
SHO# 20-002

**RE: Access to Mental Health and
Substance Use Disorder Services for
Children and Pregnant Women in the
Children's Health Insurance Program**

March 2, 2020

Dear State Health Official:

The passage of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (P. L. 115-271), referred to as the SUPPORT Act, on October 24, 2018, among other things, strengthens behavioral health coverage for children and pregnant women eligible through the Children's Health Insurance Program (CHIP). Section 5022 of the SUPPORT Act amends section 2103(c)(5) of the Social Security Act (the Act) to make behavioral health coverage a required benefit for CHIP effective October 24, 2019.

Section 5022 of the SUPPORT Act specifically requires that child health and pregnancy related assistance "include coverage of mental health services (including behavioral health) necessary to prevent, diagnose, and treat a broad range of mental health symptoms and disorders, including substance use disorders." The statute also stipulates that these services must be delivered in a culturally and linguistically appropriate manner. It applies to all CHIP eligible populations regardless of the type of coverage (e.g., benchmark coverage) elected by the state under a separate CHIP under section 2103 of the Act. We also note that the requirements in the SUPPORT Act are distinct from those in the Mental Health Parity and Addiction Equity Act (P.L. 110-343)(MHPAEA). Additional information is provided in the section below entitled, "Behavioral Health Related Regulations in CHIP."

The purpose of this State Health Official (SHO) letter is to describe this new provision, and provide guidance to states with separate CHIPs on the actions necessary to implement the requirements of section 5022 of the SUPPORT Act. In general, states with a separate CHIP will need to submit a CHIP (Title XXI) state plan amendment (SPA) to demonstrate compliance with section 5022 of the SUPPORT Act in areas related to coverage of behavioral health screening, prevention and treatment services, strategies to facilitate use of appropriate screening and assessment tools and the requirement that these services be provided in a culturally and linguistically appropriate manner. This letter also provides states with the attached SPA template created for use during the SPA submission process.

Background

a. Importance of Behavioral Health Services for Children and Pregnant Women

Mental health is key to overall health and plays a critical role in the well-being of children and pregnant women. There are unique vulnerabilities and developmental implications when it comes to mental health and substance use disorder conditions in children and pregnant women. Mental health disorders usually first arise in childhood, adolescence or early adulthood. As many as one in six U.S. children between the ages of 6 and 17 has a treatable mental health disorder.¹ In 2018, an estimated 21.2 million people aged 12 or older needed substance use treatment. About 1 in 26 adolescents aged 12 to 17 (3.8 percent), and about 1 in 7 young adults aged 18 to 25 (15.3 percent) needed treatment.² Several common mental health conditions impact Medicaid and CHIP children at higher rates than the general child population including conduct disorder, anxiety disorder, depression, autism spectrum disorder, and attention deficit disorder.³

With respect to pregnant women, approximately 40 percent experience psychological difficulties during or after pregnancy with 10 to 15 percent being diagnosed with a mental illness.⁴ Low income women are more likely to develop some form of depression compared to other mothers, ranging from 40 to 60 percent suffering depressive symptoms.⁵ Pregnant women also face challenges with substance use. A history of trauma has been associated with risk of substance use in women. During 1999 through 2014, the national prevalence of opioid use disorders increased 333 percent from 1.5 cases per 1,000 delivery hospitalizations to 6.5, an average annual increase of 0.4 per delivery hospitalizations per year⁶. In 2018, 9.9 percent of pregnant women drank alcohol, 11.6 used tobacco, and 5.4 percent used an illicit substance.⁷

SUPPORT Act Requirements

As noted above, section 5022 of the SUPPORT Act requires that child health and pregnancy related assistance “include coverage of mental health services (including behavioral health) necessary to prevent, diagnose, and treat a broad range of mental health symptoms and disorders, including substance use disorders.” This section describes the requirements for all states with separate CHIPs to cover specific behavioral health related screening and preventive services,

¹ Whitney, D.G., Peterson, M.D., JAMA Pediatrics. (2019). US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children.

² Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data/>.

³ MACPAC. (2016) Medicaid Access in Brief: Children’s Use of Behavioral Health Services. Accessed at <https://www.macpac.gov/wp-content/uploads/2016/06/Childrens-access-to-behavioral-health-services.pdf>.

⁴ Gilbert, H., Gurvich, C. and Kulkarni. (2015). Journal of Nursing Care. Special Issues for Pregnant Women with Mental Illness.

⁵ Centers for Medicare and Medicaid Services. (2016). Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children. Accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf>.

⁶ Haight SC, Ko JY, Tong VT, Bohm MK, Callaghan WM. Opioid Use Disorder Documented at Delivery Hospitalization — United States, 1999–2014. MMWR Morb Mortal Wkly Rep 2018;67:845–849.

⁷ Substance Abuse and Mental Health Services Administration. (2018). The National Survey on Drug Use and Health: 2018. Accessed at <https://www.samhsa.gov/data/report/2018-nsduh-detailed-tables>. This may be an underrepresentation of the actual prevalence of substance use during pregnancy because it is often under-diagnosed.

adhere to a periodicity schedule, and identify a strategy for facilitating the use of age-appropriate, validated screening tools.

Screening and Preventive Services

a. Coverage of Behavioral Health Related Screenings and Preventive Services

Screening⁸ and preventive services improve overall health by identifying illnesses earlier, managing them more effectively, and treating them before they develop into more complicated, debilitating conditions. This makes routine screening, early identification, and treatment of behavioral health conditions particularly important for children and pregnant women. Several organizations make evidence-based recommendations for screening and preventive services for populations in a primary care setting. The American Academy of Pediatrics (AAP) publishes the Bright Futures periodicity schedule, referred to as “Recommendation for Preventive Pediatric Health Care.”⁹ AAP/Bright Futures provides a schedule of screenings recommended at each well-child visit from infancy through adolescence. The majority of states have already adopted the current version (fourth edition published in March 2019) of the AAP/Bright Futures periodicity schedule for both CHIP and Medicaid children. Some states have maintained a previous version of this schedule, or made modifications to it. The U.S. Preventive Services Task Force (USPSTF)¹⁰ also recommends clinical preventive services for children and adults, including pregnant women.

All states will be required to provide coverage of all of the developmental and behavioral health related screenings, and preventive services recommended by AAP/Bright Futures, as well as those with a grade of an A or B by USPSTF. This new requirement is consistent with the “prevent” and “diagnose” provisions specified in section 5022 of the SUPPORT Act. The required screenings and services are specified in Table 1 below, and the detailed AAP/Bright Futures periodicity schedule can be viewed at the organization’s website.

In addition, states will be required to specify the periodicity schedule they have adopted for children. If a state elects a periodicity schedule other than the current version of the AAP/Bright Futures periodicity schedule, it will have to ensure that the types of screening and preventive services, and the recommended schedule for delivering these services at well-child visits, are at least comparable to the most up-to-date AAP/Bright Futures standards. In the future, states will need to ensure that they are covering screens and preventive services consistent with the most recently published AAP schedule. These requirements are consistent with industry standards in the private and public sector, and currently in practice in the majority of states. We recognize that periodicity schedules serve as a guideline for recommendations in this area, but clinical judgement will continue to be an important element in the provision of these services.

⁸ Screening is a formal process that employs a standardized tool to detect a particular concern or condition. Universal screening is performed on all individuals at certain ages to identify those at risk of a particular condition. Selective screening is performed for individuals who have already been identified as at risk of having a behavioral health condition.

⁹ The Health Resource and Services Administration (HRSA) launched the Bright Futures program in 1990 to address a need for unified guidance on how to design the most modern, efficient, and comprehensive pediatric checkup. The Bright Future/AAP periodicity schedule is available at: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf.

¹⁰ The Agency for Healthcare Research and Quality supports the USPSTF, an independent panel of experts on prevention and evidence-based medicine, to provide rigorous recommendations on prevention to the federal government and the public. The USPSTF recommendations are available at: <https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/#more>.

Section 6.2.1-BH of the attached CHIP state plan template allows states to specify the periodicity it has selected, and Section 6.3.1.1-BH asks states to provide an assurance that they provide the relevant AAP and USPSTF screens and preventive services below.

Table 1: Required Types of Behavioral Health Screens and Preventive Services

Type of Preventive Service	Applicable Population	Source of Recommendation
Developmental Screening	Children	AAP
Autism Spectrum Disorder Screening	Children	AAP
Developmental Surveillance ¹¹	Children	AAP
Psychosocial/Behavioral Assessment ¹²	Children	AAP
Tobacco, Alcohol, or Drug Use Assessment ¹³	Children	AAP
Depression Screening	Children and adolescents	AAP and USPSTF
Maternal Depression Screening ¹⁴	Pregnant women	AAP
Tobacco use interventions	Children and adolescents	USPSTF
Perinatal depression: counseling and intervention	Pregnant women	USPSTF
Tobacco use counseling	Pregnant women	USPSTF
Unhealthy alcohol use screening, counseling and interventions	Pregnant women	USPSTF

In addition to the required behavioral health screening and preventive services described in Table 1, we expect that most, if not all, states may provide other types of behavioral health screenings and preventive services for a range of behavioral health conditions. The attached template at 6.3.1-BH includes a section for states to describe these services.

b. Age-Appropriate, Validated Screening Tools

Incorporation of age appropriate, validated screening tools¹⁵ in the screening process is another important component to successfully addressing behavioral health conditions early on. Studies have shown that broad use of validated screening tools are more effective in detecting behavioral health problems in primary care settings, compared to less rigorous approaches to identifying behavioral health conditions.¹⁶ Many organizations support the use of validated screening tools. AAP has compiled a list of these tools for children, which can be found at <https://screeningtime.org/star-center/#/screening-tools#top>. USPSTF also includes links to validated screening tools in its published recommendations by each type of screening, which can

¹¹Developmental surveillance is a flexible, continuous process whereby knowledgeable professionals perform skilled observations of children during the provision of health care. The components of surveillance include eliciting and attending to parental concerns, obtaining a relevant developmental history, making accurate and informative observations of children, and sharing opinions and concerns with other relevant professionals. “Bright Futures Health Supervision Visits.”

¹² AAP considers Psychosocial/Behavioral Assessment to be performed in the same manner as a screening, however, the existing tools in this area are assessment tools. For this reason, the term assessment has been retained in the periodicity schedule.

¹³ A Tobacco, Alcohol, or Drug Use risk assessment should be performed with appropriate action to follow if the assessment proves positive, according to the AAP periodicity schedule.

¹⁴ The American College of Obstetricians and Gynecologists (ACOG) also recommends depression screening for pregnant women. <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression>.

¹⁵ A validated instrument is one that has been psychometrically tested for reliability (the ability of the instrument to produce consistent results), validity (the ability of the instrument to produce true results), and sensitivity (the probability of correctly identifying a patient with the condition). This definition is provided by The Joint Commission at https://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx.

¹⁶ Simonian S, Tarnowski K. Utility of the Pediatric Symptom Checklist for behavioral screening of disadvantaged children. *Child Psychiatry Hum Dev.* 2001;31(4):269–278.

be found at <https://www.uspreventiveservicestaskforce.org/BrowseRec/Index>. Below is a list of examples of validated screening tools.

Table 2: Examples of Validated Behavioral Health Screening Tools¹⁷

Name of Screen	Type of Screen and Applicable Population(s)
Ages and Stages Questionnaire: Social-Emotional (ASQ-SE-2)	Social-emotional Development for Children
Edinburgh Postnatal Depression Scale (EPDS)	Maternal Depression
Modified Checklist for Autism in Toddlers (M-CHAT-R/F)	Autism in Toddlers
Brief Screener for Alcohol, Tobacco and other Drugs (BSTAD)	Substance Use Disorder Risk Among Adolescents
CRAFFT ¹⁸	Alcohol and drugs for Adolescents and Adults, including Pregnant Women

All states will be required to identify a strategy for facilitating the use of age-appropriate, validated screening tools for children and pregnant women in primary care settings. Examples of facilitation efforts in this area include covering the costs of administering the tools, and/or the costs associated with purchasing these tools, requiring managed care organizations and their networks to use such tools in primary care practice, providing education, training, and technical resources in this area (such as a list of validated screening tools established by the state and/or national organizations with expertise in this area). Some states may already be facilitating the use of such screening tools and may provide a description of an existing strategy. Section 6.3.1.2-BH of the attached template provides a place for states to provide a description of this strategy.

Behavioral Health Treatment Services and Validated Clinical Assessment Tools

Research emphasizes the importance of offering a variety of evidence-based services across different types of settings and levels of intensity given the nature of the individualized and changing needs of children with complex behavioral health conditions. While coverage of traditional services (i.e., case management and family therapy) are important, coverage of other types of community-based support services (i.e., intensive case management and wraparound), are also considered essential for children and pregnant women with more complex needs. Treatment of pregnant women should include a focus on the mother as well as the child. This section describes the requirements for all states with separate CHIPs to:

- Demonstrate that its benefit array is sufficient to treat a broad range of behavioral health symptoms and disorders;
- Cover Medication-Assisted Treatment (MAT) and tobacco cessation benefits; and
- Identify a strategy to facilitate the use of validated clinical assessment tools for determining the most appropriate services for children and pregnant women experiencing behavioral health issues.

¹⁷ Other organizations, such as ACOG and SAMHSA, make recommendations for screening tools for pregnant women. ACOG: <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co711.pdf?dmc=1>. SAMHSA: <https://store.samhsa.gov/system/files/sma18-5054.pdf> Prenatal and postpartum care. As noted in the table heading above, this table is designed to provide examples of tools. CMS is not endorsing any specific tool.

¹⁸ CRAFFT stands for the key words of six of the items in the tool, “car, relax, alone, forget, friends, trouble.”

a. Behavioral Health Benefit Package

We recognize that there are state specific factors to consider in developing and maintaining a behavioral health benefit package, and that there is variation across states in terms of the services offered. Given these considerations, and the evolving evidence-base in this area, CMS is not specifying an exhaustive list of services to be covered under the CHIP state plan in order to meet the new statutory requirement to treat a broad range of behavioral health symptoms and disorders. States will have to describe their behavioral health services in the state plan in order for CMS to determine whether their overall benefit array and levels of care within the benefit array are sufficient to treat a broad range of behavioral health conditions consistent with section 2103(c)(5) of the Act.

All states that provide coverage to separate CHIP populations will have to describe the amount, duration and scope of each benefit at Section 6.3-BH of the attached state plan template. There is an exception for states that have already demonstrated that they provide the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit that is identical to Medicaid.¹⁹ These states will only need to provide an assurance at Section 6.2.22.1 of the attached state plan template that any type of amount, duration, and/or scope limitation associated with its benefits can be exceeded if medically necessary.

In addition to the required screenings described in Table 1 above, we are requiring Medication-Assisted Treatment (MAT) for opioid use disorders (OUDs) and tobacco cessation benefits because these treatments are considered to be the most clinically appropriate services available for the applicable conditions, and therefore, a critical part of any state's behavioral health benefit array. Tobacco cessation programs have a proven track record of reducing smoking rates and health care costs, and improving health outcomes. Studies have repeatedly demonstrated the efficacy of MAT, a combination of behavioral interventions and medications to treat opioid use disorders, in reducing illicit drug use and overdose deaths,²⁰ and improving retention in treatment.²¹ We note that MAT is only required as clinically appropriate for children. MAT will also be a required Medicaid service for opioid use disorders. Additional guidance in this area will be forthcoming.

We encourage states to review previous guidance we have released, on treatment services that are supported by scientific evidence, when considering whether an existing benefit array meets this new CHIP requirement.

- Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues, Joint CMCS and SAMHSA Informational Bulletin, released on July 1, 2019.

<https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib20190701.pdf>.

¹⁹ States have demonstrated this through the mental health parity review process.

²⁰ Schwartz, R. P., Gryczynski, J., O'Grady, K. E., Sharfstein, J. M., Warren, G., Olsen, Y. Jaffe, J. H. (2013). Opioid agonist treatments and heroin overdose deaths in Baltimore, Maryland, 1995- 2009. *American Journal of Public Health*, 103(5), 917-922.

²¹ Kresina, T. F., Melinda, C., Lee, J., Ahadpour, M., & Robert, L. (2015). Reducing mortality of people who use opioids through medication-assisted treatment for opioid dependence. *Journal of HIV & Retro Virus*, 1(1).

- Opportunities to Design Innovative Service Delivery Systems for Adults with Serious Mental Illness or Children with a Serious Emotional Disturbance, SMD#18-011, released on November 13, 2018. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>.
- Strategies to Address the Opioid Crisis, SMD#17-003, released on November 1, 2017. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>.
- Coverage of Behavioral Health Services for Youth with Substance Use Disorders, Joint CMCS and SAMHSA Informational Bulletin, released on January 26, 2015. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-26-2015.pdf>.
- Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions, Joint CMCS and SAMHSA Informational Bulletin, released on May 7, 2013. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf>.

b. Validated Clinical Assessment Tools

A proper clinical assessment is a key element in connecting individuals to the appropriate type and intensity of behavioral health treatment when they need it. An assessment is a comprehensive and formal process of defining the nature of a particular concern, determining a diagnosis, evaluating current level of functioning, and developing specific treatment recommendations to improve health and functioning. Some validated tools also include mechanisms for tracking the outcomes of treatment plans, to help ensure that services are delivered appropriately and effectively.²² Many states use validated assessment tools, such as those listed below:

Table 3: Examples of Validated Clinical Assessment Tools

Child and Adolescent Service Intensity Instrument (CASII) ²³
Child and Adolescent Strength and Needs (CANS) ²⁴
American Society of Addiction Medicine (ASAM) Level of Care Tool

Similar to the requirement for all states to identify a strategy for facilitating the use of age-appropriate, validated screening tools for children and pregnant women with behavioral health conditions in primary care settings, states will also be required to identify a strategy for facilitating the use of validated assessment tools at Section 6.4.2-BH of the attached state plan template or provide a description of an existing strategy in this area. The facilitation examples provided above for screening tools are the same for assessment tools, such as covering the costs of administering the tools, and/or the costs associated with purchasing these tools, providing education, training, and technical resources to clinicians in this area. All states will also be required to specify the assessment tools they are currently using at Section 6.4.1-BH of the attached template.

²² A validated instrument is one that has been psychometrically tested for reliability (the ability of the instrument to produce consistent results), validity (the ability of the instrument to produce true results), and sensitivity (the probability of correctly identifying a patient with the condition). This definition is provided by The Joint Commission at <https://www.jointcommission.org/about-us/about-the-joint-commission-main.aspx>.

²³ The CASII tool was developed by the American Academy of Child and Adolescent Psychiatry (AACAP) and applies to children ages 6 through 18. AACAP also has a screening tool for children under 6, which is the Early Childhood Service Intensity Instrument.

²⁴ The CANS tool was developed by the Praed Foundation.

Delivery of Culturally and Linguistically Appropriate Services

It is essential that all aspects of the delivery of behavioral health coverage be reflective of the diversity of the communities that they serve and strive to become and remain culturally and linguistically competent. Culturally and Linguistically Appropriate Services (CLAS) are defined as services that are respectful of, and responsive to, individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs and employed by all members of an organization at every point of contact, according to the Health and Human Services Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services in Health Care.²⁵

Section 5022(b)(2) of the SUPPORT Act explicitly requires behavioral health coverage be delivered in a culturally and linguistically appropriate manner regardless of delivery system. States will need to provide an assurance consistent with this provision in 6.5-BH of the attached state plan template.

There are existing CHIP regulations at 42 CFR 457.110, 457.340(e), 457.1207, and 457.1230(a), and related to the provision of linguistically appropriate services, such as establishing a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees, and making oral and written interpretation available in each prevalent non-English language. For guidance on developing a language access plan, please go to <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan.pdf>.

In addition, regulations at 457.1230(a) require that managed care organizations participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

Additional guidance on the broader topic of cultural competency has also been published by the U. S. Department of Health and Human Services.²⁶

Access to Care

Ensuring and continually improving access to high-quality, evidence-based treatment, is as critical as designing and maintaining an array of behavioral health benefits. States must adhere to existing CHIP rules at 42 CFR 457.495 and 457.1230 in this area. These rules require that states assure access to covered services, monitor and treat enrollees with chronic, complex, or serious medical conditions, and process in a timely manner decisions related to prior authorization of services. Benefits provided through a managed care delivery system must also include contract provisions to assure adequate capacity to serve the expected enrollment, and

²⁵ <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf>

²⁶ <https://www.thinkculturalhealth.hhs.gov/clas/standards>, <https://www.thinkculturalhealth.hhs.gov/clas/blueprint>

meet other standards associated with coverage, coordination, continuity of care, and authorization of services.

SPA Submission Process

States should follow the regular process for submitting a CHIP SPA as specified at 2106(b) of the Act and 42 CFR 457.60, and 457.65. A CHIP amendment may be retroactive, but in order to obtain an effective date of October 24, 2019 as required under the SUPPORT Act, states must submit the SPA no later than the end of the state fiscal year that includes that date. We encourage states to submit a SPA that solely focuses on addressing section 5022 of the SUPPORT Act rather than including additional amendments.

As a reminder, submissions will need to follow the applicable public notice, tribal consultation, and effective date regulations. For CHIP SPAs, the submission must comply with tribal consultation requirements at section 2107(e)(1)(C) of the Act and public notice requirements in 42 CFR 457.65, as well as any state-specific policies in these areas.

Behavioral Health Related Regulations in CHIP

The requirements in section 5022(d) of the SUPPORT Act are distinct from existing CHIP regulations at 457.402 and 457.410(b). Regulations at 457.402 specify services that can be considered child health assistance, including behavioral health services. Regulations at 457.410(b) list benefits that are mandatory in CHIP, which do not include behavioral health services. Coverage of behavioral health services has been optional to states prior to the SUPPORT Act.

The SUPPORT Act requirements are also distinct from those in the Mental Health Parity and Addiction Equity Act. Division C, section 512 of the MHPAEA (P.L. 110-343) amended section 2705(a)²⁷ of the Public Health Service Act to require mental health and substance abuse parity in group health plans. Section 2103(c)(7) of the Act, as amended by the SUPPORT Act, requires that states with separate CHIPs providing mental health or substance use disorder benefits ensure that the financial requirements and treatment limitations applied to these benefits are applied in the same manner as required under 2705(a) of the Public Health Service Act for such group health plans.²⁸ MHPAEA also provides that if a state's CHIP coverage includes the EPSDT benefit, it will be deemed to satisfy parity requirements.²⁹ MHPAEA does not mandate behavioral health coverage, although the majority of states have elected to provide some behavioral health coverage to their separate CHIP populations.

While the SUPPORT Act builds on MHPAEA, it is different in two important ways. Unlike MHPAEA, the SUPPORT Act explicitly requires coverage of behavioral health services. In addition, EPSDT deeming is not an included provision in the SUPPORT Act. Recent state efforts to come into compliance with MHPAEA will serve as a helpful point of reference in determining whether a state's existing behavioral health coverage will meet the new criteria at section 2103(c)(5) of the Act. However, all states with a separate CHIP, including those that

²⁷ Renumbered as section 2726(a) of the PHS Act by section 1001(2) of PPACA (P.L. 111-148).

²⁸ Section 2103(c)(7) of the Social Security Act describes mental health parity requirements in CHIP.

²⁹ Section 2103(c)(7)(B) of the Social Security Act describes the mental health parity EPSDT deeming option in CHIP.

have already demonstrated compliance with MHPAEA, are required to submit a SPA to demonstrate compliance with section 5022 of the SUPPORT Act.³⁰

Closing

CMS looks forward to its continued work with states on the implementation of this legislation, and ensuring that all CHIP-eligible children and pregnant women have access to the behavioral health coverage they need. States should consult with CMS if they have questions related to the guidance in this letter. We also encourage you to reach out to your CHIP project officer with any specific questions or concerns, or you may contact Meg Barry, Acting Director of the Division of State Coverage Programs at 410-786-1536 or meg.barry@cms.hhs.gov.

Sincerely,

Calder Lynch
Deputy Administrator and Director
Center for Medicaid & CHIP Services

³⁰ The requirement to submit this SPA is approved under OMB control number 0938-1148.