Testimony Submitted on February 8, 2022

National Health Law Program
to the
United States Senate Committee on Finance

Full Committee Hearing: Youth Mental Health: Part I – An Advisory and Call to Action

On behalf of the National Health Law Program (NHeLP), we submit this statement for the record for the U.S. Senate Finance Committee hearing entitled "Youth Mental Health: Part I – An Advisory and Call to Action."

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.

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.[1] Since the start of the Covid-19 pandemic, the proportion of pediatric emergency department visits for mental health conditions compared to visits for all other reasons has grown.[2] The American Academy of Pediatrics, Children's Hospital Association, and the American Academy of Child and Adolescent Psychiatry have declared a "national emergency in child and adolescent mental health," noting this increase in

[1] 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.

[2] 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-October 17, 2020 (Nov. 13, 2020) ("whereas the overall number of children's mental health–related ED visits decreased, the proportion of all ED visits for children's mental health–related concerns increased, reaching levels substantially higher beginning in late-March to October 2020 than those during the same period during 2019."), https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm?s_cid=mm6945a3_w.

emergency department visits and increasing "rates of depression, anxiety, trauma, loneliness, and suicidality."[3]

We appreciate the Senate Finance Committee's commitment to examining ways to improve behavioral health and reduce gaps in care, and we commend the committee for inviting the Surgeon General to address these critical needs. Below, we offer policy options in three areas where additional legislation, oversight, or guidance would further the Senate Finance Committee's priority of improving behavioral health care for young people and children: 1) improving access to intensive community-based services for children and youth enrolled in Medicaid; 2) enhancing oversight and enforcement of parity for mental health and substance use disorder services, and 3) improving Medicaid coverage for youth involved in the juvenile justice and foster care systems. We provided additional details on the recommendations below in our response to the Senate Finance Committee's request for information, submitted November 12, 2021.

I. Intensive Community-Based Services for Children and Youth

The good news is that with the right approach, youth with even the most significant mental health needs can and do thrive in family settings.[4] However, to do so, youth must have access to appropriate services and 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

[3] American Academy of Pediatrics, *A declaration from the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry and Children's Hospital Association* (Oct. 19, 2021), https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/.

[4] "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, 2013), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/cba-evaluation-final.pdf

care coordination; 2) mobile response and stabilization services, 3) in-home services; and 4) therapeutic foster care.[5] These are the essential building blocks to any functioning community-based system for children and adolescents with significant behavioral health needs.[6] Such evidence-based interventions "can prevent the unnecessary 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."[7]

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[5] 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:
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> - 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

[6] *Id.*

[7] 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/ and Jennifer Lav & Kim Lewis, Nat'l Health Law Prog., *Children's Behavioral Health Mobile Response and Stabilization Services* (Feb. 2021), https://healthlaw.org/resource/childrens-behavioral-health-mobile-response-and-stabilization-services/

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.[8] 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.[9] 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.

II. Enhancing 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

[8] 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B); 1396d(r).
[9] *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.

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

A. Improving Compliance and Disclosure

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. First, 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 to 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).[10] While a fair amount of progress has been made identifying and correcting QTLs, addressing NQTLs has been more challenging.[11] 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, if not impossible, 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

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

[11] See, e.g., Steve Melek et al., *Addiction and Mental Health v. Physical Health, Widening Disparities in Network Use and Provider Reimbursement*, 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.

Cures Act included several provisions designed to increase transparency.[12] In December of 2020, the Consolidated Appropriations Act (CAA) amended the Mental Health Parity and Addictions Equity 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.[13] Additionally, there have been recent legislative proposals to allow the Department of Labor to levy civil monetary penalties for violations of federal parity protections.[14]

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. The 2022 Annual Report to Congress noted that *none* of the comparative analysis reviewed contained sufficient information comply with the requirements of parity.[15] 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 recently decided by 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.[16] 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 without necessitating affirmative litigation against the plan to do so.

Thus, in addition to the requirements imposed by the CAA, **the Senate Finance Committee should explore ways to build upon these enforcement efforts.** We are aware that additional

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[12] 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.

[13] Consolidated Appropriations Act of 2021, P.L. 116-260 § 203 (2020).

[14] Build Back Better Act, H.R. 5736, 117th Cong. (2021), https://www.congress.gov/bill/117th-congress/house-bill/5376/text.

[15] Depts. Of Labor, Health and Human Services, and Treasury, *2022 MHPAEA Report to Congress* (Jan. 2022). https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.

[16] *See N.R. v. Raytheon,* No. 20-1639, 2022 WL 278537 (1st Cir. Jan. 31, 2022).

guidance is forthcoming, but there is also a role for Congress. The recent tri-agency report to Congress suggested amending MHPEAEA to ensure that MH/SUD benefits are defined in an "objective and uniform manner, pursuant to external benchmarks that are based in nationally recognized standards."[17] While we support this proposal, we also note it is important that any standards applied must keep in mind the non-discrimination provisions that 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 and not congregate settings. All too often, the "nationally recognized standards" rely on standards of care that incorporate an institutional bias. Instead, the standards must incorporate the types of intensive community supports outlined in this testimony above (e.g. services such as intensive care coordination; mobile response and stabilization services; in-home services; and therapeutic foster care).

Another option would be to create neutral independent auditing entities, potentially housed within the parity enforcement agencies, that have the authority to investigate plans compliance with parity regulations**.** These entities would proactively examine plans for compliance and could also respond to complaints. We discussed this option in further depth in our comments to the committee, submitted November 2021.

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.[18] Medicare covers nearly 62 million older adults and people with disabilities, including young adults and transition age youth with disabilities, and provides an important link to behavioral health coverage.[19] 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.

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[17] Supra note 15.
[18] Center for Medicare and Medicaid Services, *Behavioral Health in the United States*, https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html.
[19] 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/.

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 and 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 remains largely complaint driven, with the onus placed on individuals to file appropriate appeals and complaints, and there is no clear way to file a complaint for Medicaid. 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 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 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.[20] There are

[20] 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

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.[21] 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.[22] 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 recommend that **Senate Finance Committee investigate the status of implementation of Section 1001 of the SUPPORT ACT, and 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 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),

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Care, Nat'l Conf. of State Legs. (Nov.1, 2019), https://www.ncsl.org/research/human-services/mental-health-and-foster-care.aspx.

[21] *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/.

[22] 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.

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 17 who are 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, even if they turned 18 before 2023, regardless of where they currently live.[23] An additional bill, the Expanded Coverage for Former Foster Youth Act would remove even more barriers to Medicaid eligibility for former foster youth [24] 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 prior to age 18 because they were placed in legal guardianship with a kinship caregiver; or 3) were emancipated from foster care prior to age 18.[25]
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

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

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