Chapter 3:

Access to Behavioral Health Services for Children and Adolescents Covered by Medicaid and CHIP

Access to Behavioral Health Services for Children and Adolescents Covered by Medicaid and CHIP

Recommendations

3.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Administration for Children and Families to issue joint subregulatory guidance that addresses the design and implementation of benefits for children and adolescents with significant mental health conditions covered by Medicaid and the State Children's Health Insurance Program.

3.2 The Secretary of the U.S. Department of Health and Human Services should direct a coordinated effort by the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Administration for Children and Families to provide education and technical assistance to states on improving access to home- and community-based behavioral health services for children and adolescents with significant mental health conditions covered by Medicaid and the State Children's Health Insurance Program. Additionally, the Secretary should examine options to use existing federal funding to support state-level activities to improve the availability of these services.

Key Points

- Behavioral health disorders usually begin in childhood or adolescence and can have long-term implications for health and well-being.
- For children and youth covered by Medicaid and the State Children's Health Insurance Program (CHIP), federal requirements, including Medicaid's early and periodic screening, diagnostic, and treatment (EPSDT) benefit, are intended to ensure access to behavioral health services.
- Yet, the behavioral health needs of many children and adolescents go unmet. In 2018, only 54.1 percent of non-institutionalized youth enrolled in Medicaid or CHIP who experienced a major depressive episode received mental health treatment. These adolescents were more likely than those with private coverage to receive treatment in institutional settings, as opposed to outpatient care.
- While home- and community-based services for children and adolescents with significant mental health conditions can prevent institutional placement, these services are often unavailable or difficult to access.
- States generally have the legal authorities needed to design such benefits, but often lack the awareness and capacity to use them.
- Looking forward, the Commission will explore additional opportunities to improve access to behavioral health services for children and adolescents, including those in foster care and the juvenile justice system.

CHAPTER 3: Access to Behavioral Health Services for Children and Adolescents Covered by Medicaid and CHIP

Behavioral health disorders usually begin in childhood or adolescence and can have long-term implications for an individual's physical and mental health (WHO 2020, CMS 2018, Kessler et al. 2005). In 2018, approximately one in five non-institutionalized youth age 12–17 had experienced a major depressive episode (MDE) in their lifetime and roughly 4 percent had a substance use disorder (SUD) in the past year (SHADAC 2020). Having SUD increases one's risk of mental health disorders and vice versa, and the majority of youth with SUD have a co-occurring mental health disorder (CMS and SAMHSA 2015).

Because many mental disorders begin in childhood or adolescence, interventions aimed at early detection and treatment can mitigate problems before these conditions become disabling (Kessler et al. 2007, NIHCM 2009). Children and youth with behavioral health conditions benefit from treatment that may involve a combination of medications, therapies, and inpatient and outpatient visits (MACPAC 2015). Services may be delivered in a variety of settings, including schools, office-based settings, specialty treatment facilities, foster care settings, or a child's home.[1]

For children and youth covered by Medicaid and the State Children's Health Insurance Program (CHIP), federal laws are intended to ensure access to appropriate behavioral health services. In accordance with the Americans with Disabilities Act of 1990 (ADA, P.L. 101-336), Medicaid beneficiaries with serious mental illness are entitled to receive necessary mental health treatment in the most integrated setting possible.[2] As a result of the Supreme Court's ruling in *Olmstead v. L.C.* (119 S. Ct. 2176 (1999)), states must provide treatment for individuals with disabilities, including serious mental illness, in community-based settings, if the individuals are not opposed to such services, and such placement is appropriate and can be reasonably accommodated by the state.[3]

Although *Olmstead v. L.C.* generally requires states to provide community-based services to individuals with disabilities, it did not create an immediate right to a community placement in lieu of institutional care. As such, Medicaid beneficiaries with mental illness still have difficulty accessing services in the community (MACPAC 2019a).

The Social Security Act (the Act) also requires state Medicaid programs and CHIP to meet certain obligations that are unique to children and adolescents. Under Medicaid's mandatory early and periodic screening, diagnostic, and treatment (EPSDT) benefit, Medicaid-eligible individuals under age 21 are entitled to all medically necessary services, including behavioral health services. In separate CHIP, behavioral health services are now a required benefit.

Despite these requirements, the behavioral health needs of many children and adolescents often go unmet (SAMHSA 2019a, MACPAC 2018a). Experts have noted that although access to behavioral health services is a challenge across the lifespan, young people often face additional barriers to care, including a shortage of behavioral health providers offering tailored programming for youth willing to provide services to Medicaid and CHIP beneficiaries (Tsai 2020). In 2018, only about half of non-institutionalized youth enrolled in Medicaid or CHIP who experienced an MDE in the past year received some form of mental health treatment, and only 6 percent of adolescent beneficiaries with SUD received treatment. Moreover, beneficiaries were more likely than their privately insured peers to receive mental health treatment in a hospital or a residential facility (SHADAC 2020).

Unmet need for behavioral health services among children and adolescents has been exacerbated by COVID-19. Families have been under increased stress due to the health and economic effects of the pandemic (Brown et al. 2020). Moreover, school closings and social distancing measures have contributed to social isolation and limited access to services (Hoffman and Miller 2020). Preliminary data show a 44 percent drop in outpatient mental health visits among children covered by Medicaid and CHIP, even after accounting for an uptick in telehealth visits (CMS 2020a). Meanwhile, the proportion of mental health-related emergency department visits among children has increased (Leeb et al. 2020). The mental health consequences of COVID-19 are likely to persist, given the increased risk of depression and anxiety among children and adolescents during and after periods of isolation (Loades et al. 2020).

As the Commission examined access to behavioral health services for children and adolescents covered by Medicaid and CHIP over the past year, experts and state officials highlighted the lack of home- and community-based behavioral health services available to this population (Herman 2020, O'Brien 2020). These services have been shown to improve clinical and function outcomes, prevent out-of-home placements, and reduce involvement with child welfare and the juvenile justice system (McEnany et al. 2020, O'Brien 2020, MHA 2015, Lee et al. 2014).

While many factors affect access to services, the Commission heard from experts who highlighted state capacity as an immediate concern. States generally have the legal authorities needed to design home- and community-based behavioral health benefits for children and adolescents with significant mental health conditions; however, they often lack the awareness and ability to use them effectively (O'Brien 2020). Moreover, states often face obstacles bringing together the various agencies—behavioral health, child welfare, juvenile justice, and others—that play a role in addressing the needs of this population (Herman 2020).

The Commission, therefore, recommends that the following actions be taken by the Secretary of the U.S. Department of Health and Human Services (the Secretary) as an important initial step toward improving access to behavioral health services for children and adolescents covered by Medicaid and CHIP.

- The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Administration for Children and Families to issue joint subregulatory guidance that addresses the design and implementation of benefits for children and adolescents with significant mental health conditions covered by Medicaid and the State Children's Health Insurance Program.
- The Secretary of the U.S. Department of Health and Human Services should direct a coordinated effort by the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Administration for Children and Families to provide education and technical assistance to states on improving access to home- and community-based behavioral health services for children and adolescents with significant mental health conditions covered by Medicaid and the State Children's Health Insurance Program. Additionally, the Secretary should examine options to use existing federal funding to support state-level activities to improve the availability of these services.

This chapter begins by describing the prevalence of behavioral health conditions among adolescents and the rates at which they receive treatment. Next, we discuss the availability of behavioral health providers serving children and adolescents in Medicaid and CHIP, including state-by-state estimates of service availability. The chapter then focuses on the needs of children and adolescents with significant mental health conditions, who are often at risk of being placed in restrictive settings when appropriate home- and community-based alternatives are unavailable. We conclude by

discussing factors affecting access to care for this population, including the role of various state and federal agencies, Medicaid and CHIP coverage policies, and barriers that states encounter when trying to improve access to home- and community-based behavioral health services.

Prevalence, Disparities, and Treatment Rates

Mental health disorders usually emerge in childhood or adolescence, and the consequences of such disorders can extend into adulthood (WHO 2020, CMS 2018). About half of all lifetime cases of mental illness begin by age 14 and three-fourths by age 24 (Kessler et al. 2005). Adolescence is also the period when most individuals with SUD begin using drugs or alcohol (NIDA 2014). More than 90 percent of adults with SUD started using substances before the age of 18 (CMS and SAMHSA 2015). The majority of youth with SUD have a co-occurring mental health disorder (Chan et al. 2008). (For discussion of mental health conditions in adulthood, see Chapter 2.)

Behavioral health disorders can negatively affect physical, emotional, and social development. For example, adolescents with depression have a higher risk of attempting suicide, engaging in drug use and high-risk sexual behavior, and having problems in school or in relationships with family and peers (Murphey et al. 2013, CBHSQ 2016). SUDs can also interfere with normal brain maturation (NIDA 2014).

Below, we describe the prevalence of behavioral health conditions and treatment rates among non-institutionalized adolescents age 12–17, comparing the experience of adolescents enrolled in Medicaid or CHIP to those with other forms of coverage. Where possible, we also examine prevalence and treatment rates for Medicaid beneficiaries by race and ethnicity. Estimates are reported where sample size permits. This analysis is based on self-reported data from the National Survey on Drug Use and Health (NSDUH), a federal survey of non-institutionalized individuals age 12 and older conducted annually in all 50 states and the District of Columbia.[4] (Additional analysis of NSDUH and mental health conditions in adults is discussed in Chapters 2 and 4.)

It is important to note that because NSDUH data are self-reported, the survey may over- or underrepresent prevalence and need for treatment—individual responses are subjective and not validated using psychiatric diagnostic information (SAMHSA 2019a). They may be influenced by a variety of social and cultural factors, including beliefs and perceptions regarding mental health and SUD (Ward et al. 2013). Stigma and fear of reporting drug use that involves criminalized behavior, for example, may lead to underreporting (Wogan and Restrepo 2020). Furthermore, NSDUH does not include residents of institutional group quarters, such as juvenile detention centers. Youth in these facilities tend to have high rates of mental health conditions and disproportionate numbers of underserved racial and ethnic minority youth (Alegria et al. 2010).

Prevalence of mental health conditions

For adolescent respondents, the NSDUH captures prevalence of mental illness in two categories:

- Major depressive episode—This category includes adolescents who reported experiencing certain symptoms nearly every day in the same two-week period at any point in their life. Adolescents were defined as having an MDE in the past year if they had a lifetime MDE, felt depressed or lost interest or pleasure in daily activities for two weeks or longer in the past 12 months, and experienced during that time some of the symptoms they reported for a lifetime MDE.[5]
- MDE with severe role impairment—This category includes adolescents who reported impairment caused by an MDE in the past 12 months. Severe impairment was defined by the level of problems reported in four major life activities or role domains: (1) ability to do chores at home; (2) ability to do well at school or work; (3) ability to get along with family; and (4) ability to have a social life.[6, 7]

Prevalence of mental health conditions was similar across coverage groups. In 2018, approximately 5 million (one in five) non-institutionalized youth age 12–17 experienced a lifetime MDE (Table 3-1). Nearly 2.5 million (1 in 10) youth experienced an MDE with severe role impairment within the past year. Rates of lifetime MDE and MDE within the past year were similar when comparing adolescents covered by Medicaid or CHIP to those with private coverage and those who were uninsured (SHADAC 2020). However, when compared to their privately insured peers, Black and Hispanic youth covered by Medicaid were less likely to report a past year MDE. Females were generally more likely to report an MDE than their male peers, regardless of their coverage status (Table 3A-1) (SHADAC 2020).

TABLE 3-1. Major Depressive Episodes and Suicidal Thoughts and Behaviors among Non-Institutionalized Adolescents Age 12–17, by Insurance Status, 2018

Type of condition	Percentage of youth age 12–17			
	Total	Medicaid or CHIP	Private coverage	Uninsured
Major depressive episode (MDE)				
Lifetime MDE	20.7%	19.6%	21.2%	20.4%
MDE in past year	14.5	13.5	15.0	13.0
MDE with severe role impairment in past year	10.0	9.1	10.3	10.0
Suicide				
Thoughts of suicide in past year	11.9	11.5	12.2	8.3*
Plans of suicide in past year	5.6	5.7	5.6	4.2
Attempted suicide in past year	3.9	4.4	3.8	–

Notes: The 2018 National Survey on Drug Use and Health (NSDUH) used criteria from the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* to identify major depressive episodes. The NSDUH did not exclude depressive symptoms that occurred exclusively in the context of bereavement. Questions from the Sheehan Disability Scale determined if a major depressive episode caused severe role impairment by creating major problems with the ability to do chores at home, do well at work or school, get along with family, or have a social life.

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid or CHIP, other, or uninsured. The NSDUH classified respondents who reported they were covered by CHIP as being covered by Medicaid. Coverage source is defined as primary coverage at the time of the interview.

* Difference from Medicaid or CHIP is statistically significant at the 0.05 level.

– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC 2020.

Rates of suicidal thoughts and behaviors were similar across coverage groups. Suicidal thoughts and behaviors among adolescents have increased over time, with suicide now the second leading cause of death among those age 12–17 (KFF 2020). In 2018, roughly 12 percent of youth reported thoughts of suicide and nearly 4 percent reported attempting suicide in the past year (Table 3-1). Reported rates of past year suicidal ideation and suicide attempts were generally similar across coverage groups, with the exception of adolescents covered by Medicaid or CHIP being more likely than those without insurance to report thoughts of suicide (SHADAC 2020).

Mental health conditions were common among white beneficiaries and youth of two or more races. Among youth enrolled in Medicaid or CHIP, the reported rate of MDE for certain racial and ethnic groups differed from that of white beneficiaries. In 2018, Black and Hispanic youth covered by Medicaid or CHIP were less likely to report a lifetime MDE, MDE within the past year, or MDE with severe role impairment when compared to their white counterparts (Table 3-2). In contrast, youth of two or more races reported rates similar to those of white beneficiaries. Prevalence estimates for Asian American, American Indian or Alaska Native, and Native Hawaiian or other Pacific Islander youth covered by Medicaid or CHIP are limited due to the small sample size. However, where data are available, they show that these youth reported rates of lifetime MDE similar to those of their white counterparts (SHADAC 2021).

TABLE 3-2. Major Depressive Episodes and Suicidal Thoughts and Behaviors among Non-Institutionalized Adolescents Age 12–17 Enrolled in Medicaid or CHIP, by Race and Ethnicity, 2018

Type of condition	Percentage of youth age 12–17					
	White	Black	Hispanic	Asian American	AIAN and NHPI	Two or more races
Major depressive episode (MDE)						
Lifetime MDE	24.2%	12.3%*	18.9%*	22.6%	19.2%	24.5%
MDE in past year	17.1	7.6*	12.9*	16.0	–	18.5
MDE with severe role impairment	11.8	5.6*	7.8*	–	–	12.5
Suicide						
Thoughts of suicide	15.6	7.4*	9.8*	–	–	13.8
Plans of suicide	8.1	3.5*	4.4*	–	–	8.1
Attempted suicide	6.1	3.1*	3.8*	–	–	6.0

Notes: Hispanic is anyone of Hispanic, Latino, or Spanish origin. AIAN and NHPI combines data for respondents who identified as American Indian or Alaska Native or Native Hawaiian or other Pacific Islander and are not of Hispanic origin. White, Black, Asian American, and two or more races do not include respondents of Hispanic origin.

The 2018 National Survey on Drug Use and Health (NSDUH) used criteria from the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* to identify major depressive episodes. The NSDUH did not exclude depressive symptoms that occurred exclusively in the context of bereavement. Questions from the Sheehan Disability Scale determine if a major depressive episode caused severe role impairment by creating major problems in the ability to do chores at home, do well at work or school, get along with family, or have a social life.

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid or CHIP, other, or uninsured. The NSDUH classified respondents who reported they were covered by CHIP as being covered by Medicaid. Coverage source is defined as primary coverage at the time of the interview.

* Difference from Medicaid or CHIP is statistically significant at the 0.05 level.

– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC 2021.

Black and Hispanic youth covered by Medicaid or CHIP were also less likely to report thoughts of suicide, plans of suicide, and attempted suicide compared to their white counterparts (Table 3-2). In contrast, rates of suicidal thoughts and behaviors reported by those of two or more races were similar to their white peers.

Prevalence of substance use disorders

Although the prevalence of past year illicit drug or alcohol misuse, abuse, and dependence was similar across coverage groups, rates at which adolescents reported using alcohol and certain drugs varied when comparing adolescents covered by Medicaid or CHIP to those with private insurance (Table 3-3).[8] In 2018, Medicaid beneficiaries were less likely than those with private insurance to have ever used alcohol or to have used alcohol in the past year. Conversely, adolescents with Medicaid or CHIP coverage reported higher rates of marijuana use and were more likely to have used a pain reliever not directed by a doctor. The prevalence of past year illicit drug or alcohol dependence or abuse did not vary significantly by coverage status when examining rates by sex or race and ethnicity (Table 3A-2) (SHADAC 2020).

TABLE 3-3. Substance Misuse, Abuse, and Dependence among Non-Institutionalized Adolescents Age 12–17, by Insurance Status, 2018

Type of use	Percentage of youth age 12–17			
	Total	Medicaid or CHIP	Private coverage	Uninsured
Ever used alcohol	26.6%	24.3%	27.8%*	30.0%
Alcohol use in past year	20.1	16.3	22.5*	19.8
Ever used marijuana	15.3	17.1	14.0*	17.0
Marijuana use in past year	11.8	12.2	11.7	11.8
Ever used a pain reliever not directed by a doctor	4.5	5.5	3.8*	6.3
Ever misused psychotherapeutics	6.3	6.9	5.8	8.2
Psychotherapeutic misuse in past year	4.7	5.0	4.4	7.2
Nicotine dependent in past year	0.5	0.5	0.4	–
Illicit drug dependence or abuse in past year	2.8	3.0	2.6	3.4
Illicit drug or alcohol dependence or abuse in past year	3.8	3.8	3.8	4.0

Notes: The 2018 National Survey on Drug Use and Health (NSDUH) defined illicit drugs as including any of the following substances: marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, and the misuse of prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, and sedatives). Nicotine dependence was defined by meeting dependence criteria derived from the Nicotine Dependence Syndrome Scale or the Fagerstrom Test of Nicotine Dependence

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid or CHIP, other, or uninsured. The NSDUH classified respondents who reported they were covered by CHIP as being covered by Medicaid. Coverage source is defined as primary coverage at the time of the interview.

* Difference from Medicaid or CHIP is statistically significant at the 0.05 level.

– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC 2020.

Substance misuse, abuse, and dependence among Medicaid beneficiaries varied by race and ethnicity. In general, non-white youth enrolled in Medicaid or CHIP were less likely than their white counterparts to report using drugs and alcohol. In 2018, Black and Hispanic youth covered by Medicaid or CHIP were less likely to report experiencing drug or alcohol abuse or dependence within the past year when compared to white beneficiaries (Table 3-4). Alcohol and marijuana use were less commonly reported among Black and Hispanic youth enrolled in Medicaid or CHIP when compared to their white counterparts. Asian American beneficiaries were also less likely to report having ever used alcohol. Reported rates of alcohol and marijuana use were generally similar for American Indian, Alaska Native, Native Hawaiian, and other Pacific Islander beneficiaries and multiracial youth compared to white adolescents (SHADAC 2021).

TABLE 3-4. Substance Misuse, Abuse, and Dependence among Non-Institutionalized Adolescents Age 12–17 Enrolled in Medicaid or CHIP, by Race and Ethnicity, 2018

Type of use	Percentage of youth age 12–17					
	White	Black	Hispanic	Asian American	AIAN and NHPI	Two or more races
Ever used alcohol	30.7%	18.0%*	22.5%*	16.3%*	26.2%	29.4%
Alcohol use in past year	22.4	10.8*	14.9*	–	11.2*	16.1
Ever used marijuana	20.3	15.7*	15.6*	–	19.5	22.3
Marijuana use in past year	15.1	11.0*	10.4*	–	15.3	15.7
Ever used a pain reliever not directed by a doctor	6.0	5.2	5.1	–	–	–
Illicit drug dependence or abuse in past year	4.4	2.4*	1.9*	–	–	–
Illicit drug or alcohol dependence or abuse in past year	5.0	2.9*	3.1*	–	–	–

Notes: Hispanic is anyone of Hispanic, Latino, or Spanish origin. AIAN and NHPI combines data for respondents who identified as American Indian or Alaska Native or Native Hawaiian or other Pacific Islander and are not of Hispanic origin. White, Black, Asian American, and two or more races do not include respondents of Hispanic origin.

The 2018 National Survey on Drug Use and Health (NSDUH) defined illicit drugs as including any of the following substances: marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, and the misuse of prescription psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, and sedatives). Nicotine dependence was defined by meeting dependence criteria derived from the Nicotine Dependence Syndrome Scale or the Fagerstrom Test of Nicotine Dependence.

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid or CHIP, other, or uninsured. The NSDUH classified respondents who reported they were covered by CHIP as being covered by Medicaid. Coverage source is defined as primary coverage at the time of the interview.

* Difference from white Medicaid or CHIP beneficiaries is statistically significant at the 0.05 level.

– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC 2021.

Use of behavioral health services

In 2018, nearly one in four (24.3 percent) non-institutionalized youth age 12–17 received any form of mental health services (specialty or non-specialty) (Table 3-5). This includes a wide variety of mental health services, ranging from non-specialty services provided by a pediatrician or school counselor to specialty services provided in a psychiatrist's office or residential treatment setting. For adolescents with mental health conditions, there were a substantial number who needed but did not receive services: among Medicaid and CHIP beneficiaries, only 54.1 percent of youth with MDE and 60.4 percent of youth with MDE with severe role impairment received some form of mental health treatment in the past year (SHADAC 2020).

Adolescents covered by Medicaid or CHIP received treatment at similar rates as their peers with private coverage. However, there were differences across the types of services and settings in which adolescents accessed care (Table 3-5). Among all youth, Medicaid and CHIP beneficiaries were more likely to receive non-specialty mental health services (e.g., from a pediatrician or school counselor) than their privately insured peers, who more often received services from a private therapist, psychologist, psychiatrist, or social worker. Medicaid and CHIP beneficiaries were also more likely to have stayed overnight in a hospital or a residential facility. There was less variation across coverage groups for adolescents with MDE and MDE with severe role impairment, although youth with MDE enrolled in Medicaid or CHIP were more likely than their privately insured peers to receive specialty treatment from an in-home therapist, counselor, or family preservation worker (SHADAC 2020).

TABLE 3-5. Mental Health Treatment among Non-Institutionalized Adolescents Age 12–17 in the Past Year, by Insurance Status, 2018

Treatment characteristics	Percentage of youth age 12–17			
	Total	Medicaid or CHIP	Private coverage	Uninsured
Received specialty or non-specialty mental health services				
All youth	24.3%	25.7%	24.4%	14.1%*
Youth with MDE	50.0	54.1	49.5	30.4*
Youth with MDE with severe role impairment	56.3	60.4	57.3	33.1*
Received specialty mental health services				
All youth	16.1	16.0	17.0	8.1*
Youth with MDE	38.4	38.6	39.9	22.1*
Youth with MDE with severe role impairment	44.7	44.6	47.5	25.2*
Received non-specialty mental health services				
All youth	15.9	18.5	14.8*	9.5*
Youth with MDE	32.0	38.1	29.7*	20.8*
Youth with MDE with severe role impairment	35.0	40.5	33.5	24.1*
Stayed overnight in a hospital				
All youth	2.5	3.5	1.8*	–
Youth with MDE	5.3	5.8	4.6	–
Youth with MDE with severe role impairment	6.8	7.4	6.0	–
Stayed overnight in a residential center for emotional treatment				
All youth	1.2	2.0	0.7*	–
Youth with MDE	2.9	4.1	2.2	–
Youth with MDE with severe role impairment	3.6	4.7	2.9	–
Spent time in a day treatment program				
All youth	1.9	2.3	1.8	–
Youth with MDE	6.5	8.4	5.9	–
Youth with MDE with severe role impairment	7.3	8.5	7.3	–
Received specialty treatment in a mental health clinic				
All youth	3.9	4.4	3.8	–
Youth with MDE	15.1	17.7	14.4	–
Youth with MDE with severe role impairment	17.9	21.8	17.1	–

TABLE 3-5. (continued)

Treatment characteristics	Percentage of youth age 12–17			
	Total	Medicaid or CHIP	Private coverage	Uninsured
Received specialty treatment from a private therapist, psychologist, psychiatrist, social worker, or counselor				
All youth	12.4%	11.0%	13.9%*	5.1%*
Youth with MDE	34.0	33.7	35.4	18.1*
Youth with MDE with severe role impairment	39.4	39.2	42.0	–
Received specialty treatment from an in-home therapist, counselor, or family preservation worker				
All youth	3.9	4.5	3.8	–
Youth with MDE	9.8	13.6	8.3*	–
Youth with MDE with severe role impairment	11.3	14.2	10.4	–
Received mental health treatment from a family doctor or pediatrician				
All youth	3.1	3.6	3.1	–
Youth with MDE	8.8	10.6	8.6	–
Youth with MDE with severe role impairment	10.4	12.3	10.6	–

Notes: MDE is major depressive episode. The 2018 National Survey on Drug Use and Health (NSDUH) defined specialty mental health services as treatment or counseling for emotional or behavioral problems provided in outpatient, inpatient, or residential mental health settings. Outpatient settings include: (1) private therapists, psychologists, psychiatrists, social workers, or counselors; (2) mental health clinics or centers; (3) partial day hospitals or day treatment programs; and (4) in-home therapists, counselors, or family preservation workers. Inpatient settings include hospitals and residential treatment centers. Non-specialty mental health services are defined as treatment from a pediatrician or other family doctor; from a school social worker, psychologist, or counselor; in a juvenile detention center, prison, or jail; through participation in a school program inside a regular school or attendance at a special school for students with emotional or behavioral problems; or staying overnight or longer in foster care or in a therapeutic foster care home because of emotional or behavioral problems.

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid or CHIP, other, or uninsured. The NSDUH classified respondents who reported they were covered by CHIP as being covered by Medicaid. Coverage source is defined as primary coverage at the time of the interview.

* Difference from Medicaid or CHIP is statistically significant at the 0.05 level.

– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC 2020.

Beneficiaries of color received treatment at lower rates than their white counterparts. In 2018, among all youth covered by Medicaid or CHIP, Black, Hispanic, American Indian or Alaska Native, and Native Hawaiian or other Pacific Islander youth were less likely to receive any form of mental health services (specialty or non-specialty) than their white counterparts (Table 3-6). Generally, among Medicaid and CHIP beneficiaries with MDE, treatment rates were similar across racial and ethnic groups.

When compared to their white counterparts, access to mental health treatment is more limited for beneficiaries of color with MDE with severe role impairment (Table 3-6). Specifically, less than half

(48 percent) of Black beneficiaries with MDE with severe role impairment reported receiving some form of specialty or non-specialty mental health treatment compared to 68 percent of their white peers.

Moreover, Black and Hispanic beneficiaries with MDE with severe role impairment were less likely to report receiving specialty mental health treatment than their white counterparts (SHADAC 2021).

TABLE 3-6. Mental Health Treatment among Non-Institutionalized Adolescents Age 12–17 Enrolled in Medicaid or CHIP in the Past Year, by Race and Ethnicity, 2018

Treatment characteristics	Percentage of youth age 12–17					
	White	Black	Hispanic	Asian American	AIAN and NHPI	Two or more races
Received specialty or non-specialty mental health services						
All youth	31.1%	24.9%*	23.1%*	–	19.8%*	30.4%
MDE	59.0	50.1	54.0	–	–	60.1
MDE with severe role impairment	68.1	48.0*	62.3	–	–	57.8
Received specialty mental health services						
All youth	20.9	13.6*	14.1*	–	–	17.6
MDE	45.5	34.9	34.3	–	–	40.3
MDE with severe role impairment	55.3	36.2*	37.7*	–	–	44.4
Received non-specialty mental health services						
All youth	20.9	19.0	16.9*	–	13.8*	24.5
MDE	41.4	34.2	38.6	–	–	49.4
MDE with severe role impairment	46.1	29.6*	41.3	–	–	51.2

Notes: Hispanic is anyone of Hispanic, Latino, or Spanish origin. AIAN and NHPI combines data for respondents who identified as American Indian or Alaska Native or Native Hawaiian or other Pacific Islander and are not of Hispanic origin. White, Black, Asian American, and two or more races do not include respondents of Hispanic origin.

MDE is major depressive episode. The 2018 National Survey on Drug Use and Health (NSDUH) defined specialty mental health services are defined as treatment or counseling for emotional or behavioral problems provided in outpatient, inpatient, or residential mental health settings. Outpatient settings include: (1) private therapists, psychologists, psychiatrists, social workers, or counselors; (2) mental health clinics or centers; (3) partial day hospitals or day treatment programs; and (4) in-home therapists, counselors, or family preservation workers. Inpatient settings include hospitals and residential treatment centers. Non-specialty mental health services are defined as treatment from a pediatrician or other family doctor; from a school social worker, psychologist, or counselor; in a juvenile detention center, prison, or jail; through participation in a school program inside a regular school or attendance at a special school for students with emotional or behavioral problems; or staying overnight or longer in foster care or in a therapeutic foster care home because of emotional or behavioral problems.

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid or CHIP, other, or uninsured. The NSDUH classified respondents who reported they were covered by CHIP as being covered by Medicaid. Coverage source is defined as primary coverage at the time of the interview.

* Difference from white Medicaid or CHIP beneficiaries is statistically significant at the 0.05 level.

– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC 2021.

Youth often received specialty mental health treatment because they felt depressed. In 2018, among all adolescents age 12–17 covered by Medicaid or CHIP, the majority (62 percent) reported receiving specialty mental health treatment because they felt depressed (Figure 3B-1). Other common reasons for receiving treatment were having thought about or attempted suicide (37 percent), feeling afraid or tense (26 percent), and having problems at home or with family (23 percent). These reasons were generally reported more often among beneficiaries with MDE and MDE with severe role impairment (SHADAC 2020).

Access to school-based services

Schools fill a critical role in identifying children and adolescents with behavioral health needs and connecting them with mental health and SUD treatment as well as other needed services. They offer a point of access for care because children are in school for many hours a day, for approximately half the days of the year (CMS 1997). In addition, under the Individuals with Disabilities Education Act (IDEA, P.L. 101-476), public schools must provide all children with disabilities (generally those age 3–21) with a free and appropriate public education. This includes both education and related services, such as speech or physical therapy and behavioral health services, which support a child's ability to learn.[9] Services may be provided by school-based personnel or community providers offering outpatient services in a school setting, regardless of whether there is a school-based health center on-site. Most of the services that must be provided to children in schools are covered by Medicaid under the mandatory EPSDT benefit (MACPAC 2018b). A joint informational bulletin issued by CMS and SAMHSA in 2019 outlines how certain Medicaid authorities can help support school-based mental health and SUD services for children and adolescents (CMS and SAMHSA 2019).

In 2018, all youth and youth with MDE covered by Medicaid or CHIP were more likely to report receiving mental health services from education sources than youth with private coverage and uninsured youth (Table 3-7). All youth with Medicaid or CHIP coverage were also more likely to receive specialty treatment in a school or attend a school program for emotional problems than their privately insured and uninsured peers. Unsurprisingly, youth with MDE and MDE with severe role impairment were generally more likely than others to receive school-based services. This was observed across all coverage groups. Those with Medicaid or CHIP, regardless of diagnosis, were three times more likely than uninsured youth to speak with a school social worker, psychologist, or counselor for emotional problems (SHADAC 2020). Compared to their white counterparts, American Indian or Alaska Native and Native Hawaiian or other Pacific Islander youth enrolled in Medicaid or CHIP were less likely to report receiving mental health services from education sources, and Black beneficiaries were less likely to report talking to a school social worker, psychologist, or counselor (SHADAC 2021).

TABLE 3-7. School-Based Mental Health Services among Non-Institutionalized Adolescents Age 12–17 in the Past Year, by Insurance Status, 2018

Treatment characteristics	Percentage of youth age 12–17			
	Total	Medicaid or CHIP	Private coverage	Uninsured
Received mental health services from education sources				
All youth	13.8%	15.9%	12.8%*	8.6%*
MDE	27.8	32.7	25.9*	18.5*
MDE with severe role impairment	30.6	35.4	29.0	24.1
Received specialty treatment in a school or school program for emotional problems				
All youth	5.8	7.6	4.8*	3.3*
MDE	9.8	13.7	7.8*	–
MDE with severe role impairment	10.8	14.3	9.5	–
Talked to a school social worker, psychologist, or counselor for emotional problems				
All youth	9.6	10.5	9.4	1.3*
MDE	22.7	25.5	22.0	–
MDE with severe role impairment	25.6	29.1	24.5	–

Notes: MDE is major depressive episode. The 2018 National Survey on Drug Use and Health (NSDUH) defined mental health services from education resources as having talked to a school social worker, school psychologists, or school counselors and/or having attended a special school or participated in a special program at a regular school for problems with behavioral or emotions that were not caused by alcohol or drugs.

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid or CHIP, other, or uninsured. The NSDUH classified respondents who reported they were covered by CHIP as being covered by Medicaid. Coverage source is defined as primary coverage at the time of the interview.

* Difference from Medicaid or CHIP is statistically significant at the 0.05 level.

– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC 2020.

Youth often received school-based mental health services because they felt depressed. Nearly half (46 percent) of all youth enrolled in Medicaid or CHIP who received school-based mental health services reported receiving such services because they felt depressed (Figure 3B-2). Other common reasons for receiving school-based services included feeling afraid or tense (22 percent), having problems at school (22 percent), and having thought about or attempted suicide (18 percent). These reasons were generally reported more often among beneficiaries with MDE and MDE with severe role impairment (SHADAC 2020).

Access to substance use treatment

Across all coverage categories, adolescents with past year drug or alcohol dependence reported high rates of unmet need (Table 3-8). In 2018, nearly all (93.9 percent) non-institutionalized Medicaid and CHIP beneficiaries age 12–17 with SUD reported that they needed but did not receive alcohol or drug treatment in the past year. Only 14.6 percent of youth enrolled in Medicaid or CHIP with SUD ever received alcohol or drug treatment, and just 9.2 percent received treatment for alcohol or drug use in the past 12 months.

TABLE 3-8. Substance Use Treatment for Non-Institutionalized Adolescents Age 12–17 with Past Year Drug or Alcohol Dependence or Abuse, by Insurance Status, 2018

Treatment characteristics	Percentage of youth age 12–17			
	Total	Medicaid or CHIP	Private coverage	Uninsured
Needed but did not receive alcohol or drug treatment in the past year	94.3%	93.9%	94.6%	96.3%
Received treatment for alcohol or drug use in the past 12 months	9.2	9.0	9.5	–
Ever received alcohol or drug treatment	11.5	14.6	10.2	–

Notes: We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid or CHIP, other, or uninsured. The National Survey on Drug Use and Health classified respondents who reported they were covered by CHIP as being covered by Medicaid. Coverage source is defined as primary coverage at the time of the interview.

– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC 2020.

Availability of Behavioral Health Providers in Medicaid

Children with behavioral health conditions need access to a range of treatment services that vary in intensity. These services can be provided in a variety of settings, predominantly the following:

- Office-based settings—primary care physicians, child and adolescent psychiatrists, counselors, and other behavioral health professionals play an important role in diagnosing and treating youth and adolescents with behavioral health conditions.
- School-based health centers—often, children and adolescents with behavioral health conditions are first identified as needing treatment in schools (CMS 2018). Access to school-based health centers (SBHCs) has increased substantially in recent years, in part due to new partnerships with federally qualified health centers (FQHCs).
- Behavioral health treatment facilities—facility-based specialty care includes mental health treatment facilities that typically treat children with greater functional impairment and specialty substance use treatment facilities for youth with SUD. These facilities provide services ranging from outpatient behavioral health services, to partial hospitalization, to inpatient behavioral health care.

Below we describe the availability of behavioral health screening and treatment in these settings. We also discuss provider participation in Medicaid and the types of services offered by these providers. Where possible, we describe availability at the state level. We do not have data at the substate level.

Several data limitations prevent us from analyzing access to behavioral health care in certain settings that play an important role in treating children and adolescents enrolled in Medicaid and CHIP. First, although schools may bill Medicaid for services delivered by school-based personnel and community providers offering services outside of SBHCs, data on the availability of such services is limited. Foster care settings and juvenile detention centers also provide behavioral health services; however, the Commission does not have access to data on care delivery in these settings. Finally, home- and community-based behavioral health services play an important role for children and

adolescents with behavioral health needs, but those services are not addressed in this section due to data limitations.

Office-based settings

Many different types of providers, including social workers, psychologists, psychiatric nurse practitioners, psychiatrists, and professional counselors deliver office-based behavioral health services to children and adolescents. Because there is no data source that captures the availability of all of these providers or their willingness to participate in Medicaid, below we summarize select findings related to the availability of child and adolescent psychiatrists and pediatricians authorized to prescribe medications used to treat opioid use disorder (MOUD). Chapter 2 provides additional information on the availability of office-based behavioral health services based on an analysis of federal Health Professional Shortage Area designations, community health center data, and rates of psychiatrist participation in Medicaid. We also discuss recent federal efforts to address the capacity of the behavioral health workforce in Chapter 2.

Practicing child and adolescent psychiatrists. There is a substantial shortage of child and adolescent psychiatrists in the United States, with shortages in all 50 states, the District of Columbia, and Puerto Rico, and severe shortages in 41 states, the District of Columbia, and Puerto Rico (AACAP 2020). Shortages are particularly acute in rural areas, which face unique challenges in recruiting and retaining health professionals (Beck et al. 2018). To help address these challenges, many states have established specialty consultation models that extend the behavioral health workforce by helping pediatric primary care providers manage the behavioral health needs of their patients (Box 3-1).

BOX 3-1. Child Psychiatry Access Programs

In 2004, Massachusetts established the nation's first statewide child psychiatry access consultative program. The Massachusetts Child Psychiatry Access Program (MCPAP) is a system of regional children's mental health consultation teams who help primary care providers manage the mental health needs of their pediatric patients. Through consultation and education, MCPAP is designed to extend the mental health workforce by improving the ability of primary care providers to conduct behavioral health screening, identification, and assessment; use evidence-based practices to treat mild-to-moderate behavioral health disorders; and make appropriate referrals to community-based specialty behavioral health services when appropriate. Telephone, video, and in-person consultations are provided for free to primary care practices across the Commonwealth, regardless of a patient's insurance status (MCPAP 2021). Over 95 percent of pediatric primary care practices are enrolled in the program, and more than 80 percent use it each year to help manage behavioral health conditions and avoid the need for a specialty referral (Straus 2020).

In 2019, Massachusetts expanded MCPAP to improve the identification and treatment of adolescent substance use in primary care settings through a partnership with the Adolescent and Substance Use and Addiction Program (ASAP) at Boston Children's Hospital. Using the existing MCPAP structure, the ASAP-MCPAP program routes substance use-related consultation requests to an ASAP clinician. ASAP-MCPAP is also piloting a program in which primary care providers can connect adolescents to telehealth counseling services provided by an ASAP clinician (Thompson 2020).

BOX 3-1. (continued)

MCPAP began as a pilot program supported by a grant from MassHealth, the Commonwealth's Medicaid program. Today, it is financed through a state appropriation to the Department of Mental Health, which covers operational costs, and reimbursement from commercial insurers. In fiscal year 2014, 58 percent of encounters were for patients with commercial insurance and 42 percent were for those with Medicaid. Although the Commonwealth's Medicaid program, MassHealth, does not currently provide reimbursement for virtual MCPAP consultation services provided to beneficiaries, in-person visits are eligible for reimbursement (Thompson 2020, Straus and Sarvet 2014).

Variations of this model have been replicated in 38 states and the District of Columbia to build provider capacity and promote integration of behavioral health services into primary care settings (NNCPAP 2021). These programs are generally financed through state general revenue, private foundations, and Medicaid (Straus and Sarvet 2014). The Pediatric Mental Health Care Access Program, administered by the Health Resources and Services Administration (HRSA), also provides grant funding for child psychiatric programs in 21 states (HRSA 2021).[10]

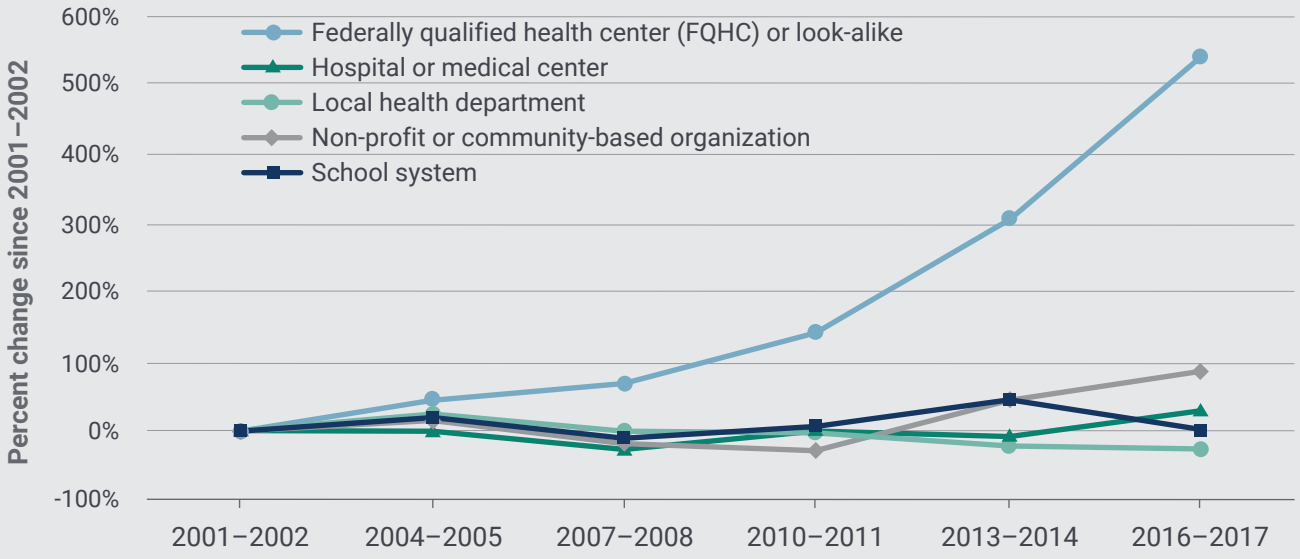
Access to MOUD. As part of their SUD treatment, youth with opioid use disorder may receive medication by an office-based provider, such as a primary care physician, as well as through opioid treatment programs.[11] The U.S. Food and Drug Administration has approved buprenorphine for opioid dependent adolescents age 16 and older (FDA 2002). Methadone may also be used for youth age 16 to 18 under limited circumstances.[12] However, access to MOUD is limited, particularly in rural areas (Andrilla et al. 2018). Most pediatricians have limited training in addiction medicine and the number of these physicians currently prescribing buprenorphine to youth enrolled in Medicaid is unknown (Saloner et al. 2017). A 2017 study found that pediatricians account for only 1 percent of physicians who have received waivers needed to prescribe buprenorphine under the Drug Addiction Treatment Act of 2000 (DATA 2000, P.L. 106-310) (Olfson et al. 2020).[13]

School-based health centers

SBHCs can improve access to behavioral health care for youth, but few public schools have an on-site SBHC (2 percent) or access to one (10 percent).[14] Even so, these providers are an important source of care for many children (MACPAC 2018b). SBHCs provide a variety of health services that go far beyond first aid treatment, including preventive care (e.g., immunizations) and routine screenings (HRSA 2017). Almost two-thirds (65 percent) of SBHCs employ a behavioral health professional, such as a psychologist, professional counselor, or social worker (Love et al. 2018a).

Over the last 10 years, there has been a substantial increase in the number of SBHCs, largely driven by an increase in FQHC sponsorship (Figure 3-1). In 2016–2017, approximately 2,500 SBHCs operated in nearly every state, providing access to 6.3 million students in over 10,600 schools.[15] More than half (51 percent) of SBHCs were sponsored by FQHCs (Love et al. 2018b).[16]

FIGURE 3-1. Change in School-Based Health Center Sponsorship Type, 2001–2017



Notes: Data represents change compared to the number of school-based health centers in 2001–2002 for each sponsor type. FQHC look-alikes are community-based health care providers that meet the requirements of the Health Resources and Services Administration's Health Center Program, but do not receive funding under that program. They provide primary care services in underserved areas on a sliding fee scale based on ability to pay and operate under a governing board that includes patients.

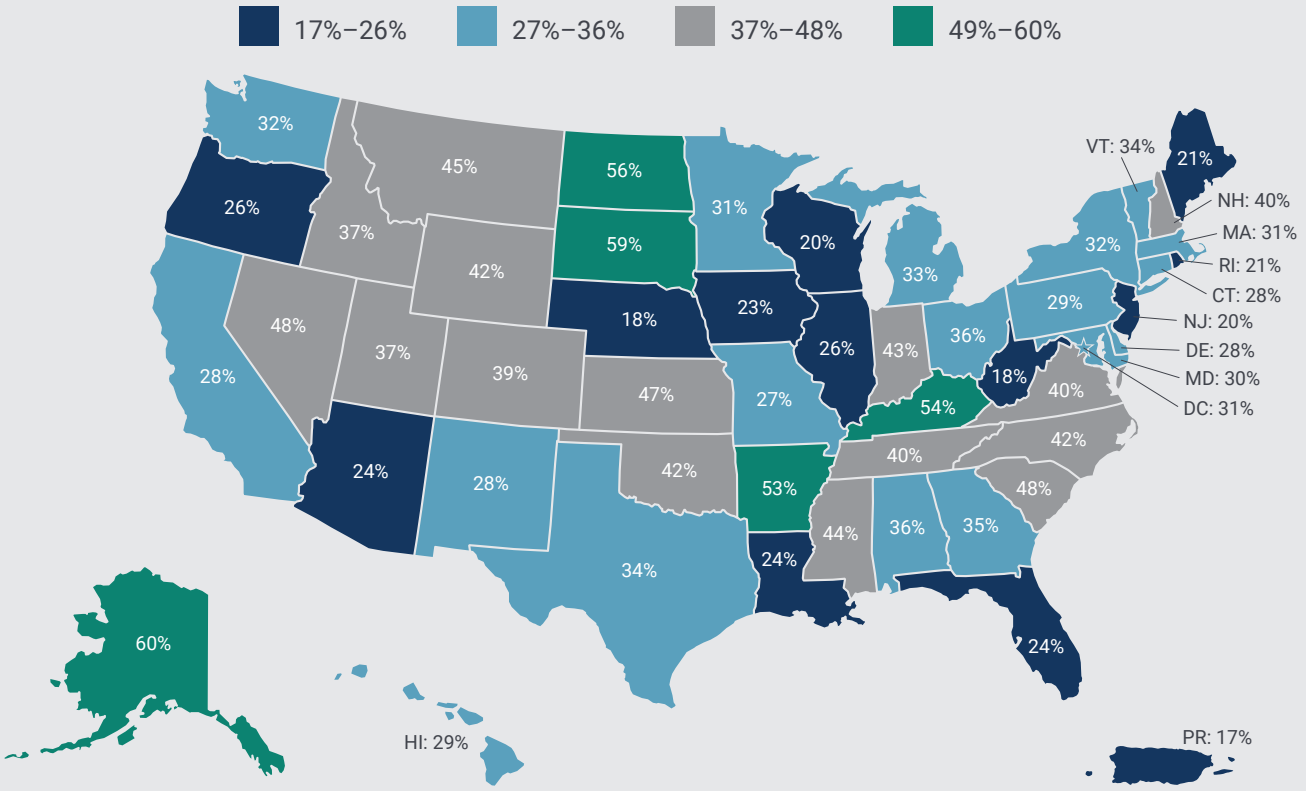
Source: Love et al. 2018b.

Supply of specialty mental health facilities

Using the 2018 National Mental Health Services Survey (N-MHSS), we examined the availability of specialty mental health treatment facilities, whether these facilities offer tailored services for youth with serious emotional disturbance (SED), and the rate at which these facilities participate in Medicaid.[17, 18] Specialty mental health treatment facilities provide services ranging from outpatient mental health services, to partial hospitalization, to inpatient psychiatric services. Generally, these facilities offer psychotherapy, cognitive behavioral therapy, group therapy, and psychotropic medication therapy. Most facilities offer family therapy (71 percent) and psychoeducation (64 percent) (SAMHSA 2019c).

In 2018, there were nearly 12,000 specialty mental health treatment facilities in the United States, but many did not accept children or youth or offer tailored programming for adolescents with SED.[19] Only one-third (32 percent) of these facilities offered such programming and participated in Medicaid. Moreover, Medicaid participation among facilities offering tailored programming for SED varied greatly by state, ranging from 17 percent in Puerto Rico to 60 percent in Alaska (Figure 3-2) (SAMHSA 2019c).

FIGURE 3-2. Share of Mental Health Treatment Facilities Offering Tailored Programming for Youth with Serious Emotional Disturbance and Accepting Medicaid by State, 2018

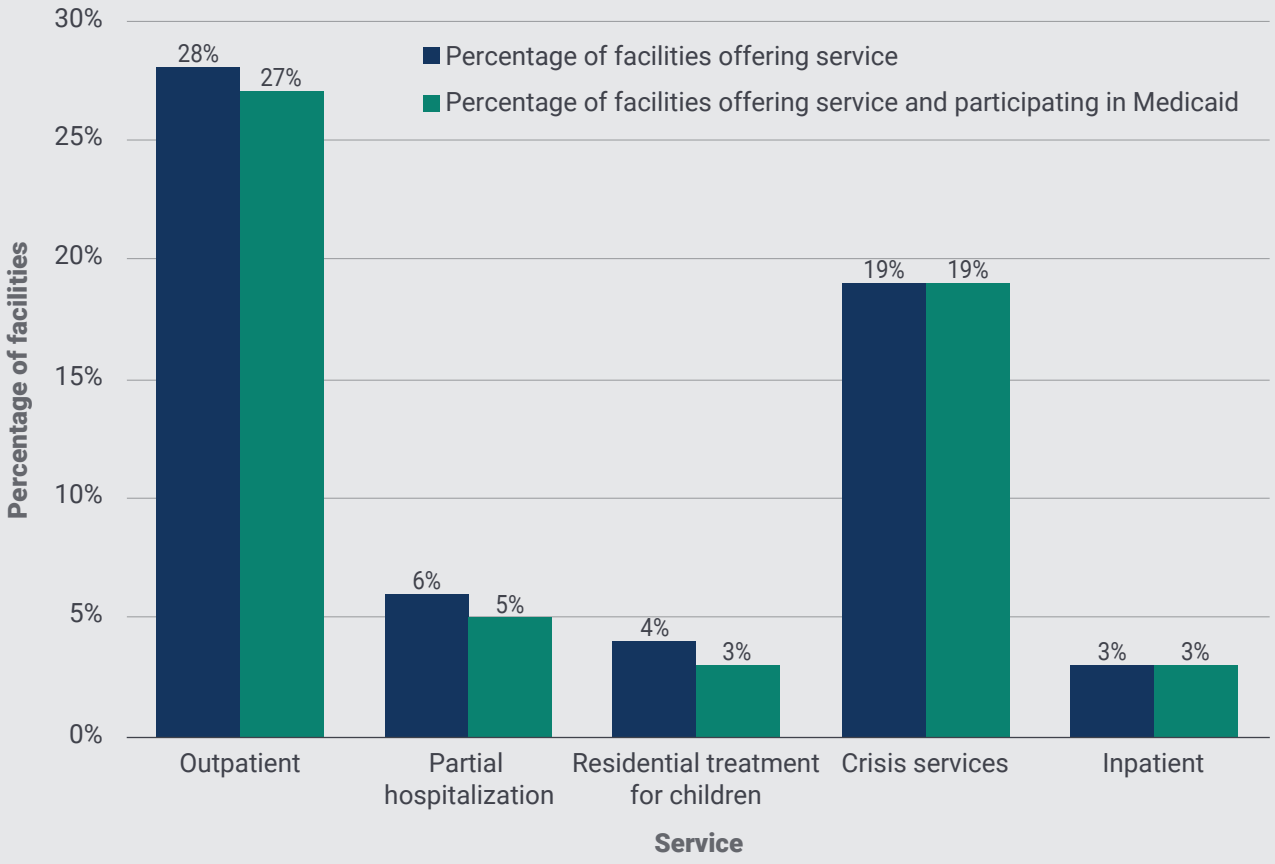


Sources: MACPAC, 2020, analysis of SAMHSA 2019c.

Adolescents with SED have limited access to specialized mental health treatment at certain levels of care. In 2018, approximately 28 percent of specialty mental health treatment facilities offered tailored programming for adolescents with SED and provided outpatient treatment services; of these facilities, the majority reported accepting Medicaid (Figure 3-3). In addition, roughly one in five facilities offered tailored programming for adolescents with SED and reported offering on- or off-site crisis services. However, more intensive services—partial hospitalization, residential treatment, and inpatient care—were much less likely to be available to Medicaid beneficiaries with SED.

Given that facilities may offer multiple services, the percentage of those accepting Medicaid is not necessarily indicative of the share of facilities that accepted Medicaid payment for a specific service. For example, a provider offering partial hospitalization and residential treatment for children may report accepting Medicaid, but may have a Medicaid provider agreement with the state only for residential treatment and choose to limit partial hospitalization services to youth with private insurance. In this instance, a child that needs partial hospitalization services would still be entitled to such services and the state would be obligated to provide or arrange for such a child to get the services from another provider.[20]

FIGURE 3-3. Share of Specialty Mental Health Facilities Offering Tailored Programming for Youth with Severe Emotional Disturbance and Accepting Medicaid by Service, United States, 2018



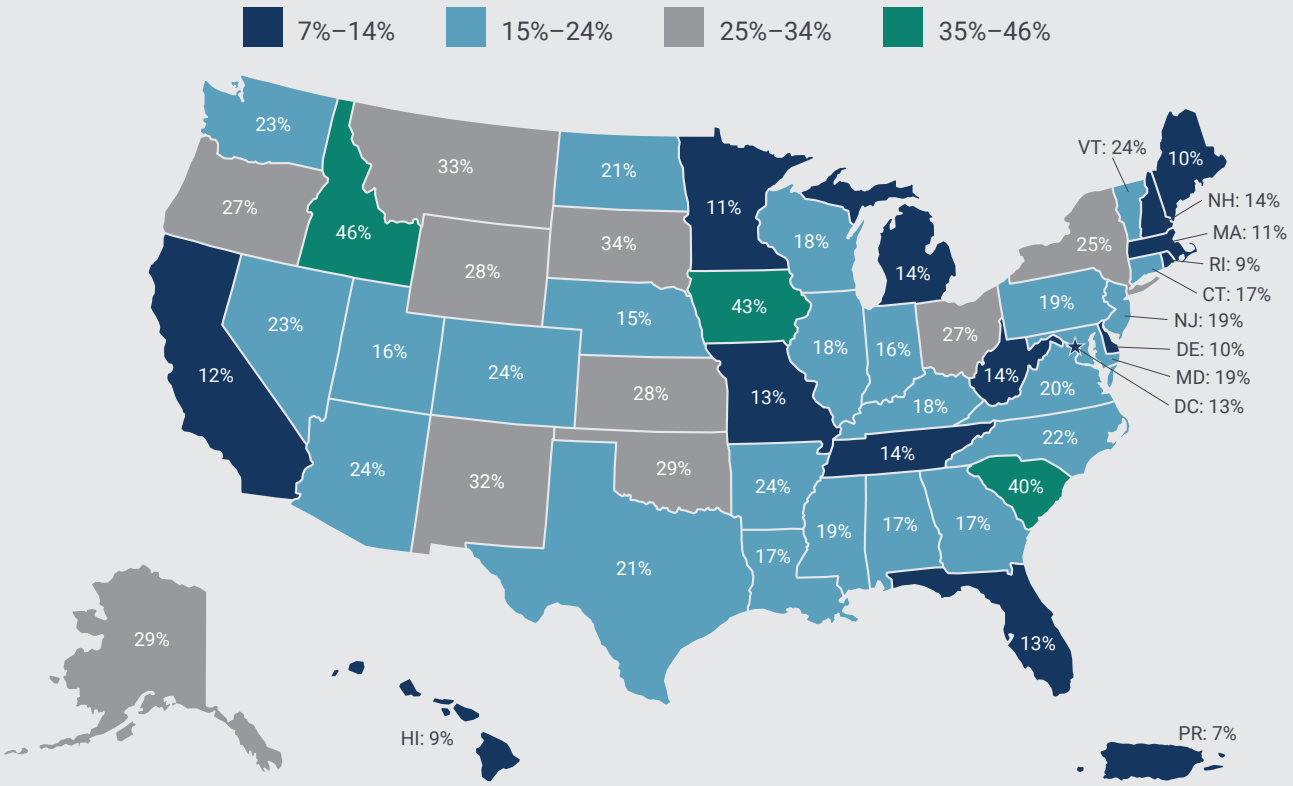
Sources: MACPAC, 2020, analysis of SAMHSA 2019c.

Supply of specialty substance use treatment facilities

Using the 2018 National Survey of Substance Abuse Treatment Services (N-SSATS), we examined the availability of specialty substance use treatment facilities, whether these facilities offer tailored services for youth with SUD, and the rate at which these facilities participate in Medicaid.[21] Specialty substance use treatment facilities provide services ranging from outpatient SUD, to partial hospitalization, to inpatient treatment. Most offer individual counseling (95 percent), group counseling (95 percent), and family counseling (85 percent) (SAMHSA 2019d).

In 2018, one-fourth (25 percent) of specialty SUD treatment programs in the United States offered tailored programming for adolescents; fewer than one in five (19 percent) offered tailored programming for adolescents and accepted Medicaid. Medicaid participation among such facilities varied greatly by state, ranging from 7 percent in Puerto Rico to 46 percent in Idaho (Figure 3-4).

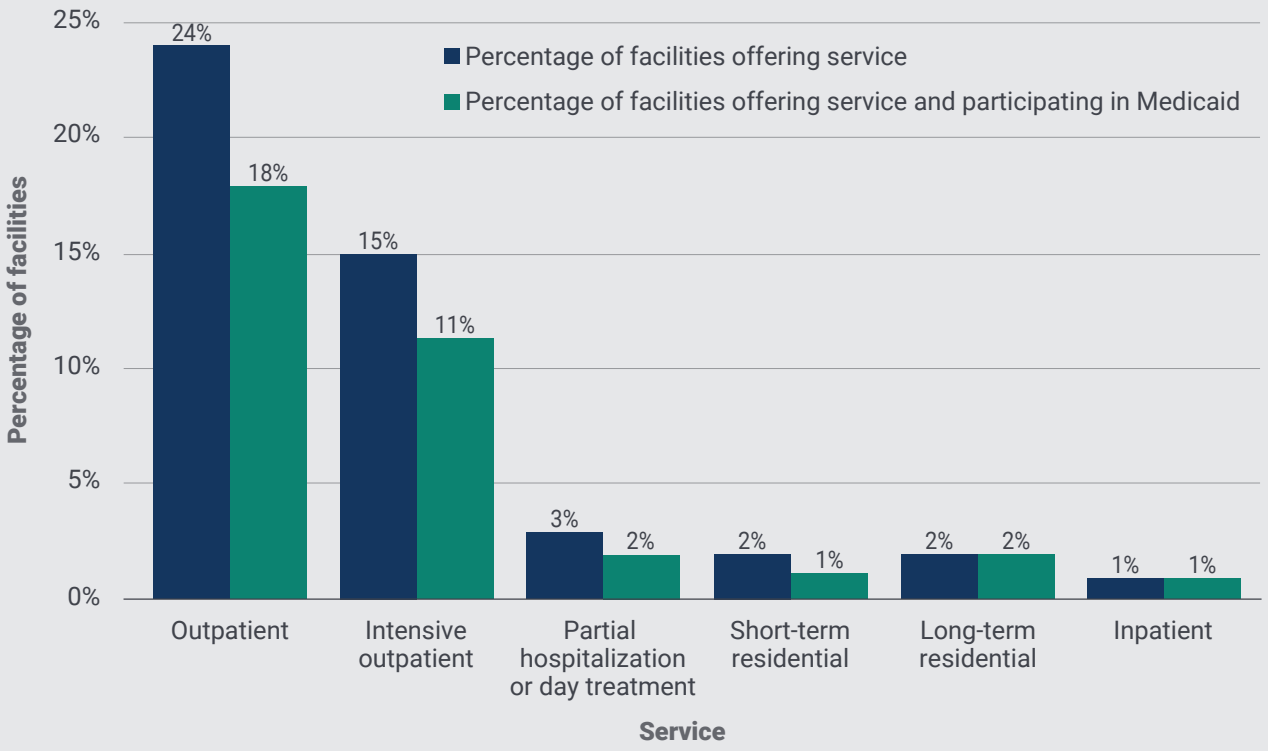
FIGURE 3-4. Percentage of Substance Use Treatment Facilities Offering Tailored Programming for Youth and Accepting Medicaid by State, 2018



Sources: MACPAC, 2020, analysis of SAMHSA 2019d.

Youth have limited access to specialty SUD treatment across all levels of care (Figure 3-5). In 2018, few facilities offered tailored programming as well as intensive outpatient treatment (15 percent), partial hospitalization (3 percent), short-term residential treatment (2 percent), long-term residential treatment (2 percent), or hospital-based inpatient treatment (1 percent). In some states, there are no facilities offering partial hospitalization, short-term residential treatment, long-term residential treatment, inpatient treatment, or tailored programming for adolescents with SUD (SAMHSA 2019d).

FIGURE 3-5. Share of Substance Use Treatment Facilities Offering Tailored Programming for Youth and Accepting Medicaid by Service, United States, 2018



Sources: MACPAC, 2020, analysis of SAMHSA 2019d.

Addressing the Needs of Children and Adolescents with Significant Mental Health Conditions

Medicaid and CHIP are a major source of coverage for adolescents with significant mental health conditions, covering one in three adolescents with a past year MDE with severe role impairment (SHADAC 2020). Such conditions can have a detrimental effect on the lives of young people as well as their families. Those with significant mental health conditions are less likely to finish high school and attain higher education (Wagner and Newman 2012, Stagman and Cooper 2010). They are also at increased risk for institutional placements, co-occurring SUD, and suicidal thoughts and behaviors (O'Brien 2020, SAMHSA 2020, Simon et al. 2018).

Intensive home- and community-based behavioral health services can help children and adolescents with significant mental health conditions remain in their communities, but these services are often unavailable or difficult to access. Below we discuss factors affecting access to care, including the role of various state and federal agencies, Medicaid and CHIP coverage policies, and barriers to using Medicaid authorities to design benefits for children and adolescents with significant mental health conditions.

Multiple agencies involved

No single government agency is responsible for addressing the needs of children and adolescents with significant mental health conditions (Sundararaman 2009). At the federal level, multiple agencies within the U.S. Department of Health and Human Services provide policy guidance, oversight, and funding to address the health and well-being of this population. The same is true at the state level. As such, designing and implementing Medicaid benefits for children and adolescents, including those with significant mental health conditions, requires state Medicaid agencies to collaborate with multiple partners. Coordination can be complex and time consuming. Key state and federal agencies involved in this process, including the design of home- and community-based behavioral health benefits, include the following:

Centers for Medicare & Medicaid Services (CMS). CMS and the states jointly administer Medicaid and CHIP, which together represent the largest payer of mental health services in the United States (CMS 2021). Benefits for children and adolescents with significant mental health conditions must be described in the state plan or waiver; both are subject to CMS approval. States may also use a portion of their CHIP administrative funds for health services initiatives to implement programs that provide behavioral health services to low-income children that are not otherwise covered by federal funding sources.

Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA develops policy and regulations and administers grants to support access to behavioral health services and practice improvement. This includes formula grants to states, territories, and one tribal entity to prevent substance use and provide community mental health services. Among other requirements, states must target use of these formula grants to certain populations, including children with emotional disturbance (SAMHSA 2018).

Administration for Children and Families (ACF). ACF promotes the economic and social well-being of families, children, individuals, and communities through a variety of programs and activities, including guidance, funding, and technical assistance to state child welfare agencies. Specifically, ACF administers funding under Title IV-E of the Act, which allows states, territories, and tribes to claim partial federal reimbursement for the cost of providing foster care, adoption assistance, and kinship guardianship assistance to children who meet federal eligibility criteria. The Family First Prevention Services Act (FFPSA, P.L. 115-123) expanded the use of Title IV-E funds to include certain behavioral health services that prevent out-of-home placements and added new restrictions on the use of Title IV-E funding for children in non-family settings (Box 3-2).

State behavioral health authorities. State behavioral health authorities are responsible for the public mental health and SUD delivery system. In some states, the behavioral health authority is a unit within the state Medicaid agency because Medicaid is a major payer of behavioral health services (Sundararaman 2009). Mental health and substance use authorities may also exist independent of one another. Behavioral health authorities oversee the use of federal grants for behavioral health services, including formula grants awarded by SAMHSA. When Medicaid does not pay for certain behavioral health services, they are typically financed by the state behavioral health authority.

State child welfare agencies. State child welfare agencies are tasked with promoting the safety, permanency planning and placement, and well-being of children. Low-income children currently or formerly served by the child welfare system are generally eligible for Medicaid and often have substantial behavioral health needs (MACPAC 2015). In some states, child welfare and children's mental health are administered by the same agency (Fields 2021a).

Juvenile justice agencies. In addition to maintaining public safety, juvenile justice agencies focus on skills development, habilitation, rehabilitation, treatment, and successful reintegration of youth into their communities (IWGYP 2021). Mental health conditions are prevalent among youth in the juvenile justice system, with as many as 70 percent of individuals having a diagnosable mental health problem (DSG 2017). Many youth served in the juvenile justice system are eligible for Medicaid or CHIP; however, federal law prohibits use of federal Medicaid funds for most health care services for individuals incarcerated in public institutions, including juvenile detention facilities, except in cases of inpatient care lasting 24 hours or more (MACPAC 2018c). In some states, the juvenile justice agency is part of the department that oversees children's mental health and child welfare (Fields 2021a).

BOX 3-2. The Family First Prevention Services Act

Enacted as part of the Bipartisan Budget Act of 2018 (P.L. 115-123), the Family First Prevention Services Act (FFPSA) enhances federal support for services that prevent out-of-home foster care placements while limiting the use of federal funds for certain types of congregate care settings. Responding to long-standing concerns that most federal child welfare funding is available only after a child has been removed from the home, the law expands eligibility for services funded under Title IV-E of the Act, allowing child welfare agencies to provide certain evidence-based behavioral health services and parenting supports before a child is placed in foster care. As of fiscal year (FY) 2020, federal support for these services is available for any child determined to be at imminent risk of entering foster care, and to the child's parents or kin caregivers if the service enables that child to remain safely at home.

At the same time, FFPSA restricts the availability of Title IV-E room-and-board payments for children in foster care unless the child is placed in specified settings, including newly designated qualified residential treatment programs (QRTPs) that meet clinical quality requirements, involve families in treatment plans, and help children and youth return to family-based settings as quickly and safely as possible. These FFPSA provisions took effect in FY 2020 but states had the option to delay implementation until FY 2022 (October 1, 2021).

FFPSA implementation will require ongoing coordination among multiple stakeholders. At the federal level, the Administration for Children and Families is responsible for providing guidance and oversight as the agency administering Title IV-E funds to states and tribal entities. CMS has provided guidance on when a QRTP may be considered an institution for mental diseases (IMD), thereby prohibiting federal financial participation for any Medicaid services provided to eligible children residing in settings that the state determines is an IMD (CMS 2019).[22]

At the state and local level, child welfare agencies are leading cross-agency efforts to enhance prevention services and implement new requirements for children in congregate foster care settings. Such efforts include coordinating with state Medicaid agencies to avoid duplication of services and to ensure Medicaid-eligible children in QRTPs can receive Medicaid-covered services as permitted by federal law.

Medicaid and CHIP coverage requirements

Medicaid, including Medicaid-expansion CHIP, must cover medically necessary behavioral and other health services for enrollees under age 21 as part of the EPSDT benefit, regardless of whether the required services are covered in the state plan (CMS 2014). EPSDT benefits are intended to discover and treat childhood health conditions before they become serious or disabling. In addition, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) made behavioral health coverage a required CHIP benefit, effective October 24, 2019. The statute specifically requires states with separate CHIP to cover services necessary to prevent, diagnose, and treat a broad range of behavioral health conditions. CMS guidance notes that states are now required to:

- cover all the developmental and behavioral health-related screenings and preventive services recommended by the American Academy of Pediatrics Bright Futures periodicity schedule, as well as those designated grade A or grade B by the U.S. Preventive Services Task Force;
- use age-appropriate, validated screening tools;
- demonstrate that CHIP benefits are sufficient to treat a broad range of behavioral health symptoms and disorders;
- cover MOUD and tobacco cessation benefits;
- identify a strategy for the use of validated assessment tools and specify tools in use; and
- deliver behavioral health services in a culturally and linguistically appropriate manner regardless of the delivery system (CMS 2020b).[23]

Despite these requirements, many children and adolescents covered by Medicaid and CHIP do not receive needed services (SHADAC 2020, MACPAC 2018a). In 2018, only 54.1 percent of beneficiaries with MDE and 60.4 percent of beneficiaries with MDE with severe role impairment received some form of specialty or non-specialty mental health treatment in the past year. In many instances, the reported unmet need for mental health treatment was greater among beneficiaries of color.[24] Adolescents enrolled in Medicaid or CHIP were also more likely than adolescents with private insurance to have stayed overnight in a hospital or residential setting (SHADAC 2021, 2020).

Although states have an obligation to provide intensive home- and community-based behavioral health services that can help these beneficiaries remain in their communities, such services are often unavailable or difficult to access. In numerous class action lawsuits, courts have ruled that states have not met their obligations under the EPSDT requirement. Settlements related to these cases identified a set of home- and community-based behavioral health services to which children and adolescents with significant mental health conditions are entitled under EPSDT benefits when determined medically necessary. One of the most far-reaching was *Rosie D. v. Romney* (410 F. Supp. 2d 18 (D. Mass. 2006)), a class action lawsuit in which a federal district court ordered Massachusetts to provide additional home- and community-based services for children with serious mental illness and ensure the use of standardized behavioral health screenings (Lav and Lewis 2018).[25] Joint guidance issued by CMS and SAMHSA in 2013 further clarifies the obligation of state Medicaid programs with regard to the EPSDT benefit, as well as under the ADA (Box 3-3) (CMS and SAMHSA 2013).

Home- and community-based services 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 (McEnany et al. 2020, O'Brien 2020, Tsai 2020, Lav and Lewis 2018). They can also prevent youth involvement in the foster care and juvenile justice systems (McEnany et al. 2020, O'Brien 2020, Zeller et al. 2014). In a survey of state officials, approximately 30 percent reported

inadequate coverage of home- and community-based behavioral health services as a somewhat or very common contributing cause of custody relinquishment, situations in which parents transfer legal custody of their child to the state to access services that the child could not obtain otherwise (Stroul 2019).

BOX 3-3. Home- and Community-Based Behavioral Health Services for Children and Adolescents

CMS and SAMHSA guidance describes specific home- and community-based behavioral health services demonstrated to be effective in improving clinical and functional outcomes, school attendance, and other measures of well-being. These include the following:

Wrap-around approach. The wrap-around approach is a form of intensive care coordination in which teams collaborate to develop and implement individualized care plans for those with complex needs and their families. This approach focuses on all life domains and includes clinical interventions and formal and informal supports.

Peer support services. Peer support services are designed to help youth, parents, and other caregivers identify goals, develop and connect with formal and informal supports, and acquire skills to improve coping abilities. Peer support providers are family members or youth who have personally faced the challenges of coping with serious mental health conditions and who serve as advocates and mentors.

Intensive in-home services. Intensive in-home services are therapeutic interventions delivered to children and families in their homes and other community settings to improve youth and family functioning and prevent out-of-home placement in inpatient or residential settings. The services are typically developed by a team that can offer a combination of therapy from a licensed clinician and skills training and support from a paraprofessional.

Respite services. Respite services help children and adolescents remain in their homes by temporarily relieving their primary caregivers. They offer safe and supportive environments on a short-term basis for children and adolescents with mental health conditions when their families need relief. Services are provided either in the home or in approved out-of-home settings.

Mobile crisis response and stabilization services. Mobile crisis response and stabilization services are designed to de-escalate difficult mental health situations and prevent hospitalizations and other out-of-home placements. Mobile crisis services are available 24 hours a day, 7 days a week, and can be provided in the home or other non-hospital-based setting. Residential crisis stabilization provides short-term, out-of-home care for children and adolescents to address acute mental health needs and coordinate a successful return to the family at the earliest possible time with ongoing services (CMS and SAMHSA 2013).

Using Medicaid authorities to design benefits for children and adolescents with significant mental health conditions

Federal guidance and legal decisions make clear that home- and community-based behavioral health services must be made available under the EPSDT benefit, but states do not always identify such services under the state plan or a waiver, which can create barriers to access. For instance, when families and health care providers seek authorization and payment for medically necessary services that are not explicitly covered in the state plan or a waiver, access to services may be delayed. Such delays may occur because the state does not have a payment methodology for the service. Moreover, if the provider is not enrolled in Medicaid, the state may need to execute a single-service agreement with the provider (Autism Speaks 2017). Providers and families who are unfamiliar with the Medicaid program may not understand their rights or how to raise concerns about these issues (Fields 2021b).

State officials and other experts have noted that it can be extremely challenging to use Medicaid authorities to define home- and community-based behavioral health services for children and adolescents with significant mental health conditions, particularly if multiple authorities are needed to meet the state's goals (O'Brien 2020, Herman 2020). Waivers under Section 1915(c) of the Act are frequently used to provide home- and community-based services as an alternative to care in institutional settings, but rarely to serve individuals with behavioral health conditions, including children and adolescents.[26] This may be because such waivers must be targeted to beneficiaries who require an institutional level of care and such services must be cost neutral to the federal government (HHS 2020, MACPAC 2020). Although states have expressed interest in using Section 1915(i) state plan authority to expand home- and community-based services for behavioral health, they report difficulty doing so and there is limited federal guidance and technical support to assist them. Challenges include defining eligibility to create highly targeted programs. In addition, states may not cap enrollment under Section 1915(i) as they can under Section 1915(c) (Herman 2020, HHS 2020, ASPE 2016).[27]

Stakeholders have also highlighted the challenges states face when designing benefits to meet the needs of children and adolescents with significant mental health conditions. Despite growing evidence of the effectiveness of interventions to support parents and legal guardians, federal guidance concerning how Medicaid can be used to support these approaches is limited and does not sufficiently address services provided to families when the child is not present. In 2016, CMS issued an informational bulletin clarifying that state Medicaid agencies may allow maternal depression screenings conducted during a well-child visit to be claimed as a service for the child as part of the EPSDT benefit, because the maternal screening is for the direct benefit of the child. Diagnostic and treatment services delivered to the child and mother together, when directly related to the needs of the child, may also be claimed as a direct service for the child (CMS 2016). CMS has also clarified that parents and legal guardians of Medicaid-eligible children can receive peer support services when the service is directly for the benefit of the child (CMS 2013). However, further guidance is needed to help states implement these options (Fields 2021b).

States and other stakeholders have also commented on the need for federal officials to clarify the ability of state Medicaid programs and CHIP to pay for early intervention services for children who do not have a formal mental health diagnosis, but who have experienced certain traumatic events (e.g., death of a parent or exposure to domestic violence) that put them at risk for a mental health condition. Early intervention is critical to preventing and addressing mental health conditions before they become serious or disabling. Providing services to children with certain risk factors, in the absence of a mental health diagnosis, can also ensure access to critical services even when a child's symptoms are not appropriately diagnosed.

Recommendations

Recommendation 3.1

The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Administration for Children and Families to issue joint subregulatory guidance that addresses the design and implementation of benefits for children and adolescents with significant mental health conditions covered by Medicaid and the State Children's Health Insurance Program.

Rationale

Updated subregulatory guidance could facilitate state adoption of home- and community-based behavioral health services that permit children and adolescents with significant mental health conditions to live in their communities and avoid institutional placements. Guidance issued in 2013 has been valuable but is now outdated. In addition, states would benefit from the opportunity to learn about innovative approaches to benefit design.

At a minimum, new guidance should describe:

- home- and community-based behavioral health services shown to improve outcomes for children and adolescents with significant mental health conditions, including intensive care coordination, family and youth peer support services, intensive in-home services, respite care, therapeutic mentoring, and crisis services;
- approaches to achieve universal behavioral health screening of children and adolescents through effective engagement of providers and managed care organizations;
- opportunities to improve access to services among communities of color;
- strategies to address barriers to care for children and youth with multiple diagnoses, such as those with significant mental health conditions and intellectual and developmental disabilities or SUD;
- policies and practices to promote trauma-informed systems of care, including early intervention services for at-risk children who do not have a formal mental health diagnosis;
- when a service can be directed toward the parent or caregiver in support of a child or adolescent with mental health needs;
- opportunities to cover telehealth and other technology-enabled services;
- the role of state Medicaid, behavioral health, child welfare, and other relevant agencies, as well as strategies for promoting interagency coordination;
- relevant Medicaid authorities and demonstration opportunities, including Section 1915(c) waivers and the Section 1915(i) state plan option; and
- recent examples from innovator states.

In developing such guidance, the Secretary should involve all relevant agencies, including but not limited to CMS, SAMHSA, and ACF. This coordination is needed to ensure the guidance adequately addresses the role of state Medicaid, behavioral health, and child welfare agencies in serving youth with significant mental health conditions, particularly as states continue implementing new requirements under FFPSA.

Implications

Federal spending. This recommendation would not have a direct effect on federal Medicaid and CHIP spending. Depending upon how states respond to guidance by providing additional or different services, costs to the federal government could be affected, although the extent to which spending will increase (due to more services being provided) or decrease (by averting care in more expensive settings) is difficult to predict.

States. Providing subregulatory guidance can raise awareness among state officials, encourage cross-agency collaboration, and expedite state efforts to expand services for children and adolescents with significant mental health conditions. States are often unaware of opportunities in Medicaid and CHIP to improve outcomes for youth with significant mental health conditions. Outlining these approaches in new guidance may draw the attention of state officials and other stakeholders and expedite efforts to expand access to effective services for this vulnerable population.

Beneficiaries. To the degree that guidance helps states implement new or improved home- and community-based services for children and youth with significant mental health conditions, this recommendation could improve access to care. These gains could be particularly important for beneficiaries of color, who are currently less likely to receive treatment for a significant mental health condition than their white counterparts (SHADAC 2021).

Plans and providers. There is no direct effect on plans and providers. However, state actions pursuant to the guidance may eventually affect these parties insofar as they are involved in the provision of services.

Recommendation 3.2

The Secretary of the U.S. Department of Health and Human Services should direct a coordinated effort by the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Administration for Children and Families to provide education and technical assistance to states on improving access to home- and community-based behavioral health services for children and adolescents with significant mental health conditions covered by Medicaid and the State Children's Health Insurance Program. Additionally, the Secretary should examine options to use existing federal funding to support state-level activities to improve the availability of these services.

Rationale

Subregulatory guidance without technical assistance and planning opportunities may be insufficient to enhance state capacity and jump-start efforts to expand the continuum of services for children and adolescents with significant mental health conditions. States are operating with limited resources and multiple competing priorities, particularly during the COVID-19 pandemic. Moreover, they face a number of challenges when designing and implementing benefits for this population, including difficulty addressing state agency silos and identifying the appropriate Medicaid authority.

Technical assistance could be modeled after the Medicaid Innovation Accelerator Program. States would benefit from general learning opportunities that disseminate best practices and lessons learned, as well as multistate forums that enable cross-state learning. CMS, working in partnership with SAMHSA and ACF, should also provide individualized technical assistance to support benefit design and implementation. This should include technical support regarding use of Section 1915(c) waivers, the Section 1915(i) state plan option, and other relevant authorities. CMS and federal partners should encourage the participation of state leaders representing Medicaid, behavioral health, child welfare, juvenile justice, and other child-serving agencies as needed to ensure the engagement and buy-in of key decision makers.

Among other options, the Secretary could consider recent increases in behavioral health funding as one avenue for supporting state planning efforts. The American Rescue Plan Act of 2021 (P.L. 117-2), for example, provided an additional $1.5 billion for the Mental Health Services Block Grant. Some of this funding could be used to help state behavioral health agencies engage key partners, including Medicaid agencies, and develop a coordinated plan to address the behavioral health needs of children and adolescents with significant mental health conditions. Under current grant requirements, states must submit a plan to SAMHSA every two years

explaining how they will use block grant funds to provide comprehensive, community mental health services to this population (as well as adults with serious mental illness). This plan must be approved by the Secretary, who could consider whether such a plan is comprehensive if it does not actively include the participation and input of the state Medicaid agency, the largest payer of behavioral health services.

Support for the planning process is particularly important now given the effects of COVID-19 on mental health and state budgets (Leeb et al. 2020, Loades et al. 2020, NASBO 2020). Designing a benefit package for children and adolescents with significant mental health conditions requires extensive planning, interagency coordination, and dedicated staff. State Medicaid agencies may identify a need for additional staff or consultant support and require approval from state legislatures for the added Medicaid expense.

Implications

Federal spending. This recommendation would not have a direct effect on federal Medicaid and CHIP spending.

States. This recommendation would enhance state capacity and address other common barriers to expanding home- and community-based behavioral health services for children and adolescents with significant mental health conditions.

Beneficiaries. To the degree that planning and technical assistance support states' ability to implement new or improved home- and community-based services for children and youth with significant mental health conditions, this recommendation could improve access to behavioral health services. These gains could be particularly important for beneficiaries of color, who are currently less likely to receive treatment for a significant mental health condition than their white counterparts (SHADAC 2021).

Plans and providers. There is no direct effect on plans and providers. However, new state actions may eventually affect these parties insofar as they are involved in the provision of new services.

Next Steps

Adoption of the Commission's recommendations would be an important initial step by the federal government to improve access to behavioral health services for children and adolescents covered by Medicaid and CHIP. MACPAC will continue to monitor state capacity to design home- and community-based services for children and youth with significant mental health needs. As discussed in Chapter 2, we will examine whether existing federal authorities are suited to serving beneficiaries of all ages who have a functional impairment resulting from a behavioral health diagnosis.

Going forward, the Commission is interested in exploring additional opportunities to improve access, with a particular focus on children and adolescents in foster care. Relative to their peers in the general population, these youth are more likely to experience mental illness and SUD (Turney and Wildeman 2016). Among other things, the Commission is interested in examining concerns that the IMD exclusion may preclude eligible youth from receiving Medicaid-covered services in certain residential treatment facilities established under the FFPSA.[28] We will also examine the experience of children and adolescents in future work on access to behavioral health services for individuals involved in the justice system and individuals who identify as lesbian, gay, bisexual, or transgender.

Endnotes

[1] Foster care settings include foster family homes and child care institutions caring for children who are under supervision of the state because they have experienced abuse or neglect (ACF 2021).

[2] The ADA extends protections to individuals with a mental health condition that "substantially limits" one or more major life activities (e.g., bipolar disorder, schizophrenia, major depression) (42 USC § 12102).

[3] The *Olmstead v. L.C.* ruling was based on two conclusions. First, that institutionalization of individuals with disabilities able to live in community settings perpetuates the unwarranted assumption that such persons are unable to live in a community. Second, that "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

[4] NSDUH respondents are residents of households and individuals in non-institutional group quarters, such as shelters, rooming houses, college dorms, and halfway houses. Individuals with no fixed household address are excluded, for example, individuals who are homeless and not in shelters, active-duty military personnel, and residents of institutional group quarters, including correctional facilities, nursing homes, and mental institutions (SAMHSA 2019a).

[5] The 2018 NSDUH defined individuals as having had a lifetime MDE if they reported at least five or more of the following symptoms in the same two-week period during their lifetime (with at least one of the symptoms being a depressed mood or loss of interest or pleasure in daily activities): (1) depressed mood most of the day, nearly every day; (2) markedly diminished interest or pleasure in all or almost all activities most of the day, nearly every day; (3) significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day; (4) insomnia or hypersomnia nearly every day; (5) psychomotor agitation or retardation at a level that is observable by others nearly every day; (6) fatigue or loss of energy nearly every day; (7) feelings of worthlessness or excessive or inappropriate guilt nearly every day; (8) diminished ability to think or concentrate or indecisiveness nearly every day; and (9) recurrent thoughts of death or recurrent suicidal ideation (SAMHSA 2019a).

[6] For adolescent respondents, the NSDUH collects data on impairment caused by MDE using the Sheehan Disability Scale, a measure of impairment due to mental health issues in four major life activities or role domains. Each section consists of four questions, and each item uses an 11-point scale ranging from 0 (no problems) to 10 (very severe problems). Ratings of seven or greater for problems in one or more role domains were classified as severe impairment (SAMHSA 2019a).

[7] As discussed, the NSDUH examines prevalence rates for MDE and MDE with severe role impairment among adolescents. It does not provide data on psychiatric diagnoses, and therefore may not reflect important trends related to the prevalence of certain mental health conditions among adolescents. Other federal data sources, using parental reports of their child's diagnoses, find that attention-deficit/hyperactivity disorder, anxiety, and behavior disorders are most commonly diagnosed among adolescents age 12-17 (CDC 2021).

[8] The NSDUH defines substance misuse as the use of a prescription drug in a manner other than how a drug is indicated or prescribed (SAMHSA 2019a).

NSDUH questions about criteria for abuse of alcohol or illicit drugs ask about the following symptoms, consistent with the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition:* (1) problems at work, home, and school; (2) doing something physically dangerous; (3) repeated trouble with the law; and (4) problems with family or friends because of use of alcohol or illicit drugs in the past 12 months. Respondents meet criteria for abuse if they report one or more of these symptoms and if the criteria for dependence were not met for that substance (SAMHSA 2019a).

NSDUH dependence questions for alcohol or illicit drugs ask about the following symptoms, consistent with the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition:* (1) spent a lot of time engaging in activities related to substance use; (2) used the substance in greater quantities or for a longer time than intended; (3) developed tolerance (i.e., needing to use the substance more than before to get desired effects or noticing that the same

amount of substance use had less effect than before); (4) made unsuccessful attempts to cut down on substance use; (5) continued substance use despite physical health or emotional problems associated with substance use; (6) reduced or eliminated participation in other activities because of substance use; and (7) experienced withdrawal symptoms. For specific illicit drugs and alcohol that include a withdrawal criterion as one of the criteria that can be used to establish dependence, respondents were defined as meeting the criteria for dependence if they met three out of the seven criteria. For illicit drugs that do not include questions in NSDUH about a withdrawal criterion for establishing dependence, respondents were defined as meeting the criteria for dependence if they met three out of the six criteria for that substance (SAMHSA 2019a).

[9] Under IDEA, services provided to children with disabilities in a school setting are documented in each child's individualized education plan or, for infants and toddlers (children under age three), the individualized family service plan.

[10] The American Rescue Plan Act of 2021 (P.L. 117-2) provided $80 million to expand the Pediatric Mental Health Care Access Program administered by HRSA.

[11] Medicaid-eligible children under age 21 are entitled to receive MOUD when medically necessary under Medicaid's EPSDT benefit. MOUD is also a required benefit for separate CHIP as of October 24, 2019 (CMS 2020).

[12] A person under age 18 must have undergone two documented unsuccessful attempts at short-term withdrawal management or drug-free treatment within a 12-month period to be eligible for maintenance treatment, and must have written consent from a parent, legal guardian, or responsible adult (42 CFR 8.12) (MACPAC 2019b).

[13] Buprenorphine was the first MOUD authorized by the U.S. Food and Drug Administration to be prescribed or dispensed in an office-based setting. Under DATA 2000, those prescribing buprenorphine in general medical settings are subject to certain federal requirements, including mandatory training and a limit on the number of patients for whom they may prescribe. Qualifying practitioners must obtain a DATA 2000 waiver to prescribe buprenorphine in settings such as offices, community hospitals, health departments, opioid treatment programs, and correctional facilities. Waivered prescribers are also required to certify to their capacity to provide counseling and ancillary services (MACPAC 2019b). Effective April 28, 2021, new federal guidelines allow certain prescribers to treat up to 30 patients without meeting certification requirements pertaining to training, counseling, and other ancillary services (HHS 2021).

[14] Compared to schools without access to SBHCs, those with SBHC access had a higher percentage of Black and Hispanic students. They also had a higher percentage of students who received free or reduced-price lunches (Love et al. 2019).

[15] In 2016–2017, Wisconsin and North Dakota did not have any SBHCs (Love et al. 2018a).

[16] The growth of SBHCs over the past two decades can be attributed to two federal efforts. First, beginning in the 2000s, funding was doubled to build an additional 1,200 new primary care access points. In addition, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148) included $11 billion to support the operation, expansion, and construction of health centers, including SBHCs. The ACA provided $200 million over four years for use by health centers for capital expenses, including construction and renovation (Love et al. 2019).

[17] SED refers to a diagnosable mental, behavioral, or emotional disorder that results in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities (SAMHSA 2019c).

[18] Administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), the N-MHSS is an annual survey that collects data on the location, characteristics, and utilization of mental health treatment services for all known specialty mental health treatment facilities in all 50 states, the District of Columbia, Puerto Rico, and other jurisdictions (SAMHSA 2019c).

[19] Roughly half (55 percent) of facilities report accepting youth age 12 or younger and participating in Medicaid, and slightly more facilities (59 percent) report accepting youth age 13–17 and participating in Medicaid. However, many of these facilities do not offer tailored programming for adolescents with SED (SAMHSA 2019c).

[20] The percentage of mental health treatment facilities accepting Medicaid and offering multiple services, including residential treatment, to adolescents with SED may not accurately reflect the percentage of facilities accepting Medicaid for residential treatment. This is due to the institutions for mental diseases (IMD) exclusion, which generally prohibits federal financial participation for otherwise coverable Medicaid services delivered in a facility with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases (§ 1905(i) of the Act).

[21] Administered by SAMHSA, the N-SSATS is an annual survey that collects data on the location, characteristics, and utilization of SUD treatment services for all known specialty substance use treatment facilities in all 50 states, the District of Columbia, Puerto Rico, and other jurisdictions.

[22] Since Medicaid was established in 1965, federal statute has largely prohibited payments to IMDs. See note 20.

[23] States must submit a CHIP state plan amendment to demonstrate compliance with the new behavioral health coverage provisions outlined in guidance issued by CMS on March 2, 2020.

[24] For example, less than half (48 percent) of Black beneficiaries with MDE with severe role impairment received some form of mental health treatment, compared to 68 percent of their white peers. Black and Hispanic beneficiaries with MDE with severe role impairment were also less likely to receive specialty mental health treatment than their white counterparts (SHADAC 2021).

[25] For the latest opinion, which pertains to reporting and monitoring obligations set forth in the remedial plan agreed to by the two parties, see the May 4, 2020, Federal Court of Appeals decision, *Rosie D. v. Baker,* 958 F.3d 51 (1st Cir. 2020), available at https://www.clearinghouse.net/chDocs/public/MH-MA-0005-0028.pdf.

[26] As of March 2020, there were nine states operating Section 1915(c) waivers to provide home- and community-based services to children with SED (MACPAC 2020).

[27] Federal guidance clarifies that states may use Section 1915(c) waivers to supplement the service otherwise available to children under Medicaid or to provide services to children who otherwise would not be eligible for Medicaid. In both cases, states must ensure that all children, including those made eligible under the waiver, receive the EPSDT services to which they are entitled. A child's enrollment in a Section 1915(c) waiver cannot be used to deny, delay, or limit access to medically necessary EPSDT services. Although states may limit services under the waiver, they may not limit medically necessary services needed by a child who is eligible for EPSDT benefits that otherwise would be covered under Medicaid (HCFA 2001).

[28] In 2019, MACPAC published a report to Congress on oversight of IMDs. The report identifies and describes facilities designated as IMDs in selected states; summarizes state licensure, certification, and accreditation requirements; and outlines Medicaid clinical and quality standards for these facilities.

References

Administration for Children and Families (ACF), U.S. Department of Health and Human Services. 2021. Foster Care. https://www.acf.hhs.gov/cb/focus-areas/foster-care.

Alegria, M., M. Vallas, and P. Andres. 2010. Racial and ethnic disparities in pediatric mental health. *Child and Adolescent Psychiatry Clinics of North America* 19, no. 4: 759–774. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3011932/.

American Academy of Child and Adolescent Psychiatry (AACAP). 2020. Workforce maps by state, practicing child and adolescent psychiatrists. Washington, DC: AACAP. https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx.

Andrilla, C.H.A., T. Moore, D. Patterson, and E. Larson. 2018. Geographic distribution of providers with a DEA waiver to prescribe buprenorphine for the treatment of opioid use disorder: A 5-year update. *Journal of Rural Health* 35(1): 108–112. https://onlinelibrary.wiley.com/doi/abs/10.1111/jrh.12307.

Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services (HHS). 2016. *The use of 1915(i) Medicaid plan option for individuals with mental health and substance use disorders*. Washington, DC: HHS. https://aspe.hhs.gov/basic-report/use-1915i-medicaid-plan-option-individuals-mental-health-and-substance-use-disorders.

Autism Speaks Legal Resource Center (Autism Speaks). 2017. *ABA through Medicaid EPSDT tool kit*. Washington, DC: Autism Speaks. https://www.autismspeaks.org/sites/default/files/2018-09/medicaid-epsdt-toolkit.pdf.

Beck, A., C. Page, J. Buche, et al. 2018. *Estimating the distribution of the U.S. psychiatric subspecialist workforce*. Ann Arbor, MI: Behavioral Health Workforce Research Center, University of Michigan School of Public Health. https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/02/Y3-FA2-P2-Psych-Sub_Full-Report-FINAL2.19.2019.pdf.

Center for Behavioral Health Statistics and Quality (CBHSQ), Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. 2016. *State estimates of major depressive episode among adolescents: 2013 and 2014*. Rockville, MD: SAMHSA. https://www.samhsa.gov/data/sites/default/files/report_2385/ShortReport-2385.html.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2021. Data and statistics on children's mental health. Atlanta, GA: CDC. https://www.cdc.gov/childrensmentalhealth/data.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021. Behavioral health services. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020a. *Fact sheet: Service use among Medicaid & CHIP beneficiaries age 18 and under during COVID-19*. Baltimore, MD: CMS. https://www.cms.gov/newsroom/fact-sheets/fact-sheet-service-use-among-medicaid-chip-beneficiaries-age-18-and-under-during-covid-19.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2020b. Letter from Calder Lynch to state health officials regarding "Access to mental health and substance use disorder services for children and pregnant women in the Children's Health Insurance Program." March 2, 2020. Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/sho20001.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. Center for Medicaid and CHIP Services guidance regarding "Qualified residential treatment programs (QRTP) and serious mental illness (SMI) and serious emotional disturbance (SED) demonstration opportunity: Technical assistance questions and answers." Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/faq092019.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018. Letter from Mary Mayhew to state Medicaid directors regarding "Opportunities to design innovative service delivery systems for adults with serious mental illness or children with a severe emotional disturbance." November 13, 2018. https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016. Center for Medicaid and CHIP Services informational bulletin regarding "Maternal depression screening and treatment: A critical role for Medicaid in the care of mothers and children." May 11, 2016. https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013. Clarifying guidance on peer support services policy. May 1, 2013. Baltimore, MD: CMS. https://www.medicaid.gov/sites/default/files/2019-12/clarifying-guidance-support-policy.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 1997. *Medicaid and school health: A technical assistance guide.* Baltimore, MD: CMS. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/Medicaid_and_School_Health_Technical_Assistance_Guide__9.pdf.

Centers for Medicare & Medicaid Services and Substance Abuse and Mental Health Services Administration (CMS and SAMHSA), U.S. Department of Health and Human Services. 2019. Center for Medicaid and CHIP Services and SAMHSA joint informational bulletin regarding "Guidance to states and school systems on addressing mental health and substance use issues in schools." July 1, 2019. https://store.samhsa.gov/sites/default/files/d7/priv/pep19-school-guide.pdf.

Centers for Medicare & Medicaid Services and Substance Abuse and Mental Health Services Administration (CMS and SAMHSA), U.S. Department of Health and Human Services. 2015. Joint Center for Medicaid and CHIP Services and SAMHSA informational bulletin regarding "Coverage of behavioral health services for youth with substance use disorders." January 26, 2015. https://medicaid.gov/federal-policy-guidance/downloads/cib-01-26-2015.pdf.

Centers for Medicare & Medicaid Services and Substance Abuse and Mental Health Services Administration (CMS and SAMHSA), U.S. Department of Health and Human Services. 2013. Joint Center for Medicaid and CHIP Services and SAMHSA informational bulletin regarding "Coverage of behavioral health services for children, youth, and young adults with significant mental health conditions." May 7, 2013. https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf.

Chan, Y., M. Dennis, and R. Funk. 2008. Prevalence and comorbidity of major internalizing and externalizing problems among adolescents and adults presenting to substance abuse treatment. *Journal of Substance Abuse Treatment* 34, no. 1: 14–24. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2238174/.

Development Services Group, Inc. (DSG). 2017. *Intersection between mental health and the juvenile justice system*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice. https://ojjdp.ojp.gov/mpg/literature-review/mental-health-juvenile-justice-system.pdf.

Fields, S. University of Maryland, School of Social Work. 2021a. E-mail to MACPAC, April 8.

Fields, S. University of Maryland, School of Social Work. 2021b. E-mail to MACPAC, April 30.

Food and Drug Administration (FDA), U.S. Department of Health and Human Services. 2002. Letter from Cynthia McCormick to Alan Young regarding "Suboxone and Subutext approval." October 8, 2002. https://www.accessdata.fda.gov/drugsatfda_docs/nda/2002/20-733_Subutex_Approv.pdf.

Health Care Financing Administration (HCFA), U.S. Department of Health and Human Services. 2001. Letter from Timothy M. Westmoreland to state Medicaid directors regarding "Olmstead update no. 4." January 10, 2001. https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd011001a.pdf.

Health Resources & Services Administration (HRSA), U.S. Department of Health and Human Services. 2021. Pediatric mental health care access program. Rockville, MD: HRSA. https://mchb.hrsa.gov/training/projects.asp?program=34.

Health Resources & Services Administration (HRSA), U.S. Department of Health and Human Services. 2017. School-based health centers. Rockville, MD: HRSA. https://www.hrsa.gov/our-stories/school-health-centers/index.html.

Herman, K. 2020. Presentation before the Medicaid and CHIP Payment and Access Commission, December 11, 2020, virtual. https://www.macpac.gov/wp-content/uploads/2019/10/MACPAC-December-2020-Meeting-Transcript.pdf.

Interagency Working Group on Youth Programs (IWGYP). 2021. Juvenile justice. Washington, DC: IWGYP. https://youth.gov/youth-topics/juvenile-justice.

Kaiser Family Foundation (KFF). 2020. *The implications of COVID-19 for mental health and substance use*. Washington, DC: KFF. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/.

Kessler, R.C., M. Angermeyer, J.C. Anthony, et al. 2007. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey initiative. *World Psychiatry* 6, no. 3: 168–176. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2174588/.

Kessler, R.C., P. Berglund, O. Demler, et al. 2005. Lifetime prevalence of age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey replication. *Arch Gen Psychiatry* 62, no. 6: 593–602. https://pubmed.ncbi.nlm.nih.gov/15939837/.

Lav, J., and K. Lewis. 2018. *Children's mental health services: The right to community-based care*. Washington, DC: National Health Law Program. https://healthlaw.org/resource/childrens-mental-health-services-the-right-to-community-based-care/.

Lee, B.R., C. Ebesutani, K. Kolivoski, et al. 2014. Program and practice elements for placement prevention: A review of interventions and their effectiveness in promoting home-based care. *American Journal of Orthopsychiatry* 84, no. 3: 244–256. https://www.apa.org/pubs/journals/features/ort-h0099811.pdf.

Leeb, R., R. Bitsko, L. Radhakrishnan, et al. 2020. Mental health-related emergency department visits among children aged <18 years during the COVID-19 pandemic—United States, January 1–October 17, 2020. *Morbidity and Mortality Weekly Report* 69, no. 45: 1675–1680. https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm.

Loades, M.E., E. Chatburn, N. Higson-Sweeney, et al. 2020. Rapid systematic review: The impact of social isolation and loneliness on the mental health of children and adolescents in the context of COVID-19. *Journal of the American Academy of Child & Adolescent Psychiatry* 59, no. 11: 1218–1239. https://jaacap.org/article/S0890-8567(20)30337-3/pdf.

Love, H., J. Schlitt, S. Soleimanpour, et al. 2019. Twenty years of school-based health care growth and expansion. *Health Affairs* 38, no. 5: 755–764. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.05472.

Love, H., S. Soleimanpour, J. Schlitt, et al. 2018a. 2016–17 *School-based health center census chart pack*. Washington, DC: School-Based Health Alliance. https://www.sbh4all.org/wp-content/uploads/2019/07/2016-17-Census-Chart-Pack.pdf.

Love, H., S. Soleimanpour, J. Schlitt, et al. 2018b. 2016–17 *School-based health care census report*. Washington, DC: School-Based Health Alliance. https://www.sbh4all.org/wp-content/uploads/2019/05/2016-17-Census-Report-Final.pdf.

Massachusetts Child Psychiatry Access Program (MCPAP). 2021. Overview, vision, history. Boston, MA: MCPAP. https://www.mcpap.com/About/OverviewVisionHistory.aspx.

McEnany, F., O. Ojugbele, J. Doherty, et al. 2020. Pediatric mental health boarding. *Journal of the American Academy of Pediatrics* 146, no. 4: e20201174. https://pediatrics.aappublications.org/content/146/4/e20201174.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2020. *State management of home- and community-based services waiver waiting lists*. August 2020 issue brief. Washington, DC: MACPAC. https://www.macpac.gov/publication/state-management-of-home-and-community-based-services-waiver-waiting-lists.

Medicaid and CHIP Payment and Access Commission (MACPAC) 2019a. *Report to Congress on oversight of institutions for mental diseases*. December 2019. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2020/01/Report-to-Congress-on-Oversight-of-Institutions-for-Mental-Diseases-December-2019.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019b. Report to Congress: *Utilization management of medication-assisted treatment in Medicaid*. October 2019. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2019/10/Report-to-Congress-Utilization-Management-of-Medication-Assisted-Treatment-in-Medicaid.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018a. *Access in brief: Adolescents' use of behavioral health services*. Washington, DC: MACPAC. https://www.macpac.gov/publication/medicaid-access-in-brief-adolescents-use-of-behavioral-health-services/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018b. *Medicaid in schools*. April 2018 issue brief. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2018/04/Medicaid-in-Schools.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018c. *Medicaid and the criminal justice system*. July 2018 issue brief. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2018/07/Medicaid-and-the-Criminal-Justice-System.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. Chapter 4: Behavioral health in the Medicaid program—people, use and expenditures. In *Report to Congress on Medicaid and CHIP*. June 2015. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program%E2%80%94People-Use-and-Expenditures.pdf.

Mental Health America (MHA). 2015. *Position statement 51: Children with emotional disorders in the juvenile justice system*. Alexandria, VA: MHA. https://www.mhanational.org/issues/position-statement-51-children-emotional-disorders-juvenile-justice-system.

Murphey, D., M. Barry, and B. Vaughn. 2013. *Adolescent health highlight: Mental health disorders*. Publication no. 2013-1. Bethesda, MD: Child Trends. https://www.childtrends.org/wp-content/uploads/2013/03/Child_Trends-2013_01_01_AHH_MentalDisordersl.pdf.

National Association of State Budget Officers (NASBO). 2020. *The fiscal survey of state*s. Washington, DC: NASBO. https://www.nasbo.org/reports-data/fiscal-survey-of-states.

National Institute for Health Care Management (NIHCM). 2009. *Strategies to support the integration of mental health into pediatric primary care*. August 2009 issue paper. Washington, DC: NIHCM. https://www.brightfutures.org/wellchildcare/toolkit/nevada/PediatricMH-FINAL.pdf.

National Institute on Drug Abuse (NIDA), National Institutes of Health, U.S. Department of Health and Human Services. 2014. *Principles of adolescent substance use disorder treatment: A research-based guide*. Bethesda, MD: NIDA. https:// d14rmgtrwzf5a.cloudfront.net/sites/default/files/podata_1_17_14.pdf.

National Network of Child Psychiatry Access Programs (NNCPAP). 2021. Our story. Boston, MA: NNCPAP. https://www.nncpap.org/about-us.

O'Brien, J. Presentation before the Medicaid and CHIP Payment and Access Commission, December 11, 2020, virtual. https://www.macpac.gov/wp-content/uploads/2019/10/MACPAC-December-2020-Meeting-Transcript.pdf.

Olfson, M., V. Zhang, M. Schoenbaum, and M. King. 2020. Buprenorphine treatment by primary care providers, psychiatrists, addiction specialists, and others. *Health Affairs* 39, no. 6: 984–992. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.01622.

Saloner, B., K. Feder, and N. Krawczyk. 2017. Closing the medication-assisted treatment gap for youth with opioid use disorder. *JAMA Pediatrics* 171, no. 8: 729–731. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6007012/pdf/nihms970846.pdf.

Simon G.E., C. Stewart, B.J. Yarborough, et al. 2018. Mortality rates after the first diagnosis of psychotic disorder in adolescents and young adults. *JAMA Psychiatry* 75, no. 3: 254–260. https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2670697#:~:text=In%20the%20group%20with%20first,approximately%20half%20of%20all%20mortality.

Stagman, S., and J.L. Cooper. 2010. *Children's mental health: What every policymaker should know*. New York, NY: National Center for Children in Poverty. http://www.nccp.org/publications/pdf/text_929.pdf.

State Health Access Data Assistance Center (SHADAC), University of Minnesota. 2021. Analysis for MACPAC of the 2018 National Survey on Drug Use and Health (NSDUH). Minneapolis, MN: SHADAC.

State Health Access Data Assistance Center (SHADAC), University of Minnesota. 2020. Analysis for MACPAC of the 2018 National Survey on Drug Use and Health (NSDUH). Minneapolis, MN: SHADAC.

Straus, J. 2020. Massachusetts child psychiatry access program. Massachusetts Behavioral Health Partnership. Presentation at NASHPCON 2020, August 19, 2020, virtual.

Straus, J., and B. Sarvet. 2014. Behavioral health care for children: The Massachusetts child psychiatry access project. *Heath Affairs* 33, no. 12: 2153–2161. https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.0896.

Stroul, B. 2019. *Relinquishing custody for behavioral health services: Progress and challenges*. Baltimore, MD: Institute for Innovation and Implementation, University of Maryland School of Social Work. https://theinstitute.umaryland.edu/media/ssw/institute/Relinquishing-Custody-Issue-Brief-FINAL-August-2020.pdf.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2020. *Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health*. Rockville, MD: SAMHSA. https://www.samhsa.gov/data/report/2019-nsduh-annual-national-report.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2019a. 2018 *National Survey on Drug Use and Health: Methodological summary and definitions*. Rockville, MD: SAMHSA. https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHMethodsSummDefs2018/NSDUHMethodsSummDefs2018.htm.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2019b. *National Survey on Drug Use and Health: Public use file codebook*. Rockville, MD: SAMHSA. https://www.datafiles.samhsa.gov/sites/default/files/field-uploads-protected/studies/NSDUH-2018/NSDUH-2018-datasets/NSDUH-2018-DS0001/NSDUH-2018-DS0001-info/NSDUH-2018-DS0001-info-codebook.pdf.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2019c. *National Mental Health Services Survey (N-MHSS): 2018 data on mental health treatment facilities*. Rockville, MD: SAMHSA. https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NMHSS-2018.pdf.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2019d. *National Survey of Substance Abuse Treatment Services (N-SSATS): 2018 — Data on substance abuse treatment facilities*. Rockville, MD: SAMHSA. https://wwwdasis.samhsa.gov/dasis2/nssats/NSSATS-2018-R.pdf.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2018. *Strategic plan FY2019–FY2023*. Rockville, MD: SAMHSA. https://www.samhsa.gov/sites/default/files/samhsa_strategic_plan_fy19-fy23_final-508.pdf.

Sundararaman, R. 2009. *The U.S. mental health delivery system infrastructure: A primer*. Washington, DC: Congressional Research Services. https://fas.org/sgp/crs/misc/R40536.pdf.

Thompson, V. 2020. *Massachusetts increases adolescent substance use treatment by building primary care provider capacity*. Washington, DC: National Academy for State Health Policy. https://www.nashp.org/wp-content/uploads/2020/11/MA-MCHPIP-Case-Study-11.23.2020.pdf.

Tsai, Dan. 2020. Presentation before the Medicaid and CHIP Payment and Access Commission, December 11, 2020, virtual. https://www.macpac.gov/wp-content/uploads/2019/10/MACPAC-December-2020-Meeting-Transcript.pdf.

Turney, K., and C. Wildeman. 2016. Mental and physical health of children in foster care. *Pediatrics* 138, no. 5: e20161118. https://pediatrics.aappublications.org/content/138/5/e20161118.

U.S. Department of Health and Human Services (HHS). 2021. Practice guidelines for the administration of buprenorphine for treating opioid use disorder. Notice. *Federal Register* 86, no. 80 (April 28): 22439–22440. https://www.federalregister.gov/public-inspection/2021-08961/practice-guidelines-for-the-administration-of-buprenorphine-for-treating-opioid-use-disorder.

U.S. Department of Health and Human Services (HHS). 2020. *Report to Congress: Innovative state initiatives and strategies for providing housing-related services and supports under a state Medicaid program to individuals with substance use disorders who are experiencing or at risk of experiencing homelessness*. November 13, 2020. Washington, DC: HHS. https://www.medicaid.gov/medicaid/benefits/downloads/rtc111320-1017.pdf.

Wagner, M., and L. Newman. 2012. Longitudinal transition outcomes of youth with emotional disturbances. *Psychiatric Rehabilitation Journal* 35, no. 3: 199–208. https://pubmed.ncbi.nlm.nih.gov/22246118/.

Ward, E., J. Wiltshire, M. Detry, and R.L. Brown. 2013. African American men and women's attitude toward mental illness, perceptions of stigma, and preferred coping behaviors. *Nursing Research* 62, no. 3: 185–194. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4279858/.

Wogan J. and M. Restrepo. 2020. Human rights, stigma, and substance use. *Health and Human Rights Journal* 22, no. 1: 51–60. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7348456/.

World Health Organization (WHO). 2020. Adolescent mental health. Washington, DC: WHO. https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health.

Zeller S., N. Calma, and A. Stone. 2014. Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. *Western Journal of Emergency Medicine* 15, no. 1: 1–6. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3935777/.

Commission Vote on Recommendations

In MACPAC's authorizing language in Section 1900 of the Social Security Act, Congress requires the Commission to review Medicaid and CHIP policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations on access to behavioral health services for children and adolescents. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on Recommendations 3.1 and 3.2 on April 9, 2021.

Behavioral Health Services for Children and Adolescents

3.1 The Secretary of the U.S. Department of Health and Human Services should direct the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Administration for Children and Families to issue joint subregulatory guidance that addresses the design and implementation of benefits for children and adolescents with significant mental health conditions covered by Medicaid and the State Children's Health Insurance Program.

Yes:	Bella, Barker, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weno	17	Yes

3.2 The Secretary of the U.S. Department of Health and Human Services should direct a coordinated effort by the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and the Administration for Children and Families to provide education and technical assistance to states on improving access to home- and community-based behavioral health services for children and adolescents with significant mental health conditions covered by Medicaid and the State Children's Health Insurance Program. Additionally, the Secretary should examine options to use existing federal funding to support state-level activities to improve the availability of these services.

Yes:	Bella, Barker, Brooks, Burwell, Carter, Cerise, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Weno	17	Yes

APPENDIX 3A: Prevalence of Behavioral Health Conditions by Demographic Characteristics

TABLE 3A-1. Prevalence of Major Depressive Episode in the Past Year among Non-Institutionalized Adolescents Age 12–17, by Demographic Characteristics, 2018

Demographic characteristics	Percentage of youth age 12–17			
	Total	Medicaid or CHIP	Private coverage	Uninsured
Sex				
Male	7.9%	7.6%	7.9%	9.0%
Female	21.4	19.6	22.3	17.8
Race and ethnicity				
White, non-Hispanic	15.2	17.1	14.3	18.8
Black, non-Hispanic	11.0	7.6	15.7*	–
Hispanic	14.5	12.9	17.0*	10.0
Asian American, non-Hispanic	13.7	16.0	13.4	–
American Indian, Alaska Native, Native Hawaiian, or Pacific Islander, non-Hispanic	15.0	–	–	–
Two or more races, non-Hispanic	18.6	18.5	19.9	–

Notes: The 2018 National Survey on Drug Use and Health (NSDUH) used criteria from the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* to identify major depressive episodes. The NSDUH did not exclude depressive symptoms that occurred exclusively in the context of bereavement.

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid or CHIP, other, or uninsured. The NSDUH classified respondents who reported they were covered by CHIP as being covered by Medicaid. Coverage source is defined as primary coverage at the time of the interview.

* Difference from Medicaid or CHIP is statistically significant at the 0.05 level.

– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC 2020.

TABLE 3A-2. Prevalence of Illicit Drug or Alcohol Dependence or Abuse in the Past Year among Non-Institutionalized Adolescents Age 12–17, by Demographic Characteristics, 2018

Demographic characteristics	Percentage of youth age 12–17			
	Total	Medicaid or CHIP	Private coverage	Uninsured
Sex				
Male	3.6%	3.9%	3.5%	–
Female	4.0	3.7	4.2	–
Race and ethnicity				
White, non-Hispanic	3.9	5.0	3.5	–
Black, non-Hispanic	3.0	2.9	–	–
Hispanic	4.0	3.1	5.4	–
Asian American, non-Hispanic	–	–	–	–
American Indian, Alaska Native, Native Hawaiian, or Pacific Islander, non-Hispanic	–	–	–	–
Two or more races, non-Hispanic	5.6	–	–	–

Notes: The 2018 National Survey on Drug Use and Health (NSDUH) based estimates of illicit drug or alcohol dependence or abuse on criteria in the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition*. Included are respondents who reported either dependence on or abuse of one or more of the following illicit drugs: marijuana, cocaine, heroin, hallucinogens, inhalants, methamphetamine, or prescription psychotherapeutics drugs that were misused.

We used the following hierarchy to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid or CHIP, other, or uninsured. The NSDUH classified respondents who reported they were covered by CHIP as being covered by Medicaid. Coverage source is defined as primary coverage at the time of the interview.

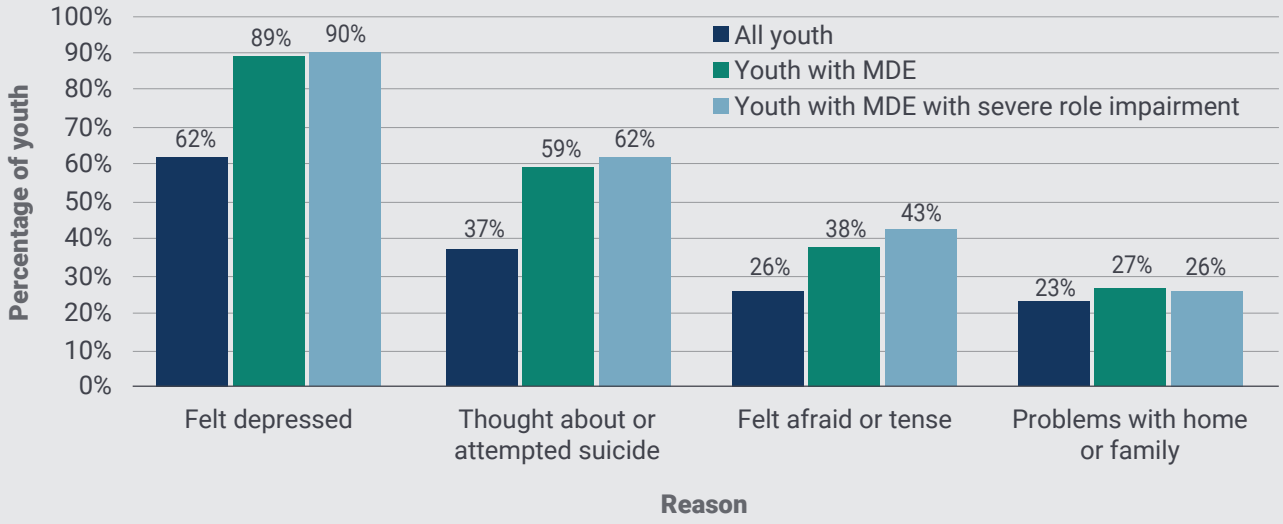
* Difference from Medicaid or CHIP is statistically significant at the 0.05 level.

– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC 2020.

APPENDIX 3B: Reasons for Receiving Mental Health Treatment

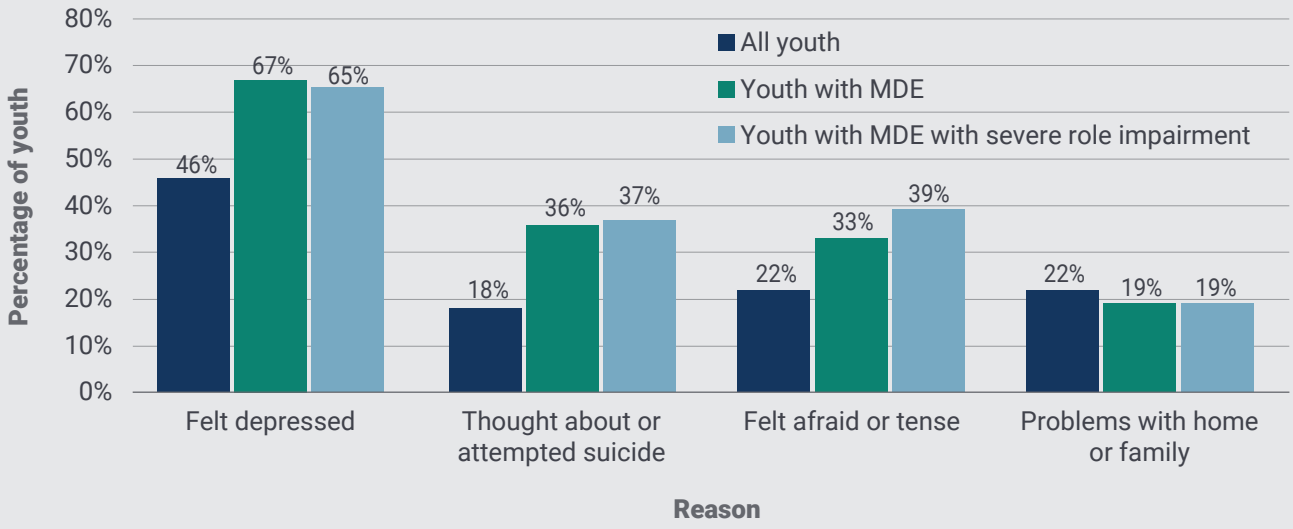
FIGURE 3B-1. Top Reasons for Receiving Specialty Mental Health Treatment among Non-Institutionalized Adolescents Age 12–17 in Medicaid or CHIP in the Past Year, 2018



Notes: MDE is major depressive episode. The 2018 National Survey on Drug Use and Health examines other reasons adolescents received specialty mental health services, including because they broke rules, had problems at school, had trouble controlling anger, had problems with friends or other people, had eating problems, got into fights, and had a self-reported mental disorder.

Source: SHADAC 2020.

FIGURE 3B-2. Top Reasons for Receiving School-Based Mental Health Services among Non-Institutionalized Adolescents Age 12–17 in Medicaid or CHIP in the Past Year, 2018



Notes: MDE is major depressive episode. The 2018 National Survey on Drug Use and Health examines other reasons adolescents received school-based mental health services, including because they broke rules or acted out, had an eating problem, had trouble controlling anger, were in physical fights, had problems at home or in their family, had problems with a friend, had problems with other people, had a diagnosed mental disorder, and other reasons.

Source: SHADAC 2020.