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Coverage of Services to Promote Children's Mental Health

Analysis of State and Insurer Non-Compliance with Current Federal Law

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Abstract

CONTEXT

Despite advances in health policy, children's mental health has declined steadily in the US over the past decade and faced further challenges as a result of the COVID-19 pandemic. To address this growing children's mental health crisis, experts recommend implementation of effective interventions to promote positive family mental health and prevent mental health conditions in children as one critical strategy. It is unknown how current health law does or does not support the implementation of interventions to promote children's mental health.

METHODS

To determine state Medicaid and health insurer coverage requirements related to preventing children's mental health conditions, federal statutes are surveyed. Clinical practice guidelines are reviewed to determine which services for preventing children's mental health conditions fall within reasonable standards of medical practice. State Medicaid fee schedules are examined to identify current state payment policies, and studies on children's access to preventive care in mental health are analyzed to assess potential compliance with current law.

FINDINGS

The analyses find that current state Medicaid and commercial health insurance payment policies likely fail to adequately reimburse for effective interventions to promote positive family mental health, and that this failure violates current law.

CONCLUSIONS

States and health insurers need to ensure legal compliance and take steps to remediate historic underinvestment. The federal government should support these efforts by providing enhanced matching funds for children's mental health services in Medicaid, bolstering training programs for providers in children's mental health, increasing funding for programs that meet families' health-related social needs, and more aggressively enforcing compliance with existing law as it relates to children's mental health.

POLICY POINTS:

Current federal laws require health insurers and state Medicaid to fairly reimburse for services that prevent mental health conditions in children.

Evidence indicates that few health insurers or states meaningfully cover these services and most children cannot access them, in violation of current law.

Additional federal matching funds and related investments can support states and insurers to comply with the law and ensure children get access to services.

Current Mental Health Services Are Inadequate for Meeting the Needs of Children

Over the past two decades, health policy reforms in the U.S. have increased the accessibility of mental health care, primarily through changes in health insurance coverage. Federal legislation, such as the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA), regulated mental health coverage and have extended more equitable mental health benefits to millions.[1] States also have increasingly provided more comprehensive mental health care in their Medicaid plans, including coverage for peer-support models, integration with social services, and new systems of crisis response.[2,3,4] Other reform initiatives, such as value-based payment programs, have tested new incentives for healthcare systems to more systematically address mental health needs in the populations they serve.[5,6,7] As a result of these policies, one study estimated that the rate of depression screening in ambulatory settings increased more than four-fold between 2008 and 2015,[8] and the proportion of adults receiving treatment for depression after a positive screen increased by more than 20% between 2007 and 2016.[9]

Despite these policy advances, children's mental health and wellbeing are in greater danger than ever. Between 2012 and 2018, the average number of depressive symptoms that adolescents reported experiencing grew by 20%.[10] The proportion of adolescents reporting feeling sad or hopeless rose by 40% from 26.1% to 36.7% between 2009 and 2019, and the proportion of those reporting a suicide attempt grew 41% during this time.[11] Although less national data is available about the mental health of young children, trends in family circumstances indicate new threats to their mental health as well. For example, even though many adverse childhood experiences (ACEs –challenges facing families that are linked to children's mental health outcomes) have decreased for U.S. children overall during the past two decades, rates of caregiver substance use and addiction have grown, which may lead to further declines in mental health.[12,13]

These aggregate statistics also mask wide disparities. The rate of adolescents reporting feeling sad or hopeless in 2019 was 45.5% for those identifying as American Indian or Alaska Native, 40% for Hispanic or Latino, and 66.3% for gay, lesbian, or bisexual, as opposed to 36% for those identifying as White and 32.2% for those identifying as heterosexual. Some threats to adolescent mental health that may partially account for these disparities have only recently begun to be quantified as an adverse childhood experience, such as racism. It has been shown that poverty and racism have measurably different and lasting effects on children and adolescents, but historically the independent effects of racism have been missed.[14] As additional data on issues like racism are collected, the inequities impacting adolescent wellbeing will become increasingly apparent.

Health care reforms that expanded access to mental health services broadly were critical, but have been demonstrated to be insufficient for meeting the unique needs of children – and this divide is likely to grow in the aftermath of the COVID-19 pandemic.[15] A survey found that over 25% of young adults in a representative sample taken June 24–30, 2020, seriously considered attempting suicide in the past 30 days.[16] Adolescents have also been found to have significantly increased signs of depression and significant psychological impact as a result of COVID-19.[17] The child poverty rate is expected to rise by 53% as a result of the COVID-19 pandemic and recession.[18] Early research has found that the increased stress

in families has led to marked increases in emergency room admissions associated with family violence, but also likely underreported child maltreatment events that do not end in emergency room admissions.[19,20] In addition, primary care preventive visits for children have declined, resulting in fewer opportunities to address mental health needs and respond to related social needs, such as food insecurity and child maltreatment.[21] Many of the longer term impacts will need to be untangled over time, but there is evidence that children may not recover from the interruptions to their schooling and the challenges in later finding employment during a recession, absent intervention.[22] Both the COVID-19 infections and the related economic fallout are disproportionately impacting racial, ethnic, and socioeconomic groups that were already facing the greatest disparities, causing further disparities in mental health and wellbeing for children.[23,24]

Greater levels of intervention and support will be needed to meet the growing mental health needs of children and achieve long-term health equity. While attention to screening and referral to high-quality mental health treatment will remain important, additional focus is needed on strategies for supporting families to address needs *before* mental health conditions arise. Numerous consensus studies of the National Academies of Sciences, Engineering, and Medicine (NASEM) find that interventions to address family stressors and support families to promote mental health are the most critical missing components of the US mental health system.[25,26] For example, interventions that provide support to caregivers in building skills to promote their child's healthy mental development or address their specific behavioral concerns have demonstrated effectiveness at a population level in reducing the onset of mental health conditions later in the child's life.[27] Similarly, interventions that support families in connecting with community-based resources to meet their social needs have demonstrated potential for preventing later mental health problems.[28] Decades of research has also found that mental health promotion interventions integrated into schools or early care and education settings can prevent mental health conditions – with the greatest benefits for those children facing the greatest risk – and newer research finds that healthcare providers can play a role in supporting these interventions through consultative models.[29,30] Related interventions have demonstrated not only improved mental health outcomes for both the children and their caregivers, but also positive impacts on educational attainment and ultimately social and economic outcomes.[31] Widespread implementation of these interventions would also advance equity, as these interventions often demonstrate greater impacts on families facing higher levels of disadvantage.[32]

Additional reform would be helpful to advance access to interventions that promote mental health, but current law already mandates access to many of these interventions, and focus on compliance with existing law is also critical. Access to health insurance and coverage of broad classes of benefits rightly received much attention during the past several decades of health reform, but less attention has been paid to what these policies meant for access to specific services – especially as they relate to children.

The Law Requires Coverage of Effective Interventions for Promoting Children's Mental Health

Current laws – from the Social Security Act that created Medicaid in 1965, to more recent laws such as MHPAEA in 2008 or the ACA in 2010 – govern coverage and access to mental health care for children. These statutes respond to a history of discrimination, disenfranchisement, and inequity in mental health while expressing America's commitment that children should not be denied access to mental health care. Ultimately, these statutes ensure access to certain mental health and related services for children and families across Medicaid fee-for-service, Medicaid managed care, and commercial health insurance through a series of interlocking requirements. Illustrative provisions are excerpted in Table 1.

Table 1. Selected Excerpts of Federal Laws Governing Children's Mental Health Care

The Medicaid Statute
EPSDT. The term "early and periodic screening, diagnostic, and treatment services" means the following items and services . . . Screening services which are provided at intervals which meet reasonable standards of medical and dental practice . . . which shall at a minimum include a comprehensive health and developmental history (including assessment of both physical and mental health development) . . . and health education (including anticipatory guidance) . . . [and] such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan. 42 U.S.C. § 1396d(r)
Network Adequacy. Each Medicaid managed care organization shall provide the State and the Secretary with adequate assurances (in a time and manner determined by the Secretary) that the organization, with respect to a service area, has the capacity to serve the expected enrollment in such service area, including assurances that the organization offers an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled in such service area, and maintains a sufficient number, mix, and geographic distribution of providers of services. 42 U.S.C. § 1396u–2(b)(5)
The Mental Health Parity and Addiction Equity Act
Non-Discrimination. Such plan or coverage shall ensure that . . . the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. 29 U.S.C. § 1185a/42 U.S.C. § 300gg–5
The Affordable Care Act
Essential Health Benefits. The Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories: . . . mental health and substance use disorder services, including behavioral health treatment . . . preventive and wellness services and chronic disease management . . . pediatric services, including oral and vision care." 42 U.S.C. § 18022
Preventive Care. Shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for . . . with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. 42 U.S.C. § 300gg–13

The Social Security Amendments of 1965 offered federal matching funds for states to implement plans to provide public health insurance to low-income children and families through Medicaid.[33] With the Social Security Amendments of 1967, the Medicaid statute was amended to include a required benefit of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for all children up to age 21.[34] EPSDT requires state Medicaid plans to cover screening related to children's mental health and development, health education (referred to as "anticipatory guidance"), and services to address needs identified in the screening – whether or not the needed services are covered under the state plan. The specific services covered are determined based on "reasonable standards" of medical practice. EPSDT is a unique benefit that guarantees children access to the evidence-based prevention and early intervention services they need to stay well, regardless of the state's choices about its Medicaid design.[35,36] In 1997, the Balanced Budget Act created the Children's Health Insurance Program, which funded states to create programs that extended coverage to children in many families that did not qualify for Medicaid, and which also extended the ESPDT entitlement in many of these state-designed programs, depending on the specifics of the state program design.[37] In 2010, the ACA expanded Medicaid eligibility for families up to 138 percent of the federal poverty level, and although many states chose not to expand Medicaid eligibility after a Supreme Court case gave states discretion, this further extended Medicaid enrollment and the right to EPSDT coverage to millions of families.[38]

The ACA also put in place a number of requirements for some commercial health insurers to provide coverage for certain benefits (referred to as "Essential Health Benefits"), which included mental health, preventive care, and pediatric care, as well as requirements to ensure the adequacy of provider networks to offer these services. For children covered under many commercial health insurance plans, these provisions guarantee access to a relatively similar scope of preventive services as EPSDT under Medicaid. Further, MHPAEA and the ACA implemented special protections for mental health benefits, prohibiting insurers from imposing greater restrictions on access to mental health services than they impose on other benefits.[39] These protections for mental health benefits apply to both commercial health insurance and Medicaid managed care, and further expand the scope of required services for children.

As a result of these laws, almost all children in the US have a right to EPSDT or other coverage for mental health and preventive care under their Medicaid fee-for-service, Medicaid managed care, or commercial plans. This coverage must include anticipatory guidance to prevent mental health conditions, screening for mental health needs at all points in development, and services to address identified needs, based on reasonable standards of medical practice (although the requirements for treatment services may not be as sweeping where EPSDT does not apply). In addition, nominal coverage is not adequate – children have a right to accessible providers who offer these particular services.

The rights of children to access mental health care under these laws also have clear federal, state, and individual enforcement mechanisms. Some statutes provide families with a right of action to sue if they cannot access statutorily mandated services or if the coverage policies represent discrimination against mental health benefits. For example, lawsuits brought by families have led to sweeping state reforms in how states administer EPSDT in Medicaid and have changed the framework by which health insurers make coverage decisions around mental health.[40,41] However, families face inequities in access to justice and most cannot exercise their rights and challenge potential violations.[42] The federal government can also ensure legal compliance, but unfortunately it has largely abdicated this responsibility to states. Ideally, the federal government would lead compliance initiatives rather than relying on individual families to shoulder the burden of enforcement.

Note that this analysis relies on current statutes remaining in effect or being built on. A number of efforts in recent years have sought to repeal or limit some of the foundational laws in this analysis, or to cut budgets from programs such as Medicaid.[43] Limiting existing laws or cutting budgets would likely result in harms to children's access to effective mental health care.

Despite the clarity of the federal statutory requirements and availability of strong enforcement mechanisms, these laws remain poorly implemented.[44,45] This discrepancy becomes more apparent when standards of reasonable medical practice in children's mental health are analyzed.

Clinical Guidelines Set Out Specific Expectations for Promoting Family Mental Health

The mental health and related services to which children have a right depend on what are considered reasonable standards of medical practice. At minimum, these reasonable standards would include clinical practice guidelines, which are evidence-based consensus statements offered by professional societies to support effective practice.[46] For example, the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule and the related Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents were used in part to determine the scope of the Preventive Care Essential Health Benefit by the Health Resources and Services Administration.[47,48] States and health insurance plans must ensure that children at least have access to the mental health services and supports recommended by prevailing clinical practice guidelines. This review does not include services recommended by high-quality systematic reviews and other potential sources of evidence, which should also be considered part of reasonable standards of medical practice.

In this study, nine sources of clinical practice guidelines were reviewed, including: AAP Bright Futures Periodicity Schedule, AAP Bright Futures Guidelines, other AAP Clinical Practice Guidelines, the American Academy of Child and Adolescent Psychiatry (AACAP) Clinical Practice Guidelines, the American Academy of Family Physicians (AAFP) Clinical Practice Guidelines, the American Psychiatric Association (APA Psychiatric) Clinical Practice Guidelines, the American Psychological Association (APA Psychological) Clinical Practice Guidelines, the Agency for Healthcare Research & Quality (AHRQ) Evidence-based Practice Center Systematic Reviews, and U.S. Preventive Services Task Force (USPSTF) A or B Recommendations. The AHRQ Evidence-based Practice Center Systematic Reviews and the USPSTF A or B Recommendations are not clinical practice guidelines, but are frequently incorporated into clinical practice guidelines after the reviews are completed. The USPSTF recommendations also help to define the Preventive Care Essential Health Benefit. Guidelines that were not considered to be current and in effect by the publisher were excluded.

Each of the guidelines was reviewed to identify recommendations on universal, selective, or indicated prevention of mental health conditions in children.[49] Universal preventive interventions include any intervention that would be delivered to all children regardless of risk, and that have been demonstrated to prevent mental health conditions, such as health education for caregivers about their children's changing behavioral needs. Selective prevention includes any intervention given to children at higher risk of developing a mental health condition, such as interventions delivered after identifying family risk factors for mental

health conditions. Relevant risk factors for mental health conditions were identified based on risk factors discussed in the NASEM consensus study *Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth: A National Agenda*.[21] Indicated prevention includes interventions delivered after early signs of developing mental health needs have been identified. The findings from the review are displayed in Table 2.

Table 2. Recommendations from Clinical Guidelines for Preventing Children's Mental Health Conditions

Source	Recommended Intervention	Age Range
Bright Futures Periodicity Schedule	Psychosocial/Behavioral Assessment	All
	Depression Screening	12–21
	Maternal Depression Screening	1mo–6mo
	Anticipatory Guidance	All
Bright Futures Guidelines	Identifying social needs and connecting to community resources, including violence in the home and caregiver behavioral health	All
	Connecting to home visiting and/or group-based caregiver supports	Prenatal – 18mo
	Anticipatory guidance to caregivers – mental health promotion	All
	Anticipatory guidance to children – mental health promotion	5–21
	Connecting to early childhood service system, child care, preschools, and schools	2–8
AAP Clinical Practice Guidelines	Depression screening	12–21
AACAP Guidelines	Mental health consultation in schools (and early care)	4–21
APA (Psychological) Guidelines	Evidence-based mental health prevention	All
USPSTF Recommendations	Interventions to prevent perinatal depression	Perinatal
	Depression screening	12–21
	Maternal depression screening	Perinatal
	Maternal intimate partner violence screening	All

Six of the clinical practice guidelines yielded relevant recommendations (AAP Bright Futures Periodicity Schedule, AAP Bright Futures Guidelines, AAP Clinical Practice Guidelines, AACAP Guidelines, APA (Psychological) Guidelines, and USPSTF Recommendations), while three did not (AAFP Clinical Practice Guidelines, APA (Psychiatric) Guidelines, and AHRQ Evidence-based Practice Center Systematic Reviews. For universal prevention, the Bright Futures Periodicity Schedule and Guidelines recommended anticipatory guidance to caregivers on promoting mental health for children of all ages and to children themselves starting at age 5, which was further supported by APA (Psychological) Guidelines' recommendation on evidence-based mental health prevention. Notably, AACAP Guidelines include recommendations for mental health consultation in schools as a way to provide similar mental health education and anticipatory guidance to other adults who shape the lives of children as well as support schools as another site of selective and indicated prevention.

For selective prevention, the Bright Futures Periodicity Schedule, the Bright Futures Guidelines, and the UPSTF recommend screening for maternal depression, maternal intimate partner violence, other caregiver mental health and substance use treatment needs, and other health-related social needs such as food or housing supports – along with assistance for families in accessing services that can meet their identified needs. The USPSTF also recommends interventions to prevent perinatal depression for women at increased risk, a key risk factor for later children's mental health conditions.[50]

For indicated prevention, the AAP Bright Futures Periodicity Schedule and Guidelines, other AAP Clinical Practice Guidelines, and the USPSTF recommend psychosocial screening for developing mental health needs for children using validated tools at every well-visit (e.g. the Strengths and Difficulties Questionnaire) and screening for symptoms of depression at every well-visit starting at age 12, along with direct provision of integrated care to address identified needs or assistance in accessing specialty services. It is important to note that the clinical guidelines recommend that children receive services to ameliorate clinically significant symptoms after a positive screen – not that they require *diagnosis* of a specific condition to receive further treatment. For example, a moderate level of need on the psychosocial screen in young children should be addressed without having to obtain a diagnosis of oppositional defiant disorder, as obtaining a diagnosis would create barriers beyond what is recommended by the clinical guidelines.[51]

Each recommended service is based on systematic reviews of programs and practices that demonstrated efficacy in preventing mental health conditions. The recommendations support the implementation of these evidence-based practices – not any service that only nominally aligns with the topic area. For example, the USPSTF recommendation on preventing perinatal depression is for empirically supported counseling interventions at a sufficient duration and intensity to be effective based on evaluations of specific programs.[52,53] The USPSTF does not recommend counseling interventions that are not based on empirically-supported practices or are at an insufficient dosage to be effective.

As clinical practice guidelines from leading medical societies and recommendations from federal agencies, these findings should be assumed to constitute the floor of reasonable standards of medical practice and thus incorporated into the coverage mandates previously examined.

Clinical Guideline Recommendations Dictate Requirements for Current Payment Policies

Federal law about health insurance benefits and coverage is given meaning through the payment policies of states and health insurance carriers. The American Medical Association (AMA) through its Current Procedural Terminology (CPT) codes and the Centers for Medicare & Medicaid Services (CMS) through its Healthcare Common Procedure Coding System (HCPCS) codes (which are heavily aligned with CPT codes) provide definitions for discrete units of service. Payment policies govern which of these fee-for-service codes will be reimbursed, for which providers, for which diagnoses, at what location, at what frequency, and at what rate. Although recent reforms around value-based payment have sought to deemphasize the role of fee-for-service coverage, the majority of healthcare payment continues to be built on fee-for-service architecture.[54] This section examines Medicaid payment policy in selected states as it relates to coverage of interventions to prevent mental health conditions in children, to illustrate how current law and clinical guideline recommendations interact (and diverge) in practice. Clinical guidelines recommendations also interact with requirements for commercial health insurance plans, although that is not explored in detail here.

Using *Coding for Pediatric Preventive Care 2020* created by the AAP, CPT and HCPCS codes were extracted that were relevant to the services recommended by the clinical practice guidelines for preventing children's mental health conditions, as examined above.[55] The extracted codes included four CPT codes: preventive medicine services, which include routine screenings as well as counseling, anticipatory guidance, or risk factor reduction; preventive medicine counseling, which provides additional time increments for counseling or risk factor reduction; patient/caregiver risk assessment, which supports administration and scoring of a validated screening instrument; and psychosocial assessment, which is similar to the risk assessment code but specifically for emotional or behavioral conditions. Four HCPCS codes were also included: a generic code to note an EPSDT service; parenting classes provided by a non-physician; patient education classes provided by a non-physician; and stress management classes provided by a non-physician. A code for mental health consultation in schools was not identified.

Note that this approach does not cover all potential payment strategies that a state could employ. For example, a state could have payment policies that specifically designate the use of psychotherapy codes in pediatric primary care to reimburse for some preventive services, or care coordination codes to reimburse for efforts to connect families to community resources. These reimbursement strategies would not be captured in the review.

The Medicaid fee schedule(s) relevant to well-care for children were reviewed for New York, Massachusetts, California, North Carolina, and Washington – diverse states that have also been engaged in efforts to improve mental health care for children and families – to identify the extent to which their payment policies provided coverage for the relevant CPT and HCPCS codes. Table 3 summarizes the findings.

Table 3. Medicaid Coverage of Services for Preventing Children's Mental Health Conditions in Selected States, 2020

CPT/HCPCS Code Definition	CPT/ HCPCS Number	CA	MA	NC	NY	WA
Preventive Medicine Services: New or Established Patients	99381-5/ 99391-5	X	X	X	X	X
Preventive Medicine Counseling	99401-4/ 99411-2	X	X			X
Patient/caregiver risk assessment	96160-1		X	X	G8431 for depression	X
Psychosocial assessment	96127	X	X	X		X
EPSDT Service	S0302		Add-on			
Parenting classes, non-physician	S9444					Special billing rules[a]
Patient education, non-physician	S9445-6				Only for lactation	X
Stress management class, non-physician	S9454					Special billing rules[a]
Mental health consultation services			X			

a. Washington state covers certain evidence-based programs through newly created billing codes.

All states covered the basic preventive medicine services under their Medicaid plan. New York did not provide coverage for any of the other CPT codes, except for depression screening. Massachusetts and Washington provided coverage for all of the relevant CPT codes. Massachusetts covered other EPSDT services as an add-on HCPCS code and created a new code for mental health consultation in schools. Washington State covered the patient education HCPCS code and created special billing codes for certain evidence-based prevention programs, including Triple P Positive Parenting Program and Strengthening Families Program.[56] Both California and North Carolina covered three out of the four CPT codes – California did not cover the patient/caregiver risk assessment and North Carolina did not cover preventive medicine counseling – and neither covered any of the HCPCS codes.

While there is not only one way to cover the required services, the payment policies must fairly cover them in alignment with the state's overall approach to the fee schedule. In the same way that the AMA and CMS create standard services definitions for reimbursement, they also create standard methods for valuing those services. CMS publishes a resource-based relative value scale (RBRVS) to value service codes relative to one another with input from the AMA, based on the amount of provider effort associated with the service, the practice expenses incurred, and the associated medical liability insurance.[57] States and health insurers then use these relative values to guide their decisions about how much to pay for specific services, making adjustments as necessary to meet their needs.

State decisions about payment using the RBRVS and incorporating other considerations must fairly compensate providers for the recommended services. Clinical practice guidelines have changed over time—notably many of the recommendations related to preventing mental health conditions were only issued within the past decade—and payment policy must reflect these changes. New York can choose to only cover the preventive medicine services code, but then must ensure that the reimbursement amount reflects the valuation of the additional underlying services required by changing clinical practice guidelines – including evidence-based anticipatory guidance, screening for caregiver behavioral health and health-related social needs and connection to community-based services, and screening for child psychosocial needs. Adding additional requirements to the description of the code without proportionally increasing the payment to reflect the additional value of the services would violate federal law.

For other states that provide coverage for additional CPT and HCPCS codes, such as Massachusetts, Washington, California, and North Carolina, the same issue applies. When separate codes are covered, they must support the provision of evidence-based practices. Evidence-based universal mental health promotion interventions are extremely heterogeneous in format, but most take more than fifteen minutes and often involve multiple sessions, sometimes in groups.[58] Covering a single unit of preventive medicine counseling to prevent mental health conditions may not be sufficient, unless a state can identify high-quality evidence that this can be as effective as the interventions cited in clinical practice guidelines. For addressing family social and behavioral needs, payment policy must value the provider effort for building the community-based connections as well as effectively supporting families in accessing services, as existing evidence indicates that simply screening is likely to be ineffective.[59,60] The current caregiver risk assessment code on its own may not capture the time and effort of the evidence-based practice for addressing these needs, and may need to be combined with other codes.

While out of scope of the present analysis, the effectiveness of screening for family social and behavioral needs is in part contingent on whether federal and state policy adequately funds relevant community-based services and supports. Pediatric healthcare can be a key touchpoint for addressing families' social needs, as families make frequent contact for immunizations and to assess other developmental health milestones for their children. Despite the existence of many screening scales for evaluating families' needs, providers do not uniformly administer them, in part because of concerns about the availability of follow-up resources.[61,62] When providers do use standardized screens, they find dramatic results, with one study finding over 49% of families reporting more than one stressor and/or at least one unmet social need, and parents reporting being supportive of the screening.[63] Where there are resources accessible, these types of screening can be critical in connecting families to additional supports. In many cases, there may not be resources available or healthcare providers may not be aware of them. State and federal policymakers should ensure that existing policy supports the accessibility of the community-based services and supports that families need, such that pediatric screening efforts can effectively meet the needs of families.

Under any payment policy, coverage needs to reflect the value of the guideline-indicated services. To ensure compliance, payment policies should be cross-walked with evidence-based practices to ensure that at least one practice is completely supported. Even though the practices may be heterogeneous and not all approaches may be covered, it is critical to compliance for states and health insurers to demonstrate that at least one practice for each area of guideline-indicated services is covered and correctly valued. For states like New York

where one code is used to encompass all of the services, the policies must ensure that the payments reflect the effort required to address the needs of the families that a provider serves (i.e. takes into account case mix) so that, on average, the payments capture how often families screen positive for additional needs and reflect the effort required to address these needs, or allow providers to capture this through add-on codes.

The rates can also be influenced by network adequacy, as some states and health insurers may offer enhanced rates to incentivize providers to offer services to members and promote access. Current law governing network adequacy for most types of health insurance leaves a great deal of discretion to states about monitoring and enforcement, and state approaches differ widely but generally focus on collaboration between regulators and plans.[64,65] The relationship between reimbursement rates and access to services is well documented, so increasing reimbursement rates to ensure access to services would be an essential part of ensuring accessibility, whether as a result of an enforcement action or part of bringing greater value to members.[66]

Reimbursement rates are only part of making services accessible to families. The diagnoses that allow services to be reimbursed, the provider types allowed to offer them, and the sites from which they can be provided are also important. While this review focused on prevention up to screening, payment policies must reimburse treatment services after a positive mental health screen in the absence of a specific diagnosis. If a payment policy requires a specific diagnosis to address identified needs, it creates a barrier to access that contravenes clinical guidelines and violates children's rights to the services necessary to ameliorate needs identified by screening under EPSDT. Future reviews should examine the ICD-10 codes that can be used in conjunction with child and family mental health therapy CPT codes to ensure that states and health insurers have aligned their payment policies with clinical guidelines.

The types of providers allowed to bill for these codes will also impact access and network adequacy. Payment policies can address inevitable access barriers and network adequacy issues by expanding the types of providers that can bill for the related codes, based on the evidence from the literature. Many evidence-based preventive interventions in children's mental health incorporate a range of professionals and paraprofessionals, indicating that it would be effective to expand the range of providers that can provide preventive care as part of promoting access.[67] For example, caregiver and young adult peer support specialists – individuals who use their lived experience with a mental health condition and additional training to assist others – have been effective in addressing mental health needs in families.[68,69]

Finally, the location from which services can be provided is an important part of payment policy. Mental health consultation with schools and early care and education settings was recommended by the clinical guidelines, so payment policies must ensure that providers can be reimbursed for their consultative and related services in those settings. Providing mental health preventive care in schools and early care and education also creates another pathway for increasing the accessibility of services by creating opportunities to reach children and families where they are.[70] On the other hand, family-focused interventions have traditionally been provided in schools or other community settings, there is growing evidence that healthcare may be an acceptable and even preferable setting for receiving trusted health information – if reimbursable.[71,72].

Lack of Coverage for Guideline-Recommended Mental Health Care Violates Current Law

There is strong evidence that almost all public and private health insurers fail to adequately reimburse for services to prevent mental health conditions. Approximately 40% of children and families do not report receiving any amount of anticipatory guidance on basic topics, such as seatbelt safety or proper nutrition, which indicates the lack of sufficient incentives for anticipatory guidance in general – making it very unlikely that many children are receiving an evidence-based amount of anticipatory guidance for mental health.[73,74] Although data is not systematically collected for mental health screening in young children, the rate of developmental screening in Medicaid was approximately 40% in 2018, and the rate of mental health screening is likely dramatically lower because it has not been the subject of meaningful policy and quality improvement attention.[75]

Further, almost none of the evidence-based practices for preventing children's mental health conditions or addressing family social needs report being sustainable through current healthcare payment policies almost anywhere in the country. For example, Healthy Steps for Young Children – an intervention focused on addressing short-term behavioral needs and facilitating connections to community resources through an integrated specialist – has repeatedly demonstrated its cost-effectiveness but remains unsustainable under current payment policies, absent special payment considerations by health insurers.[76] The same is true of related programs such as Help Me Grow and Project DULCE.[77,78] Similarly, none of the programs that focus on anticipatory guidance for preventing mental health conditions in universal or selective populations have been able to scale due to financing barriers (with the exception of payment approaches like in Washington, where certain programs are specifically covered).[79] Ultimately, this is a reason why NASEM consensus studies repeatedly identify services to prevent mental health conditions as one of the biggest gaps facing America's approach to mental health. Current payment policies do not adequately reimburse for the interventions recommended in clinical guidelines to make these practices sustainable.

Unless states and health insurers can demonstrate that current payment policies fairly reimburse for and value a code or set of codes for which there is evidence demonstrating that the corresponding amount of time and effort is effective in preventing mental health conditions in children and addressing family risk factors, current state Medicaid and health insurer payment polices violate current federal law. It is unlikely that the majority of states and health insurers can meet this threshold, and they should evaluate and revise their current payment policies immediately to comply and avoid costly litigation based on their violations of EPSDT, mental health parity, and related statutes. States and health insurers also need to ensure that payment policies support reimbursement for treatment services to address mental health needs identified by screening, without requiring a specific diagnosis. The sites for billing should also be reviewed to ensure that mental health consultation in schools and early care and education is adequately supported.

Note that the majority of states contract with Medicaid managed care organizations to administer their Medicaid plan, and pay them in a per-member-per-month capitation. Some health insurers also pay capitations or use historic payment information in value-based payment contracts with providers. In these capitated arrangements or other payment models that rely on historic data, the capitation amounts for children will need to be recalculated

to reflect the changes in reimbursement rates and expected utilization of preventive mental health service codes. By fairly compensating Medicaid managed care organizations and other entities that are paid through capitation, the state can better promote access to preventive mental health care for families among its contractors.

These payment policy revisions would only be a first step—revision alone would likely not fully correct the violation. As has been observed in other areas with sudden changes in payment policy, the historic lack of reimbursement causes providers to need support reorienting their practices to offer the newly covered services, as they may not have the experience or knowledge needed to confidently begin providing the new care.[80,81] States and health insurers should invest in evidence-based training initiatives, such as Project Extension for Community Healthcare Outcomes (ECHO) learning collaboratives, to ensure that providers have the necessary skills and support to offer the new services,[82] and they should invest in incentives to encourage adoption of these new practices. The incentives could include enhanced reimbursement rates for the newly valued codes, as outlined above for addressing network adequacy issues, or performance-based payments based on the uptake of the newly valued codes. Without investments in training and incentives, states and health insurers are likely to be providing only nominal coverage and continue to violate current law since the services would remain inaccessible to members even after they revise payment policies.

Training and incentives will still likely be inadequate for meeting the mental health needs of children and families in the face of a shortage of providers. To address this gap, states and health insurers should support reimbursement for a range of professionals and paraprofessionals, as indicated by the evidence in the literature, and extend the training and incentives to these providers. Expanding the workforce will also bring a collateral benefit of increasing high-quality, stable employment in the state.

To ensure compliance, both states and health insurers should publish data on rates of families receiving the newly coded services. As with other areas of quality improvement, such transparency will focus attention on continued progress. Note that auditing and monitoring activities alone – without the changes in payment policy and investments to drive uptake – would not sufficiently address current violations. These steps that states and health insurers must take to remedy current violations of law are summarized in Table 4.

Table 4. State and Health Insurer Actions to Remedy Violations of Current Law for Children's Mental Health

Revise Payment Policies: Conform payment policies with evidence-based practice for prevention in children's mental health in a way that fairly values these services, including allowing for treatment after screening without a specific diagnosis. This should also include adjustments to align capitated payments to health insurers and other entities with these changes.
Provide Training and Incentives: Invest in training programs for providers to ensure competency in the evidence-based practices and provide financial incentives for providers to implement these practices.
Expand Provider Types: Allow a range of professionals and paraprofessionals to provide preventive mental health care in line with the evidence in the literature.
Report on Compliance: Publish data on rates of utilization for the newly valued codes related to evidence-based prevention in children's mental health.

Federal Policy Should Support States in Correcting Legal Violations

The COVID-19 pandemic set off a recession nationwide that will exacerbate growing state budget shortfalls.[83] Investments in mental health and wellbeing of children and families will lead to long-term economic gains for states,[84] but given current budget shortfalls the federal government should support states in making these critical investments and achieving full legal compliance with existing healthcare statutes. The federal role is especially critical as the COVID-19 pandemic threatens the long-term mental health of children, and effective strategies to mitigate these impacts are important for the health and economic wellbeing of our nation. Federal policy recommendations are displayed in Table 5. Supportive policies should build on federal monitoring and enforcement efforts to ensure that states and health insurers are providing statutorily required mental health care to members and beneficiaries. Given the availability of data on the uptake of revised fee-for-service codes by providers, the federal government can take a straightforward approach to data-driven oversight and enforcement with states and health insurers.

Table 5. Federal Policy Recommendations to Promote Compliance with Existing Law for Children's Mental Health

Monitoring and Enforcement: Monitor state and health insurer revisions to payment policies to ensure legal compliance and collect metrics on uptake of related services, including enforcement actions where necessary.
Support for Implementation: Provide 100% federal matching funds for state Medicaid programs for services to prevent, identify, and treat mental health needs in children, including addressing the needs of families.
Training for Providers: Increase funding for both pre-service and in-service training for primary care providers as well as a range of other professional and paraprofessional providers that can be engaged in delivering evidence-based interventions to prevent children's mental health problems.
Invest in Community-Based Organizations: Increase funding and flexibility for federal programs that support community-based organizations to address family risk factors and promote mental health, including building the coordinating capacities of schools and early care and education.

The federal government should offer a 100% federal match in Medicaid for services to prevent, identify, and treat mental health needs in children, including addressing family risk factors. Although the total amount of spending on children's mental health – even after states achieve compliance with current federal law – will likely be small compared to other areas of health spending, the additional federal support with financing could help states achieve full compliance, even in the face of budget challenges. Enhanced federal matches are a common strategy for incentivizing states to implement Medicaid changes, especially those that offer both improved outcomes and reduced long-term costs.[85] The enhanced federal match is critical in the context of children's mental health to ensure that states can offer sufficient incentives to begin to make up for decades of underinvestment.

While states and health insurers have an obligation to invest in training as part of ensuring network adequacy, the federal government should supplement these resources. A number of federal programs currently support both in-service training (for providers currently practicing) and pre-service training (for providers still in their educational programs) for health professionals. Funding for these programs should be increased and focused on family mental health promotion in primary care as well as schools and early care and education to meet the growing mental health needs of our nation in the fallout of the COVID-19 pandemic. The provider training should engage a range of professional and paraprofessional providers who will be key in offering preventive services and ensuring that care is accessible to families.

Many of the interventions to prevent mental health needs in children involve coordinating services from community-based organizations, particularly schools, to meet the needs of families. Unfortunately, the COVID-19 pandemic has caused countless community-based organizations to close and threatened the sustainability of the ones that remain, creating a situation in which services will not be available for many families in need. To ensure that providers can effectively connect families with resources, the federal government should increase investment in its programs that support the related community-based organizations, such as those programs that address family financial security, intimate partner violence, or food security. Home visiting programs were also referenced in the clinical guidelines as a key resource for families, and home visiting must be sufficiently funded federally to ensure that every family that would benefit from these services has access.[86] The particularly central role that schools and early care and education settings have in the lives of families should be acknowledged, and additional resources built in these settings for coordination with healthcare and social services, as is currently underway in the community schools movement.[87]

With policy support from the federal government, states will be better equipped to achieve full legal compliance and protect the rights of children to access effective services that promote their mental health.

Conclusion

Current state Medicaid and health insurer payment policies do not fairly reimburse for services to promote children's mental health, and this failure violates federal law. To ensure compliance, states and health insurers must revise their payment policies to ensure that they can sustain evidence-based practices recommended by clinical practice guidelines, as well as invest in training and incentives for providers to implement these new practices. Given state budget shortfalls associated with the COVID-19 pandemic, the federal government should offer 100% matching funds for children's mental health services in Medicaid, increase funding for primary care provider training in mental health, and enhance programs that support community-based organizations to address the needs of families.

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