December 4, 2023

The Honorable Daniel Tsai
Deputy Administrator and Director, Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Request for Comments on Processes for Assessing Compliance with Mental Health Parity and Addiction Equity in Medicaid and CHIP

Dear Deputy Administrator Tsai,

The National Health Law Program (NHeLP) is pleased to provide comments on processes for assessing compliance with Mental Health Parity and Addiction Equity in Medicaid and CHIP. NHeLP protects and advances health rights of low-income and underserved individuals and families. We advocate, educate and litigate at the federal and state levels to advance health and civil rights in the U.S. We appreciate the opportunity to comment. NHeLP has also contributed to comments submitted to CMS on November 27, 2023 by Lauren Finke at The Kennedy Forum. We write separately to expand our comments on one of the questions posed by CMS.

10. Are there any MH conditions or SUDs that are more prevalent among enrollees in Medicaid MCOs, Medicaid ABPs, or CHIP? What are the most significant barriers to accessing treatment among enrollees with these conditions?

In the joint comments submitted by the Kennedy Forum, we noted that beneficiaries with conditions that require specialized or intensive treatment face particular barriers to care. To expand, we note that the COVID-19 pandemic has had

significant impacts on behavioral health, with sharp increases in the prevalence of conditions such as anxiety and depression, and with low-income people experiencing a disproportionate impact.[1]

Low-income children and youth are also more likely than their higher-income counterparts to have Serious Emotional Disturbance (SED), or other mental health, developmental, or behavioral conditions.[2] One review of children and youth in SSI (who are by definition, enrolled in Medicaid), found that these youth had high prevalence of attention deficit disorder/attention deficit hyperactivity disorder (ADHD), autistic disorder and other pervasive developmental disorders (ASD), intellectual disability (ID), mood disorders, learning disorder (LD), organic mental disorders, oppositional/defiant disorder (ODD), anxiety disorders, borderline intellectual functioning (BIF), and conduct disorders.[3] As discussed in the Kennedy Forum comments, the EPSDT mandate requires states to cover a comprehensive range of mental health and behavioral interventions for children and youth under age 21. But too often, states fall short, particularly in providing intensive services such as Intensive Care Coordination, Mobile Crisis Response and Stabilization Services, and Intensive In-Home Services, for children with the highest level of need.[4] Too often, families and their advocates have had to resort to litigation to ensure that youth in Medicaid receive the intensive mental and behavioral health services to which they are entitled.[5]

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[1] Mark E. Czeisler, *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic – US, June 24-30, 2020,* CDC Morbidity & Mortality Wkly. Rpt. (2020), https://perma.cc/7V2Q-4SLU. Serious Mental Illness (SMI) is more prevalent among low-income adults. SAMHSA, *Serious Mental Illness Among Adults Below the Poverty Line*, https://www.samhsa.gov/data/sites/default/files/report_2720/Spotlight-2720.html (last visited Nov. 29, 2023); *see also* Peter J. Cunningham et al., Commonwealth Fund, *Income Disparities in the Prevalence, Severity, and Costs of Co-Occurring Chronic and Behavioral Health Conditions*, 56 MED. CARE 139 (2018). A disproportionate number of adults with SMI are, therefore, enrolled in Medicaid. *See* Julia Zur et al., Kaiser Family Found., *Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals* (2017), https://www.kff.org/mental-health/issue-brief/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals.

[2] *See* Nat'l Acad. of Sciences, Eng., Med., *Mental Disorders and Disabilities Among Low-Income Children* (Thomas F. Boat & Joel T. Wu, Ed. 2015); CDC, *Data and Statistics on Children's Mental Health*, https://www.cdc.gov/childrensmentalhealth/data.html (last visited Nov. 29, 2023); Stacy Hodgkinson et al., *Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting*, 139 PEDIATRICS e20151175 (2017).

[3] Nat'l Acad. of Sciences, Eng., Med., *supra* note 2, at 71-72.

[4] *See* CMS & SAMHSA, *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions* (2013), https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/CIB-05-07-2013.pdf.

[5] *See, e.g., Katie A., ex rel. Ludin v. Los Angeles*, 481 F. 3d 1150 (9th Cir. 2007);*C.A. v. Garcia,* 4:23-cv-00009 (S.D. Iowa 2023), https://healthlaw.org/resource/c-a-v-garcia-united-states-district-court-for-the-southern-district-of-iowa; *C.K. v. Basset,* 2:22-cv-01791 (E.D.N.Y

EPSDT compliance is even more problematic in the context of SUD. There are significant inconsistencies regarding Medicaid coverage of SUD services for youth and adolescents across all states. Unfortunately, many state Medicaid programs make no distinctions between adult SUD services and youth services. While there are fundamental SUD treatment interventions that are recommended for both adults and minors alike (including medications for substance use disorders), just as with mental health, there is widespread agreement among experts that the use of certain interventions should be emphasized to address with the needs of minors with or at risk of developing an SUD.

For example, experts agree that screening, brief intervention, and referral to treatment services (more commonly known as SBIRT) is particularly important for minors because of how susceptible they are to development of SUDs. Recommendations also extend to using SBIRT even when the minor has yet developed an SUD as a prevention mechanism.[6] In addition, guidelines for youth and adolescent SUD treatment call for interventions that are tailored to the unique needs of the youth, including individual, group, and family therapies.[7] Furthermore, guidelines place significant emphasis on the use of behavioral therapies that are sensitive to cultural and gender differences, and on identifying and treating co-occurring mental health conditions, as well as testing for sexually transmitted diseases and monitoring for signs of violence, child abuse, and risk of suicide.[8] Finally, despite states' increasing reliance on residential treatment at Institutions for Mental Diseases (IMD) to address SUDs among Medicaid beneficiaries, these services may be particularly harmful and ineffective for youth and adolescents. While community-based SUD services are more appropriate for most beneficiaries of all ages, the benefits are heightened in the context of minors.[9]

Because the standard of care for youth and adolescents with or at risk of SUD differs in significant ways from adult interventions, states that make no distinctions between adult

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2022), https://healthlaw.org/resource/c-k-v-bassett-eastern-district-of-n-y; *A.A. v. Gee,* 3:19-cv-00770 (M.D. La. 2019), https://healthlaw.org/resource/a-a-v-gee-middle-district-of-louisiana; *T.R. v. Dreyfus,* 2:09-cv-01677 (W.D. Wash. 2009), https://healthlaw.org/resource/t-r-v-dreyfus-u-s-district-court-western-district-of-washington; *Rosie D. v. Patrick*, 497 F. Supp. 2d 76 (D. Mass. 2007).

[6] AAP Committee on Substance Use and Prevention, *Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians*, 128 PEDIATRICS 128:e1330 (2011).

[7] NIDA, *Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide*, January 2014, https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/podata_1_17_14.pdf.

[8] NASADAD, *State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide* (2014), http://nasadad.org/wp-content/uploads/2014/09/State-Adolescent-Substance-Use-Disorder-Treatment-and-Recovery-Practice-Guide-9-24-14.pdf.

[9] *See, e.g.,* Philip S. Goldman et al*., Institutionalization and Deinstitutionalization of Children 2: A Systematic and Integrative Review of Evidence Regarding Effects on Development*, 4 LANCET PSYCHIATRY 606, 609 (2020).

and minor treatment, and states that fail to cover certain necessary interventions, may be in violation of EPSDT. Unfortunately, however, CMS has not provided sufficient guidance or engaged in sufficient enforcement efforts, to determine whether the level of coverage for SUD services for minors is appropriate under federal law. That means that deeming compliance with parity just because a state has not been found to be in violation of EPSDT may unintendedly ignore deep gaps in access to necessary services.

Further, we note that SUDs, OUDs, AUD, stimulant use disorders, affect low-income people disproportionately.[10] Pursuant to CMS' report to Congress on SUDs, 8% of Medicaid beneficiaries were treated for any type of SUD in 2020, almost twice as much as the percentage of individuals aged 12 and older who received SUD treatment in 2022 (4.6%). Similarly, while about 0.8% of all adults in the general population received medications for OUD, about 3% of Medicaid beneficiaries receive OUD services. A similar pattern is seen in the context of alcohol use disorders (2% of Medicaid beneficiaries received treatment vs. 0.3% of the general population received medications for alcohol use disorders).[11]

Moreover, while SUDs affect people of all walks of like and socioeconomic status, lower-income individuals are less likely to receive the support needed to address SUD-related issues. Thus, even for specific conditions that are more prevalent for higher-income populations, low-income individuals may be more likely to experience negative outcomes as a result of their condition.

We urge CMS to ensure a close review of Medicaid Programs' provision of intensive mental health and behavioral interventions and SUDS is sufficient to comply with parity and to meet the needs of beneficiaries. Lack of compliance enforcement or identified issues by CMS is insufficient to identify whether there is actually compliance with EPSDT, as the aforementioned litigation demonstrates. Therefore, while under the regulation a state may rely on its EPSDT compliance for compliance with mental health parity, CMS should be demanding more of states to demonstrate, rather than simply assure, EPSDT compliance in parity reporting.

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[10] *See*, *e.g.*, Kesha Baptiste-Roberts & Mian Hossain, *Socioeconomic Disparities and Self-reported Substance Abuse-related Problems*, 10 ADDICT. HEALTH 112–22 (2018) (finding that low-income individuals self-identify as having an SUD issue related to illicit drug use at higher levels than higher-income individuals); *see also* Susan E Collins, *Associations Between Socioeconomic Factors and Alcohol Outcomes*, 38 ALCOHOL RES. 83–94 (2016) (finding that lower socioeconomic status can increase the likelihood of death associated with alcohol use).

[11] *See* SAMHSA, *Key Substance Use and Mental Health Indicators in the United States: results from the 2022 National Survey on Drug Use and Health* (Nov. 2023), https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-nnr.pdf; *see also* CMS, *T-MSIS Substance Use Disorder (SUD) Data Book Treatment of SUD in Medicaid, 2020* (Dec. 2022), https://www.medicaid.gov/sites/default/files/2022-11/2020-sud-data-book.pdf.

Thank you for considering our feedback. Please do not hesitate to contact me (coursolle@healthlaw.org) should you have any questions.

Sincerely,

Abbi Coursolle
Senior Attorney,
National Health Law Program