Bipartisan Policy Center

Youth Mental Health and Substance Use Task Force

REDESIGNING THE HEALTH CARE DELIVERY SYSTEM TO BETTER MEET THE NEEDS OF YOUTH

January 2025

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BPC would also like to thank the over 50 experts and thought leaders from across the political spectrum and health care delivery system who provided valuable input throughout this report's development, including at two roundtables.

DISCLAIMER

The findings expressed herein do not necessarily represent the views or opinions of BPC's founders, funders, or its board of directors.

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Letter From the Task Force Co-Chairs

When the Bipartisan Policy Center invited us to co-chair its Youth Mental Health and Substance Use Task Force, we agreed that now was the time to redouble bipartisan efforts to support youth who suffered greatly in the aftermath of the COVID-19 pandemic. While the challenges facing our nation's youth began well before the lockdowns and school closures, the pandemic took a devastating toll on children, adolescents, and their families.

Our directive was simple: develop pragmatic, politically viable, near-term policy solutions to the youth mental health and substance use crises for federal policymakers.

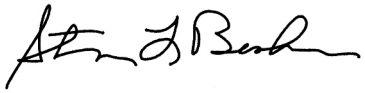
We have been honored to serve alongside a seasoned group of bipartisan former elected and administration officials, health care providers, industry leaders, policy experts, and youth advisers. Over the course of the past year, the task force deliberated on a range of topics, with the goal of releasing actionable reports in three critical areas. This report, *Redesigning the Health Care Delivery System to Better Meet the Needs of Youth*, is the second in our series and focuses on how to reform the health care system to better serve young people and their families. Our first report examined the influence of social media on youth and proposed policies to promote safe and secure social media use. Our final report will look further upstream at how to reduce mental health and substance use issues among youth through early intervention and education.

We must think creatively about how to address the serious challenges facing our nation's youth, and not default to old frameworks that rely heavily on increased federal spending. The recommendations contained in this report provide targeted, nuanced actions for Congress and the executive branch. We balance new, smart spending requests with efforts to better leverage our existing investments in the health care delivery system, such as through our public insurance programs like Medicaid and the Children's Health Insurance Program, which provide health insurance coverage for almost 40% of children nationally.

As former President Donald Trump prepares to re-enter the White House for a second term, we look forward to working with his administration and congressional leaders to address the urgent challenges facing our nation's youth.

BPC's Youth Mental Health and Substance Use Task Force is dedicated to creating lasting change and fostering a healthier future for young Americans.

Signed,



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Glossary of Acronyms

ACEs	Adverse Childhood Experiences
AHRQ	Agency for Healthcare Research and Quality
ASPE	Assistant Secretary for Planning and Evaluation
BHECN	Behavioral Health Education Center of Nebraska
CCBHCs	Certified Community Behavioral Health Clinics
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CoCM	Collaborative Care Model
DOD	Department of Defense
DOJ	Department of Justice
DOT	Department of Transportation
EMS	Emergency Medical Services
EMSC	Emergency Medical Services for Children
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ET3	Emergency Triage, Treat, and Transport Model
FCC	Federal Communications Commission
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
IMLC	Interstate Medical Licensure Compact
MCO	Managed Care Organization
MHPAEA	Mental Health Parity and Addiction Equity Act
MOUD	Medications for Opioid Use Disorder
MRSS	Mobile Response and Stabilization Services
NHTSA	National Highway Traffic Safety Administration
NIH	National Institutes of Health
OIG	Office of Inspector General
OJJDP	Office of Juvenile Justice and Delinquency Prevention
OUD	Opioid Use Disorder
PCBH	Primary Care Behavioral Health
PMHCA	Pediatric Mental Health Care Access Program
PSYPACT	Psychology Interjurisdictional Compact
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening Brief Intervention and Referral to Treatment
SPARK	SAMHSA Program to Advance Recovery Knowledge
SUD	Substance Use Disorder

This is the second of three reports from BPC's Youth Mental Health and Substance Use Task Force. The first addressed safe and secure social media use, and the third will cover prevention and early identification of mental health and substance use disorders.

Executive Summary

The challenges facing youth today are daunting and widespread: Many struggle with their mental health and substance use. A national survey showed that nearly all indicators of poor mental health for teens worsened from 2013–2023—including increases in the percentage of high school students who experienced persistent feelings of sadness and hopelessness (rising from 30% to 40% over the 10-year period).[1] The 2022 National Survey on Drug Use and Health revealed that a larger percentage of young adults ages 18–25 have a substance use disorder (27.8%) than any other age group.[2] Although COVID-19 placed unprecedented stress on youth, these trends were in motion long before the pandemic began in 2020. Fortunately, these trends are also treatable—and sometimes preventable—with a health care delivery system that is primed and ready to tackle the unique needs of youth and their families.

A common refrain among child-serving health care professionals is that the health care system and its financing mechanisms are not designed to optimally serve youth and their families. BPC's Youth Mental Health and Substance Use Task Force aims to change that.

Over the past year, the task force convened over 50 experts and thought leaders from across the health care spectrum: health professionals, children's hospitals, payers, consumer advocates, youth, and caregivers, as well as Republicans, Democrats, and independents. They considered how to maximize the potential of the U.S. health care system to better serve youth and to formulate recommendations for the next administration and Congress.

The task force focused on five key areas.

1. Across the health care system, opportunities exist to build new workforce capacity, make the existing workforce more effective, and redirect care to more appropriate sites.

2. The task force examined ways to increase compliance with existing screening and treatment requirements, including network adequacy standards and mental health and addiction parity requirements.
3. Further integrating primary care and behavioral health services in pediatric settings was key to the work of the task force.
4. The task force addressed services for youth with the highest acuity behavioral health needs. Many of these children have experienced significant emotional and physical trauma, may be involved in the child welfare or the criminal justice systems, and often require immediate, intensive, specialized care.
5. Lastly, the group focused on strengthening our nation's patchwork of crisis and stabilization services to improve the experience and outcomes of youth in crisis.

Detailed recommendations for reforming the health care delivery system to better serve youth and their families include:

1. Strengthen and Grow the Behavioral Health Workforce

This section focuses on supplementing states' efforts to enlarge their behavioral health workforce; expanding behavioral health providers' participation in health insurance networks by easing the credentialing burden for behavioral health providers; increasing state and providers' participation in interstate licensure compacts; and improving licensure portability. The benefits of these recommendations stretch beyond supporting youths' access to behavioral health services.

a. Congress should authorize funding for the Department of Health and Human Services (HHS) to provide grants of up to $2 million over three years to establish up to 10 regional behavioral health education centers to recruit and retain the behavioral health workforce.

b. HHS and the Substance Abuse and Mental Health Services Administration (SAMHSA) should coordinate to develop national core competencies specific to young adults and parent/caregiver peer support and recovery specialists.

c. To increase participation in behavioral health provider networks, the Centers for Medicare and Medicaid Services (CMS) should provide technical assistance (TA) to and learning collaborative opportunities for state Medicaid agencies. These agencies should offer a streamlined provider credentialing process so that providers can submit one credentialing application packet with standardized criteria and minimize their burden of applying to multiple Medicaid managed care plans with varying requirements.

d. Congress should direct HHS, specifically CMS and SAMHSA, to convene a work group to develop baseline standards and standard naming conventions for behavioral health provider credentialing.

e. Congress should support the growth of interstate licensure compacts by streamlining FBI background checks.

f. Congress should direct an impartial entity such as the Government Accountability Office to identify key barriers to state and provider participation in compacts, as well as to identify concerns related to compact implementation, by conducting a comprehensive study. Results should inform additional efforts by Congress and the administration to increase states' and providers' participation in compacts.

g. Congress should allow providers to deliver comprehensive telehealth services to out-of-state patients—if they have an established patient-provider relationship—under a limited set of circumstances deemed appropriate by the HHS secretary. Alternatively, Congress and the administration could offer incentives and technical assistance to states and territories to pass standardized model language that would allow providers to deliver telehealth services to established out-of-state patients.

2. Ensure Increased Transparency and Compliance with Existing Screening and Treatment Requirements

This section focuses on ensuring public and commercial health plans' compliance with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). It also looks at health plans' ability to meet network adequacy and provide the Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit.

a. CMS should direct Medicaid agencies to track and report utilization data for youth from Medicaid managed care organizations (MCOs) by disaggregating demographics and mental health and substance use separately; this data should be used to assess parity compliance, as well as trends in prior authorization frequency, denial rates, prescription drug utilization management, and out-of-network requests.

b. CMS and SAMHSA should deliver technical assistance to states to support compliance with EPSDT, including the newly released guidance by CMS, with a specific focus on leveraging the EPSDT benefit to cover Screening, Brief Intervention, and Referral to Treatment (SBIRT), and leveraging EPSDT to provide substance use treatment for youth.[3]

c. Congress should authorize up to $10 million in grants annually to state Medicaid agencies to develop MHPAEA expertise and to support parity and network adequacy compliance, like what was authorized in

the 117th Congress for state insurance departments. Congress should also fully appropriate the parity compliance grant funding to state insurance departments that was authorized in the 2023 Consolidated Appropriations Act.

d. Congress should require state Medicaid programs and Children's Health Insurance Programs (CHIP) to include language in their managed care contracts that requires Medicaid managed care plans to conduct parity analyses, to disclose information consistent with their parity obligations to the state, and to publicly post state Medicaid program and CHIP parity compliance reports on a single website.

3. Promote Integrated Primary Care and Behavioral Health Services in Pediatric Settings

Increasing screening, consultation, referral, and treatment availability for mental health and substance use in primary care and pediatric settings can greatly improve overall access to mental health and substance use services for young people. This section focuses on ways to increase the availability of integrated primary care and behavioral health services, including developing more pathways for children to receive behavioral health treatment before receiving a formal diagnosis.

a. CMS should leverage existing incentives to encourage states to align EPSDT requirements with the Bright Futures pediatric guidelines for mental health and substance use for children up to age 21, require annual behavioral health screening during well child visits, and monitor compliance and outcomes.

b. Congress and HHS should ensure the continued growth and sustainability of tele-consultation services, such as the Pediatric Mental Health Care Access Program, by renewing program appropriations of at least $52 million. They should also develop sustainable funding sources from all payers or state investments, or both.

c. To increase the uptake of integrated behavioral health care—including the Primary Care Behavioral Health (PCBH) Model and the Collaborative Care Model (CoCM) in pediatric settings—CMS should allow adaptations to make it more feasible for pediatric providers to modify billing for coordinated care. It should also clarify reimbursement rules for care provided without a formal diagnosis. In addition, Congress should increase the reimbursement rate to meet pediatric provider needs.

d. CMS should provide education and technical assistance to states on how to promote integration in pediatric settings and/or issue a state Medicaid Director letter on how states can implement best practices in pediatric integration by leveraging permissible Medicaid authorities.

e. CMS should direct states to collect data on youth behavioral health screening separate from the youth developmental screening data in the Child Core Set. The agency should also describe in its managed care quality strategy how a state can advance pediatric behavioral health integration in Medicaid and CHIP.

f. HHS, in coordination with the Agency for Healthcare Research and Quality (AHRQ), SAMHSA, and the Office of the Assistant Secretary for Planning and Evaluation (ASPE), should aggregate and evaluate publicly available data that allow understanding of how well each state, and managed care organizations within a state, are meeting indicators on and regulatory requirements for children's behavioral health.

4. Address the Needs of Youth with the Highest Acuity Behavioral Health Needs

This section focuses on increasing access to intensive services for youth with the highest acuity needs. The recommendations include expanding access to substance use treatment and intensive home- and community-based services for youth, and focusing on improved care for high-risk, justice-involved youth.

a. Congress and HHS should ensure that Certified Community Behavioral Health Clinics (CCBHCs) have the capacity and expertise to deliver care to youth, to report youth-specific performance and quality measures, and to survey CCBHCs' certification and other outpatient settings' criteria at the state level; this will help ensure that the clinics are meeting the needs of youth in crisis or at elevated risk of crisis.

b. To build capacity for intensive services provided in home- and community-based settings for youth with moderate-to-severe behavioral health needs, Congress should authorize HHS to administer a new Medicaid and CHIP demonstration for up to six states with an enhanced federal match of 85% over four years.

c. Congress should direct the National Institutes of Health (NIH) to prioritize research on the effective treatment of and recovery interventions for youth with co-occurring mental health and substance use disorders.

d. CMS should disaggregate network adequacy wait time data for substance use disorder treatment and recovery services specific to adolescents and racial and ethnic minorities, and it should report the findings to Congress.

e. SAMHSA should evaluate states' and tribal entities' engagement with SAMHSA's Program to Advance Recovery Knowledge (SPARK). This effort should include assessing SPARK's ability to help states and tribes adopt,

scale, and evaluate evidence-based, culturally competent substance use recovery practices (e.g., peer-led programs, family-centered initiatives, and support groups) for youth.

f. The Department of Justice (DOJ) should encourage states to use funding from the Edward Byrne Memorial Justice Assistance Grant Program to train juvenile justice professionals in culturally informed adverse childhood experiences (ACEs), trauma-informed interventions, and mental health and substance use conditions.

g. The DOJ, with SAMHSA and CMS, should improve data collection for incarcerated youth and should identify ways to reduce youth suicide and suicide risk in jails, in prisons, and after release.

5. Strengthen Crisis and Stabilization Systems

Recommendations in this section support building the capacity of the crisis workforce, including emergency medical personnel, and improving crisis system financing.

Further develop crisis and stabilization systems

a. SAMHSA and CMS should submit a joint letter to state Medicaid Directors encouraging the uptake of evidence-based crisis and stabilization models, such as the Mobile Response and Stabilization Services (MRSS) for children, using existing SAMHSA and CMS incentives.

b. HHS, the Department of Defense (DOD), and the Department of Education should provide federal guidance on and technical support for administering and evaluating crisis response and stabilization services for youth in crisis across home, school, military, and community settings, with best practice standards of care for all services in the continuum.

c. Congress should direct HHS, in collaboration with the Federal Communications Commission (FCC), the Department of Transportation (DOT), and the Justice Department, to provide guidance and technical support and to clarify roles and responsibilities between public safety access point, law enforcement, and 988 call and text center personnel. This effort should involve outlining protocols to address overdoses and other behavioral health-related medical emergencies.

d. To better inform policymakers of progress and challenges, Congress could direct HHS to require a standard set of state-specific data on youth behavioral health crisis services to be publicly reported as part of the Mental Health Block Grant. Additionally, HHS should direct CMS and SAMHSA to develop joint guidance on best practices and recommended

structural, process, and outcome measures, including youths' and families' experiences with care.

Invest in the crisis and stabilization workforce

e. Congress should support emergency medical services' youth crisis response by providing funding to the National Highway Traffic Safety Administration (NHTSA). This money should be used to revise the national Emergency Medical Services Education Agenda and other EMS training standards to better incorporate and promote responses to youth behavioral health crises.

f. Congress should leverage funding from existing EMS-focused grant programs, such as HRSA's Emergency Medical Services for Children (EMSC) program, to build EMS capacity and expertise for youth crisis care and to better engage families.

g. CMS should publish and share lessons learned from the discontinued Emergency Triage, Treat, and Transport (ET3) Model to create sustainable financing for youth crisis services that serve any youth, at any time, regardless of ability to pay.

h. The Department of Education should disseminate crisis line resources by directing eligible higher education institutions to include them on new student identification cards, so they are available to students and faculty. It should also direct these institutions to collaborate with SAMHSA to develop and disseminate crisis protocols, especially relating to first episode psychosis and substance use disorder.

Improve financing for crisis systems

i. HHS and the departments of Labor and Treasury should clarify MHPAEA requirements, ensuring that mobile crisis services and crisis stabilization are classified as emergency benefits and are covered under the No Surprises Act.

j. CMS and SAMHSA should coordinate Medicaid coverage, block grants, opioid settlement funds, and other federal programs to support crisis services for youth mental health and substance use disorder (SUD), as well as support best practices; they should also elevate youth crisis services using the crisis set-aside in the Community Mental Health Block Grant.

k. CMS should provide technical support to states on how to claim the enhanced federal match for mobile crisis services under the American Rescue Plan Act and extend the enhanced funding opportunity for an additional three years.

Health Care Delivery System Redesign Recommendations

1. STRENGTHEN AND GROW THE BEHAVIORAL HEALTH WORKFORCE

The behavioral health workforce is experiencing disproportionate shortages compared with the rest of the health care field.[4] More than half of the U.S. population lives in a mental health professional shortage area.[5] Additionally, 70% of counties lack a child and adolescent psychiatrist, and 80% lack child and adolescent psychologists.[6,7] Further compounding the strain, many behavioral health providers do not participate in insurance networks: A 2024 report found that patients went out of network 3.5 times more often for behavioral health clinician office visits than patients went out of network for physical health visits.[8]

Without an adequate workforce, those in need of mental health and substance use treatment may not be able to access services at all or in a timely way. Additionally, workforce shortages worsen providers' stress, resulting in burnout and providers preemptively leaving or cutting back their practices.[9]

Recommendations in this section focus on building behavioral health workforce education centers, easing the behavioral health provider credentialing burden to increase health insurance network participation, and increasing participation in interstate licensure compacts to improve licensure portability.

a. Congress should authorize funding for the Department of Health and Human Services (HHS) to provide grants of up to $2 million over three years to establish up to 10 regional behavioral health education centers to recruit and retain the behavioral health workforce.

There are several examples of successful state-led behavioral health care workforce development programs. One is the Behavioral Health Education Center of Nebraska (BHECN), which is financed by the state and operated through the University of Nebraska's Medical Center.[10] Since BHECN began in 2009, Nebraska has seen a 44% increase in its behavioral health workforce, and two states, Nevada and Illinois, have modeled their programs after BHECN.[11]

BHECN spans the entire workforce pipeline, from engaging high school students in behavioral health careers, to funding educational scholarships for those entering graduate-level psychology, social work, or pediatric and

family therapy programs, to supporting continuing education for individuals in the workforce. BHECN works closely with state health officials, as well as local community and county workers, to ensure that programs they fund are appropriate for workforce needs.

BHECN has already provided technical assistance to other states looking to create similar workforce education programs.[12] Illinois began its state Behavioral Health Workforce Center with an initial investment of nearly $4.5 million from the state Department of Human Services.[13,14] The Behavioral Health Education, Retention, and Expansion Network of Nevada was started with an initial investment of $4.7 million over three years from the state Department of Education.[15]

New regional behavioral health education centers could provide career pathways and mentoring programs, and prepare students for graduate school, residency, supervision, and licensure. To receive funding, centers should work closely with local universities, academic medical centers, children's hospitals, state and local health departments, and other local training programs. Partnerships with local universities and colleges are important to connect prospective and current students with career opportunities in the behavioral health workforce. Additionally, partnerships with state universities could be used to collect data on existing workforce needs and report back to state and local officials on progress in workforce development. Grantees would be expected to participate in a national learning collaborative to share knowledge and best practices.[16]

With congressional action and appropriated funds, HRSA should provide modest startup grants of up to $2 million over three years to establish similar behavioral health workforce education programs regionally. With startup capital, coordination, and technical assistance from the federal government, these centers could provide a new pipeline of behavioral health professionals across the country.

In addition to the HRSA startup grant funding, states should explore other funding sources. For example, state-level appropriated funds built existing centers. HRSA should also consider requiring a modest state funding match to ensure sustainability. HRSA could scale regional behavioral health education centers over time, initially beginning with investment in only a few regions.

b. HHS and SAMHSA should coordinate to develop national core competencies specific to young adults and to parent/caregiver peer support and recovery specialists.

Peer support and recovery specialists ("peer specialists") are individuals living with mental health or substance use disorders (SUD). In their role, peer and family support providers offer support, guidance, advocacy, or help connecting with necessary tools or services.[17] For insurance plans to cover peer support and recovery services, CMS requires that all specialists must be trained and

certified, but CMS has provided no guidance on how or in what peer specialists should be trained. This results in states having a wide range of requirements and curricula that may not be tailored to youth specifically. To create consistency across states, HHS and SAMHSA should coordinate to develop a national set of core competencies designed for educating young adults and parent/caregiver peer specialists.

Currently, 18 states allow for youth and peer support and recovery services through their Medicaid programs.[18] CMS defines peer support providers as "self-identified consumers who are in recovery from mental illness and/or substance use disorders," and it adds that they "must be sufficiently trained to deliver services."[19] As more states cover youth and peer support services, national standards would create greater consistency in knowledge and training across the country.

SAMHSA has an existing set of core competencies for peer specialists in behavioral health services but has nothing tailored to youth behavioral health.[20] Additionally, SAMHSA released a National Model Standards for Peer Support Certification that states can utilize to certify their peer support and recovery specialists.[21] The national model standards provide a certification framework outlining essential qualifications, training, and competencies based on experts' input. Because states ultimately determine their own peer specialist certification practices, SAMHSA's National Model Standards serve as a valuable reference. The agency, however, cannot mandate their adoption. In a 2023 report on the nonclinical workforce, BPC recommended that the federal government work with states to build a set of core competencies for peer specialists and other professionals that states can use to construct their own competencies and to create consistency across the profession.[22] SAMHSA and HHS should build off existing core competencies to allow for more seamless integration and creation of the necessary core competencies for youth-specific peer support and recovery specialists.

Young adult peer specialists (18 years old and older) and parents/caregivers can be an integral part of care for children and young people with mental health and SUD challenges. Peer support and recovery specialists are effective in reducing emergency department (ED) admissions, improving physical health, reducing care costs, improving patient self-esteem, and decreasing substance misuse and depression.[23] There is federal momentum toward scaling these professionals. On June 5, 2024, CMS clarified that states "have the option to offer [p]eer [s]upport services as a component of a comprehensive mental health and substance use service delivery system."[24] CMS also encouraged expanding peer support services to youth and families and in spaces such as the ED and inpatient settings. HHS and SAMHSA can use this policy momentum as a foundation upon which to guide states toward developing core competencies for young adult peer specialists and parents/caregivers.

HHS and SAMHSA should consider how training should vary for adult/caregiver peer support and youth/young adult peer support. Georgia and other states have reduced the number of participants in their training sessions for youth peers to increase active participation in these sessions.[25] Education for peer support providers should include training on co-occurring mental health and SUDs, as these may go hand in hand for some youth and young adults.

c. To increase behavioral health providers' participation in insurance networks, CMS should provide technical assistance and learning collaborative opportunities for state Medicaid agencies to offer a streamlined provider credentialing process; providers would be able to submit one credentialing application packet with standardized criteria. This would minimize their burden of applying to multiple Medicaid managed care plans with varying requirements.

Even when a community has behavioral health professionals, many are unlikely to participate in health insurance networks. Just over 50% of psychiatrists accept private insurance or Medicare, with an even lower rate accepting Medicaid.[26] As a result, behavioral health care services are often unattainable for individuals who cannot afford to use out-of-network providers. The reasons for this situation are multifaceted, and many behavioral health providers cite low reimbursement as a barrier to network participation. However, other friction points also exist and are more unique to behavioral health professionals, who often operate independently or in small group practices. Without the same level of office support as other providers, behavioral health professionals experience more administrative friction to participate in multiple insurance networks and manage back-end billing and administrative functions for reimbursement.

Streamlined provider credentialing processes increase uniformity and reliability while minimizing discrepancies. Behavioral health providers often cite frustration with paperwork and burdensome application processes as reasons for not participating in insurance networks. Centralized credentialing has also proven to be cost effective by reducing the need for multiple credentialing systems.[27] Such a streamlined system is essential for expanding service capacity in the youth mental health and substance use fields.

When providing technical assistance, CMS could use states like North Carolina and Ohio, which centralize provider enrollment and credentialing systems, as examples of best practices.[28,29] Some hospital systems, such as Hackensack Meridian Health, have adopted a centralized credentialing platform.[30] These examples enable states to reimagine their credentialing processes and move toward systems like the "common application" that high school students use to submit a single application to multiple higher education institutions.

CMS should also work with state Medicaid agencies that already centralize credentialing to create learning collaboratives and influence technical assistance on streamlining provider credentialing.

d. Congress should direct HHS, specifically CMS and SAMHSA, to convene a work group to develop baseline standards and standard naming conventions for behavioral health provider credentialing.

In behavioral health provider credentialing, state-by-state variability pose barriers to professionals considering careers in this area, as they create a complex environment to navigate for students and early career professionals.[31] This lack of consistency restricts the portability of a credential, which presents a barrier to career mobility and can disincentivize individuals from entering the field.

CMS and SAMHSA should convene a work group to develop baseline standards and standard naming conventions for behavioral health provider credentialing. Baseline standards and aligned naming conventions (e.g., peer support specialist and behavioral health technician) would help ensure that providers meet a minimum level of competence within specific provider types. Uniform standards can smooth the credentialing process for each provider type and minimize the risk of application errors and inconsistencies.[32] These standards can also help organizations and individuals comply with state and federal regulations. Consistency across provider types also increases the likelihood of interstate licensure agreements forming.

In November 2024, SAMHSA released a tool that displays each state's requirements for different behavioral health careers.[33] The tool displays the level of schooling, practice hours, licensing, or exam requirements needed to work in various mental health professional roles.[34] The user friendly format allows individuals looking to enter the workforce to determine the basic requirements at the state level, or it allows those already in the workforce to quickly determine what is required to maintain their state license.

e. Congress should support the growth of interstate licensure compacts by streamlining FBI background checks.

Restrictions on state medical licensing are uniquely problematic for young adults who often travel across states for school, summer breaks, and shorter duration jobs or internships. Three million students attend college outside of their home state, and approximately half a million of those students lose access to psychiatric treatment each year—one reason is state licensure barriers.[35]

Interstate licensing compacts simplify the process of obtaining and maintaining licenses in multiple states. In July, HRSA identified behavioral health as a priority in its state licensure compact work. The agency awarded $2.5 million to launch a social worker licensure compact and bolster additional

compacts, including the Psychology Interjurisdictional Compact (PSYPACT) and the Interstate Medical Licensure Compact (IMLC).[36]

State participation in licensure compacts varies widely across professions and regions; some compacts enjoy broad support, while others have more limited reach. Some states—such as California, Massachusetts, and New York—have not joined key compacts for physicians and nurses. Since HRSA began investing in licensure compacts, IMLC and PSYPACT have grown to include 40 states, Washington, DC, and one territory, demonstrating the importance of strategic federal support.

Federal law requires criminal background checks on all applicants within a compact. The FBI must authorize State Identification Bureaus to perform these background checks, but the bureau recently withheld approval over concern that compact professionals might access the reports, which would violate federal law restricting access to federal background checks to government entities.[37] Despite assurances that only the state medical board would have access to these checks, professionals in interstate licensure compacts still face difficulties obtaining them.

Congress should streamline background checks by directing the FBI to release criminal history records to state licensing authorities, issuing guidance to State Identification Bureaus regarding statutory authorization requirements for performing background checks, or providing sample legislative language to help state lawmakers draft compact legislation. The SHARE Act, H.R. 1310, would authorize the FBI to share criminal history records with state licensing authorities for the purpose of conducting background checks.[38]

f. Congress should direct an impartial entity such as the Government Accountability Office to identify key barriers to state and provider participation in compacts, as well as to identify concerns related to compact implementation, by conducting a comprehensive study. Results should inform additional efforts by Congress and the administration to increase states' and providers' participation in compacts.

Only a small percentage of providers participate in compacts, and several heavily populated states like New York and California do not currently participate in state compacts. Many interstate licensure compacts experience low provider participation: For example, only about 10% of licensed psychologists in PSYPACT states are members, and less than 2% of all physicians are IMLC members.[39,40]

Fees and lengthy application processing times often disincentivize providers from participating in compacts, our research found.[41,42] Providers, for instance, must pay the IMLC a $700 participation fee in addition to the cost of licenses in any state where the provider wants to practice.[43] PSYPACT requires a $400 fee

to practice telepsychology and a $200 fee for a temporary in-person practice, in addition to annual renewal fees.[44]

Disparities in the adoption of licensure compacts across states and professions suggest complex underlying challenges. Addressing these issues effectively requires a clear understanding of regulatory, financial, and logistical barriers. A detailed study could uncover the primary barriers and implementation challenges associated with licensure compacts. These insights could help guide HRSA's recent $2.5 million investment and future funding more effectively. Overall, better understanding of these drivers could help inform the growth of existing compacts and the recently announced licensure compact for social workers.[45]

g. Congress should allow providers to deliver comprehensive telehealth services to out-of-state patients—if they have an established patient-provider relationship—under a limited set of circumstances deemed appropriate by the HHS secretary. Alternatively, Congress and the administration could offer incentives and technical assistance to states and territories to pass standardized model language that would allow providers to deliver telehealth services to established out-of-state patients.

During the COVID-19 pandemic, nearly all states and the federal government approved unprecedented flexibilities in licensing rules, enabling providers to offer more care than ever across state lines. Much of this care occurred between patients and providers with established relationships. Now that these licensure flexibilities have expired, many patients with out-of-state providers have stopped seeking care rather than transitioning to in-person services.[46] A major concern is that youth seeking behavioral health services—including college students and children at summer camp—now risk losing access to care.

Congress has already established exemptions to state licensure for specific federal health programs and circumstances. In 2017, Congress removed state licensure requirements for Veterans Affairs-affiliated telehealth providers.[47] Then in 2018, Congress passed the Sports Medicine Licensure Clarity Act to allow sports medicine professionals to treat athletes across state lines without needing additional state licenses.[48] Under long-standing policy, the TRICARE system for uniformed service members, retirees, and their families allows medical licenses to be issued based on the physician's location rather than the patient's.[49] Bills to establish additional exemptions to state licensure have been introduced in the House, but have not passed. These include the TELE-MED Act of 2013 to implement reciprocity in Medicare and the 2023 TREAT Act to allow mental telehealth services to be provided across state lines during public health emergencies.[50,51]

Additionally, most states have commonsense continuity-of-care exemptions to licensure laws, permitting providers to practice telehealth across state lines for patients who are traveling, but these exemptions are often inconsistent

and confusing to providers. Key stakeholders, such as the American Medical Association and the Federation of State Medical Boards, support efforts to streamline telehealth regulations, reduce confusion among providers, and enhance continuity of care for patients. The Federation of State Medical Boards has model guidance for state medical boards and lawmakers that would allow for "episodic and follow-up care for established patients" via telehealth.[52]

Federal licensure exceptions for established patient-provider relationships would ensure that fewer patients lose access to care. These exemptions could focus on youth seeking behavioral health services, or more broadly allow for continuity of care for young adults (up to age 26). Congress would need to make clear determinations about how to oversee care delivery, especially prescribing, across state lines. Grievances could be filed in the state where the patient-provider relationship was established. Congress could also outline in-person visit requirements for interstate provider-patient relationships.

Alternatively, Congress and the administration could offer incentives and technical assistance to all states and territories to pass standardized model language that would allow providers to deliver telehealth services to out-of-state patients—if they have an established patient-provider relationship—for a limited set of circumstances. A state-by-state approach would require increased effort and a longer timeline but would help federal policymakers avoid disrupting the long-standing functions of state licensing boards.

2. ENSURE INCREASED TRANSPARENCY AND COMPLIANCE WITH EXISTING SCREENING AND TREATMENT REQUIREMENTS

State Medicaid and CHIP agencies' compliance with the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit and the Mental Health Parity and Addiction Equity Act (MHPAEA) are crucial for ensuring that children and youth receive appropriate care for both physical and mental health needs.[53,54]

Established in 1967 under Section 1905(r) of the Social Security Act, EPSDT is the definitive standard for children's health coverage, guaranteeing that Medicaid-enrolled children under 21 receive comprehensive, preventive, and medically necessary services, regardless of whether they are in the state's Medicaid plan. In 2022, CMS issued a bulletin reminding states of their obligation to cover screenings and treatment for children's behavioral health needs. The bulletin included a best practice guide, a critical step in addressing the growing gap in access to services for youth with mental health and substance use disorders.[55,56] In September 2024, CMS released an important State Health Official (SHO) letter, providing states with best practice information on federal EPSDT requirements, strategies that states

can take to comply with these requirements, and approaches that states can adopt to maximize the effectiveness of meeting EPSDT responsibilities. The letter discussed ways states can meet their EPSDT obligations to ensure children receive appropriate mental health screenings and medically necessary treatment. CMS anticipates publishing a children's behavioral health toolkit to further assist in this area.

The MHPAEA, passed in 2008, prevents health insurers from offering coverage of mental health and substance use treatment that is more restrictive than coverage for medical and surgical services. It also requires parity across all types of health coverage, including Medicaid, CHIP, private plans, and qualified health plans (Marketplace plans) under the Affordable Care Act. Final rules were released in September 2024 by the departments of Health and Human Services (HHS), Labor, and the Treasury.[57] Additionally, CMS in September 2023 requested comments on "Templates for Documenting Compliance with Mental Health Parity and Addiction Equity Act Requirements in Medicaid and CHIP." Despite making this request more than a year ago, CMS has not yet released revised rules similar to the commercial market.

Compliance with MHPAEA and EPSDT remains inconsistent despite these statutorily specified protections. A 2024 HHS Office of Inspector General (OIG) audit of Medicaid managed care in eight states found that CMS had not ensured parity requirements were fully met.[58] Strengthening enforcement of EPSDT in Medicaid and CHIP and MHPAEA across public and private plans is essential to aligning coverage standards across all health plans and ensuring that children and youth have equitable access to mental health and SUD treatment.

Recommendations in this section focus on ensuring compliance with existing screening and treatment requirements in Medicaid, CHIP, and across commercial plans.

a. CMS should direct Medicaid agencies to track and report utilization data for youth from Medicaid managed care organizations (MCOs) by disaggregating demographics and mental health and substance use separately; this data should be used to assess parity compliance, as well as trends in prior authorization frequency, denial rates, prescription drug utilization management, and out-of-network requests.

Although the MHPAEA was enacted over 15 years ago, states continue to face challenges overseeing and enforcing its requirements.[59] MHPAEA mandates parity in financial requirements, quantitative treatment limits, and nonquantitative treatment limits[a] across mental health, SUD, and medical/

[a] Nonquantitative Treatment Limitations are limitations placed by health plans on the duration or scope of benefits provided. Examples include step therapy or fail-first policies and tiered network designs. It also includes limits on experimental or inappropriate care.

surgical benefits. A 2022 Robert Wood Johnson Foundation brief points out that states often lack the resources to meet these mandates and need additional federal support.[60] Although some states conduct market reviews through the National Association of Insurance Commissioners, these reviews typically lump together mental health and SUD claims data, obscuring the specific conditions most at risk for parity compliance issues.[61] Additionally, insurers often aggregate claims data across demographics, including race/ethnicity, age, and gender, making it difficult to identify and address disparities.[62] Disaggregated data is needed to improve oversight and enforcement of parity standards.

States currently assess and oversee EPSDT compliance through a combination of Medicaid reporting requirements, state-specific program reviews, and CMS oversight.[63] However, the processes and the quality of oversight vary across states.[64] States typically report aggregated data for youth services by mental health, SUD, or key demographic characteristics. This aggregation makes it difficult to assess whether specific groups are receiving appropriate care. Additionally, states struggle with inconsistent data collection and underreporting of mental health and SUD services.

HHS is taking steps to disaggregate key federal datasets. In March 2024, the White House Office of Management and Budget revised Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity for the first time since 1997.[65] By September 2024, HHS operationalized these changes by releasing a fact sheet that disaggregated racial and ethnic data on Asian American, Native Hawaiian, and Pacific Islander populations. This change helped reveal specific community needs previously hidden by aggregated reports.[66] However, aggregated claims data still limit the ability to precisely determine service needs. A December 2023 study by the HHS assistant secretary for planning and evaluation highlighted how aggregated claims data during the pandemic public health emergency led to inaccurate estimates of hospitals' ventilator capacity. The data focused on broad geographic distinctions rather than specific hospitals.[67]

CMS should require both Medicaid managed care organizations (MCOs) and Medicaid fee-for-service programs to disaggregate youth claims data by mental health, SUD, and key demographics, such as race, ethnicity, age, and gender. Disaggregating this data would provide more accurate insights into parity compliance under MHPAEA and EPSDT requirements for preventive services; regulators could then pinpoint disparities in care, service gaps, and capacity issues. By evaluating how insurers treat mental health and SUD claims, particularly for young people, regulators can identify where targeted enforcement and policy interventions are needed. These detailed data are essential for crafting effective regulations, ensuring equity in care, and holding insurers accountable. Ultimately, this approach would foster a more transparent and fair health care system, leading to better long-term outcomes for youth.

b. CMS and SAMHSA should deliver technical assistance to states to support compliance with EPSDT, including the newly released guidance by CMS, with a specific focus on leveraging the EPSDT benefit to cover Screening, Brief Intervention, and Referral to Treatment (SBIRT), and leveraging EPSDT to provide substance use treatment for youth.

CMS issued guidance in 2013 requiring states to provide behavioral health services to Medicaid-eligible youth under EPSDT, including screening and preventive services, through age 21.[68] Unfortunately, many states do not mandate annual screenings. In 2020, 30 states released developmental/behavioral health screening rates for children through the first three years of life; of these 30, only seven reported rates above 57%, with the median being 36%.[69] In CMS's latest EPSDT guidance released in September 2024, CMS acknowledges that a standard for assessing patient mental health needs and for describing the continuum of care using common language is not yet nationally available.[70] This lack of a standard complicates efforts to ensure consistency in mental health screenings across states, further contributing to the variability in care.

As part of providing technical assistance, CMS should encourage states to conduct gap analyses to assess where their Medicaid benefits fail to encompass the full scope of behavioral health services for children and youth, including prevention, outpatient services, crisis care, and intensive services in home- and community-based settings.

Barriers to billing for preventive services remain when children do not receive a formal mental health diagnosis. States such as California and Massachusetts have overcome this barrier by allowing Medicaid-eligible youth to access services without a formal diagnosis.[71,72] The latest EPSDT guidance also clarified that states can provide certain mental health services without a formal diagnosis, but additional clarity may be needed at the state level. This gives primary care providers the flexibility to integrate preventive mental health and substance use services during routine checkups and help address behavioral problems early.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Screening for substance use is a key area where technical assistance can help states fully utilize the EPSDT benefit. SAMHSA estimates that fewer than 10% of adolescents needing specialty care receive it, often due to a lack of screening.[73] The SBIRT model of intervention allows pediatricians and primary care doctors to quickly connect youth to appropriate services, yet it has not been widely implemented in pediatric settings.[74,75] Without screening tools, only one-third of youth engaged in excessive alcohol use are identified, highlighting the need for more consistent adoption.[76] SAMHSA and CMS can play a critical

role by offering guidance and technical assistance to ensure that Medicaid covers SBIRT or equivalent models under EPSDT and by enabling states to use funds from the Substance Use Prevention, Treatment, and Recovery Services block grant and other discretionary sources when appropriate. They should also clarify the appropriate use of SBIRT versus other behavioral health or substance use screening codes to standardize adoption.

CMS's latest EPSDT guidance highlights an opportunity to address the failure to establish a national screening standard for youth mental health. The guidance notes that while the Bright Futures periodicity schedule is designed for preventive services for patients ages newborn to 21, it is not tailored for mental health screening.[77] CMS can encourage states to utilize the Bright Futures guidelines under the EPSDT benefit to screen for mental health issues and require reporting to evaluate the impact and effectiveness of these guidelines as part of its technical assistance to states.

Many physicians rely on clinical impressions instead of validated screening tools, leading to missed diagnoses of SUDs in children and young adults. Although EPSDT requires screening and treatment, providers often miss the follow-up steps of brief intervention and referral to treatment. Research shows that brief interventions for adolescents presenting to emergency departments with substance use issues effectively reduce alcohol and marijuana use and are more cost effective than brief education alone.[78] To support states, SAMHSA and CMS should survey pediatric offices to assess SBIRT use and barriers, such as limited treatment options, insufficient time during visits, inadequate reimbursement, and potential screening bias.[79] By coordinating efforts to improve pediatricians' ability to screen, detect, and refer youth early and by issuing clear guidance, SAMHSA and CMS can clarify how to cover SBIRT as an EPSDT benefit. They can also drive broader adoption of this proven model to enhance early intervention for youth.[80]

In addition to screening, youth—particularly those with opioid use disorder (OUD)—struggle to get access to effective treatment. Despite unprecedented levels of substance misuse and OUD, less than 9% of youth receive any form of treatment, and only 7.2% have accessed specialized facilities.[81] Disparities in access to medications for opioid use disorder (MOUD) are particularly stark, with fewer than 25% of insured youth with OUD receiving the medications.[82] These rates are even lower for younger, female, Black, and Hispanic youth.[83]

Leveraging EPSDT for SUD treatment

Residential care is a crucial treatment option for youth with substance use disorder, but the lack of availability and high costs pose significant barriers for Medicaid beneficiaries, even when treatment is medically necessary. A recent study found that only 57% of residential facilities accept Medicaid; disparities in access and patient care between for-profit and nonprofit providers, as well as long wait times, are particularly notable.[84,85] Twenty-three states lack any

Medicaid-accepting residential treatment facilities. Members of Congress are investigating how these facilities address the needs of youth with SUD, focusing on potential harms to youth, particularly those in foster care.[86]

To address these challenges, federal partners should assist states and tribes in fully utilizing the EPSDT benefit for MOUD. This entails helping them improve access to high quality supportive residential treatment programs for youth with acute care needs and for other evidence-based SUD treatments.[87] According to SAMHSA data, barriers to treatment include a lack of readiness to stop using substances, unawareness of available treatment options, and insufficient health care coverage.[88] Providing technical assistance around the EPSDT benefit to states can equip them with the necessary resources to improve treatment access, enhance coverage, and improve service delivery for Medicaid-eligible youth and young adults.

c. Congress should authorize up to $10 million in grants annually to state Medicaid agencies to develop MHPAEA expertise and to support parity and network adequacy compliance, like what was authorized in the 117th Congress for state insurance departments. Congress should also fully appropriate the parity compliance grant funding to state insurance departments that was authorized in the 2023 Consolidated Appropriations Act.

In a March 2024 audit of eight Medicaid managed care states, the Office of the Inspector General (OIG) recommended that CMS strengthen its oversight of states' compliance with mental health and SUD parity requirements and that it direct states to enhance their monitoring of managed care organizations' compliance.[89] MHPAEA addresses both quantitative limitations, such as the number of covered inpatient days or outpatient visits, as well as nonquantitative treatment limitations, such as prior authorization requirements, claim denial rates, and provider networks.

Inconsistencies in parity compliance across commercial insurers lead to coverage gaps, particularly for community-based services crucial for youth. This is problematic, as community-based services are often the most accessible and effective means of care for young people because they can address lifelong mental health and substance use issues early.

CMS stated that it will take steps to strengthen its follow-up procedures for monitoring states' compliance with mental health and SUD parity requirements, including steps for verifying that states have performed required parity analyses; following up with states that have identified noncompliance with mental health and SUD parity requirements; and maintaining documentation of its communications with states relating to compliance with parity requirements and actions taken to correct identified deficiencies.[90] In addition, CMS said it will issue guidance to states to ensure MCOs' ongoing compliance with parity requirements. Expanding oversight to ensure coverage

of community-based services would address critical access gaps and help prevent costlier interventions later.

Congress should authorize up to $10 million in grants annually to state Medicaid agencies to develop MHPAEA expertise. By developing this expertise, state Medicaid agencies can better work with managed care entities or internal staff in the case of fee-for-service Medicaid states to ensure compliance with MHPAEA. This would also enable state Medicaid agencies to better help providers deliver services that meet the standard of care.

Congress should also fully appropriate the authorizations approved in the 117th Congress for state insurance departments.

According to the MHPAEA Comparative Analysis Report to Congress, July 2023, many insurers did not compile a required comparative analysis to ensure their plans were designed to comply with parity.[91] Other challenges documented in the report included differences in access to mental health and SUD benefits, plus insufficient documentation, data, and standards applied by insurers when—compared with other health benefits—they limited mental health and SUD treatment coverage. Insurers have an even greater need for resources and technical assistance to comply with final parity rules released in September 2024, including for the coverage of behavioral health benefits for children and youth.

By providing additional technical assistance on MHPAEA and more extensive resources, federal agencies can better partner with state insurance divisions and the plans created under the Employee Retirement Income Security Act of 1974 to support meaningful compliance with MHPAEA. California's Senate Bill (SB) 855, which sought to set standards for assessing and defining medical necessity for mental health and addiction treatment, serves as a model for commercial insurers.[92] The bill aimed to expand parity and improve youth access to community-based behavioral health and SUD services by preventing insurance carriers from limiting coverage to only short-term or acute care settings.

d. Congress should require state Medicaid programs and Children's Health Insurance Programs (CHIPs) to include language in their managed care contracts that requires Medicaid managed care plans to conduct parity analyses, to disclose information consistent with their parity obligations to the state, and to publicly post state Medicaid program and CHIP parity compliance reports on a single website.

Public disclosure of parity analyses and documentation promotes transparency and encourages continuous improvement. Youth, families, providers, and youth-serving organizations can use this information to better understand the responsibilities of Medicaid and CHIP plans related to behavioral health care. The OIG's 2024 audit of Medicaid found numerous opportunities for increasing

parity compliance.[93] All eight states reviewed in the audit were missing the required parity provision and public documentation by the compliance date in their state contracts with Medicaid MCOs. Additionally, the states did not ensure that mental health and substance use services were delivered to MCO enrollees in compliance with current law, and five of the states reviewed did not conduct required parity analyses. OIG recommended that CMS improve its monitoring of MCO's parity and require more reporting on compliance. This effort to increase transparency and oversight would further ensure compliance with the MHPAEA requirements.

3. PROMOTE INTEGRATED PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES IN PEDIATRIC SETTINGS

Integrating primary care and behavioral health screening, diagnosis, and treatment in pediatric settings increases the chances that children and youth will receive appropriate mental health and substance use services. According to 2022 data compiled by the Centers for Disease Control and Prevention, 94% of individuals under 18 have had a doctor visit within the past year.[94] Children are more likely to utilize behavioral health services offered through their primary care provider, and they typically see their primary care providers more regularly than adult patients.[95]

Recommendations in this section focus on leveraging the success of existing programs to promote integrated primary care and behavioral health services, including refining them to work for children before receiving a formal diagnosis.

a. CMS should leverage existing incentives to encourage states to align EPSDT requirements with the Bright Futures pediatric guidelines for mental health and substance use for children up to age 21, require annual behavioral health screening during well child visits, and monitor compliance and outcomes.

Along with mental health care, integration efforts should address gaps in substance use screening. Under Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, health care providers are required to screen for and address mental health and substance use disorders in individuals under age 21. Through Section 1905(a) of the Social Security Act, CMS mandates that states establish and maintain schedules for periodic screening services for children up to age 21.[96] These screenings must occur at intervals that adhere to reasonable standards of medical practice, ensuring that young children receive comprehensive health assessments, including developmental, behavioral, and physical health screenings. Despite CMS's best practice guidance issued in September 2024, confusion exists about screening

processes and annual requirements.[97] Adoption of best practices varies significantly by state.[98]

The Affordable Care Act requires private plans to provide no-cost screening for children as part of an essential health benefit. States must establish schedules for periodic screenings that align with reasonable medical standards and for consultations with child health care organizations. Most states use a nationally recognized schedule like Bright Futures.[99]

Bright Futures offers a comprehensive schedule of recommended screenings from infancy through adolescence for preventive services (e.g., physical exam, vision and hearing screening, and oral health risk assessments).[100] CMS issued earlier guidance in 2013 mandating mental health and substance use treatment for individuals under age 21 in accordance with EPSDT requirements, and identified Bright Futures as a best practice for screening.[101]

To address these shortcomings, CMS should leverage the incentives from Section 4106 of the Affordable Care Act to encourage states to align their screening practices with Bright Futures pediatric guidelines and ensure compliance with EPSDT requirements for children up to age 21.[102] Section 4106 provides a 1-percentage-point increase to states' match rates for preventive services, and it could support states that are investing in and implementing comprehensive annual screening programs during well child visits, such as Bright Futures, in primary care settings. Additionally, CMS should require monitoring to assess compliance with EPSDT requirements and evaluate the impact and effectiveness of Bright Futures on longer-term mental health and substance use care for children up to age 21. By requiring Medicaid agencies and Medicaid MCOs to adequately reimburse for these screenings, CMS can significantly improve mental health and substance use screening rates among youth, ensuring that they receive the comprehensive care they need.

b. Congress and HHS should ensure the continued growth and sustainability of tele-consultation services, such as the Pediatric Mental Health Care Access Program, by renewing program appropriations totaling at least $52 million, as well as ensuring the development of sustainable funding sources from all payers and/or state investments.

Many primary care providers report lacking sufficient time, reimbursement, and knowledge to provide mental health and substance use screening and treatment services.[103] The Pediatric Mental Health Care Access (PMHCA) Program helps pediatric health professionals with mental health consultation, training, resources, and referrals. This support helps add mental health screening and treatment to routine physical health checkups, especially for mild to moderate behavioral health needs.[104] Congress and HHS must ensure the continuation of the PMHCA Program by renewing the program's appropriations, as well as ensure the development of sustainable funding mechanisms by bringing in support from all payers.

A RAND study found that 12.3% of children in states with PMHCA or similar programs had received behavioral health services, while only 9.5% of children in states without such programs received these services.[105] The study concluded that federal investments in psychiatric telephone consultation programs could significantly increase the number of children receiving mental health services. This is especially true in rural communities, where only one fifth of the needed child and adolescent mental health professionals are practicing.[106] Additionally, a survey of pediatricians found that they needed help gaining access to pediatric mental health and SUD providers, additional time during patient visits, improved reimbursement, increased education and resources, and improved care management and coordination. PMHCA offers many of these services.[107] This program increases pediatric providers' capacity to screen, refer, or treat children's mental health and in doing so, PMHCA programs free up specialists' time to handle more complicated referrals.

In a recent pilot study conducted in Arkansas, hospitals, health systems, and independent clinics were given financial support to adopt e-consults (or tele-consultations), including reimbursement for both primary care provider and referred specialist.[108] This study found that e-consults saved the insurer $195 per patient on average, although that number varied widely by specialist type. Unfortunately, this saving came after large initial costs to cover training and the integration of e-consults into existing electronic health record systems.

Currently, PMHCA programs provide services across an entire state, region, territory, or tribal organization for primary care providers who need resources, e-consults, or help navigating referrals to mental health services. When primary care providers gain access to these services, more children can receive needed mental health treatment services in primary care settings. The need for more expensive care, such as psychiatrists or emergency room care, might decrease as a result. The benefit of the PMHCA Program accrues to all payers; as such, all payers should contribute to a fund that supports the continuation of PMHCA programs to reduce behavioral health care costs for their beneficiaries.

In conjunction with the current HRSA-funded grants for PMHCA, states should work to create sustainable funding sources for their programs. HRSA, which provides grants and technical assistance, should offer additional guidance to PMHCA programs on forming agreements with commercial payers, Medicaid, and states, or it should award additional grant funding to support PMHCA.[109] For example, Washington state charges commercial payers a proportional rate based on the population they cover.[110] Massachusetts has passed legislation requiring commercial plans and Medicaid to fund PMHCA services in the state.[111] Other states have utilized state-level funding, whether through grants or appropriated state funds, to support their tele-consult services. In recent EPSDT guidance, CMS clarified that PMHCA agencies can claim fee-for-service payments "for some of the costs incurred to administer a PMHCA program."[112] CMS should continue to provide technical assistance on its role in funding PMHCA programs, and HRSA grants should continue to support

the establishment and enhancement of state PMHCA programs. HHS could consider forming a learning collaborative so that states can learn from each other and share resources, such as draft legislation to secure funding from commercial and public payers.

Although PMHCA programs are building sustainable funding sources, existing funding through SAMHSA's Substance Use Prevention, Treatment, and Recovery Services Block Grant could be leveraged to continue building networks that connect patients with appropriate substance use treatment services.[113] Expanding substance use treatment networks through PMHCA could help remove some of the barriers experienced in the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model.[114] SBIRT allows pediatricians or primary care doctors to link young people with appropriate services quickly, and it reduces the likelihood of continued mental health and substance misuse issues.[115] Barriers to the SBIRT model include lack of access to appropriate treatment options, inadequate time to provide screening and intervention during visits, and lack of reimbursement for screening and referral to services.[116] Providing an e-consult option, as is done through the PMHCA Program, for providers to refer patients would aid in removing some of the barriers to SBIRT.

PMHCA receives annual federal appropriations of $13 million. In addition, the program received $80 million in additional funding as part of the American Rescue Plan Act and the Bipartisan Safer Communities Act of 2022, which reauthorized the program at $31 million for each year in FY2023–FY2027. In September, HRSA announced additional funding for 27 grantees. In total, the PMHCA program currently receives $52 million annually.[117]

c. To increase the uptake of integrated behavioral health care—including the Primary Care Behavioral Health (PCBH) Model and the Collaborative Care Model (CoCM) in pediatric settings—CMS should allow adaptations to make it more feasible for pediatric providers to modify billing for coordinated care. It should also clarify reimbursement rules for care provided without a formal diagnosis. In addition, Congress should increase the reimbursement rate to meet pediatric provider needs.

In a 2018 letter to state Medicaid Directors, CMS identified the CoCM as an evidence-based approach to behavioral health integration.[118] The CoCM has improved patient outcomes and increased provider confidence in offering care, while also producing cost savings.[119] The foundation of CoCM is a care team that includes a care manager who works with the primary care provider and, when needed, a psychiatric consultant. Treatment can range from talk therapies to medication, and screening tools and a practice registry regularly monitor a patient's progress. The CoCM is one of the few models with CMS reimbursable

billing codes for integrated care services, making it the most accessible model for many providers.[120]

The PCBH model, adaptable to pediatric settings, centers on a behavioral health consultant—a licensed professional who serves as a core member of the primary care team.[121] The consultant, who may be a counselor, clinical social worker, or a psychologist, engages with a large portion of the clinic population, seeing patients of any age with any health condition, ideally on the same day they are referred. The behavioral health consultant enhances the team's assessment and intervention skills by providing brief (15–30 minute) consultations and working with the primary care provider until the patient's functioning improves. The Veterans Health Administration, the Department of Defense (DOD) Medical Health System, and Cherokee Health Systems widely use the PCBH model.[122] Studies show that PCBH improves access to and experience of care.[123] Patients and families are more likely to access mental health care, engage with specialty care when needed, and adhere to antidepressants more than patients who are not accessing care through the PCBH model. Additionally, PCBH can help reduce waiting times for accessing mental health care and improve the relationship between patients and providers.

Unfortunately, the uptake of CoCM and PCBH codes remains low.[124] Providers say CoCM isn't easily adaptable to pediatric settings, as its requirements for diagnosis and psychiatric consultation make it a challenging model. Several possible factors include providers' challenges in meeting upfront costs at current reimbursement rates, beneficiary co-pays, and onerous documentation requirements related to billing, registry maintenance, and patient consent. Switching a health care practice to CoCM is not as simple as billing new codes; it can require changes in staffing and a reorganization of roles within the care team.[125] A study by Meadows Mental Health Policy Institute found that startup costs for CoCM can be as high as $652,000, with a median cost of $161,000.[126] It found that smaller clinics, typically those with less funding on hand, had higher median costs per clinic. This can be a significant barrier to adopting an integrated model.

The Senate Finance Committee outlined options for Congress to raise Medicare payment rates for a set period to help providers with the higher startup costs.[127] States such as North Carolina's Medicaid program have already increased reimbursement levels for CoCM codes from 70% to 120% of existing Medicare rates.[128] These higher reimbursements expand technical assistance capacity for practices integrating CoCM into their work. Higher reimbursements are important for the various levels of coordination with families, schools, and other child guardians needed for effective integrated care. CMS could also consider additional startup funding for providers or health care systems to ease the burden.

Congress should consider allowing increased reimbursement for behavioral health workers who coordinate care and work with parents of children referred to their care. Parent-based treatment has been shown to be effective at supporting children with anxiety disorders.[129] However, traditional reimbursement structures do not cover this crucial piece of care for children and young adults. Additionally, recent EPSDT guidance permits reimbursement for treatment without a formal diagnosis, but CMS should clarify how this option can be used in existing integrated care models.[130] Treating children without a formal diagnosis can increase the speed for receiving care and improve prevention, reducing the need for more intensive care. Congress has also shown interest in moving integration policies forward through such legislation as the KIDS Health Act of 2023, which would expand funding for integrated care demonstration programs.[131] Research has found that early treatment decreases behavioral health challenges as children age. Similar results have been shown in studies on early access to SUD services.[132]

In a 2021 report on behavioral health and primary care integration, BPC's Behavioral Health Integration Task Force supported CoCM reimbursement increases by 75% in the first year of the new policy for all practices using collaborative care, 50% in the second year, and 25% in subsequent years.[133] Cost estimates for enacting that policy were $80 million over five years. More information on how this number was calculated can be found in the Health Management Associates' 2021 cost analysis.[134]

d. CMS should provide education and technical assistance to states on how to promote integration in pediatric settings and/or issue a state Medicaid Director letter on how states can implement best practices in pediatric integration by leveraging permissible Medicaid authorities.

Additional education and ongoing technical assistance for providers and health systems are needed to properly integrate care models including but not limited to the Primary Care Behavioral Health (PCBH) Model and the Collaborative Care Model (CoCM). CMS should consolidate content from previous guidance, such as the state health official letter on interprofessional consultation in Medicaid and CHIP, and the bulletin on leveraging federal programs for youth mental health and SUD services.[135,136]

Including care managers is a crucial part of the CoCM model, and the role becomes more important as the model is used in youth populations.[137] Unlike adults, children attend appointments with a caregiver, parent, or guardian, adding an additional person into the process of coordinating care. Care coordinators are often connected with a child's school as well, introducing more complexity to their work. Due to the different roles and the time needed to explain care to both a young patient and an adult caregiver, providers might need more coordination time for proper care than for older populations.

Additional insights into strategies that states have used in Section 1115 waivers to establish billing and quality parameters for CoCM in managed care can also be included in guidance to states. Medicare recently increased the number of medically unlikely edits (the maximum units of service) for care coordination in the CoCM model from two to four units.[138] This change applies only to Medicare and states that directly follow Medicare guidance in their Medicaid programs. For many states that do not, they may be unaware of the changed guidance in the number of billable hours for care coordination in CoCM. CMS education and technical assistance should provide updates on updated federal guidance that can help states implement or enhance integrated behavioral health strategies and clarify how existing billable codes in Medicaid support different aspects of these models. TA should also include information on how states can amend or create contracts with MCOs to increase integration, reimbursement, and services. Additionally, CMS could provide technical assistance to states on using existing authorities to test tiered enhanced payments that meet the criteria for different levels of integration of behavioral health care for children and youth.[139] Tiered models of enhanced financing, coupled with tiered criteria for integrated care and quality measures, could allow more health centers to develop the capacity and expertise to serve children with low to moderate behavioral health needs.

e. CMS should direct states to collect data on youth behavioral health screening separate from the youth developmental screening data in the Child Core Set. The agency should also describe in its managed care quality strategy how a state can advance pediatric behavioral health integration in Medicaid and CHIP.

The Child Core Set is a set of metrics that states must report on each year about their Medicaid and CHIP programs.[140] Data from the Core Set is used to strengthen the quality of care and health outcomes of children across the country. These measurements ensure that state Medicaid and CHIP programs meet CMS access and quality care requirements. The Child Core Set can be updated yearly to add in metrics as needed. CMS will report seven behavioral health measures as part of its 2025 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP ("Child Core Set"), including one on screening ("Screening for Depression and Follow-Up Plan: Ages 12 to 17").[141] Although useful, this one metric narrows the scope of documented prevention-related health care services. CMS already has codes for various screenings, including for emotional and behavioral health assessments.[142] To fully understand the scope of mental health and substance use disorders, CMS should expand the Core Set to include young adults ages 17–21, aligning with EPSDT requirements and Bright Futures guidelines, and it should incorporate additional metrics beyond depression screening. CMS can use existing measures to make the Child Core Set more clinically focused.

Requiring CMS to collect youth behavioral health screening data beyond the

metrics in the Child Core Set can help federal decisionmakers gauge youth service needs for other mental health conditions and substance use among youth. Children and young adults deal with a variety of mental health issues, including depression, anxiety disorders, behavioral issues, and ADHD.[143] Limiting screening to one type of mental health disorder will result in missing information and affect access to treatment for children and young adults experiencing other types of issues. Additionally, widening the age of screening will help to increase the number of young adults who are referred to additional treatment or provided with a brief intervention from their provider.

Under federal rules, states contracting with a managed care organization must establish a quality strategy for assessing and improving the quality of care and services. The state quality strategy must include the following: 1) state-defined network adequacy and availability of services standards for MCOs, 2) the state's goals and objectives for continuous quality improvement, 3) a description of quality metrics and performance targets to measure MCOs' performance and improvement, 4) a description of performance improvement projects, and 5) the process for independent reviews of MCO performance, among other requirements. A 2024 final rule requires that all MCOs post their managed care quality strategy on their websites, creating easier access to data on care provided.[144] In the future, CMS should require states to include in their quality strategies their integration plans for children and young adults. This information should be publicly accessible.

States are already required to report on access to Medicaid services, certain quality metrics, and costs for services under fee-for-services and MCOs.[145] Better reporting on integration at the state level allows CMS to create more standardized Medicaid access rules for consistency across the country. Seventy-four percent of Medicaid beneficiaries are enrolled in an MCO.[146] Including integration plans in the quality strategy would require states to describe how they will work with MCOs, any subcontracted entities, and, if applicable, the behavioral health agency in the state. Reporting should include data on how many providers or health systems utilize integrated care models and reimbursement codes. Metrics should also include the average wait time for patients to access mental health or substance use care. All these metrics should be collected and reported on for both children and young adults, along with adult Medicaid patients.

f. HHS, in coordination with the Agency for Healthcare Research and Quality (AHRQ), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) should aggregate and evaluate publicly available data that allow understanding of how well each state, and managed care organizations within a state, are meeting indicators on and regulatory requirements for children's behavioral health.

The federal government is promoting behavioral health integration and has taken numerous actions, but transparent data are lacking to understand how states and managed care organizations provide integrated care to children and youth. Multiple programs provide funding for mental health and substance use care and prevention services, but confusion persists around quality, delivery of services, and gaps in care and resources.

The AHRQ and SAMHSA collect data in various forms on care delivery, cost, and utilization. These include claims data and grant-specific datasets that fill critical gaps in Medicaid's coverage of mental health and substance use services. To best understand this data, HHS should work with these agencies to create data visualizations that can aid states, researchers, and providers in understanding how services are being delivered and resources are being utilized. Using the collected data, ASPE can evaluate where states and communities may need additional resources to deliver high quality mental health and substance use services. Below are some of the data sources that could be utilized in the visualization:

- Healthcare Cost and Utilization Project (HCUP): Collected by AHRQ, it includes a kids' inpatient database to track inpatient use, access, charges, quality, and outcomes.[147]
- Medical Expenditure Panel Survey (MEPS): Collected by AHRQ, it surveys families and individuals on health care coverage, cost, and utilization.[148]
- Transformed Medicaid Statistical Information System (T-MSIS): Collected by state Medicaid and CHIP programs, the data show eligibility, demographics, service use, and spending at the enrollee level.[149]
- Community Mental Health Block Grant: Collected by SAMHSA, it includes information from states on access to services, quality, and satisfaction in addition to yearly reports on how the grant money is being spent.[150]
- Substance Use Prevention, Treatment, and Recovery Services Block Grant: Administered by SAMHSA, it collects information on how funding is used, types of services provided, and service locations.[151]

Without proper data collection and reporting, determining where improvements can be made—or understanding how successful groups are in integrating mental health, substance use care, and primary care—is difficult. During the COVID-19 pandemic, HHS created data visualizations called HHS Protect that aggregated data from over 300 sources.[152] HHS Protect shows data related to COVID-19 cases, testing, mortality, local policy decisions, and other important metrics for tracking disease progression and response. This tool improved response time to changing COVID trajectories and allowed for a whole-of-government response to resource management. A similar transparent data visualization could promote continuous quality improvement and spur innovations in financing and practice to achieve better outcomes. Evaluations from ASPE could provide additional insights into the impact of these services

on youth. An aggregated, publicly available data visualization tool could also help nongovernmental organizations understand how, and to what extent, federally funded behavioral health care is administered to youth.

HHS already uses data and surveys to assess access to care, and calls for improvements when necessary. Recently, CMS released a rule related to wait times for outpatient behavioral health, primary care, and OB/GYN services.[153] The wait time requirements will take effect in 2027 for Medicaid and CHIP MCO plans. Ensuring that MCOs meet these new requirements will rely on data collected in the various datasets listed above. Proper data visuals will allow for an easier understanding of where MCOs may be falling short in their access to services.

Measures HHS should consider including in the visualization: locations providing mental health and substance use care for children and youth, the ages of those seeking care, wait times for access, and the distribution of block grant funding. These metrics (and others not listed) could help officials better understand where more resources are needed for child and youth care and what areas are facing the highest rates of mental health and SUDs.

4. ADDRESS THE NEEDS OF YOUTH WITH THE HIGHEST ACUITY BEHAVIORAL HEALTH NEEDS

This section focuses on increasing access to services for youth with the highest acuity behavioral needs. These youth face complex challenges that will persist over their lifetimes, have usually experienced serious trauma, and often require intensive, ongoing services.

This section includes recommendations to increase youths' access to substance use treatment options, which are sorely lacking, as well as intensive home- and community-based services. Intensive services address the needs of young people with acute or complex mental health, substance use, or co-occurring conditions, including youth with intellectual or developmental disabilities. Extremely challenging behaviors can sometimes require children to be treated in facility-based settings, and acuity needs for youth can evolve during a mental health/substance use condition. Many experts convened by the task force agreed that greater availability of intensive in home- and community-based services are needed, especially for younger children, to ensure a comprehensive delivery system from prevention to acute intervention.

The task force also focused on advancing policy changes to improve care for high-risk youth transitioning out of the criminal justice system, as well as enhancing the care they receive while incarcerated. Justice-involved youth experience high rates of mental health and substance use disorders. When left untreated, these conditions contribute to elevated rates of recidivism,

poorer overall health outcomes, and significant challenges in education, social relationships, and employment.

a. Congress and HHS should ensure that Certified Community Behavioral Health Clinics (CCBHCs) have the capacity and expertise to deliver care to youth, to report youth-specific performance and quality measures, and to survey CCBHCs' certification and other outpatient settings' criteria at the state-level; this will help ensure that the needs of youth in crisis or at elevated risk of crisis are being met.

Congress designed the Certified Community Behavioral Health Clinics Demonstration program through the Protecting Access to Medicare Act of 2014.[154] CCBHCs are required to deliver a range of behavioral health services, including crisis services; psychiatric rehabilitation services; peer, family support, and counseling services; and treatment planning. However, providers and policy experts have raised concerns that there is limited visibility into how CCBHCs care for youth today and their capacity to do so.

CCBHCs participating in Medicaid currently provide care to over 3 million people across 22 states.[155] All clinics either operate a crisis line or can refer individuals in crisis to other community crisis lines.[156] CCBHCs have requirements that they must meet to be eligible for funding either from a SAMHSA grant or through a Section 1115 waiver.[157,158] CCBHCs provide nine core services directly or through formal partners: outpatient mental health and substance use services; person- and family-centered treatment planning; community-based mental health care for veterans; peer, family support, and counselor services; targeted case management; outpatient primary care, screening, and monitoring; psychiatric rehabilitation services; screening, diagnosis, and risk assessment; and crisis services. Although the 2023 CCBHC requirements noted examples of ways to apply them to youth, they did not directly specify that these nine core services must be tailored toward youth, making them optional for clinics.

Congress and HHS should ensure CCBHCs have the capacity and expertise to deliver care to youth as well as report youth-specific performance and quality measures. SAMHSA and CMS can survey states on CCBHCs' certification and other outpatient settings' criteria and youth-specific implementation to ensure that requirements are meeting the needs of youth in crisis or at elevated risk of crisis.

One initiative authorized by the American Rescue Plan Act provides an 85% match—known as the Federal Medical Assistance Percentage—for states to develop and expand mobile crisis response services for three years.[159] States can opt into the enhanced match from April 1, 2022, through March 31, 2027. This match covers various costs associated with establishing and running mobile crisis response services, including administrative costs and IT system

enhancements.[160] In addition to the enhanced match for mobile crisis, there is an enhanced federal match for CCBHCs.[161] However, the competing requirements for enhanced match for mobile crisis and CCBHCs might complicate how organizations can fully utilize both incentives, especially since all CCBHCs must provide mobile crisis services. Although the guidance would not target youth crisis response, clarifying the requirements can streamline federal Medicaid investments, improve resource allocation, reduce duplication, enhance coordination and partnerships, and optimize workforce capacity.

Ensuring CCBHC requirements meet the needs of youth could better enable facilities to handle these cases. Moreover, because CCBHCs are not available in all states, other types of outpatient settings should be considered for helping youth in crisis. Studies would help determine whether facilities are equipped to handle such crises.

In addition to exploring youth-specific requirements for CCBHCs and other outpatient settings, officials should look at the gap in public information about the extent to which CCBHCs serve youth and how well they are coordinating with other settings (e.g., hospitals, pediatrician offices, and schools). Currently, SAMHSA funds the National Council for Mental Wellbeing to operate the National Training and Technical Assistance Center for CCBHC Expansion Programs.[162] This center provides training, technical assistance, and resources to CCBHC grantees, focusing on incorporating best practice models that meet service needs, and the center offers a vehicle for carrying out this policy proposal. Through this work, SAMHSA could help identify ways to enhance youth-specific requirements and opportunities for improving reporting and transparency.

In 2022, SAMHSA increased grant funding for starting CCHBCs to $1 million per year for four years.[163] This brought the total funding for CCBHCs to $123.6 million in fiscal year 2023.[164]

b. To build capacity for intensive services provided in home- and community-based settings for youth with moderate-to-severe behavioral health needs, Congress should authorize HHS to administer a Medicaid and CHIP demonstration for up to six states with an enhanced federal match of 85% over four years.

Growing the availability of intensive services nationally is crucial for children and youth with complex behavioral health issues.[165]

Historically, two major federal initiatives—SAMHSA's Children's Mental Health Initiative (CMHI) and CMS's Psychiatric Residential Treatment Facility (PRTF) Demonstration Program—have helped address the needs of children, youth, and young adults with significant mental health conditions.[166,167] Evaluations of these programs found that services provided in home- and community-based settings significantly improved the quality of life for these

individuals and their families, and they had a positive financial impact on Medicaid programs that designed benefits for this population.[168]

The evaluations of the services provided to children in home- and community-based settings in the Psychiatric Residential Treatment Facility Demonstration also revealed significant cost savings.[169] These services cost only 32% of the expected total to serve them in a PRTF, resulting in an average savings of $40,000 per year per child. State Medicaid agencies substantially reduced annual costs per child within the program's first six months. After 12 months of service, 44% of children and youth improved their school attendance, and 41% improved their grades. States also noted a rise in behavioral and emotional strengths among enrollees: 33% of youth significantly improved their behavioral strengths after 12 months of service, increasing to 40% after 24 months, compared with their strengths measured prior to participating. Behavioral and emotional strengths include forming interpersonal relationships, making positive connections with family, functioning positively at school, and demonstrating self-confidence. Caregiver reports found that 40% of children served showed a decrease in clinical symptoms after entering the program.

Given these positive results, CMS should incentivize more states to expand intensive services provided in home- and community-based settings by offering an enhanced federal match of 85% over four years. These settings would serve as alternatives to residential treatment for youth with moderate-to-severe behavioral health needs. CMS and state Medicaid programs should require providers to adopt stronger admissions criteria to deter providers from cherry-picking youth with lower-acuity needs or using a first-come, first-serve approach for services. CMS could additionally incentivize states to offer evidence-based practices implemented with fidelity. States should include intensive outpatient programs and settings that offer partial hospitalization programs in community-based settings.

c. Congress should direct the National Institutes of Health (NIH) to prioritize research on effective treatment of and recovery interventions for youth with co-occurring mental health and substance use disorders.

During the pandemic, youth reported a decline in drug and alcohol use, but drug overdose deaths among teens ages 15–19 surged.[170] The increased presence of fentanyl in the drug supply was largely responsible for this anomaly. Even with lower overall substance use rates, the overdose risk has remained high post pandemic, underscoring the urgent need for comprehensive youth SUD education and treatment options.[171]

Youth with SUD have access to various treatment options.[172] They can receive medications for opioid use disorder as part of their treatment plan for as long as is clinically appropriate, and they can enter intensive outpatient

programs.[173] However, limited youth-specific facilities, long wait times, high costs, and limited Medicaid coverage make MOUD and withdrawal services difficult to obtain.[174] Residential care, another treatment option, presents additional challenges, such as long wait times, high costs, and limited Medicaid acceptance.[175] A recent Senate Finance Committee hearing highlighted the harms of residential treatment, especially for youth in foster care who may experience mistreatment.[176] Longer-term recovery options are scarce and often not integrated into the health care system, limiting access for many young people.

Research shows that many youth with SUD also have co-occurring mental health disorders, making it critical to address both conditions simultaneously for successful recovery.[177] However, a gap exists in understanding how to effectively treat these co-occurring conditions, further complicating efforts to provide high acuity care. Although programs like Multidimensional Family Therapy show promise, the NIH should explore tailored interventions for youth with co-occurring conditions. These interventions are essential for improving treatment options and shifting the focus away from residential treatment.

d. CMS should disaggregate network adequacy wait time data for substance use disorder treatment and recovery services specific to adolescents and racial and ethnic minorities, and should report the findings to Congress.

In 2023, CMS began evaluating marketplace plans for compliance with federally established network adequacy standards relative to time and distance. The evaluation has expanded to include wait times in 2024. Further transparency into youths' waiting times for SUD treatment is critical. According to a recent study of residential addiction treatment facilities, only seven states had a facility that accepted Medicaid, had a bed open the same day, and offered buprenorphine.[178] Because residential treatment access is often limited, the focus should be on expanding effective outpatient services for youth. Intensive outpatient programs, partial hospitalization programs, and other intensive treatment services offered in home- and community-based settings can provide timely access to care, often without the prolonged wait times associated with residential facilities. These services can be more flexible and allow for immediate intervention, greater family involvement, and the integration of MOUD.

e. SAMHSA should evaluate states' and tribal entities' engagement with SAMHSA's Program to Advance Recovery Knowledge (SPARK). This effort should include assessing SPARK's ability to help states and tribes adopt, scale, and evaluate evidence-based, culturally competent substance use recovery practices (e.g., peer-led programs, family-centered initiatives, and support groups) for youth.

Regarding youth opioid use disorder, the evidence base for recovery supports

is expanding, but experts are still determining which services ensure long-term success. Research highlights the importance of families' and caregivers' involvement in recovery, particularly through MOUD treatment and family-based interventions.[179,180] Family-centered approaches are especially crucial for Native American youth with SUD, and could potentially improve their engagement with care.[181,182] Peer support and recovery services also play a key role, as individuals who have navigated recovery offer relatable guidance, reduce stigma, and provide role models for youth. Youth preferences for services vary. Some benefit from the structure of intensive outpatient programs that offer regular meetings and accountability, while others prefer the flexibility and peer connections of 12-step groups.[183] As experts continue to explore effective recovery strategies, the federal government can assist states and tribal entities in building systems that promote long-term recovery.

SAMHSA's Program to Advance Recovery Knowledge (SPARK) initiative provides states, tribal entities, and other stakeholders with expert guidance, resources, and support to advance substance use recovery.[184] Launched in November 2023, the SPARK initiative promotes the adoption, implementation, and evaluation of evidence-based, culturally competent practices through comprehensive technical assistance and its online resource center, focusing on culturally tailored approaches, peer support integration, evaluation tools, and knowledge sharing.[185] Although SPARK prioritizes youth recovery needs, its newness raises questions about its effectiveness in helping states and tribal entities adopt, scale, and evaluate programs, such as youth recovery models, trauma-informed care, and peer support. SAMHSA can assess state and tribal engagement with SPARK on youth substance use recovery and develop strategies to strengthen participation among state and tribal leadership.

SAMHSA's other initiatives, such as Bringing Recovery Supports to Scale Technical Assistance Center, the National Child Traumatic Stress Network, and the Children's Mental Health Initiative, can coordinate with SPARK to improve the technical assistance offered.[186,187] SPARK staff can collaborate with program managers for the State Opioid Response and Substance Use Prevention, Treatment, and Recovery Services block grants to help recipients utilize existing funds to enhance youth recovery services. To ensure SPARK's sustainability and effectiveness, evaluating engagement is crucial, especially in addressing gaps in youth-specific recovery programs, peer specialists, and family-centered care for marginalized groups, including Native American youth. SAMHSA can also leverage SPARK to distribute existing resources on tribal behavioral health care and foster greater state and tribal participation.[188] Additionally, SAMHSA should assist states in using the Prevention Fellows program to embed youth recovery specialists or recovery evaluation researchers in relevant state-level entities (e.g., department of health), addressing critical needs in these areas.[189]

There is also a shortage of data on youth SUD recovery outcomes—such as employment, housing stability, drug use abstinence, and program attendance—

which are rarely disaggregated by age, gender, race, and geography. This lack of outcome tracking limits policymakers' ability to address disparities. Improved coordination, implementation, and data collection are needed to strengthen youth recovery services. Through targeted technical assistance, SPARK can help states and tribal entities adopt evidence-based practices that emphasize family engagement, peer support, and culturally competent care. SAMHSA can guide states in using federal grants and opioid settlement funds to expand youth-focused recovery efforts. Additionally, SAMHSA can assess how states and tribal entities use technical assistance to identify disparities at the state and tribal levels in recognizing, organizing, and participating in that assistance. By enhancing program implementation and evaluation, SPARK will support tracking long-term outcomes, enabling continuous improvement of equitable youth recovery services.

f. The Department of Justice (DOJ) should encourage states to use funding from the Edward Byrne Memorial Justice Assistance Grant Program to train juvenile justice professionals in culturally informed adverse childhood experiences (ACEs), trauma-informed interventions, and mental health and substance use conditions.

The DOJ's Edward Byrne Memorial Justice Assistance Grant Program provides funding to states, tribes, and local governments to support a broad range of criminal justice initiatives aimed at reducing crime.[190] These grants can be used for various purposes, including law enforcement, prosecution, crime prevention and education, corrections and reentry, and technology improvement.[191] Additionally, recipients can use Edward Byrne Memorial Justice Assistance Grant Program funds for drug treatment and enforcement, and mental health programs related to law enforcement and corrections programs.

The DOJ should allow and encourage states, local governments, and tribal entities to use grant money to train juvenile and adult justice professionals on culturally informed ACEs and trauma-informed practices. As is the case with many parts of the health care system serving youth with mental health and substance use conditions, the juvenile justice sector has experienced workforce shortages that became more pronounced in the wake of the COVID-19 pandemic.[192] The inability to recruit and retain staff can compromise safeguards for the youth they serve, and can lead to poor conditions (e.g., overcrowding). This training would help workers in the criminal justice system better understand the impact of childhood trauma, which can contribute to criminal behavior, and the need for mental health and substance use interventions.

To support grantees who wish to use funding from the Edward Byrne Memorial Justice Assistance Grant Program in this way, the DOJ should establish training guidelines. Such guidelines might include understanding ACEs and their long-term effects, identifying and responding to trauma-related behaviors,

incorporating mental health and substance use treatment into the justice system, and identifying and incorporating best practices for reducing stigma associated with youth mental health and substance use needs in juvenile correctional facilities and with justice-involved youth and young adults in adult carceral facilities. In addition to workforce training, grantees can also implement wellness support to help staff cope with any secondary on-the-job trauma.[193]

g. The DOJ, with SAMHSA and CMS, should improve data collection for youth who are incarcerated and should identify ways to reduce youth suicide and suicide risk in jails, in prisons and after release.

Youth suicide in U.S. jails and prisons is a significant public health and justice system crisis.[194] Adolescents in the justice system face heightened mental health risks due to trauma, SUD, and ACEs. Incarceration often worsens these risks, contributing to social isolation, limited access to quality mental health care, and additional trauma within correctional environments. However, data on youth suicides in jails and prisons remain scarce, making it challenging to assess the full extent of the issue or to determine the effectiveness of current interventions. Existing systems often do not adequately track mental health and suicide prevention efforts, resulting in care gaps for incarcerated youth.

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) at the Justice Department, tasked with preventing juvenile delinquency and improving the juvenile justice system, could enhance data collection efforts on youth mental health and suicide. Currently, OJJDP collects data through its Statistical Briefing Book Data program, which tracks information on juvenile arrests, detentions, case processing, and probation.[195] Additionally, the office gathers data on youth demographics, offense types, and facility conditions, but the examination of mental health outcomes, suicide prevention, and the effectiveness of behavioral health interventions within youth correctional settings is limited. Expanding data collection to include these areas would significantly enhance the ability to address youth suicide and mental health needs in jails, in prisons, and post-release by using probation data.

Such enhanced data collection could also support compliance efforts. The Consolidated Appropriations Act of 2023, which reformed the Medicaid Inmate Exclusion policy, has allowed Medicaid and CHIP to cover certain services for Medicaid-eligible youth and young adults.[196,197] Effective January 2025, this mandate includes case management, behavioral health screenings, and referrals to further services in the 30 days before and after release. However, CMS has yet to issue guidance for implementing this mandate, which affects youth under 21 and former foster youth up to age 26.[198] Similarly, CMS's September 2024 EPSDT guidance also requires screening and diagnostic services for Medicaid-eligible youth 30 days before reentry, so expanded data could inform the provision of and compliance with these service

requirements.[199] By partnering with SAMHSA, OJJDP could use data to better understand the risk factors for youth suicide in correctional settings and implement evidence-based, targeted interventions. Through the Consolidated Appropriations Act 2023 mandate, CMS can also illustrate how states can leverage the EPSDT benefit for justice-involved youth with mental health and substance use conditions.

This improved data would track critical outcomes, such as recidivism rates, youth mental health improvements, and the effectiveness of substance use interventions. Strengthening OJJDP's data collection and analysis capacity would not only enhance mental health interventions and suicide prevention protocols in juvenile facilities but also increase accountability and transparency, fostering improved conditions for incarcerated youth.

5. STRENGTHEN CRISIS AND STABILIZATION SYSTEMS

Children and adolescents, especially those with complex or acute behavioral health needs, require specialized crisis intervention and stabilization to prevent unnecessary emergency room visits, psychiatric hospitalizations, and interactions with law enforcement. The health care system often lacks the appropriate tools for addressing behavioral health crises, which can lead to prolonged waits in emergency departments or inappropriate responses from law enforcement. Without proper intervention, these crises can escalate, causing long-term trauma and worsening mental health outcomes. Youth in crisis need timely care tailored to their unique needs, minimizing the disruption to their daily lives and avoiding the overuse of costly and sometimes traumatic emergency services.

Recognizing these challenges, the federal government has issued guidance to improve youth crisis systems. In 2013, SAMHSA and CMS jointly released guidelines, and in 2022, SAMHSA followed up with more detailed guidance on youth crisis care.[200,201] Recent federal initiatives, such as the enhanced funding for mobile crisis services in Medicaid (expiring in March 2027) and the 5% crisis set-aside in the Mental Health Block Grant, have enabled some states to invest in these essential services.[202,203] However, a pressing need remains to expand and strengthen these systems to ensure that all youth can access appropriate crisis intervention when needed.

To address these gaps, the task force has prioritized recommendations that further develop crisis and stabilization models, invest in the crisis workforce, and secure sustainable financing for youth crisis systems. Expanding these services would help create a more effective, responsive crisis continuum that better meets the needs of young people facing behavioral health emergencies.

Further develop crisis and stabilization systems

a. SAMHSA and CMS should submit a joint letter to state Medicaid Directors encouraging the uptake of evidence-based crisis and stabilization models, such as the Mobile Response and Stabilization Services (MRSS) for children, using existing SAMHSA and CMS incentives.

SAMHSA and CMS should highlight how states can utilize the mobile crisis set-aside in the Community Mental Health Block Grant to implement and evaluate the effectiveness of the Mobile Response and Stabilization Services (MRSS) model, while also identifying barriers to scaling the model up nationally.[204] The MRSS model offers a comprehensive crisis intervention that includes mobile rapid response, 24/7 availability, assessment and referral, short-term stabilization, collaboration with other providers, and a family-centered approach. This evidence-based model empowers families and youth to recognize a crisis without needing a professional diagnosis and provides in-home stabilization and support services for up to eight weeks.

To successfully scale youth-specific crisis practices like MRSS, additional resources might be necessary, along with innovative strategies to expand the crisis workforce. The primary objective is to deliver community-based support and immediate assistance to families facing behavioral health crises related to their children, with a focus on de-escalation and stabilization within the home and skill-building. Several states, including Maryland, Ohio, Oklahoma, Oregon, and Washington, have adopted the MRSS model, demonstrating its potential effectiveness in crisis intervention.[205,206,207,208]

Although findings on the MRSS program show promise in addressing youth crisis and potentially demonstrating long-term savings, the suite of comprehensive services may lead to additional federal spending upfront if the program is scaled nationally.[209,210] The federal government should explore the effectiveness of and barriers to scaling the model nationally.

b. HHS, the Department of Defense (DOD), and the Department of Education should provide federal guidance on and technical support for administering and evaluating crisis response and stabilization services for youth in crisis across home, school, military, and community settings, with best practice standards of care for all services in the continuum.

SAMHSA's current guidance has been helpful for states in building their crisis systems.[211] Two years into the 988 call and text program, states believe they could use updated guidance about best practices, especially for stabilization. In SAMHSA's National Guidelines for Child and Youth Behavioral Health

Crisis Care, experts acknowledge that in-home de-escalation and stabilization supports are better for meeting youths' needs.[212] Currently, youth crisis care relies heavily on emergency departments, which are under resourced and may not be able to handle behavioral health crises. Although there are some promising stabilization models, such as Emergency Psychiatry Assessment, Treatment, and Healing units, that are located in formal health care facilities, there is not enough evidence that these are being used and are working well for youth.[213,214]

Service members in the National Guard and Reserve Component face similar challenges.[215] Addressing behavioral health crises is essential for young adults in the Guard and Reserves, where over 30% are age 25 or younger.[216] These "citizen soldiers" face higher rates of suicidal ideation and attempts than their active-duty counterparts, as they balance civilian life with military duties.[217,218] Many live far from military installations, relying on civilian mental health services during crises. However, poor coordination between civilian providers and military facilities often leads to gaps in care, especially during transitions between duty statuses. Civilian providers might also lack awareness of military-specific stressors, hindering effective follow-up care. Ensuring timely and coordinated crisis intervention is critical to the well-being and stability of these young service members.

Moreover, families of youth in crisis may need follow-up support. Programs must be family oriented and include support for caregivers. Evidence suggests that youth who have experienced behavioral health crises are more likely to stabilize and recover if they can remain in their homes.[219] Providers who administer in-home crisis stabilization note that youth appear to be more comfortable in their homes than in a formal health care setting. Although a default stabilization site tends to be emergency departments, practitioners in the Netherlands focus on intensive home treatment where multidisciplinary teams administer home-based crisis stabilization.[220] For youth with needs that cannot be met at home, the National Academy for State Health Policy has a toolkit with state-level case studies on additional youth stabilization best practices.[221]

HHS could use the toolkit and research on MRSS as a starting point for updating SAMHSA's 2023 best practice toolkit for youth crisis care.[222] HHS and the DOD can also further explore the benefits of home- and community-based stabilization services for young adults residing in higher education settings and young service members who transition between military and civilian health care facilities.[223] Any best practice outlined in official HHS publications would need to include an implementation plan with steps that states can take to scale these programs, and an evaluation plan.

c. Congress should direct HHS, in collaboration with the Federal Communications Commission (FCC), the Department of Transportation (DOT), and the Justice Department, to provide guidance and technical support and to clarify roles and responsibilities between public safety access point, law enforcement, and 988 call and text center personnel. This effort should involve outlining protocols to address overdoses and other behavioral health-related medical emergencies.

988 call and text personnel might not be fully equipped to handle medical emergencies that are related to behavioral health crises (e.g., overdoses). Moreover, routing calls from 911 to 988, or from 988 to 911, and through internet service providers can be difficult.[224] Stakeholders familiar with the 988 call and text center processes have noted that they run into issues locating texters who use web chat (not their phones), as this only provides IP addresses. They emphasized the need for a regulatory body to ensure that 988 call and text operators can locate individuals and support them if they are at imminent risk of suicide.

Although this proposal does not target youth, clarifying this diverse set of roles helps improve the equitable delivery of crisis services for marginalized youth, such as people of color and youth with disabilities. Reports from RAND and the National Council for Mental Wellbeing have both noted gaps in coordination and interoperability between the 988 and 911 systems.[225,226] Clearly defined roles and responsibilities from the FCC, DOT, and DOJ can help both the 988 and 911 systems handle behavioral health-related medical emergencies. As these agencies define their roles and policies surrounding issues such as geolocation and georouting, officials should clearly communicate these policies to the public. Campaigns may need to target youth and young adult callers to ensure they are informed on how 988 utilizes their location to provide appropriate care.

The National Association of State Mental Health Program Directors convened key stakeholders and, in 2023, released a playbook for public safety access points.[227] Public safety access (or answering) points are call centers typically operated by local government that handle emergency calls, such as those made to 911 and 988. The playbook aims to help public safety access points work better with 988 personnel, sets criteria for 988 readiness through core competencies, and describes best practices around the country. The playbook's recommendations are suggestive and not a mandate, but they can serve as a starting point for individuals in HHS (especially at SAMHSA) to outline roles for 988 personnel. The FCC can also use this playbook to understand issues that 988 personnel have, work with internet service providers to lower barriers, and identify protocols for public safety access points when their support for 988 calls or texts is needed.

d. To better inform policymakers of progress and challenges, Congress could direct HHS to require a standard set of state-specific data on youth behavioral health crisis services to be publicly reported as part of the Mental Health Block Grant. Additionally, HHS should direct CMS and SAMHSA to develop joint guidance on best practices and recommended structural, process, and outcome measures, including youths' and families' experiences with care.

The 988 Suicide and Crisis Lifeline and the 5% mobile crisis set-aside in the Mental Health Block Grant offer opportunities to expand crisis services and SAMHSA's overall understanding of crisis response performance. While recipients must report metrics to SAMHSA on its crisis response performance, no state-specific data are available on other aspects of the crisis continuum, including the capacity for youth mobile crisis and stabilization services. Current CMS measures also do not capture how well the crisis system(s) address behavioral health needs for youth. Several opportunities to identify and scale quality measures are available:

- CMS will report seven behavioral health measures as part of its 2025 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP ("Child Core Set"), two of which could help assess quality of care for crisis-adjacent services ("Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17" and "Follow-Up After Emergency Department Visit for Mental Illness: Ages 13 to 17").[228]
- Outside of CMS, the National Council for Mental Wellbeing has quality measures for crisis services (not specific to youth) from 2023, and the Meadows Mental Health Policy Institute has recommendations for quality measures for crisis services for youth from 2014.[229,230]

However, not as many resources are focused on assessing performance. Notably, the National Council convened experts to develop the Roadmap to the Ideal Crisis System 2021, which includes an extensive set of measurable criteria for states to assess implementation progress.[231] In our 2022 report on crisis response, BPC recommended that these be used to assess state-level progress on implementing crisis systems.[232] Mental Health America's State of Mental Health in America report notes that one of the primary reasons young people are not receiving care is their fear of coercive treatment.[233] As a result, it is important to capture data reported in the Mental Health Block Grant indicating how often this occurs and, importantly, youth's experience of care during an emergency response.

Various data are needed to provide valuable insights about implementation progress for the system overall. Performance measures could strengthen technical assistance capabilities and collaboration between states and the federal government, and offer insights about the location of care (e.g., rural

and tribal). The National Council's scorecard is split into three distinct areas: accountability and finance, basic array of capacity and services along the continuum, and basic clinical practice. HHS could use this scorecard as a starting point for performance measures that are tailored to youth crisis service needs, especially to ensure equitable care across the country. HHS could also work with AHRQ to identify hospital and ED data in the Health Care Cost and Utilization Project dataset that might better inform whether state crisis response services are affecting mental health and substance use-related visits among youth.

Invest in the crisis and stabilization workforce

e. Congress should support emergency medical services' youth crisis response by providing funding to the National Highway Traffic Safety Administration (NHTSA). This money would be used to revise the national Emergency Medical Services Education Agenda and other EMS training standards to better incorporate and promote responses to youth behavioral health crises.

Emergency medical services (EMS) personnel tend to be among the default emergency responders in rural and underserved areas, both for 911 and 988. Congress should provide funding to NHTSA, which oversees EMS within the Department of Transportation, to revise the national EMS Education Agenda and other guiding standards to incorporate crisis response training across EMS professionals.[234]

Over 10% of pediatric ambulance runs involve mental health emergencies, with considerable variation in the use of interventions like sedative medications and physical restraint.[235] EMS already faces staffing shortages: About 11% of full-time and 39% of part-time emergency medical technician positions were open in 2022. Insufficient training exacerbates the issue.[236] Expanding training materials can better support the existing and incoming workforce. Updated training standards would better ensure that first responders—regardless of location or the availability of crisis care infrastructure—have the skills needed to handle behavioral health crises, especially in underserved rural areas, and help individuals access more specialized services.

f. Congress should leverage funding from existing EMS-focused grant programs, such as HRSA's EMS for Children (EMSC) program, to build EMS capacity and expertise for youth crisis care and to better engage families.

The Health Resources and Services Administration's EMSC program provides resources for youth emergency services across all states, seven territories, and jurisdictions, affecting over 15,000 prehospital organizations and more than

5,000 hospitals. EMSC, which reaches an estimated 30 million children and families, advances pediatric emergency care through the EMSC Data Center and the Pediatric Emergency Care Applied Research Network.[237,238,239] A bill reauthorizing the program passed the House in May 2024.[240]

Other EMS-focused programs also support workforce capacity.[241] SAMHSA's Rural Emergency Medical Services Training program recruits and trains EMS personnel in rural areas to address SUD and co-occurring mental health disorders.[242] HRSA's Medicare Rural Hospital Flexibility Program – Emergency Medical Services Supplement strengthens rural EMS programs through recruitment, retention, and financial aid strategies.[243] These programs collectively bolster EMS capacity and support this critical segment of the crisis workforce. Capacity can also include telemental health services during a mental health emergency, which several states have successfully used.

The EMSC program is committed to high quality emergency care for youth.[244] It supports the National Pediatric Readiness Project, which evaluates overall pediatric readiness—a measure assessing emergency departments' ability to ensure they can coordinate health care, personnel, procedures, and medical equipment for ill and injured children.[245,246] The EMSC program scored highly in pediatric readiness. It is associated with 76% lower mortality in ill children and 60% lower mortality in injured children, and has saved at least 1,400 lives each year.[247] The EMSC program also includes a Family Advisory Network, which offers opportunities to further engage families to improve pediatric emergency care.[248] Although the EMSC program does not focus on behavioral health emergencies, it helped develop a toolkit for Pediatric Mental Healthcare Access (PMHCA) awardees who are seeking to expand their emergency care capabilities.[249] Other federal grant programs for EMS could have an impact on emergency care for youth even when they are not youth specific. For example, SAMHSA's Rural Emergency Medical Services Training program and HRSA's Medicare Rural Hospital Flexibility Program – Emergency Medical Services Supplement, which are designed to strengthen the rural EMS workforce, can support recruiting and retaining emergency workers to increase overall capacity.[250,251]

Besides helping to build workforce capacity, the EMSC and other relevant programs can contribute to developing expert resources that provide technical support to first responder programs. EMSC's toolkit for PMHCA awardees points to opportunities to collaborate across programs to enhance and improve crisis response among EMS personnel, as well as to improve emergency response among behavioral health providers. If passed, the bipartisan EMSC Reauthorization Act (H.R.6960) would reauthorize the EMSC program at $24.3 million annually for FY2025–FY2029. This is equivalent to previously appropriated amounts.[252]

g. CMS should publish and share lessons learned from the discontinued Emergency Triage, Treat, and Transport (ET3) Model to create sustainable financing for youth crisis services that serve any youth, at any time, regardless of ability to pay.

The Emergency Triage, Treat, and Transport (ET3) model was a five-year voluntary payment model that became active in March 2020 but ended early on December 31, 2023.[253] The model aimed to offer more flexibility to ambulance care teams to provide emergency care to Medicare Fee-for-Service beneficiaries following a 911 call. CMS provided payment for transport to EDs and alternative destination partners (e.g., community mental health centers) and care initiation in place (either in person or via telehealth). The goal of the ET3 model was to improve quality and lower costs by reducing avoidable transport to the ED and unnecessary hospitalizations that follow. However, the model was discontinued due to low levels of participation.

Alternative financing models are needed to ensure that a youth continuum of crisis care can be developed and sustained in states to serve all youth. While the ET3 model may have been beneficial to mental health and SUD emergency care, much is unknown about the impact of this model and the barriers to uptake (e.g., costs associated with 24/7 availability to serve anyone regardless of coverage). Learning from the discontinued ET3 model can help improve crisis-focused payment models.

h. The Department of Education should disseminate crisis line resources by directing eligible higher education institutions to include them on new student identification cards, so they are available to students and faculty. It should also collaborate with SAMHSA to develop and disseminate crisis protocols, especially relating to first episode psychosis and substance use disorder.

The Improving Mental Health Access for Students Act would require colleges and universities to provide contact information for the National Suicide Prevention Lifeline (988), Crisis Text Line, and a campus mental health center on student identification cards.[254] Several states (Arizona, California, Colorado, Illinois, and West Virginia) already require higher education institutions to include this information on their student ID cards.[255,256,257,258] The New York legislature approved a similar bill requiring student ID cards to contain the 988 number, and it is awaiting the governor's signature.[259]

Multiple studies show that college students are experiencing high rates of mental health and substance use issues.[260] The National Education Association reported that in 2023, 73% of college students experienced moderate to severe psychological distress.[261] College students also commonly use alcohol and illicit substances, such as stimulants and painkillers.[262] Since the COVID-19 pandemic, ED visits for mental health conditions, suicide-related behaviors,

and drug overdoses among college-age students have remained high.[263] This increase has led to heightened attention on the need for accessible behavioral health services on campuses. However, few students with mental health disorders receive any form of intervention.[264] Higher education counseling centers are overwhelmed, with long waiting lists and many counselors experiencing burnout. The ongoing prevalence of these crises highlights the need for enhanced support and intervention strategies. Providing colleges and universities with access to crisis protocol best practices tailored to their specific needs can improve their ability to respond effectively to mental health and SUD crises.

Crisis hotlines are highly effective: Less than 2% of those calling the National Suicide Hotline, which preceded the 988 Lifeline, and less than 1% of those texting 988 needing to be referred to emergency services.[265,266] Most callers report feeling significantly less depressed, suicidal, and overwhelmed, and feeling more hopeful after speaking with a crisis counselor. However, a 2023 Pew Charitable Trusts survey found that only 14% of individuals ages 18–24 have heard of 988 and know its purpose.[267] A recent study found that most university students would not use 988 for substance use concerns.[268] Ensuring higher education students are aware of these valuable resources and their role in addressing both mental health and substance use crises through their student IDs could be an effective strategy in increasing 988 utilization.

988 vendors, such as Crisis Text Line, which operates 988's texting capabilities, have additional resources for college-age individuals. One is Crisis Text Line's College Toolkit, which helps students identify strategies that help them take better care of their mental health.[269] Higher education institutions could also note national resources like the toolkit as part of the information included on student IDs. The Department of Education can implement a behavioral health advisory council for college-age youth, families, and mental health providers to provide feedback on recommendations related to national college mental health and substance use resources.

Recent increases in youth overdoses and suicidal ideation have shone a spotlight on higher education institutions' abilities to respond.[270,271] Preventive interventions, such as naloxone training and distribution, can build harm reduction capacity, but higher education institutions have the potential to create more formal crisis response systems.[272,273] The Department of Education's Best Practices Clearinghouse helps campus communities recover from the effects of COVID-19.[274] It includes resources that target the needs of relevant stakeholders in K-12 schools, early-childhood education programs, and higher education. It highlights best practices and lessons for safe and healthy environments, ways to provide support to youth and families, and ways to address faculty and staff well-being. Although the toolkit includes some crisis-specific best practices, many are not geared toward colleges and universities.[275]

Improve financing for crisis systems

i. HHS and the departments of Labor and Treasury should clarify MHPAEA requirements, ensuring that mobile crisis services and crisis stabilization are classified as emergency benefits and are covered under the No Surprises Act.

The No Surprises Act mandates that insurers cover crisis stabilization services without prior authorization, even if the provider is out of network.[276] These services must also comply with the MHPAEA. CMS clarifies that surprise-billing protections apply to behavioral health crisis response services classified as "emergency services" under state law.[277] However, these protections apply only in states where crisis stabilization is designated as emergency care. This creates inconsistency in coverage. Although the Department of Labor's 2022 rules confirmed that behavioral health crises qualify as emergency services, confusion remains about whether insurers must cover crisis receiving and stabilization facilities.[278] Clearer guidelines would help ensure broader funding for these essential services.

Despite improvements in behavioral health coverage, most private insurance plans do not cover mobile crisis services, which are critical in a comprehensive crisis response system. In BPC's 2022 report, we recommended extending coverage for mobile crisis services, including youth-specific models like Mobile Response and Stabilization Services (MRSS).[279] Washington state has already enforced MHPAEA to require health plans to cover mobile crisis response at parity with emergency services.[280] The federal government could adopt a similar strategy to improve access.

To ensure equitable coverage of crisis services, the departments of Labor, Health and Human Services, and Treasury should issue guidance or update regulations to classify behavioral health crisis services, including mobile crisis teams, under MHPAEA's emergency benefits. This would align treatment limitations with those for emergency medical services, such as ambulance transport or ED care.

j. CMS and SAMHSA should coordinate Medicaid coverage, block grants, opioid settlement funds, and other federal programs to support crisis services for youth mental health and SUD, as well as to support best practices; they should also elevate youth crisis services using the crisis set-aside in the Community Mental Health Block Grant.

Several grant programs and Medicaid incentives are available to fund crisis services, but gaps in Medicaid coverage create challenges for fully supporting the entire continuum of care, especially for youth. Coordinating federal grant

funding can help bridge these gaps and strengthen partnerships across programs. States also have flexibility from opioid settlement funds, offering additional resources to fill these coverage gaps. In BPC's 2022 report, we recommended "braiding" federal funding streams, using House and Senate Appropriations Committee language to require collaboration between similar programs.[281] This would allow federal agencies to maximize resources for youth crisis services, while directing states to identify Medicaid coverage gaps and supplement them with grants such as SAMHSA block grants or State Opioid Response program funds.

The Children's Interagency Coordinating Council is a collaborative body designed to bring together key federal and state agencies, policymakers, and stakeholders to address youth's needs, including mental health, substance use, education, and social services. By coordinating efforts across sectors, the council has the potential to play a key role in coordinating funding from Medicaid, federal block grants, opioid settlement funds, and other funding streams to maximize impact while adhering to funding requirements. The council could coordinate these funds to promote best practices, enhance youth crisis service delivery, support workforce development, and establish data systems to reduce duplication and ensure youth crisis services are well-funded and effective.

The 2021 Consolidated Appropriations Act required a 5% crisis set-aside within SAMHSA's Mental Health Block Grant to enhance crisis services nationwide. Although there is guidance on how these funds can be used, it does not address best practices for a youth crisis continuum or require states to report on how they are using the set-aside.[282] With the Mental Health Block Grant receiving over $1 billion annually, some states have allocated the set-aside to support implementing the 988 program. However, without detailed data, it remains difficult for the federal government to ensure long-term support for crisis services.

To improve transparency and effectiveness, states should also collaborate with SAMHSA to identify how they are using these crisis funds and provide regular reporting. This would help the federal government offer better support and ensure that youth crisis services are sustained, evaluated, and improved based on best practices.

k. CMS should provide technical support to states on how to claim the enhanced federal match for mobile crisis services under the American Rescue Plan and extend the enhanced funding opportunity for an additional three years.

As mentioned earlier in the report, states can leverage an 85% enhanced Medicaid match to develop and expand mobile crisis response services for three years until March 31, 2027, covering various costs associated with establishing and running these services, including administrative costs and IT system enhancements.[283] Since February 2024, only 15 states have taken advantage of the enhanced federal match for expanded mobile crisis services.[284] To encourage states to improve Medicaid coverage for youth-specific crisis services, CMS should provide targeted technical support to states that received planning grants to expand their mobile crisis services but have yet to do so, and it should extend the expiration of the enhanced funding an additional three years.

To help states fully leverage this funding, CMS can assist them in defining mobile crisis response team structures, assessing youth-specific training, reviewing transportation policies, enhancing telehealth, defining crisis episodes, and maximizing other Medicaid incentives.[285,286,287] Increasing state-level adoption of the enhanced funding would increase overall capacity to respond to youth in crisis. Providing this technical assistance will help build crisis capacity without incurring extra federal costs before the match expires.

CMS could ensure that state Medicaid agencies use SAMHSA's National Guidelines for Child and Youth Behavioral Health Crisis Care as the baseline for covering youth crisis services across the care continuum, in addition to exercising the enhanced funding for mobile crisis.[288] Currently, payers refer to SAMHSA's National Guidelines for Behavioral Health Crisis Care, which focus primarily on adult crisis services, to guide their coverage. Although payers typically fund behavioral health crisis care through a mix of payments, coverage for specific services—such as emergency department visits, crisis stabilization units, mobile crisis teams, and short-term inpatient care—varies significantly by payer and plan.

SAMHSA's national guidelines define each component of the crisis continuum, but payers often focus on the adult-specific guidelines, neglecting to fully adopt the service criteria for youth crisis care. CMS could offer technical support to state Medicaid agencies, highlighting how they can leverage the Early and Periodic Screening, Diagnostic, and Treatment benefit to implement SAMHSA's National Guidelines for Child and Youth Behavioral Health Crisis Care, thereby expanding service coverage for youth crisis services.

To inform policymaking, CMS should also collect essential data, such as service utilization, expenditures, outcomes, and how states use the funds to improve crisis response. Gathering this data will enable more effective policymaking for mobile crisis services and ensure that states are making the most of existing federal benefits.

Conclusion

The scale of our nation's youth mental health and substance use crises demands immediate action. The recommendations from BPC's Youth Mental Health and Substance Use Task Force provide a clear roadmap to strengthen the federal response to these crises. With strong federal leadership and actionable, evidence-based policies, we can ensure children, adolescents, and young adults receive the care and support they need to thrive and contribute to a healthier, more productive society.

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