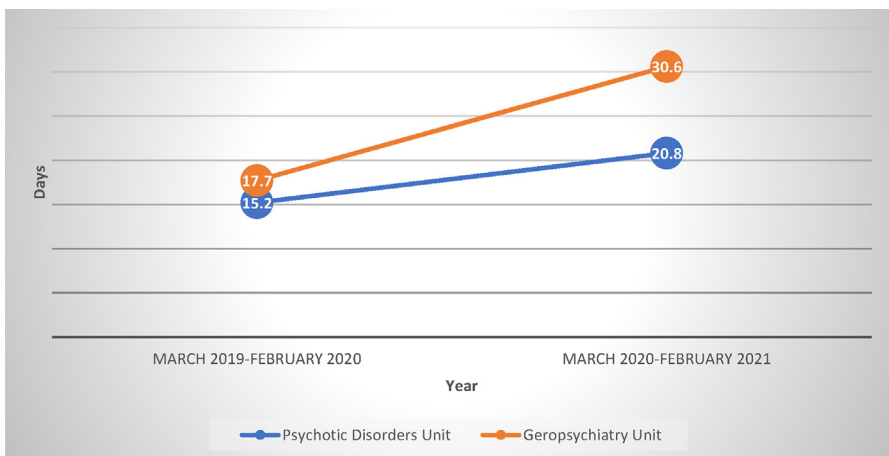


Fig. 4. Comparison of average lengths of stay before COVID-19 and during COVID-19. (Data from Francki J, Penaskovic KM. University of North Carolina Hospital Discharges Pre and Post Covid-19 [Quality Improvement Project, April 9]. Chapel Hill, NC; 2021[Unpublished].

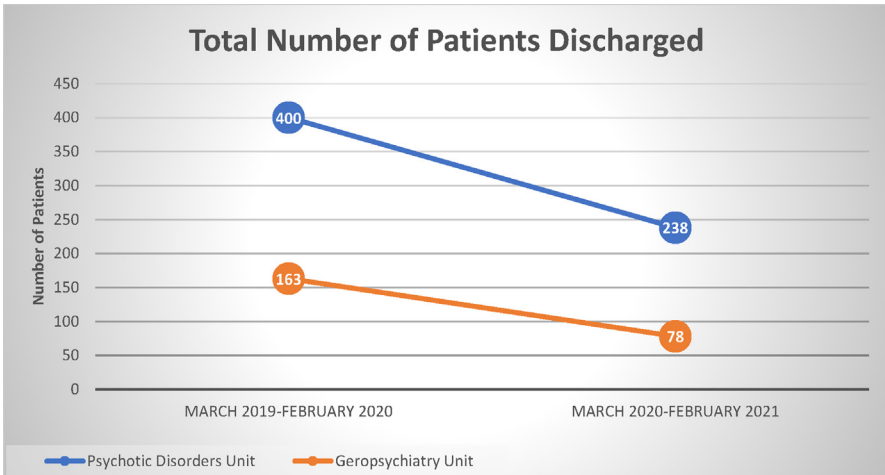


Fig. 5. Comparison of patient discharges before COVID-19 and during COVID-19. (Data from Francki J, Penaskovic KM. University of North Carolina Hospital Discharges Pre and Post Covid-19 [Quality Improvement Project, April 9]. Chapel Hill, NC; 2021[Unpublished].)

*among every 40 persons in the general population with COVID-19 in states with available data.*²³

Furthermore, long-standing racial and ethnic disparities in the quality of care in long-term care, compound overall quality of care issues seen in the behavioral health population.²⁴

The COVID-19 pandemic turned up the volume on growing efforts to reinvent financing of long-term care, such as assisted living and skilled nursing facilities,²⁵ especially given the higher COVID-19 morbidity and mortality rate in long-term care facilities. Long-term care financial reform continues to challenge policymakers and families, as evidenced by the 2019 launch of the CMS value-based program for long-term care, focused on the skilled nursing level of care, the Skilled Nursing

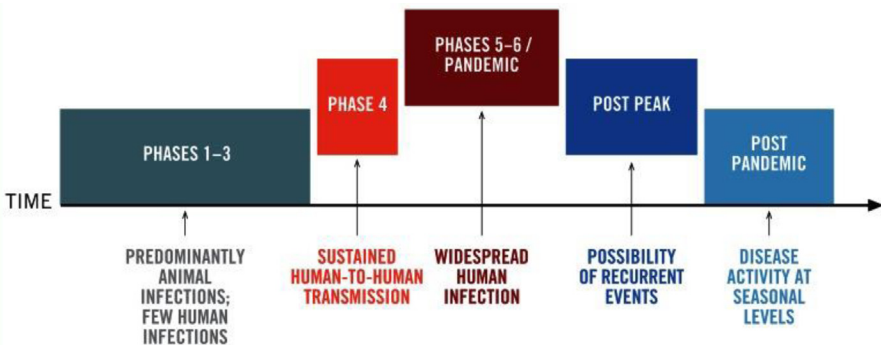


Fig. 6. Pandemic phases of preparedness. (From Pandemic Influenza Preparedness and Response: A WHO Guidance Document. Geneva: World Health Organization; 2009. 4, THE WHO PANDEMIC PHASES. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK143061/>.)

Value-Based Purchasing Program. The program rewards skilled nursing facilities for meeting quality of care goals, such as hospital readmissions.^{26,27} Even modest long-term care finance reform proposals overlook the needs of long-term care residents with behavioral health conditions.

Pre-COVID-19 efforts to achieve a more nuanced continuum of long-term care services (Table 2), such as the capitated Program for All-Inclusive Care for the Elderly (PACE), resemble efforts to promote care in the least restrictive setting for individuals with mental illness. Policymakers, facility owners, consumers, and caregivers can learn from behavioral health experiments in creating less restrictive therapeutic community-based support and services, such as assertive community treatment and supportive housing programs. The PACE program, for example, incorporates behavioral health professionals into the core staffing model, although direct behavioral health services beyond those provided by primary care providers, are not included in the capitated rate. One may even liken PACE to a collection of piecemeal community-based, typically Medicaid-funded, behavioral health services that incorporate ancillary, medical, and site-based services. Long-term care and community-based behavioral health services share a reliance on Medicaid for primary funding and, hence, innovation in noninstitutionalized care.^{28,29} Perhaps a middle ground between PACE and home-based care, as exemplified in Medicaid innovations, is a starting point to address the needs of the seriously mentally ill population in long-term care facilities.

Preparing for the Next Pandemic

Although the COVID-19 pandemic is unprecedented in scale and virus transmissibility, a pandemic viral respiratory illness was not unexpected and remains an ongoing threat. The COVID-19 pandemic resulted in, as of June 24, 2021, 603,181 excess deaths in the United States and 3,902,187 in the world,³⁰ in addition to an increase in job loss, school disruption, social isolation, and child abuse. The unprecedented and rapid global research and dissemination of COVID-19 pathophysiology, epidemiology, clinical course, public health prevention, and immunotherapy represents a triumph; yet we learned that effective state, national and international leadership, communication and coordination are critical to improve the global response to the next pandemic.³¹

How can behavioral health leaders financially prepare their organizations and patients for the next pandemic? We categorize pandemic preparedness within 2 World Health Organization phases of a pandemic: phases 5 and 6 and after the peak.

	Home-based Care	Community-based Care	Facility-based Care
LTC example	Home health, caregiver support	PACE program ^a , senior centers, Kapuna Caregivers Program ^a	Skilled nursing facility
BH example	Assertive community treatment ^a	Psychosocial rehabilitation	Residential

^a Value-based program.

Adapted from: National Conference of State Legislatures: Long-Term Services and Supports: FAQs: 2013. <http://www.ncsl.org/research/health/long-term-services-and-supports-faqs.aspx>.

Initial pandemic response

Pandemic declaration occurs when an epidemic affects multiple countries or continents and indicates geographic spread as opposed to disease severity. As we described, the pace of financial policy change was a key influence on the ability to maintain behavioral health services across the care continuum after the pandemic declaration. In future pandemics, policymakers and payers can build from COVID-19 lessons learned to more quickly allow providers to transition to virtual care and ensure safe conditions for patients and providers in office-based or facility-centered care. Proactive strategies to obtain personal protective equipment access and implement social distancing strategies are critical to allow behavioral health providers time to safely transition, as indicated, to virtual care methods. Facility-based partners should be included in surge and initial pandemic planning to ensure the employment conditions of behavioral health workers and needs of behavioral health patients are well-represented.

Finally, the reliable and accurate communication of pandemic conditions, evolving disease burden, and health sector service use are critical to ensuring health security for patients and providers. Anticipatory guidance to obtain and interpret accurate, timely and relevant information to guide financial and operational policy for behavioral health services coverage, payment, and provision is as critical in the acute pandemic response phase and pathophysiology and treatment. For example, the Centers for Disease Control and Prevention outlines an entire health communication strategy at their website <https://npi.cdc.gov/pages/health-communication-strategies>.

CLINICS CARE POINTS

- Financing models should be evaluated for their resilience and ability to maintain services during a crisis.
- Developing alternative payment models that are more flexible are necessary to address the need for a rapid response to a financial health care crisis.
- Developing and sustaining partnerships between government agencies and behavioral health clinicians is essential for a rapid response to any crisis.

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DISCLOSURE

The authors have nothing to disclose.

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