November 12, 2021

Senator Ron Wyden
Chair
Senate Committee on Finance
Washington, DC 20510

Senator Mike Crapo
Ranking Member
Senate Committee on Finance
Washington, DC 20510

Dear Senators Wyden and Crapo:

Thank you for the opportunity to provide information on opportunities to improve behavioral health care.

The National Health Law Program (NHeLP) is a public interest law firm working to protect and advance the health rights of low income and underserved individuals. Founded in 1969, NHeLP advocates, litigates, and educates at the federal and state levels. Consistent with its mission, NHeLP works to ensure that all people in the United States have access to affordable, quality health care, including comprehensive behavioral health services.

We appreciate the Senate Finance Committee's commitment to examining ways to improve behavioral health and reduce gaps in care. Below, we offer policy options where additional legislation, oversight, or guidance would further the Senate Finance Committee's priorities of increasing integration, coordination and access to care; ensuring parity; and improving access to behavioral health care for young people and children.

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I. Increasing Integration, Coordination, and Access to Care

A. Improving Access to Intensive Community-based Services for Adults

To improve access to care across the behavioral health continuum, specific attention must be paid to intensive community-based services for adults that have a proven track record of helping adults with significant behavioral needs live in the community, maintain housing and employment, and avoid the crises that drive the demand for inpatient hospitalization. These services, which are typically more intensive than the traditional clinic-based medication management and counseling, include:

- **Assertive Community Treatment (ACT)** is an evidence-based, highly individualized, team-based service designed to support adults with the most intensive mental health needs.[1]

- **Individual Housing Transition and Tenancy Support Services** are services available to individuals who need support to transition to and maintain housing. Such services may include an assessment to identify preferences and barriers to housing, developing a housing support plan with short and long-term goals, developing a housing crisis plan to prevent disruption of housing, early identification and intervention for behaviors that may jeopardize housing, education and training about how to maintain housing and the roles of landlords and tenants, assistance in resolving disputes, and linkage to other community resources to prevent eviction.[2]

- **Individualized Placement and Support Employment Services** is an evidence-based supportive employment model that has become the standard of care for individuals with serious mental illnesses.[3]

- **Peer Support Workers** are individuals who have the lived experience of recovering from a mental health condition, substance use disorder, or both. Peers use "non-clinical, strengths-

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[1] SAMHSA, *Assertive Community Treatment: The Evidence* (2008), https://store.samhsa.gov/sites/default/files/d7/priv/theevidence_1.pdf.

[2] Vicki Wachino, Ctrs. for Medicaid & Chip Servs., *Coverage of Housing-Related Activities and Services for Individuals with Disabilities* (June 26, 2015), https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf.

[3] Gary Bond, *Evidence for the Effectiveness of Individual Placement and Support Model of Supported Employment (*July 2021), https://ipsworks.org/index.php/evidence-for-ips/.

based support," drawing from their own life experiences with recovery, to support others experiencing similar challenges.[4]

The above-listed services, along with other interventions such as psychosocial rehabilitation services and community-based mobile crisis intervention services, are the building blocks of any functioning system of care for adults.[5] And while many states cover all or some of these services in their Medicaid state plans or waivers, the need far outstrips the availability. For example, in 2020, only 1.8 % of adults served by state behavioral health systems (who are often individuals who are covered by Medicaid and have a serious mental illness) received ACT services.[6] Experts estimate that the need is dramatically higher.[7] Similarly, only 1.9 % receive supported employment, and 2.3 % have access to supported housing.[8]

We encourage the Senate Finance Committee to explore the use of targeted investments or mandates to expand access to integral, recovery-oriented adult community-based behavioral health services. Specifically, we encourage the committee to strategically use the levers available in Medicaid to improve the availability and quality of these behavioral health services. Congress could mandate that states cover some subset of well-researched and successful behavioral health interventions.[9] Alternatively, Congress could increase states' FMAP for particular service or set of services, to incentivize states to expand such effective and evidence-based services rather than rely on less effective and more costly institutional care and hospitalizations. However, any funding incentive must be carefully tailored to the goal the Senate seeks to achieve. Assuming the goal is to increase the availability of certain high-quality

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[4] SAMHSA, *Value of Peers* (2017), https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf; CMS, Dear State Medicaid Director (Aug. 15, 2007) (SMD # #07-011) (guidance on covering peer support services under Medicaid), https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf.

[5] MACPAC, *Report to Congress on Medicaid and CHIP, Medicaid Coverage of Mental Health Benefits for Adults*, Appendix 2B (June 2021), https://www.macpac.gov/wp-content/uploads/2021/06/June-2021-Report-to-Congress-on-Medicaid-and-CHIP.pdf.

[6] SAMHSA, *2020 Uniform Reporting System (URS) Output Tables* (June 25, 2021), https://www.samhsa.gov/data/report/2020-uniform-reporting-system-urs-output-tables.

[7] Gary S. Cuddeback, et al. *How Many Assertive Community Treatment Do We Need*, Psych. Servs. (Dec. 1, 2006), https://ps.psychiatryonline.org/doi/full/10.1176/ps.2006.57.12.1803.

[8] SAMHSA, 2020 Uniform Reporting System (URS) Output Tables, June 25, 2021, https://www.samhsa.gov/data/report/2020-uniform-reporting-system-urs-output-tables.

[9] The use of mandates to improve behavioral health Medicaid services Medicaid has precedent. In 2018, Congress mandated that states provide Medication Assisted Treatment for opioid use disorder, which was previously only an optional state services. *See* 42 U.S.C. § 1396d(ee).

community-based services, a general FMAP increase for all behavioral health services is not narrowly tailored enough to achieve this goal. Instead, we recommend that incentives be explicit regarding the change that is sought, and that any additional funding is both tied to specific desired outcomes and a requirement that the federal increase supplement and not supplant current state funding.

B. Improving Access to Services and Care Coordination for Criminal Justice-Involved Adults

Integration and care coordination for adults with behavioral health needs in the criminal justice system requires additional attention and different interventions. Incarcerated individuals have significantly and disproportionately high rates of mental health needs.[10] Studies have found that over half of incarcerated individuals report frequent drug use prior to entering incarceration and people recently released from prison have a mortality rate that is twelve times higher than the general population.[11] Ensuring that individuals leaving incarceration are enrolled in Medicaid presents opportunities to improve health outcomes and improve access to care.

The Medicaid Act prohibits states from obtaining federal financial participation for "care or services for any individual who is an inmate of a public institution," but there is absolutely no requirement that states terminate Medicaid enrollment upon incarceration.[12] And while best practice is to suspend eligibility and ensure that individuals leave incarceration with active Medicaid, some states still fail to meet this relatively modest goal.[13] Of the states that choose to suspend rather than terminate eligibility, many do not have an electronic, automated data exchange process between

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[10] MACPAC, R*eport to Congress on Medicaid and CHIP, Medicaid Coverage of Mental Health Benefits for Adults*, 41-42 (June 2021), https://www.macpac.gov/wp-content/uploads/2021/06/June-2021-Report-to-Congress-on-Medicaid-and-CHIP.pdf.

[11] Christy Visher et al., *Life After Prison: Tracking the Experiences of Male Prisoners Returning to Chicago, Cleveland, and Houston*, Urban Inst. (May 2010), https://www.urban.org/sites/default/files/publication/28671/412100-Life-after-Prison-Tracking-the-Experiences-of-Male-Prisoners-Returning-to-Chicago-Cleveland-and-Houston.PDF; Ingrid A. Binswanger et al., *Release from Prison – A High Risk of Death for Inmates*, 356 N.E. J. Med. 157 (2007), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836121/.

[12] 42 U.S.C. § 1396d(a)(31)(A).

[13] Kaiser Family Foundation, *States Reporting Corrections-Related Medicaid Enrollment Policies In Place for Prisons or Jails, SFY 2019, https://www.kff.org/medicaid/state-indicator/states-reporting-corrections-related-medicaid-enrollment-policies-in-place-for-prisons-or-jails/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D*

the corrections and Medicaid agency, causing unnecessary delays in accessing services upon release.[14]

To improve access to care and strengthen care coordination, Congress should require states to indefinitely suspend rather than terminate eligibility for all Medicaid-enrolled individuals entering incarceration. Further, we recommend that Congress require states to conduct a redetermination of eligibility prior to release for individuals who had Medicaid coverage prior to incarceration, and to ensure that the coverage is in effect and no longer suspended upon release for all individuals who remain eligible. Congress has already required these reforms for individuals under 21 and for former foster care youth up to age 26.[15] We recommend that Congress follow the model of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act and require suspension rather than termination of eligibility for all Medicaid-enrolled individuals entering incarceration.[16]

In addition to these reforms, to the extent that Congress is considering partial repeals of the inmate exclusion to assist with reentry, we strongly encourage the Committee to consider ways to target such changes to ensure that new federal funding is appropriately directed towards community-based providers who can do "reach-in" services to help connect individuals to community-based services and supports upon release.

II. Ensuring Parity

Congress enacted federal mental health parity laws to end long-standing discriminatory practices that allowed insurance plans to restrict access to mental health and substance use disorder treatment. Parity laws require plans to cover these services on par with other medical surgical services. Yet, more than two decades after Congress's first attempts to level the playing field and enact behavioral health parity, serious gaps remain. In order to eliminate current holes in the system, Congress should: a) improve enforcement mechanisms for current parity protections; b) extend behavioral health parity to Medicare and Medicaid fee-for-service programs; and c) require the agencies responsible for enforcing parity to establish a centralized, accessible, public-facing

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[14] *Id*.
[15] 42 U.S.C. 1396a(a)(84).
[16] *See* Andrew Hayes and Cathren Cohen, Nat'l Health Law Prog., *Juvenile Justice Laws Provide Model for Improving Health Care Access for Individuals Leaving Incarceration* (May 27, 2021), https://healthlaw.org/juvenile-justice-laws-provide-model-for-improving-health-care-access-for-individuals-leaving-incarceration/.

complaint process and create easy-to-understand educational materials about parity for the general public.

A. Improving Enforcement

Despite strong efforts by Congress and the federal agencies, parity noncompliance remains a significant problem that prevents millions of people in the United States from accessing necessary behavioral health services. Enforcing behavioral health parity is a significant challenge for multiple reasons. To begin with, the current system of parity compliance relies almost entirely on consumer complaints, placing the burden on an individual seeking behavioral health services to first be able to identify that their denial, increased costs, or additional administrative burdens are a parity violation, and then walk through a convoluted web of paperwork, appeals, and agency enforcement mechanisms.

Additionally, analysis of parity complaints is complex, requiring evaluation of both quantitative treatment limits (QTLs) (*e.g.*, limits on the number of visits to a provider or the length of a specified treatment) and non-quantitative treatment limits (NQTLs) (*e.g.*, medical necessity criteria used to deny treatments or prescription drug formulary designs).[17] While a fair amount of progress has been made identifying and correcting QTLs, addressing NQTLs has been more challenging.[18] In part, this is because enforcement of NQTLs requires disclosure of a broad range of detailed information by the plan itself. Not only is it difficult for individuals to access this information, but even once they have it, the level of analysis required to determine whether a plan has violated parity rules is difficult and requires a high level of technical expertise. Over the past six years, Congress has taken several steps to improve enforcement of NQTLs. The 21st Century Cures Act included several provisions designed to increase transparency.[19] In December of 2020, the Consolidated Appropriations Act (CAA) amended the Mental Health Parity and Addictions Equity

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[17] CMS, *The Mental Health Parity and Addictions Equity Act (MHPAEA)*, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.

[18] See, e.g., Steve Melek et al., *Addiction and Mental Health v. Physical Health, Widening Disparities in Network Use and Provider Reimbursemen*t, https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf (parity issues remain in NQTLs of network adequacy and provider reimbursement); Mental Health & Substance Use Disorder Parity Task Force, *Final Report* 12 (2016), https://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.PDF.

[19] 21st Century Cures Act, P.L. 114-255 (2016). These provisions included a requirement for the Secretary of Health and Human Services to create a parity action plan, mandating that the Department of Labor issue a report on parity violations in Employee Retirement Income Security Act (ERISA) plans, and directing the Government Accountability Office to produce a report on parity compliance.

Act (MHPAEA) to require plans to perform and document a comparative analysis of NQTLs applied to mental health and substance use disorder benefits versus those applied to medical-surgical benefits. Plans must be prepared to disclose this analysis, upon request, to the applicable enforcement agency.[20] The current Budget Reconciliation plan also includes a plan that would allow the Department of Labor to levy civil monetary penalties for violations of federal parity protections.[21]

While we support these efforts, we believe that there is more Congress can do to help ensure robust parity enforcement. The CAA takes one-step toward improving plan transparency and disclosure requirements, yet it relies exclusively on the plans themselves to perform a comparative analysis of NQTLs and to disclose all the information necessary to support this analysis. We have little faith in health plans' willingness to perform a comprehensive analysis of NQTLs and even less confidence that plans will disclose the type of information truly necessary to perform this comparison or that they will disclose the information at a level that allows parity violations to be identified. This lack of disclosure, even at a minimal level, occurs in practice even when plans are required to do so by law. For example, a case currently pending at the First Circuit Court of Appeals involves a family who requested documents under the regulatory mandate that preceded CAA, but were unable to obtain the documents they needed from the plan, even with legal assistance.[22] Congress must work with the enforcement agencies to ensure that, whenever it is required by law, plans fully disclose, upon request, all documents and information necessary to ensure parity compliance.

Thus, in addition to the requirements imposed by the CAA, **the Senate Finance Committee should explore the feasibility of creating neutral independent auditing entities, potentially housed within the parity enforcement agencies, that have the authority to investigate plans compliance with parity regulations.** It is crucial that any such auditing entity have access to all plan documents necessary to perform a truly comprehensive analysis of NQTLs and determine whether plans are parity compliant. Congress would need to appropriate sufficient funding to ensure that any independent auditing entities are staffed with individuals who have with appropriate training and expertise to perform these complex analyses. We note that while it is important that any parity analysis ensure that individuals with behavioral health conditions have access to clinically appropriate levels of care, auditors should bear in mind non-discrimination provisions that

[20] Consolidated Appropriations Act of 2021, P.L. 116-260 § 203 (2020).
[21] Build Back Better Act, H.R. 5736, 117th Cong. (2021), https://www.congress.gov/bill/117th-congress/house-bill/5376/text.
[22] *See N.R. v. Raytheon,* No. 20-10153-RGS, 2020 WL 3065415 (D. Mass. June 9, 2020), *appeal docketed,* No. 20-1639, (1st Cir.).

protect the right of individuals with disabilities to not be segregated from society by receiving services in restrictive settings that can be provided through community-based services or less congregate settings.

B. Extending Parity to Medicare and Fee-For-Service Medicaid

Medicaid is the largest payer of mental health services in the United States and plays a vital role in ensuring access to behavioral health services for Medicaid's more than 80 million of low-income enrollees.[23] Medicare covers nearly 62 million older adults and people with disabilities and provides and important link to behavioral health coverage.[24] Yet, current federal parity protections apply only to Medicaid Managed Care Organizations (MCOs), Medicaid Alternative Benefit Plans (ABPs) and the Children's Health Insurance Program (CHIP), but not to fee-for-service Medicaid or Medicare.

To strengthen behavioral health coverage in Medicare and Medicaid, **Congress should extend the federal parity protections to all Medicare plans and Medicaid fee-for-service plans.** However, as discussed above, extending federal parity protections alone is not enough. To ensure that parity provides meaningful protections for Medicare, Medicaid, and CHIP recipients, Congress must work to ensure that there is strong oversight and enforcement of these provisions in both public and private health plans. Congress should explicitly affirm that parity protections can be privately enforced by Medicare, Medicaid and CHIP beneficiaries. Additionally, as addressed above, Congress should continue to mandate strong disclosure and transparency requirements for all health plans.

C. Improving Public Facing Materials and Supports

Behavioral health care and insurance systems can be difficult to navigate. Knowing what behavioral health services are covered and then finding care often requires multiple phone calls, sifting through complex insurance paperwork, provider directories and drug formularies. Most beneficiaries are not familiar with the specifics of federal parity protections. Even if they were, the current federal parity enforcement scheme is complex and multi-faceted with enforcement authority spread between states and multiple federal agencies. Further, our parity enforcement system

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[23] Center for Medicare and Medicaid Services, *Behavioral Health in the United States*, https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html.
[24] Wyatt Kom, et al., Kaiser Family Foundation, *A Snapshot of Sources of Coverage Among Medicare Beneficiaries in 2018* (Mar. 23, 2021), https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries-in-2018/.

remains largely complaint driven, with the onus placed on individuals to file appropriate appeals and complaints. Navigating this patchwork system of enforcement is confusing and overwhelming.

Therefore, Congress should mandate that the agencies responsible for enforcing parity should coordinate to create a centralized, easily accessible, public complaint process. Further enforcement agencies should coordinate to produce easy-to-understand educational materials for the general public. These materials should include clear examples of what parity violations look like and should be part of an ongoing outreach campaign to provide up-to-date support, information, and resources on behavioral health parity.

III. Improving Coverage and Access to Behavioral Health Services for Children and Youth

We commend the Senate Finance Committee for prioritizing behavioral health care for children and youth. As this committee is well-aware, an unacceptable number of children in the United States struggle with unmet mental health needs, and the pandemic has only exacerbated crucial gaps in services and supports. We are gravely concerned by the growth in the proportion of pediatric emergency department visits for mental health conditions during the pandemic.[25]

A. Intensive Community-Based Services for Children and Youth

With the right approach, youth with even the most significant mental health needs can and do thrive in family settings.[26] However, to do so, youth must have access to appropriate services and

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[25] CDC, Morbidity and Mortality Weekly Report, *Mental Health-Related Emergency Department Visits Among Children Aged <18 Years During the Covid-19 Pandemic—United States, January 1-Ocobter 17, 2020 (*Nov. 13, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm?s_cid=mm6945a3_w.

[26] "Family setting" is used here to refer to non-group home-based settings. A family could be biological parent(s), a foster parent, a grandparent or other relative, or adoptive family. *See generally* Annie E. Casey Found., *Every Kid Needs a Family* (2015), http://www.aecf.org/m/resourcedoc/aecf-EveryKidNeedsAFamily-2015.pdf. In 1999, the Surgeon General released a seminal report finding that there is convincing evidence to support the use of in-home services for this population. See SAMHSA and Nat'l Inst. of Mental Health, *Mental Health: A Report of the Surgeon General* 168 (1999), https://www.surgeongeneral.gov/library/reports/index.html. *See* SAMHSA, *The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program, Report to Congress* (2015), https://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf. *See also* Joint CMS and SAMHSA Informational Bulletin, *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions* 5 (May 7, 2013), https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf. *See* Oswaldo Urdapilleta et al.*, National Evaluation of the Medicaid Demonstration Waiver Home- and Community-Based Alternatives to Psychiatric Residential Treatment Facilities, Final Evaluation Report* (May 30, 2012, Amended April 2,

supports. At a bare minimum, any robust community-based system of care for children and adolescents with significant behavioral health needs must include:1) intensive care coordination; 2) mobile crisis Services, 3) in-home services; and 4) therapeutic foster care.[27] These are the essential building blocks to any functioning community-based system for children and adolescents with significant behavioral health needs.[28] Such evidence-based interventions "can prevent the use of emergency departments and other restrictive settings, such as inpatient and residential treatment facilities, that remove children and adolescents from their homes, schools, and communities."[29]

2013), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/cba-evaluation-final.pdf

[27] As DOJ explained in its findings letter regarding its investigation of West Virginia Children's Mental Health System,

> A sufficient array of in-home and community-based services incorporates several discrete clinical interventions, including, at a minimum:
>
> - Intensive care coordination, e.g., Wraparound with fidelity to the National Wraparound Initiative standards;
> - In-home and community-based direct services of sufficient frequency, intensity, comprehensiveness, and duration to address the youth and family's needs . . .
> - Responsive and individualized crisis response and stabilization services available 24 hours a day, 7 days a week, including immediate access to back-up crisis stabilization when actually needed so a youth can spend the majority of his/her time living in a more integrated community setting; and
> - Therapeutic Foster Care, which . . . is an intensive, individualized mental health service provided in a family setting, using specially trained and intensively supervised foster parents.

Dep't of Justice, *Findings Letter, Investigation of West Virginia Children's Mental Health System Pursuant to the Americans with Disabilities Act* 22 (June 1, 2015), https://www.ada.gov/olmstead/documents/west_va_findings_ltr.pdf

[28] *Id.*

[29] MACPAC, *Report to Congress on Medicaid and CHIP, Access to Behavioral Health Services for Children and Adolescents Covered by Medicaid and CHIP* 79 (June 2021), https://www.macpac.gov/wp-content/uploads/2021/06/June-2021-Report-to-Congress-on-Medicaid-and-CHIP.pdf. For more information on the evidence base for these services, see Kim Lewis & Jennifer Lav, Nat'l Health Law Prog., *Children's Mental Health Services: The Right to Community-Based Care*, *Appendix: Selected Students of Home-Bases Services for Children with Significant Mental Health Needs* (Aug. 2018), https://healthlaw.org/resource/childrens-mental-health-services-the-right-to-community-based-care/

Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, state Medicaid agencies are required to provide enrollees under age 21 with access to periodic and preventive screenings, as well as services that are necessary to "correct or ameliorate" medical conditions, including behavioral health conditions.[30] Thus, states must cover medically necessary behavioral health services for enrollees under age 21, regardless of whether the services are included in the state's plan.

Because state Medicaid programs must cover children's behavioral health services, including the intensive services described above, it is unnecessary and counterproductive for Congress to mandate or incentivize children's behavioral health services that states are already required to provide pursuant to the EPSDT benefit. However, compliance with EPSDT is still a serious issue, and enforcement of states' requirement to provide behavioral health treatment often requires years of litigation to vindicate the rights of Medicaid enrollees.[31] Thus**, we recommend that the Senate Finance Committee evaluate the need for increased guidance and technical assistance, and oversight of states' implementation of the EPSDT mandate**. For example, recently MACPAC recommended that HHS should direct CMS and SAMHSA to issue joint guidance regarding states' obligation to provide these community-based services. We agree that updates to guidance to reflect current best practices may be helpful.

B. Improving Coverage of Youth in the Juvenile Justice and Foster Care Systems

The behavioral health needs of justice-involved and child-welfare involved children and youth are significantly higher than their non-system-involved peers, yet their needs are far too often not met. Research suggests that 70 percent of youth in the juvenile justice system experience mental illness

[30] 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B); 1396d(r).
[31] *See e.g. Rosie D. v. Romney*, 410 F. Supp. 2d 18, 25 (D. Mass. 2006); *Katie A. ex rel. Ludin v. Los Angeles County,* 481 F.3d 1150, 1158 (9th Cir. 2007); Settlement Agreement, *T.R. v. Dreyfus,* C09-1677-TSZ (W.D. Wash. Dec. 19, 2013), https://www.disabilityrightswa.org/wp-content/uploads/2017/12/Settlement-Agreement-and-Order-signed-8.30.2013_0.pdf; Dep't of Justice, *Findings Letter, Investigation of West Virginia Children's Mental Health System Pursuant to the Americans with Disabilities Act* (June 1, 2015), https://www.ada.gov/olmstead/documents/west_va_findings_ltr.pdf; *Disability Rights North Carolina v. Brajer*, 5:16-cv-854 (E.D.N.C. 2016) http://www.disabilityrightsnc.org/sites/default/files/L28-3-1%20Settlement%20Agreement.pdf; Alabama Joint Settlement Agreement, https://centerforpublicrep.org/wp-content/uploads/2018/01/Alabama_Joint-Settlement-Agreement.executed.pdf.

and 80 percent of children in foster care have significant mental health issues; in contrast between 18 and 22 percent of youth in the general population experience mental health issues.[32]

There are several concrete steps Congress could take now to improve coverage of these populations, thus improving access to care.

First, the 2018 SUPPORT Act prohibits states from terminating youths' Medicaid eligibility upon incarceration, and instead requires states to suspend eligibility for the period of incarceration and then to lift that suspension upon release.[33] This allows for youth leaving the juvenile justice system to more quickly and seamlessly receive behavioral health care they need upon release, including counseling, case management, substance use disorder treatment, and other supports. In addition, the SUPPORT Act requires states to conduct a redetermination of eligibility before youth are released from custody *without* requiring them to submit a new application. Finally, the law mandates that states process applications from eligible youth who apply for Medicaid prior to their release.

We are concerned, however, that the promises of the SUPPORT Act have not been fully realized. As a bipartisan group of Senators and Representatives identified last year, the full implementation of these provisions has been delayed in states across the country.[34] It appears that CMS has yet to confirm that all state Medicaid programs have enacted these provisions in order to better serve these young people. Thus, we suggest that **Senate Finance Committee investigate the status of implementation of Section 1001 of the SUPPORT ACT, and should remove any barriers to implementation of the requirement to suspend, not terminate, Medicaid eligibility for youth in the juvenile justice system.**

Second, Congress could remedy gaps in coverage for youth who age out of the foster care system. While virtually all youth in foster care are covered by Medicaid, once a young person ages out of foster care, they may experience gaps in coverage. Currently, in order to be eligible for Medicaid

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[32] Sarah Hammond, *Mental Health Needs of Juvenile Offenders*, Nat'l Conf. of State Legs. (2007), https://www.ncsl.org/print/health/Mental_health_needsojuvenileoffendres.pdf; Mental Health and Foster Care, Nat'l Conf. of State Legs. (Nov.1, 2019), https://www.ncsl.org/research/human-services/mental-health-and-foster-care.aspx.

[33] *See* Jennifer Lav, *New Omnibus Opioid Law Contains Medicaid Fix for Justice-Involved Children and Youth*, Nat'l Health Law Prog. (Jan. 30, 2019), https://healthlaw.org/new-omnibus-opioid-law-contains-medicaid-fix-for-justice-involved-children-and-youth/.

[34] Senator Chris Murphy, Press Release: *Murphy, Booker, Cardenas, Griffith Demand Answers on Delayed Implementation of Health Care Coverage for Youth in Juvenile Justice System* (Sept. 29, 2020), https://www.murphy.senate.gov/newsroom/press-releases/murphy-booker-crdenas-griffith-demand-answers-on-delayed-implementation-of-health-care-coverage-for-youth-in-juvenile-justice-system.

under the former foster youth pathway, a young person must be (1) under age 26, (2) have been in foster care upon reaching age 18 (or any age up to 21 if the state extends foster care to that age), and (3) have been enrolled in Medicaid while in foster care. Thus, youth who move from one state to another to pursue education or employment may lose their eligibility.

Section 1002 of the SUPPORT Act included a partial remedy this problem by requiring every state to offer Medicaid coverage to any former foster youth up to age 26, including youth who were in foster care in a different state. Unfortunately, Section 1002 only applies to youth who turn 18 on or after January 1, 2023. Thus, children currently as young as 15 who are currently in the foster care system still risk losing their coverage if they move states after they age out of Medicaid. The Dosha Joi Immediate Coverage for Foster Youth Act would make Section 1002 effective immediately, ensuring Medicaid eligibility for all former foster youth in the country, regardless of where they currently live, immediately.[35] An additional bill, the Expanded Coverage for Former Foster Youth Act would remove even more barriers to Medicaid eligibility for former foster youth [36] Currently, youth must have been enrolled in Medicaid while in the foster care system and have been in foster care when they "aged out" at 18, or a later age up to 21 if a state has decided to extend foster care accordingly. The Expanded Coverage for Former Foster Youth Act would broaden eligibility to young people who 1) may not have been enrolled in Medicaid while in the foster care system; 2) left foster care at any age because they were placed in legal guardianship with a kinship caregiver; or 3) were emancipated from foster care prior to age 18."[37] **We urge the Senate Finance Committee to move forward and pass both the Dosha Joi Immediate Coverage for Foster Youth Act and the Expanded Coverage for Former Foster Youth Act.**

[35] Dosha Joi Immediate Coverage for Foster Youth Act, S.B. 712, 117th Cong. (2021), *available at* https://www.congress.gov/bill/117th-congress/senate-bill/712/.
[36] Expanded Coverage for Former Foster Youth Act, S.B. 709, 117th Cong. (2021), *available at* https://www.congress.gov/bill/117th-congress/senate-bill/709.
[37] *Id.*

IV. Conclusion

We appreciate the Senate Finance Committee's commitment to engaging in bipartisan reform to improve access to timely, quality behavioral health care. Thank you for your consideration of our comments. If you have questions about these comments, please contact Jennifer Lav (lav@healthlaw.org).

Sincerely,

Jennifer Lav
Senior Attorney