Consensus Recommendations on Network Adequacy and Oversight for Advancing Equitable Access to Mental Health and Substance Use Care for Children and Youth

Background

The US is experiencing a crisis of mental health and substance use among children and youth. In 2021, the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry and Children's Hospital Association declared a National Emergency in Child and Adolescent Mental Health. Several months later, the US Surgeon General issued an advisory on Protecting Children's Mental Health. In 2022, President Biden set a goal to "get all Americans the mental health services they need" during his State of the Union address, with an accompanying national strategy focused on children and youth. Each acknowledged the role of racism and inequities in access in shaping mental health disparities across the US.

Existing federal laws that protect children's access to care. The Affordable Care Act (ACA), the Medicaid statute, and the Mental Health Parity and Addiction Equity Act (MHPAEA), among others, provide certain standards for access to mental health and substance use care for children. Some statutes guarantee access to specific services, such as the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit in Medicaid or the Essential Health Benefits in qualified health plans on the individual market under the ACA. Other statutes, such as MHPAEA, protect against discrimination in access to mental health and substance use services relative to care for other conditions. For any of these statutes to have meaning, children in the US need standards that define what adequate mental healthcare includes and oversight strategies that ensure children can access the mental health services to which they are entitled.

Many children and youth do not have access to mental health and substance use care. In 2020, less than half of adolescents (42%) with depression in the past year reported receiving any treatment – with Black, Indigenous, and Youth of Color having lower access. Among young adults with mental illness in the past year, 47% of reported unmet needs for mental health care. These low rates of treatment indicate that young people's rights to adequate networks and accessible mental health and substance use care under the law are not being protected.

The Biden Administration has the opportunity to improve oversight and enforcement of existing federal laws to improve children and youth's equitable access to mental health and substance use care. Only by ensuring access to mental health and substance use services can the Biden Administration begin to address the growing public health crisis in young people's mental health. To support the Biden Administration's work, leading national organizations committed to mental health, children's health, and health equity convened to offer consensus recommendations on what constitutes an adequate insurance network for mental health and substance use, and how to ensure that children receive access in practice.

Recommendations

Leading national organizations committed to mental health, children's health, and health equity recommend that the Center for Medicare & Medicaid Services: (1) set rigorous network adequacy standards for mental health and substance use care in regulated public and private health insurance programs that effectuate current law; (2) oversee network adequacy using data-driven approaches and enforce those standards; and (3) build federal and state capacity for oversight to ensure all children receive equitable access to mental health and substance use care.

1. **Set Rigorous Network Adequacy Standards**

The organizations developed consensus on a set of quantitative standards that public and private health insurers should comply with that effectuate the relevant federal laws governing children and youth's access to mental health and substance use care:

- Maximum wait for initiation of mental health and substance use treatment[b] with providers with child and youth-focused expertise[c] within a pre-specified travel time (from home to clinic), by provider type,[d] with further disaggregation to reflect culturally and linguistically appropriate services.[e]
- Maximum wait for follow-up appointments for mental health and substance use treatment[b] with providers with child and youth-focused expertise[c] within a pre-specified travel time (from home to clinic), by provider type,[d] with further disaggregation to reflect culturally and linguistically appropriate services.[e]
- Minimum number of available[a] mental health and substance use care providers with child and youth-focused expertise[c] (that are seeing new patients) per enrollee, by provider type,[d] with further disaggregation to reflect culturally and linguistically appropriate services.[e]
- Minimum standards for addressing network failures and beneficiary complaints, including processes for reimbursement of out-of-network care if no in-network care is available.

a. Standards can include wait times, travel times, and available providers that are virtual only if the beneficiary has documented consent to access virtual care.

b. Initiation refers to primary care providers that indicate capacity to either provide integrated care in the practice or screen and refer to external specialty care providers, which could also be determined through claims or quality measures (e.g. performance on Depression Screening and Follow-up). Follow-up can include either integrated care in the primary care practice or specialty care services provided after referral.

c. Providers with child and youth-focused expertise could be determined by specialty and qualifications, indication during the provider paneling process, or based on claims (e.g. treating pediatric patients), with disaggregation to ensure availability of effective services at each developmental stage.

d. Initially, providers could be partitioned based on four categories: (1) primary care providers that can deliver integrated preventive and mental health and substance use care, (2) prescribers of psychiatric medication, including medication-assisted treatment, (3) providers of psychotherapy, and (4) providers located at psychiatric emergency evaluation centers, including crisis centers or emergency departments, as determined through methods outlined in (c). Going forward, CMS should work with states and plans to build toward additional provider categories that can include: family and youth peer support specialists, providers with early childhood and dyadic expertise for ages 0-6, parent support groups and other preventive service, and community health workers.

e. Disaggregation can increase as the richness of data improves. Initially, it can include availability of services in non-English languages or that share other demographic features that are predominant within that beneficiary population, based on data availability. In the future, it can include access to providers who have received certain minimum amounts of training in culturally and linguistically appropriate services. It can also evolve to include access to providers that share preferred racial, ethnic, gender, sexuality, cultural, or religious backgrounds of a beneficiary.

2. Oversee Network Adequacy Standards

The organizations developed consensus on a set of strategies that CMS and states can implement to oversee compliance with the network adequacy standards, ensuring that children and youth have adequate access to the mental health and substance use services to which they are legally entitled.

Note that not all of the findings from these oversight approaches represent violations of the network adequacy standards. Some indicate potential violations or other gaps in network adequacy, and provide cause for additional investigation and collaboration to improve access. As with above, all data should be disaggregated to the extent possible to identify disparities and enhance equity based on racial, ethnic, gender, sexuality, or socioeconomic backgrounds. Availability of virtual care should also be considered in the same way as in the network adequacy standards.

Method for Oversight	Data Collection Strategy
Rate of receipt of mental health and substance use services after a positive screen, from a mental health or substance use provider with child and youth-focused expertise within a pre-specified travel time, by provider type, disaggregated.	Depression/Alcohol Use Screening and Follow-Up HEDIS measure and claims data
Time to receipt of mental health and substances use services after positive screen, from a mental health or substance use provider with child and youth-focused expertise within a pre-specified travel time, disaggregated.	Depression Screening and Follow-Up HEDIS measure and claims data
Time to return visit for mental health or substance use care, from a mental health or substance use provider with child and youth-focused expertise within a pre-specified travel time, disaggregated.	Claims data
Actual provider to enrollee ratio for mental health and substance use providers with child and youth-focused expertise within a pre-specified travel time, by provider type that are seeing new patients	Claims data
Patient satisfaction with access and care, disaggregated	CAHPS[a]
Rate of receipt of follow up care after hospitalization or emergency department utilization for mental health or substance use, disaggregated.	HHS Child Core Set/HEDIS measure
Rate of utilization of the emergency department for mental health or substance use without previous use of mental health or substance use services.	Claims data
Out-of-network provider utilization for outpatient services and emergency mental health care.	Claims data
Rate of receipt of mental health or substance use preventive services and screening before receipt of specialty care services (when billed as a separate service).	Claims data
Length of emergency department and medical unit boarding for patients awaiting transfer to psychiatric care (e.g. medically cleared).	Claims data
Time to compliance with network adequacy standards after identified non-compliance with network adequacy standards.	Data sources as outlined above, reporting by states and health insurance plans.
Proportion of providers who have fulfilled training requirements for cultural and linguistic competency.	Reporting by states and health insurance plans,
Results from independent “secret shopper” audits (i.e. regulatory staff act as beneficiaries and attempt to access care).	New data collection.

a. Could begin with CAHPS supplemental mental health care items for the Health Plan Survey, Experience of Care and Health Outcomes (ECHO) Survey items, or relative performance on standard Health Plan Survey CAHPS items for those with identified mental health and substance use needs. Over

time, additional measures of patient experience should be implemented to better assess the extent to which services meet needs, empower with information and resources that enable prevention and meeting of health-related social needs, and advance equity.

3. **Build Federal and State Capacity for Oversight**

To implement the recommended network adequacy and oversight provisions, CMS and states will need substantial additional capacity. The undersigned recommend that, as part of the President's national mental health and substance use strategies, CMS set aside a small amount of funds to:

- Create additional job roles, hire additional internal staff, and build information technology capabilities that can enable effective and collaborative oversight and enforcement of network adequacy standards.
- Support states to build similar oversight and enforcement capabilities in their departments of Medicaid and insurance.
- Host a public-private collaborative with states, payers, providers, and patients to accelerate progress toward network adequacy and equitable access through data collection, innovation, shared learning, and multi-stakeholder alignment.

Supporting Organizations

American Academy of Child and Adolescent Psychiatry

American Psychiatric Association

American Psychological Association

California Children's Trust

Families USA

Inseparable

Kennedy Forum

Mental Health America

National Alliance on Mental Illness

National Association of Social Workers

Well Being Trust

ZERO TO THREE