

## TREATMENT OF MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS IN CHILDREN AND ADOLESCENTS ENROLLED IN MEDICAID AND CHIP DURING THE EARLY COVID-19 PUBLIC HEALTH EMERGENCY

### KEY POINTS

- Use of mental health services during the COVID-19 public health emergency declined for children and adolescents in Medicaid. Little is known about how this overall decline varied by type of service, type of behavioral health condition and medication use. This analysis used Transformed Medicaid Statistical Information System data to fill this knowledge gap for children and adolescents ages 3-17 in the early public health emergency. Findings can be used to inform pediatric mental health capacity planning for emergency planning efforts.
- Average monthly mental health service use declined slightly, by 4.6%, at the start of the public health emergency among children and adolescents with a mental health condition.
- For children and adolescents with mental health conditions, the average monthly use of outpatient services declined by 7.5%; the average monthly use of telehealth services increased by 23.6%; and the average use of psychotropic medication remained stable.
- Child and adolescent beneficiaries with attention-deficit/hyperactivity disorder and behavior/conduct disorder experienced a larger decline in average rate of service use than beneficiaries with other conditions (7% and 10% declines, respectively). During the same period, average rate of service use increased by 22% among beneficiaries with other mental health conditions (including eating disorders, some sleeping disorders, and uncategorized mental health conditions).
- Child and adolescent substance use disorder (SUD) service use during the public health emergency declined by 4% compared with the pre-emergency level.
- For children and adolescents with SUDs, the average use of outpatient services between January 2019-February 2020 and March 2020-December 2020 remained stable; the average use of telehealth increased by 2.3%; and the average use of medication for opioid use disorder remained the same during these periods.

### BACKGROUND

As the COVID-19 public health emergency progressed, children and adolescents' need for mental health treatment grew. The Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission found that before the emergency period, only half of children and adolescents enrolled in Medicaid or CHIP who had a major depressive episode received treatment.<sup>1</sup> Nearly 70% of adolescents ages 12-17 reported that the public health emergency affected their mental health negatively during 2020.<sup>2</sup> Further, emergency room visits for suspected suicide attempts by adolescents ages 12-17 increased during the public health emergency.<sup>3</sup> However, receipt of mental health services among children and adolescents has not kept pace with this increased need: during the public health emergency, children and adolescents younger than 19 enrolled in Medicaid and CHIP used 23% fewer mental health services and 24% fewer substance use disorder (SUD) services than they did in the same period before the emergency.<sup>4</sup> Numerous studies have

highlighted challenges in obtaining specialist treatment for children’s and adolescents’ mental health and SUD needs, and these challenges are particularly pronounced among children insured by Medicaid and for certain demographic and geographic groups (i.e., children/adolescents of Hispanic or Black non-Hispanic race/ethnicity; lacking a medical home; uninsured or receiving public insurance; without adequate and continuous insurance over the past 12 months; or from a household with lower income or with a single parent or other non-two parent structure).<sup>3,5,6,7</sup> An important omission in the literature, however, has been the impact the public health emergency has had on mental health and SUD service use by *specific* type of service and by type of mental health condition, which can help to more precisely identify persistent gaps in the delivery of pediatric behavioral health services, and in turn inform capacity planning and other policy actions to expand access to care.

This brief provides additional insight into children’s and adolescents’ mental health service use in Medicaid and CHIP during the early public health emergency using a national Medicaid claims database. Specifically, this study examines mental health and SUD service use during the early public health emergency among Medicaid-covered children compared with use before the emergency by service type, diagnosis, and use of psychotropic medication for opioid use disorder (MOUD) and medication for alcohol use disorder. These findings are intended to inform efforts to increase access to mental health and SUD services for children and adolescents enrolled in Medicaid and CHIP.

## METHODS

This analysis relied on the 2018-2020 Transformed Medicaid Statistical Information System Analytic Files (TAF) Research Identifiable Files (RIF).<sup>i</sup> We used the annual Demographics and Eligibility (DE) file and the four claims files: (1) inpatient; (2) long-term care; (3) other services; and (4) pharmacy. The annual DE file includes demographic, eligibility, and enrollment information for all Medicaid and CHIP beneficiaries enrolled during the calendar year. We analyzed DE records from 2018 to 2020 to identify demographic and enrollment characteristics. The claims files include fee-for-service claims, managed care encounters, and financial transaction records (including capitation payments, service tracking claims, and supplemental payments) paid for by Medicaid or CHIP. We analyzed claims records from 2018 to 2020 for all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands to identify mental health and SUD conditions<sup>ii</sup> and related service use.

We limited our analysis to beneficiaries enrolled in Medicaid or CHIP for at least six consecutive months in each year, who were eligible for full or comprehensive benefits, were ages 3-17. Mental health conditions include attention-deficit/hyperactivity disorder (ADHD); anxiety, behavior or conduct disorders; depression; mood disorders (including bipolar disorder); psychotic disorders; trauma or stress related disorders; Tourette’s syndrome and tic disorders; and other mental health conditions.<sup>iii</sup> SUD conditions include alcohol use disorder, opioid use disorder, and other drug use disorders (cannabis; sedative, hypnotic or anxiolytic; cocaine; stimulants; hallucinogens; inhalants; and codes for “other psychoactive substance abuse”).

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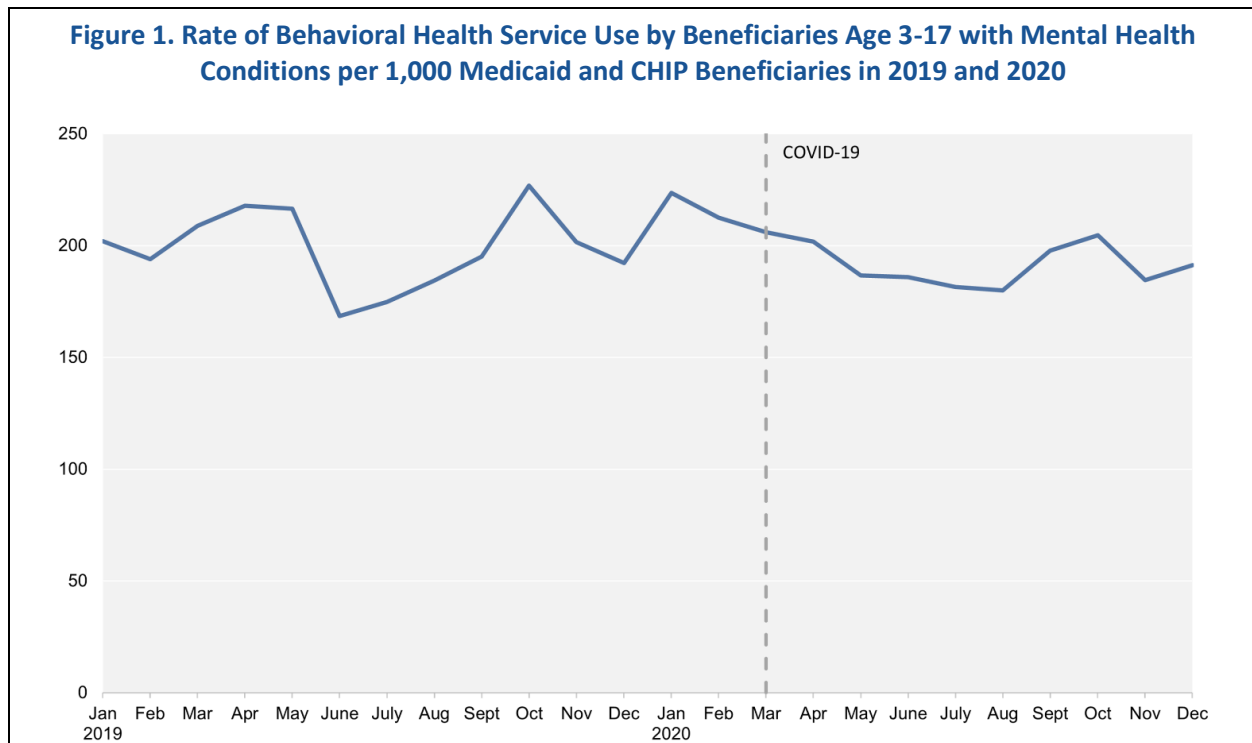
<sup>i</sup> We used TAF RIF for 2018-2019 in the lookback period to identify beneficiaries with mental health and SUD conditions.

<sup>ii</sup> We identified mental health and SUD conditions using the Centers for Medicare & Medicaid Services’ standardized approach for identifying individuals with mental health and SUD conditions in claims data, which is available from the Chronic Conditions Data Warehouse.

<sup>iii</sup> Other mental health conditions include eating disorders; sleeping disorders; fictitious disorder imposed on self, unspecified; mental health and behavioral disorders associated with the puerperium, not elsewhere classified; psychological and behavioral factors associated with disorders or diseases classified elsewhere; and unspecified behavioral syndromes associated with physiological disturbances and physical factors.

We calculated the number of children and adolescents enrolled in Medicaid and CHIP who received any behavioral health services for each month from 2019 to 2020 by mental health and SUD condition, and by type of service. We then counted behavioral health visits and medications for alcohol use disorders (acamprosate, antabuse, disulfiram, and naltrexone) and opioid use disorders (buprenorphine, methadone, and naltrexone) and psychotropic prescriptions per 1,000 beneficiaries, by month, in 2019 and 2020, with January 2019 to February 2020 as the pre-COVID period and March 2020 to December 2020 as the COVID-19 period. We identified a behavioral health claim as one with a diagnosis code for a mental health and SUD condition; or a prescription claim for MOUD. The diagnostic codes were included regardless of their position on the claim. We then classified behavioral health claims into either an inpatient or long-term care stay; or a claim for emergency care, intensive outpatient services or partial hospitalization; outpatient or telehealth services based on the revenue codes, procedure codes, or modifiers on the claim.

## FINDINGS



**Source:** Transformed Medicaid Statistical Information System Analytic Files, 2018-2020 version 5.

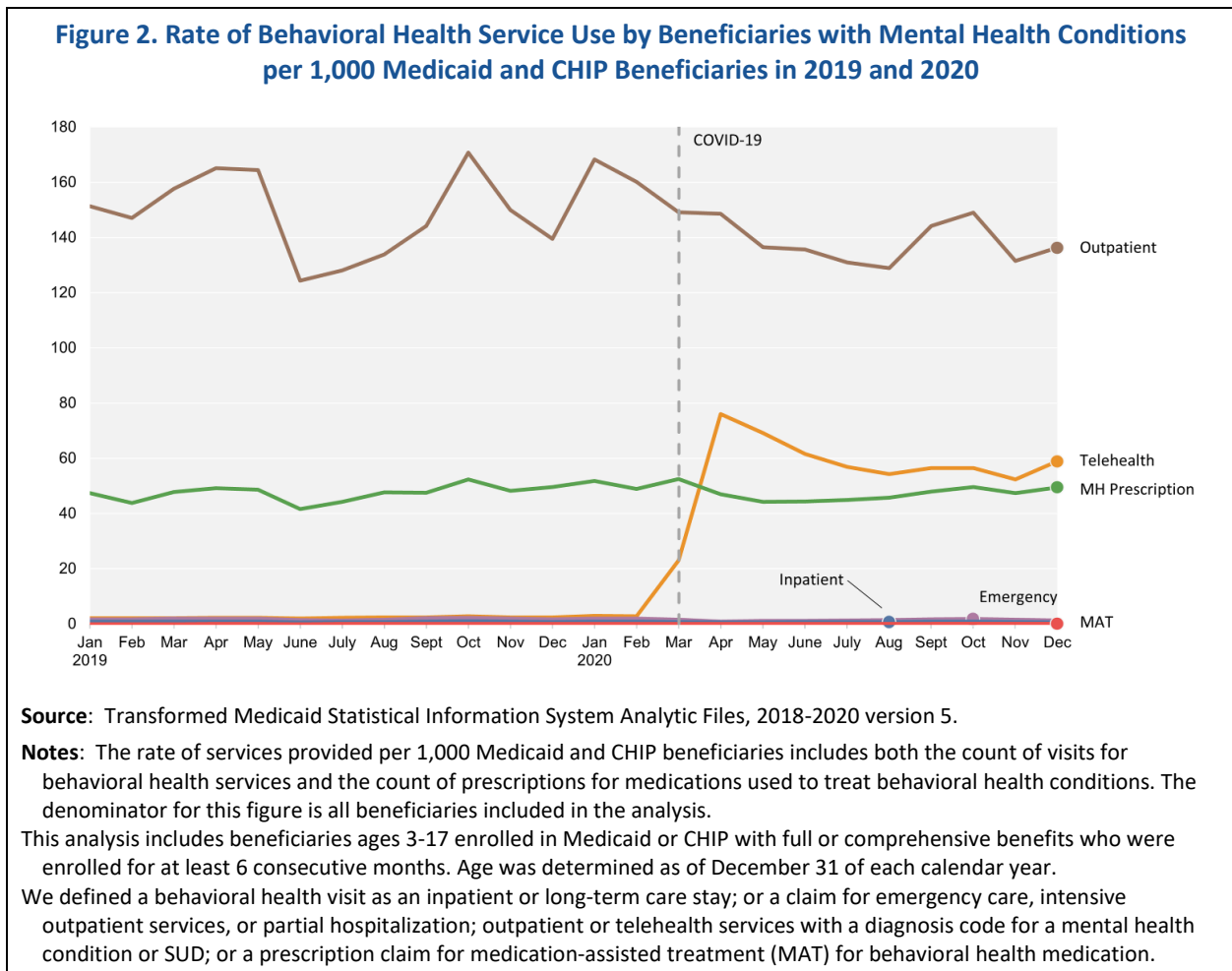
**Notes:** The overall rate of services provided per 1,000 Medicaid and CHIP beneficiaries with mental health conditions includes both the count of visits for behavioral health services and the count of prescriptions for medications used to treat behavioral health conditions. The denominator for this figure is all beneficiaries included in the analysis.

This analysis includes beneficiaries ages 3-17 enrolled in Medicaid or CHIP with full or comprehensive benefits who were enrolled for at least 6 consecutive months. Age was determined as of December 31 of each calendar year.

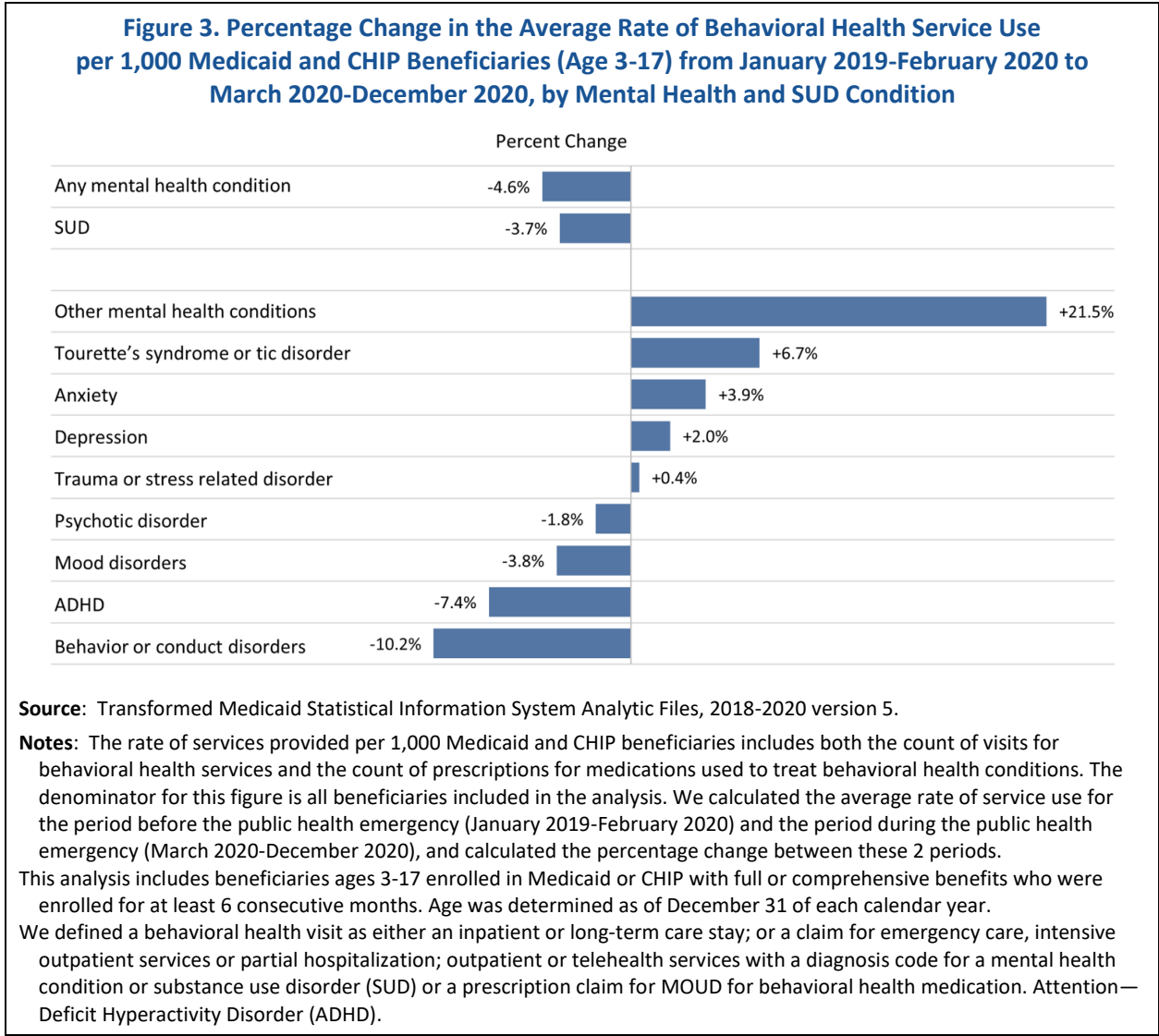
**The average monthly rate of treatment for children and adolescents with mental health conditions declined slightly by 5% from before the COVID-19 public health emergency to during the early emergency for the nearly 4.5 million Medicaid and CHIP beneficiaries ages 3-17 included in this analysis (Figure 1).** On average, from January 2019 through February 2020, Medicaid and CHIP beneficiaries with mental health conditions received 201.2 behavioral health services per 1,000 beneficiaries per month. When the COVID-19 public health emergency (PHE) was declared in March 2020, receipt of mental health treatment began a declining trend that continued through August 2020, after which it fluctuated up and down through December, 2020. On average, during the emergency in 2020, Medicaid and CHIP beneficiaries with mental health conditions received 192.0

behavioral health services per month per 1,000 beneficiaries (from March 2020 to December 2020), representing a 4.6% decline in average behavioral health service use compared to prior to the public health emergency. Beneficiaries with mental health conditions received the most behavioral health services in March 2020 (205.9 services per 1,000 beneficiaries) and the fewest in August 2020 (180.0 services per 1,000 beneficiaries).

**Changes in behavioral health service use by beneficiaries with mental health conditions during the early public health emergency varied by the type of service provided (Figure 2).** Over the course of the emergency, use of outpatient behavioral health services declined by 7.5% among beneficiaries with mental health conditions, from an average of 150.2 outpatient services per 1,000 beneficiaries per month from January 2019 to February 2020 to an average of 139.1 outpatient services per 1,000 beneficiaries per month from March 2020 to December 2020. As expected, use of telehealth services for mental health increased during the public health emergency, from an average of 2.3 telehealth services per 1,000 beneficiaries per month from January 2019 to February 2020 to an average of 56.5 telehealth services per 1,000 beneficiaries per month from March 2020 to December 2020. Psychotropic medication use remained stable for beneficiaries with mental health conditions during the public health emergency, declining from an average of 47.7 prescriptions per 1,000 beneficiaries per month from January 2019 to February 2020, to an average of 47.3 prescriptions per 1,000 beneficiaries per month from March 2020 to December 2020. We also found some variation based on school year enrollment vs out of schools which impacts the month to month estimates, which is why we are presenting the overall difference in trends, especially in outpatient services.

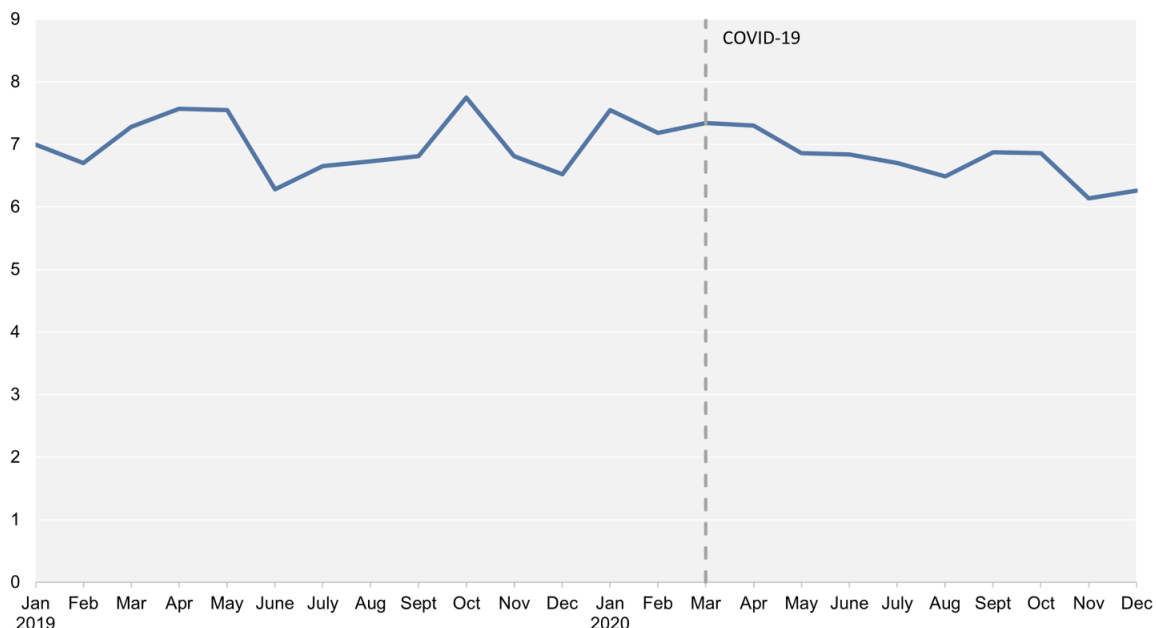


The rate of behavioral health service use among beneficiaries with a mental health condition varied by the type of mental health condition over the course of the public health emergency. (Figure 3). For example, beneficiaries with ADHD and behavior/conduct disorder experienced larger declines in the average rate of service use -- 7% and 10% declines, respectively -- than beneficiaries with other conditions. During the same period, the average rate of service use *increased* by 22% among beneficiaries with other mental health conditions (including eating disorders, some sleeping disorders, and uncategorized mental health conditions). During the same period, the average rate of service use increased by 7% for beneficiaries with Tourette’s syndrome or tic disorder, 4% for beneficiaries with anxiety, and 2% for beneficiaries with depression.



**The average monthly rate of behavioral health treatment for children and adolescents with SUDs remained stable from the period before the COVID-19 public health emergency and during the early public health emergency (Figure 4).** On average, from January 2019 through February 2020, Medicaid and CHIP beneficiaries with SUDs received 7.0 behavioral health services per 1,000 beneficiaries per month. During the early public health emergency, Medicaid and CHIP beneficiaries with SUDs received an average of 6.8 behavioral health services per month per 1,000 beneficiaries (from March 2020 to December 2020), representing a 3.7% decline in average monthly rate of behavioral health service use for those with SUD as compared to prior to the emergency. Beneficiaries received the most services to treat SUDs in March 2020 (7.3 services per 1,000 beneficiaries) and the fewest in November 2020 (6.1 services per 1,000 beneficiaries).

**Figure 4. Rate of Behavioral Health Service Use by Beneficiaries with SUDs per 1,000 Medicaid and CHIP Beneficiaries in 2019 and 2020**



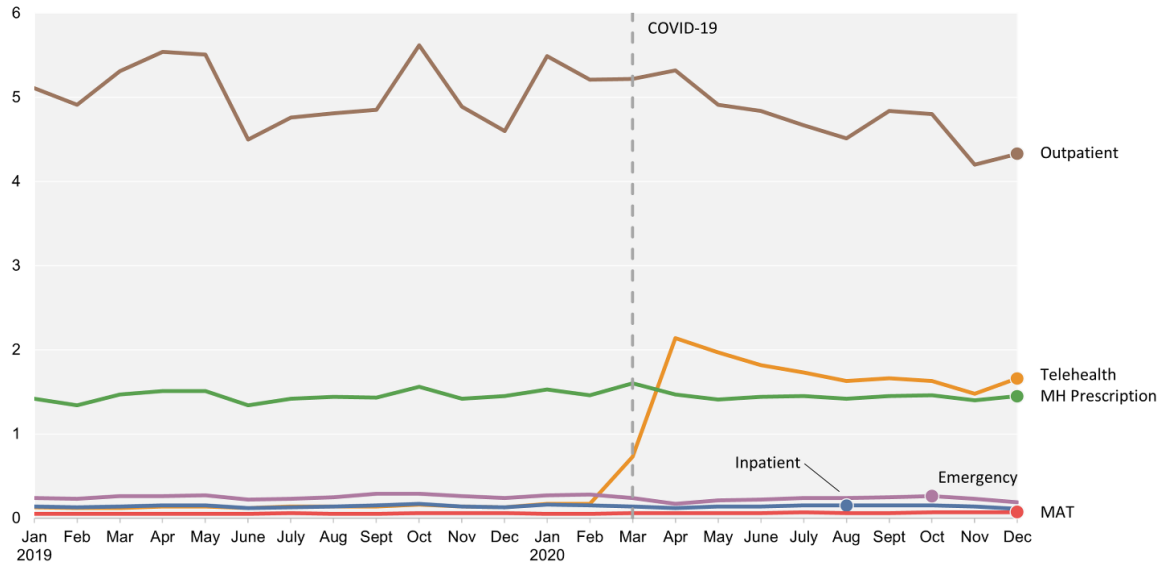
**Source:** Transformed Medicaid Statistical Information System Analytic Files, 2018-2020 version 5.

**Notes:** The overall rate of services provided per 1,000 Medicaid and CHIP beneficiaries includes both the count of visits for behavioral health services and the count of prescriptions for medications used to treat behavioral health conditions. The denominator for this figure is all beneficiaries included in the analysis.

This analysis includes beneficiaries ages 3-17 enrolled in Medicaid or CHIP with full or comprehensive benefits who were enrolled for at least 6 consecutive months. Age was determined as of December 31 of each calendar year.

**Changes in service use during the early public health emergency for the treatment of SUD conditions varied by the type of service provided (Figure 5).** Over the course of the early emergency, use of outpatient behavioral health services remained stable among beneficiaries treated for SUDs, from an average of 5.1 outpatient services per 1,000 beneficiaries per month from January 2019 to February 2020 to an average of 4.8 outpatient services per 1,000 beneficiaries per month from March 2020 to December 2020. Telehealth service use increased for beneficiaries with SUD during the public health emergency but still remained low, from an average of 0.2 telehealth services per 1,000 beneficiaries per month from January 2019 to February 2020 to an average of 1.7 telehealth services per 1,000 beneficiaries per month from March 2020 to December 2020. Use of MOUD remained the same for beneficiaries with SUD conditions between January 2019-February 2020 and March 2020-December 2020 at 1.5 prescriptions per 1,000 beneficiaries per month.

**Figure 5. Rate of Behavioral Health Service Use by Beneficiaries Age 3-17 with SUDs per 1,000 Medicaid and CHIP Beneficiaries in 2019 and 2020**



**Source:** Transformed Medicaid Statistical Information System Analytic Files, 2018-2020 version 5.

**Notes:** The rate of services provided per 1,000 Medicaid and CHIP beneficiaries includes both the count of visits for behavioral health services and the count of prescriptions for medications used to treat behavioral health conditions. The denominator for this figure is all beneficiaries included in the analysis.

This analysis includes beneficiaries ages 3-17 enrolled in Medicaid or CHIP with full or comprehensive benefits who were enrolled for at least 6 consecutive months. Age was determined as of December 31 of each calendar year.

We defined a behavioral health visit as either an inpatient or long-term care stay; or a claim for emergency care, intensive outpatient services or partial hospitalization; outpatient or telehealth services with a diagnosis code for a mental health condition or SUD; or a prescription claim for medication-assisted treatment for behavioral health medication.

## LIMITATIONS

There are several limitations to the analysis. First, claims data contain only information about services provided. We cannot assess how the underlying prevalence of mental health and SUD conditions among Medicaid or CHIP-enrolled children has changed during the COVID-19 public health emergency, and therefore to what extent any changes in utilization affected unmet need. In particular, COVID-related changes in Medicaid eligibility/enrollment increased not only the total number of children eligible for treatment, but also potentially changed the composition of the Medicaid and CHIP-enrolled youth population in terms of the underlying prevalence and severity of behavioral health conditions. Second, we are limited to the diagnosis and procedure codes included on medical claims to identify mental health and SUD conditions and services. Providers might not document all relevant diagnosis or procedure codes if they are not required for reimbursement. This might result in undercounting of mental health and SUD conditions and services.

## DISCUSSION

After the onset of the COVID-19 public health emergency, service use varied by treatment type and by condition, with outpatient MH use declining, and telehealth MH use increasing, while for SUD services the service use remained stable except for an increase in SUD telehealth services. Medication use in our sample remaining stable between 2019 and 2020 for both children and adolescents with MH or SUD.

The changes in service use for children and adolescents enrolled in Medicaid and CHIP during the onset of the COVID-19 public health emergency is consistent with other research on the use of mental health and SUD care during the public health emergency. Similar variations in the use of outpatient mental health care for children and adolescents were found in Ontario, Canada.<sup>8</sup> Our findings build on this research by analyzing the national rate of service use by children and adolescents in the United States enrolled in Medicaid and CHIP, and by including children and adolescents with SUDs. Similarly, the marked increase in the use of telehealth services aligns with existing research and gives us insight into the use of telehealth services by children and adolescents, and for those with mental health conditions and SUDs.<sup>4,9</sup> In addition, prior research on medication use for the treatment of behavioral health conditions has shown that use remained relatively stable throughout the public health emergency.<sup>10,11</sup> However, our results demonstrate this finding for the children and adolescents enrolled in Medicaid and CHIP.

The increase in service use among beneficiaries with other mental health conditions (including eating disorders, some sleeping disorders, and uncategorized mental health conditions) might be linked to an increase in need for services,<sup>12</sup> an increase in the prevalence of unclassified or new types of disordered behavior, or increased utilization of MH and SUD services due to growing awareness of these disorders and reduced stigmatization over time.<sup>13</sup> The increase in treatment of other mental health conditions might also reflect use of medication to gain behavioral compliance.<sup>14</sup> In addition to the increase in use of treatment for other mental health disorders, mental health and SUD providers have reported an increase in diagnoses of Tourette's syndrome and tic-related disorders in children and adolescents, particularly adolescent girls, during the COVID public health emergency.<sup>15,16</sup> Research has also identified increased clinical need for mental health and SUD services for children and adolescents diagnosed with anxiety and depression during COVID.<sup>17</sup>

These findings could be used to better understand the degree to which children and adolescents are diagnosed with and treated for specific mental health and SUD conditions, the types of Medicaid and CHIP services that they use, and how the COVID-19 public health emergency has impacted these patterns. Other studies that considered Medicaid and CHIP data from 2019-2020 showed that increased use of telehealth during the PHE did not fully account for the decrease in in-person mental health services among children,<sup>18</sup> especially Hispanic, Black non-Hispanic or American Indian/Native American children.<sup>19</sup> Several studies from this period concluded that a combination of in-person and telehealth services was necessary to support people with behavioral health conditions.<sup>20,21</sup> These findings can inform future emergency planning efforts when planning for pediatric behavioral health care capacity,.

HHS has led the national response to the children's and youth mental health crisis. In December 2021, the U.S. Surgeon General issued an advisory on children's mental health that included a call to improve research on children's mental health needs and trends in service use.<sup>22</sup> This advisory was followed by a national call to strengthen the mental health and SUD care system.<sup>23</sup> Additional guidance for state Medicaid agencies on how to support school-based mental health services for children and adolescents,<sup>24</sup> and guidance on using federal resources to expand the continuum of behavioral health care available to children and adolescents have been published.<sup>25</sup> Providing treatment where children are -- in both community and clinical settings -- can improve children and youth's well-being as part of comprehensive federal and state approach to address the youth mental health crisis the United States has been facing.



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