American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

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Senator Ron Wyden
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington DC, 20510

Senator Mike Crapo
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo,

The American Academy of Pediatrics (AAP), a non-profit professional organization of 67,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents, and young adults, welcomes this opportunity to provide comments in response to the Senate Finance Committee Request for Information on Barriers to Accessing Mental Health Care.

The COVID-19 pandemic has had a profound effect on the emotional and behavioral health needs of children, adolescents, and families. There are many factors unique to this pandemic (e.g., duration of the crisis, rapidly changing and conflicting messages, need for quarantine and physical isolation, and uncertainty about the future) that have increased its effects on emotional and behavioral health. Groups with a higher baseline risk, such as populations of color, communities and families living in poverty, historically under resourced communities, children who are refugees and seeking asylum, children and youth with special health care needs, and children involved with the child welfare and juvenile justice systems, may be especially vulnerable to these effects. The impact of the pandemic is also compounded by the interruption in vital supports and services including school, health care services, and other community supports.

This is why AAP recently joined the American Academy of Child and Adolescent Psychiatry and the Children's Hospital Association to declare a National State of Emergency in Children's Mental Health. The challenges facing children and adolescents are so widespread that we are naming the situation exactly what it is, a national emergency for children and adolescents. We must identify strategies to meet these challenges through innovation and action, using state, local and national approaches to improve the access to and quality of care across the continuum of mental health promotion, prevention, and treatment. And we must tackle the disproportionate impact of the pandemic on young people in communities of color who face inequities resulting from structural racism.

Emotional and behavioral health challenges were of growing concern before the COVID-19 pandemic, and the public health emergency has acutely exacerbated these challenges. The pandemic highlights preexisting disparities in morbidity and mortality, access to health care, quality education, affordable housing, adequate nutrition, and safe environments, which create more challenges and stressors for many families and communities. Studies have found

higher rates of anxiety, depression, and post-traumatic symptoms among children during the pandemic, especially among young people of color.

Suicide is the second leading cause of death of youth ages 10-24 in the U.S. and rates have been rising for decades.[i] Between March and October 2020, the percentage of emergency department visits for children with mental health emergencies rose by 24 percent for children ages 5-11 and 31 percent for children ages 12-17.[ii] The CDC also found a more than 50 percent increase in suspected suicide attempt Emergency Department visits among girls ages 12-17 in early 2021 as compared to the same period in 2019.[iii]

Last spring, the AAP, joined by 29 other leading organizations, released a comprehensive set of Child and Adolescent Mental and Behavioral Health Principles that, if enacted in policy, would increase access to evidence-based prevention, early identification, and early intervention; expand mental health services in schools; integrate mental health into pediatric primary care; strengthen the child and adolescent mental health workforce; increase insurance coverage and payment; extend access to telehealth; support children in crisis ; and address the mental health needs of justice-involved youth. We recommend the principles document to you as develop forthcoming legislation.[iv]

Now more than ever, families and children from infancy through adolescence need access to mental health screening, diagnostics, and a full array of evidence-based therapeutic services, including trauma-informed care to appropriately address their mental and behavioral health needs. Tackling the pediatric mental health crisis requires a comprehensive approach that addresses the full continuum of healthy mental development and includes promotion and prevention, early intervention and treatment as well as crisis response. To do this, we must ensure that children are able to access care in the settings where they are: schools and early childcare settings, their pediatrician's office, community settings, and emergency departments. This is especially important given the serious shortages of pediatric mental health professionals, which is impeding access to care for children.

While detailed comments in response to the RFI are below, we'd like to highlight several specific policy recommendations that we urge you to consider as you draft legislation. We recommend the committee: (1) support the development of sustainable funding models that allow for integration of mental health practitioners in a pediatric primary care practice; (2) allow providers to bill for time spent coordinating care and provide funding for care coordinators or navigators who help families navigate the mental health system; (3) increase payment rates for mental/behavioral health care; (4) allow providers to bill non-specific codes when a child does not have a diagnosable condition but has significant mental health needs that require care; and (5) stand up a trauma-informed support system that children and families as well as pediatricians can access when children are in crisis.

AAP stands ready to work with you to further develop these ideas in order to ensure children and adolescents are able to access the comprehensive mental health care they so desperately need.

Unique Needs of Children and Adolescents

Given the impact of the pandemic on children's mental health which has exacerbated challenges children faced prior to the pandemic, any redesigning of the U.S. mental and behavioral health care system must adequately and specifically address the needs of children. From prevention to early identification to treatment to crisis intervention, reforming our mental health care system cannot be achieved without addressing the full continuum of children's needs. Children are not little adults, and the behavioral health care needs of children

differ from those of adults. For children, the continuum of care spans promotion of mental health, prevention and early identification of behavioral health issues, assessment, referral, and management/co-management of behavioral health issues. The severity of mental health issues in children and adolescents is predominately mild to moderate, and treatment is often focused on maximizing functioning of the child, reducing distress for the child and family, and prevention of adult morbidity. Solutions for adults are not the same as solutions for children. Half of the adults in the United States with a mental health disorder had symptoms by the age of 14 years.[1] Children whose mental health needs go unaddressed grow into adults whose needs are also likely to be unaddressed and more severe.

To date, a disproportionate amount of federal funding for mental health, such as the Community Mental Health Services Block Grant, only addresses children with serious emotional disturbances. We recommend Congress focus on comprehensive approaches to getting children, adolescents, and their families the supports they need to maintain emotional and behavioral health including trauma-informed care and community supports and services. Mental health disorders are chronic diseases, and programmatic federal funding should evolve from being primarily crisis focused to helping address the ongoing needs of children and adolescents at various developmental stages.

Additionally, children's emotional and behavioral health is greatly impacted by that of their parents and caregivers. Parents and caregivers experiencing their own mental health problems, health issues, substance use disorder, or increased stress due to loss of income, housing, and access to nutrition and other supports during the pandemic may impact the emotional health of children and adolescents. The mental health system must be prepared to meet the needs of whole families, not just individuals. Oftentimes it is impossible to treat a child's mental health issues without involving the family, especially if a parent or family member has their own mental health or substance use challenges. Dyadic/family-focused therapies (e.g., treatment for maternal depression or parental substance use) for child mental health would help pediatricians refer parents for these services since pediatricians often see the parents more than the parents' own medical providers do. Parenting education is often the preferred first line of treatment for many pediatric behavioral concerns, especially for younger children. Embedding multigenerational integrated behavioral health services in primary settings, such as parenting/development/behavior specialists, could help to identify and address child, family, and community needs.

To date, more than 140,000 children in the U.S. have lost a primary or secondary caregiver to COVID-19 with Black youth experiencing the highest rates of loss.[v] The consequences of orphanhood can last a lifetime, and special attention must be paid to support these children who face higher risks to their health, safety, and well-being.

Role of the Pediatrician

Pediatric primary care clinicians have unique opportunities to affect the mental health of children and adolescents: preventing mental health problems by guiding parents in behavior management; identifying mental health symptoms as they emerge; intervening early, before symptoms have evolved into disorders; managing more common conditions themselves; facilitating referral of children, adolescents, and their family members when mental health or substance use specialty services are needed; collaborating with child and

[1] Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE.Arch Gen Psychiatry. 2005 Jun;62(6):593-602. doi: 10.1001/archpsyc.62.6.593.

adolescent psychiatrists, developmental and behavioral pediatricians and other mental health professionals in caring for children with severely impairing mental health and substance use disorders; and coordinating the primary and specialty care of children with mental health conditions and substance use disorders, as they do for children with other special health care needs. Because primary care clinicians are familiar with developmentally appropriate behavior, they are able to distinguish between typical behaviors and concerning behaviors as children grow and age and intervene to prevent disorders. Behavioral health screening should be a required standard of care, independent of provider, patient, or parent biases.

Training for pediatricians

Given the workforce shortage and increased number of children and adolescents presenting in primary care offices with mental health symptoms, pediatricians have had to take on a larger role in the assessment and management of mental and behavioral health issues. However, pediatricians routinely report that their training programs did not adequately train them to provide this care, and they may lack the confidence to do so. Residency education related to pediatric mental and behavioral health conditions should be enhanced in pediatrics, medicine-pediatrics, and family medicine.

Trauma-Informed Care

Our understanding of the lifelong effects of early childhood adversities necessitates a trauma-informed care approach which operationalizes the biological evidence of toxic stress with the insights of attachment and resilience to enhance health care delivery to mitigate the effects of trauma. Promoting and restoring resilience in children and adolescents, partnering with families to support relational health, and reducing secondary trauma among pediatric health care clinicians are essential elements of trauma-informed health care delivery. Clinicians and providers should be trained in providing culturally sensitive care with a trauma-informed approach in every accredited training program. This should include training related to anti-racism and implicit bias. Training and education of all administrators, clinicians, and staff, both clinical and nonclinical, can promote the appreciation of the lifelong effects of trauma on child and adolescent development and family resilience and the implementation of trauma-aware practices.[2] Continuous quality-improvement programs translate new knowledge and skills about childhood trauma into supervision, training, and patient care.

To develop networks of trauma-informed care, we recommend creating Medicaid-financed behavioral health supports for children and youth in or at risk of entering foster care. Such investments could be supported by capacity-building funding in Title IV-B of the Social Security Act to develop networks of trauma-informed care focused on this population. Expanded resources through Medicaid and Title IV-B could provide a network of service providers dedicated to meeting the needs of children in care as well as the payment support necessary to ensure children's access to timely care that supports placement stability and reduces the need for residential care.

Increasing Integration, Coordination, and Access to Care

Important research shows that the integration of mental health and primary care makes a difference for infants, children, and adolescents in terms of expanded access to mental health care, improved health and functional outcomes, increased satisfaction with care, cost savings, and improved coordination among primary

[2] James Duffee, Moira Szilagyi, Heather Forkey, Erin T. Kelly; COUNCIL ON COMMUNITY PEDIATRICS, COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE, COUNCIL ON CHILD ABUSE AND NEGLECT, COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, Trauma-Informed Care in Child Health Systems. Pediatrics August 2021; 148 (2): e2021052579. 10.1542/peds.2021-052579

care clinicians and behavioral providers in clinics and school-based and community settings. Integration also allows for the primary care clinician to receive training that enables them to practice more advanced mental health care. Most integrated care efforts are funded through a patchwork of short-term public and private grants, limiting their reach and sustainability.

Best practices for integrating behavioral health with pediatric primary care recognize the medical home as a critical component of mental and behavioral health in a whole-person care approach. Mental health professionals should be included as members of the medical home team with participation in preventive, acute, and chronic care visits. Working in partnership with mental health practitioners to practice integrated care can improve care, enhance preventive services, lower costs, and strengthen the medical home. Incentives to integrate behavioral health with primary care should be created and funded, such as providing enhanced payment for services housed within a primary care setting. Co-location of mental health providers in primary care offices and schools is the gold standard of care and allows for warm handoffs and brief interventions at visits and effective referrals to psychiatric care when needed.

Pediatric primary care clinicians have a longitudinal, trusting relationship with patients and their parents. Given this special relationship, parents often seek joint visits with their trusted primary care physician and a mental health specialist. However, there is currently no payment model to support this type of visit. Allowing a specialist to provide a brief intervention with a pediatrician will increase access, allow intervention before symptoms reach the level of a disorder, and train pediatricians to better provide mental health care. Payment should be provided for behavioral health services embedded within primary care, on the same day as other primary care services.

Barriers to the provision of integrated care should be eliminated. For example, in many clinical settings, co-located behavioral health providers cannot bill for a patient on the same day that the primary care clinician sees that patient (at least for the same mental health problem), making warm hand-offs extremely difficult. Different kinds of providers need to be able to bill for the same patient for the same diagnosis on the same day in order to promote integrated care.

Payment mechanisms that minimize fee-for-service/volume-based payment and encourage value-based, high-quality care, such as bundled payments or per member per month (PMPM), could encourage integration of behavioral health with primary care. It is critical that pediatric alternative payment models are designed to appropriately measure quality of care, health outcomes, and value to ensure that financial incentives support primary care practices investing in behavioral health services.

Collaborative care models that are effective in improving care for adults, often don't have evidence of improvement in the pediatric population. Because mental health symptoms in children and adolescents may be addressed before they reach the level of a diagnosis, a social worker, psychologist, or other mental health specialist may be qualified to intervene, as medications or the expertise of a psychiatrist is not always needed. Policies and models that expand the capacity of front-line pediatric and family medicine clinicians to respond to the mental health needs of children and adolescents, such as the child psychiatry consultation model and models that integrate a mental health or developmental specialist within a primary care practice, such as the Primary Care Behavioral Health Consultation model (PCBH), should be supported.

The Health Resources and Services Administration (HRSA) Pediatric Mental Health Care Access Program promotes behavioral health integration into pediatric primary care by supporting pediatric mental health care telehealth access programs. The AAP applauds Congress for including an additional $80 million in the American Rescue Plan for the program, which recently announced grants to an additional 24 states, D.C., tribes, and territories to enable pediatric mental health teams to provide tele-consultation, training, and technical assistance to pediatric primary care practices. This model of supporting pediatric primary care practices with telephonic consultation with child mental health teams is helping increase access to mental health services for children and enabling primary care clinicians to manage certain mental health conditions. We appreciate that the House FY 2022 Labor-HHS appropriations bill includes a $15 million increase for this program, and that the Senate bill includes a $10 million increase from FY21.

Care Coordination

Significant barriers exist to care coordination between mental health professionals and primary care clinicians. While coordination and communication take a lot of time, time spent coordinating care is often not paid for. Non-physicians are rarely able to be paid for care coordination and physicians are only able to bill for coordination with a specialist if the conversation with the specialist occurs on the same day as the patient's visit—which often proves to be impossible to schedule. Payment should be provided for care coordination activities such as time spent by pediatricians discussing a child's mental health with a behavioral health specialist, school staff, or family member whenever the consultation occurs.

Further, administrative barriers frequently prevent standardized communication between mental health professionals and primary care clinicians. Pediatricians report difficulty in care coordination due to real or perceived barriers under Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA). Behavioral health specialists are often reluctant to share information with primary care clinicians, believing HIPAA proscribes such communication. Because mental health information is considered to be more protected than information about physical health, the rules for sharing information are perceived to be stricter. If a patient consents to having their provider or care team speak to other health professionals about their care, mental and behavioral health information should be included—separate consent should not be required for behavioral health information.

Delays in releasing patient records to other providers prevents timely care and the best quality of care, as the current care team is often forced to begin treatment without full knowledge of previous treatment efforts. With a signed online release of records by the patient, it is essential to allow real time access to records and previous care. This can often be complicated by the fact that electronic medical records of different systems do not talk to each other. Each health system decides their own rules about what mental health information is shared with other systems. When information is able to be shared, data elements and quality indicators are often different as they are not standardized across health records. Information sharing should be facilitated by creating electronic health records that allow for patient data to be accessed across institutions and settings, including schools. This could be done by having a patient or parents sign a form that allows hospitals/clinics, schools, counseling offices, and others involved in care to share data and communicate with each other.

Navigation

Funding should also be available for primary care practices to hire care coordinators or navigators who help families navigate the often-complex mental health care system. Systems for care linkages and follow-ups, including referral to outpatient and community behavioral health centers should be created. Payment should

also be provided for time spent addressing social drivers of health, such as nutrition, safety, transportation, and housing, which often impact mental health.

Family navigators and family support providers are key partners in addressing the spectrum of mental health needs in children and adolescents. Navigating the landscape of behavioral health care can often be difficult for families: dealing with limited provider networks, insurance, calling offices, finding appointment times are all time-consuming tasks. Family navigators, partnering with primary care and mental health, assist families in understanding and keeping up with their array of services, identifying community resources, and following up with recommendations. Home visitors similarly help with coordination and also support implementing strategies in the home environment. These providers should collaborate and communicate with both the medical home and the family and should not serve as a substitute for high quality behavioral health intervention.

Workforce

Across the United States, there is a dire shortage of practitioners specializing in mental and behavioral health to care for infants, children, adolescents, and young adults. Prior to the pandemic, in 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that 4.5 million additional behavioral health practitioners are needed to address the needs of children with serious emotional disturbances and adults with serious mental illness, including an additional 49,000 child and adolescent psychiatrists.[3] The gap between currently available child and adolescent providers and what is needed to provide evidence-based mental and behavioral health care for this population is stark. New incentives and opportunities are needed to quickly expand a diverse child and adolescent mental and behavioral health workforce. The shortage of providers with specialized training to treat mental health conditions in infants and toddlers is even more extreme. When working with children and families, it is very important for the provider to be trained in child development—children are not little adults.

The lack of sufficient providers, including child and adolescent psychiatrists, developmental-behavioral pediatricians, psychologists, and social workers, prevents patients from accessing needed behavioral health care services. Today, 50% of children with mental health conditions receive no treatment at all.[4] Pediatric patients trying to access services often face long wait times for a behavioral health appointment, long travel times to providers, or are unable to find a provider who accepts insurance.

Low payment rates for the provision of behavioral health services heavily contributes to the workforce shortage. For example, the fields of developmental and behavioral pediatrics and psychiatry have become more popular but the interest in these fields has not grown in part because of the length of training without the subsequent increase in salary. Trainees report no incentive to enter a career in pediatric mental health care when they are not guaranteed enough payment to make a living. Providers must be adequately paid for the care they provide. Feedback from providers reflects that payment for mental and behavioral health services does not reflect the difficulty of the work performed by these providers.

Academic medical centers and universities should be supported to train medical students, residents, and pediatric fellows. There has recently been an increase in medical schools throughout the U.S., but the number

[3] https://www.samhsa.gov/sites/default/files/behavioral-health-workforce-report.pdf

[4] Whitney DG, Peterson MD. US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. JAMA Pediatr. 2019;173(4):389–391. doi:10.1001/jamapediatrics.2018.5399

of post-graduate training programs, internship and residency slots have not expanded at the same rate. Investments in Children's Hospitals Graduate Medical Education (CHGME) would help to strengthen the pediatric workforce and improve access to care for all children. This program reduces the growing gap between the federal investment in physician training for adults compared to children.

Better utilizing pediatricians to provide care for behavioral health issues would also help to reduce the effects of the behavioral health workforce shortage. Training programs should be established for general pediatricians and those going into subspecialty care to gain additional expertise in mental health promotion, prevention, diagnosis, and treatment so that pediatricians are competent to assess and manage mild to moderate common conditions. The educational curriculum of pre-hospital personnel, emergency department staff, nurses, and trainees, including emergency medicine residents and pediatric emergency medicine fellows should include training to provide patient/family-centered, trauma-informed, and culturally appropriate mental and behavioral health care.

Rural and Underserved Areas

The pediatric behavioral health workforce shortage is acutely felt in rural and underserved communities. It is important for day treatment, outpatient therapy, and other more intensive mental health services to be close to a patient's home, which is often challenging for smaller communities. Various incentives, from loan forgiveness, increased payment rates, and professional support, can make these environments more attractive to providers. Loan repayment programs that require time practicing in rural and other underserved areas, such as HRSA's National Health Services Corps should be supported. Training programs should be stood up and supported in rural and underserved communities and then trainees should be incentivized to stay in said community after training. Further, recruitment for providers should occur in underserved environments in order to build a pipeline of providers from rural and underserved areas to return to their local communities.

Professional support in rural areas should be improved. Rural providers should be encouraged to maintain ongoing connections to, and training in new developments in care and innovation. Funding mechanisms for paid collaboration with colleagues at academic centers or hospital systems (potentially virtually) are needed.

Lastly, encouraging and decreasing the barriers to telehealth can increase behavioral health workforce access in rural environments; this includes increasing access to broadband. A mix of in-person and telehealth practice allows clinicians more flexibility in where they live. Allowing telehealth services to cross state lines should be allowed in rural areas to increase access to care.

Diversity of Workforce

Expanding the diversity of the child and adolescent mental and behavioral health workforce, as well as increasing cultural and linguistic competency, is critical for addressing the enormous unmet mental and behavioral health needs of infants, children, adolescents, and young adults. Patients often desire to build a relationship with a mental and behavioral health provider that they can relate to and feel safe with. Often times, they prefer to work with someone who comes from their community, someone that may look like them, or someone who they feel shares a common bond. Patients who do not speak English or who are more comfortable receiving care in a language other than English often find it difficult to access care. More physicians and non-physicians of color and providers of diverse backgrounds and identities are needed to expand the workforce and increase access for patients and families. We urge Congress to prioritize recruitment

and retainment of a more diverse mental and behavioral health workforce and support the ability of patients to find providers they are most comfortable with.

In order to increase diversity in the behavioral health care workforce, there must be increased funding for the recruitment, training, and compensation of a diverse population of providers. Pipeline programs should target schools in underinvested neighborhoods to strengthen the pipeline of youth/young adults with the academic preparation and credentials to obtain college- or graduate-level clinical training. Training programs at institutions that have large proportion of diverse students such as Historically Black Colleges and Universities (HBCUs) and universities focused on serving American Indian and Alaska Native students should be expanded, and certificate programs (e.g., at the AA or BA level) training providers to provide mental health services under the direction of an MA/PhD level psychologist or social worker should conduct outreach to immigrant and racial minority communities and offer instruction in multiple languages. Mentorship and professional development programs to improve the pipeline of behavioral health clinicians must exist throughout the educational progression, including in high school, college, and professional school.

Generous financial aid programs to enable this education must be funded and supported. Loan repayment programs should increase focus and tuition payback for those serving underserved communities of color, serving other diverse populations, or serving in rural areas. A language-skills pay differential could provide monetary compensation for professionals that provide behavioral health services in a language other than English. Providing such a pay differential can contribute to recruitment and retention of professionals from diverse backgrounds and also address disparities in care among underserved communities (e.g., communities of color, refugees or immigrants). Requiring insurance companies to document their percentage of non-English speaking providers relative to the non-English speaking beneficiaries in a region could also spur recruitment of a diverse workforce.

Workforce wellness

The intensity and stress of caring for patients with mental health needs, especially over the past year and a half of the pandemic, impacts the well-being of behavioral health providers. Even before the pandemic, mental health data showed that physicians in the United States face a higher incidence of suicide than any other profession. The 2018 Medscape National Physician Depression and Burnout Report showed 66 percent of male physicians and 58 percent of female physicians revealed they were experiencing symptoms often referred to as "burnout", depression, or both. The study also discussed that many of the professionals were not seeking help and had no plans to do so because of barriers such as stigma and the professional risks associated with disclosing their treatment activities to medical boards. In the fall of 2020, the National Institute for Health Care Management (NIHCM) Foundation found that 20 percent of surveyed physicians reported symptoms of clinical depression and 13 percent reported suicidal ideation. Nearly 70 percent of doctors said they felt down, blue, or sad.

The dearth of available mental health providers along with low payment rates for the provision of behavioral health care also leads to symptoms often described as "burn-out". Improving payment rates and reducing case loads would lessen the burden on providers. Further, payment for care coordination and care coordinators would help to alleviate workloads. Time constraints are especially severe for primary care physicians who often have 15 minutes to complete an entire exam. Paperwork burdens for documentation and billing, especially when working collaboratively with the patient/family, primary care clinician, specialist, teachers, and community resources, are onerous and should be reduced.

Many behavioral health providers speak of the "moral injury" of trying to help patients when feeling powerless to effect meaningful change in a patient's life when resources for needed services or basic needs are out of reach. Mental health providers often recognize a lack of basic needs as a contributor to mental health problems, but do not necessarily have the tools or bandwidth to address these needs. This can often lead to feelings of burnout and frustration. Improved access to services can be achieved by increasing staff that can assist patients in navigating and enrolling in social safety net programs. Barriers to eligibility and access to programs such as Medicaid, SNAP, WIC, TANF, and other family supports should be reduced and direct certification for programs with similar eligibility criteria should be expanded. Funding social services that support families across the continuum—educational, vocational, nutrition, child care, etc.—will greatly improve mental and behavioral health of families and, as such, should be sufficiently funded and supported.

AAP is a strong supporter of H.R. 1667, the *Dr. Lorna Breen Health Care Provider Protection Act*, an important proposal that aims to prevent and reduce the prevalence of suicide, mental and behavioral health conditions among health care professionals, sometimes referred to as "burn out", and substance use disorders. Through grants, education, and awareness campaigns - the legislation will help reduce stigma and identify resources for health care providers and clinicians seeking assistance. We urge Congress to pass this important legislation. We must do all that we can to protect the health and well-being of the medical providers that have sacrificed so much during this pandemic to keep our country safe and healthy. We must also continue to work to ensure that the systems that they practice in are supportive and safe for patients and health care workers alike.

Role of Health Insurance Plans

Children and adolescents with behavioral health needs often face waiting times of several weeks, or even months, to get an appointment (even in large cities with more developmental and behavioral pediatricians or child psychiatrists than most parts of the country), and this wait time often extends to months for children whose preferred language is not English. While more providers are needed to address the mental health needs of the pediatric population, payment rates for these services are a key barrier to both building the workforce and building practices. Many providers choose to work in cash-only practices that do not accept insurance because payment rates for mental health services are so low, especially for patients on Medicaid/CHIP.

Insurance payment models must be designed to support integrated, team-based care that includes payment for primary care management, services delivered in school-based settings, and service coordination. Payment for these services should reflect the difficulty of providing mental and behavioral health care. Insurers, whether public or private, must have adequate network resources to serve their families. If the network is inadequate, plans should be obligated to make it easier to access out-of-network providers without a higher financial burden on families. Given the shortage of pediatric behavioral health specialists, especially who participate in insurance, pediatric patients are ten times more likely to see an out-of-network provider for mental health care than medical/surgical healthcare.[5] The lack of out-of-pocket caps for out-of-network providers poses significant financial hardship on families. Geographic "carve-outs" that limit where patients can receive behavioral health services (for example, contracts for a given city or county) should be eliminated.

[5] https://www.milliman.com/-/media/milliman/importedfiles/ektron/addictionandmentalhealthvsphysicalhealthwideningdisparitiesinnetworkuseandproviderreimbursement.ashx

Many clinicians choose not to participate in insurance plans due to low payment rates, onerous paperwork, and delayed payments. Families who are experiencing financial challenges often have many unmet needs and challenges, making their care complex and time consuming. However, the payment for providing care through Medicaid is so low that a provider often loses money by providing these services. Pediatricians routinely report that the Medicaid payment rates to care for children with complex mental health needs is inadequate to maintain an inpatient or outpatient clinic setting. Payment rates for mental/behavioral health care must be improved. Medicaid payment rates for pediatric mental, emotional, and behavioral health services should be increased to at least 100% of Medicare levels for similar services. On top of these low payment rates, the no-show rate for behavioral health visits tends to be very high (almost 50% in some practices).

In addition to low payment rates, it is often difficult for pediatric primary care clinicians to receive payment for preventive mental health services, especially for children and adolescents, and for family-oriented mental health services (working with both parent/child or with the whole family). Many times, emotional distress and behavioral problems are not well-differentiated in childhood (and cannot be accurately diagnosed, especially in younger children) or the condition is still evolving and hasn't risen to the level of a DSM diagnosis. In fact, 19% of children and adolescents have impaired mental health functioning and do not meet the criteria for a disorder. At the same time, we know these children benefit from receiving evidence-based therapies such as Child-Parent Psychotherapy (CPP), Parent-Child Interaction Therapy (PCIT), Cognitive-Behavioral Therapy (CBT), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). However, behavioral health clinicians are typically unable to be paid for delivering these services without an accompanying ICD-10 diagnostic code, creating a disincentive and financial challenge for mental health professionals to be able to serve these children and maintain their practice. Given the unique needs of children, pediatric clinicians and mental health professionals should be allowed to bill non-specific codes even when there is not a diagnosable condition.

Further, the needs of children and adolescents may not align with what is covered by an insurance plan. Group visits, secure text check-ins, short video check-ins, or virtual visits with a care team can be part of an effective treatment model and should be adequately paid for. Restrictions on yearly maximum visits should be eliminated.

Primary care behavioral health services should be funded as part of the medical benefit, not through behavioral health carve-outs. Carving out mental health services takes care out from the medical home and away from the primary care clinician. The outsourced companies typically are not pediatric specific, are usually staffed by lower-level providers who cannot provide comprehensive services such as medication management, and they rarely communicate with the medical home. Carve-out mental health imposes greater administrative burdens through prior authorizations, excessive reporting requirements, assignment of patients that may not be appropriate for expertise (e.g., child patient assigned to a clinician who treats adults) and hindering collaboration with the primary care clinician by precluding a warm handoff and making feedback difficult. Having a medical provider who has assessed the patient and determined the need for mental health referral should not require a prior authorization, which becomes a significant and unnecessary expense.

Setting and provider type restrictions that prevent behavioral health services from being delivered in primary care settings should be eliminated. This includes eliminating same-day billing restrictions and other structural barriers like pre-authorization, behavioral health diagnoses, and limits to episodes of care. Appropriate mental health providers should be able to be credentialed within the medical home, without a need to also enroll with behavioral health carve out programs and without a primary care practice needing to change their contracts to

reflect a multi-specialty group. The full continuum of integrated behavioral health services in primary care settings from prevention and health promotion (e.g., HealthySteps) to early identification and early intervention, to consultation and intervention, to care coordination and systems navigation, to triage and referral should be funded using alternative payment methodologies rather than fee for service models.

Medicaid Access Considerations

Medicaid is designed to meet children's unique needs, particularly through its Early and Periodic Screening, Diagnostic, and Treatment benefit (EPSDT). Together, the Medicaid equal access provision and the EPSDT benefit should ensure that children have timely access to needed care, including mental health services. However, state Medicaid programs implement EPSDT and medical necessity determinations differently, a challenge exacerbated by the proliferation of contract with Medicaid managed care plans with varied benefit designs and coverage limitations. Congress can take action to direct CMS to review how EPSDT is implemented in the states to support access to prevention and early intervention services, as well as developmentally appropriate mental health services across the continuum of care. In particular, specific assessment of mental health network adequacy and access to services should be included in future rulemaking regarding Medicaid enrollees' access to care through fee-for-service and managed care programs. Congress can also request that the Medicaid and CHIP Payment and Access Commission study children's timely access to mental health care and make recommendations to Congress about future actions to bolster this essential care.

Mental Health Parity

Despite enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) and its subsequent expansions to Medicaid managed care, CHIP, and the insurance marketplaces, there has been a persistent need to improve oversight and compliance with the requirements of MHPAEA. Further, MHPAEA still needs to be expanded to children and adolescents enrolled in Medicaid fee-for-service arrangements. While new compliance measures included in recently passed legislation are promising, many children and adolescents still face barriers in accessing mental health and substance use disorder treatment due to insurance discrimination that singles out these services. Increased oversight is needed to ensure that insurers are complying with mental health parity laws to promote broader mental health insurance networks.

Congress could improve oversight and enforcement of mental health parity laws by requiring insurers to document and report the wait time from primary care referral to first outpatient mental health specialty appointment compared to referrals to other specialists. Reporting on the percentage of referrals that were denied care or never were able to access treatment should be required. Data tracking the number of claims and payment rates for mental health codes compared to the known prevalence of mental health issues based on national public health surveys would also showcase shortfalls in compliance with parity law. Patterns of service utilization that indicate gaps in access such as out-of-network provider utilization; use of psychotropic medications without psychosocial therapies; use of emergency department without previous use of psychosocial therapies; and follow-up after emergency department utilization should be identified and tracked. Health plans could be held accountable for mental health outcomes (e.g., universal PHQ-9 and GAD-7 screening and improvement in depression/anxiety symptoms) and be required to report mental health performance as a publicly available metric.

In order to achieve true parity, especially in Medicaid, providers must be paid appropriately for behavioral health services. Currently, commercial insurance payment rates for mental healthcare are 20% lower than

medical/surgical services.[6] An hour of clinical time should be paid the same whether the diagnosis is mental health or physical health. The current use of billing for E/M by either time or MDM must be enforced for mental health as well.

Telehealth

Issues related to access, network adequacy, and pediatric workforce create significant barriers for children and adolescents with behavioral health conditions from being able to receive the care that they critically need. However, the ability of the medical home and other specialty providers to interact with the child, family, and behavioral health professionals using telehealth technologies has the potential to optimize care, to minimize family disruption, and to avoid unnecessary medical utilization.

Telehealth services can be rendered if the technology deployed allows sufficient quality and necessary examination capabilities to ensure a thorough evaluation and comprehensive service delivery. Telehealth is best considered as a channel for delivering appropriate care, rather than as a type of care itself. As such, telehealth services should be used to extend, enhance, and supplement the pediatric medical home and medical neighborhood, connecting a child with their care team rather than supplanting a usual source of care. Telehealth access is particularly important for children and youth with special health care needs who experience significant barriers to receiving necessary care. Mental and behavioral health services are especially amenable to remote care and can also be provided as an extension of the medical home.[7] For example, telehealth can offer more flexibility by eliminating transportation barriers and reducing travel time to appointments, which often results in less missed school. For children with autism, for example, telehealth has proven to be particularly useful, as being able to conduct the visit in the patient's natural environment at home is often less distressing than an office environment. Each of these modalities provides necessary care when the physician and patient cannot meet in person, or they can be used as an adjunct to in-person services.

Barriers to telehealth persist because of poverty, systemic racism, and other inequities, such as lack of devices, inability to access broadband, and the need for education on how to use telehealth (especially for immigrant and non-English speaking patients). Many adolescent patients, especially those in foster care, also lack a confidential, safe setting to conduct the virtual appointment. While an in-person visit guarantees patient privacy, with a virtual visit the clinician is unable to ensure that a parent or someone else isn't listening in to the conversation. Younger children, or those with a lower cognitive age, often have shorter attention spans that make it difficult to conduct telehealth appointments.

Equitable access to broadband internet is critical to the promotion of health equity and quality of care outcomes through telehealth. Congress should provide support for further broadband deployment to reduce geographic and sociodemographic disparities and access to care. Additionally, while we recognize that audio-visual visits allow clinicians to see a patient's expressions and demeanor (which is especially helpful for

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[6] https://www.milliman.com/-/media/milliman/importedfiles/ektron/addictionandmentalhealthvsphysicalhealthwideningdisparitiesinnetworkuseandproviderreimbursement.ashx

[7] Telehealth: Improving Access to and Quality of Pediatric Health Care. Alison L. Curfman, Jesse M. Hackell, Neil E. Herendeen, Joshua J. Alexander, James P. Marcin, William B. Moskowitz, Chelsea E. F. Bodnar, Harold K. Simon, S. David McSwain**.** Pediatrics Sep 2021, 148 (3) e2021053129; DOI: 10.1542/peds.2021-053129. https://pediatrics.aappublications.org/content/148/3/e2021053129

younger children who are not very verbal), payment for audio-only forms of telehealth should be equal to that for video visits, particularly when patients don't have access to reliable internet or internet-connected devices with enough data. For many forms of counseling and psychiatric evaluation, an audio conversation is still quite productive without visuals. Expanded coverage of telehealth for behavioral health services has been critical and should continue. Other asynchronous technologies, such as portal messages, must also be adequately paid. The COVID-19 flexibilities for providing telehealth services for behavioral health care have greatly improved access to care--particularly the elimination of originating site restrictions and geographic limitations for practicing across state lines--and should be maintained.

While quality telehealth care promises to increase access and mitigate barriers to care for patients, this must be done in support of and integrated within the medical home, not in place of it. Expansion of telehealth services should be coupled with an intention to provide care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.[8] Expanding telehealth services in isolation, without any regard for previous physician-patient relationship, previous medical history, or the eventual need for a follow-up hands-on physical examination can undermine the basic principles of the medical home, increase fragmentation of care, and lead to the patient receiving suboptimal care.[9] Ultimately, telehealth should enhance the physician-patient relationship, not disrupt it. Any permanent expansion of telehealth services should promote coordinated and continuing care provided by the medical home and not limit or steer patients to receive services provided by vendors disconnected from a patient's usual source of care.

Technology

Access to technology that facilitates convenient, secure, and confidential communication between a child/family, medical home, therapist, and educational setting to coordinate care and obtain needed information for diagnosis and treatment provision and monitoring should be improved. Technologies that allow for information sharing across electronic health records systems should be invested in and rolled out across the country. Another way to support providers is by having algorithms and prompts within an electronic health record that includes electronic screening for mental and behavioral health conditions along with decision support for positive screens such as follow up rating scales or questions to ask. Decision support can also link to patient education materials that can be shared with the family to help with care management.

Every primary care clinic, hospital, and school should be equipped with private rooms with robust telehealth capabilities that patients can use to access behavioral health or specialty care. Creating loaner programs for tablets or hot spots would also help to enable telehealth visits in patients' homes. Hotline numbers should be created where patients can call for help in accessing mental health services.

School-Based Mental Health Care

Children must be able to access care in the settings where they are, particularly in schools. Lack of mental health professionals in schools is another significant barrier to children's access to needed services. Comprehensive school mental health systems provide an array of supports and services that promote positive

[8] The Use of Telemedicine to Address Access and Physician Workforce Shortages COMMITTEE ON PEDIATRIC WORKFORCE Pediatrics Jul 2015, 136 (1) 202-209; DOI: 10.1542/peds.2015-1253: https://pediatrics.aappublications.org/content/136/1/202#ref-15

[9] Sprecher, Eli, and Jonathan A. Finkelstein. "Telemedicine and Antibiotic Use: One Click Forward or Two Steps Back?" American Academy of Pediatrics, American Academy of Pediatrics, 1 Sept. 2019, pediatrics.aappublications.org/content/144/3/e20191585.

school climate, social and emotional learning, and mental health and well-being, while reducing the prevalence and severity of mental illness.[10] By having mental health services available in schools, children can have access to the care they need with minimal disruption to their school day, and in the case of acute behavioral health crises in school, they could receive urgently needed services and de-escalation on site.

At the very least, every school should have a staff member with mental health training who can recognize behavioral health issues and is able to facilitate connection to appropriate resources. Ideally, schools should have an on-site therapist who can provide trauma-informed psychotherapy to children free of charge and education to teachers, staff, parents, and students about mental wellness, stress management, basic Cognitive Behavioral Therapy (CBT) principles to cope with anxiety/depression, and Mental Health First Aid. Increased funding is needed to support multi-tiered systems that promote mental health and help reduce the prevalence and severity of mental health disorders in schools There is a large need for school-based mental health professionals to serve the needs of children and adolescents; providers must be adequately trained and supported.

With parental consent and involvement, school counselors, school psychologists, school social workers, Individualized Education Program (IEP) coordinators need to be part of the care team with primary care, mental health, parents, and the adolescent. Again, barriers such as FERPA and HIPAA that prevent collaboration and communication should be reduced so that there is an integrated web of community supports. Teachers should be encouraged to involve therapists in working with children with behavioral problems instead of taking a reflexively punitive approach. Further, a mental health problem does not in itself confer eligibility for an IEP or a 504 plan, but accommodations and support could significantly improve functioning.

Children and Adolescents in Crisis

Clinicians are witnessing an alarming number of children and adolescents in behavioral health crisis, with emergency departments seeing increases in suicidal ideation and self-harm. From April to October 2020, hospitals across the U.S. saw a 24% increase in the proportion of mental health emergency department visits for children ages 5 to 11, and a 31% increase for children and adolescents ages 12 to 17. Behavioral health clinicians have reported over the last several years that children and adolescents are increasingly "boarding" in emergency departments for days because they do not have sufficient supports and services. In addition, research shows significant disparities in suicide rates, risk, and care for youth across cultures and communities; support is needed to enhance suicide prevention efforts for youth of color, youth who identify as LGBTQ, and youth from communities that have been marginalized or medically underserved.

AAP was pleased to support legislation expanding the Suicide Prevention Lifeline and is eager to see the 988 hotline rolled out. It is important to have a standard, national phone number to address mental health concerns. 988 should have 24/7 availability and assurance that mobile crisis services are available within a short timeframe. Any crisis response system must account for the fact that the needs of children in crisis are different from that of adults, understand how crisis symptoms present in children and adolescents across cultures and communities, must have specific pediatric and family-based training for crisis intervention teams, engage peer support, and be able to refer children and adolescents to pediatric-specific care. Pediatric crisis intervention should be accessible for children, families, and pediatricians and be designed to meet the needs of LGBTQ

[10] https://downloads.aap.org/dochw/dshp/Supporting_Mental_Health_in_Schools_Final_Report-June_2021.pdf

youth. Access to professional interpreter services and/or interpreters trained in crisis management should be made available for patients and families with limited English proficiency.

Trained crisis response teams should be used as an alternative to having law enforcement respond to a mental or behavioral health emergency in the community. Crisis Assistance Helping Out on the Streets (CAHOOTS) and similar services more appropriately address the needs of people in crisis and prevents injury and death. These models, by having staff who are knowledgeable about and connected to community resources can facilitate warm handoffs. Universal implementation of such models should be a goal. Mobile health crisis teams should be available to respond to schools, physician offices, homes, or wherever children are. Given the current workforce shortage and that crisis intervention services tend to be underpaid positions, professionals who do this work should be given a competitive wage to ensure a high-quality workforce and improve retention.

Because of the lack of available pediatric behavioral health services, children and adolescents experiencing suicidal ideation or other mental health crises often end up in the emergency department seeking care. Prehospital personnel should be trained in acute management of pediatric behavioral health emergencies. Emergency department staff should be supported and trained in recognizing and providing initial care to youth with potentially increased risks of behavioral health concerns, including LGBTQ youth, victims of maltreatment, abuse, or violence, including physical trauma, mass casualty incidents, and disasters; and those with substance use-related problems (e.g., acute intoxication, overdose), pre-existing conditions (eg, autism spectrum disorder, developmental delay, intellectual disability), post-traumatic stress, depression, and suicidality.

Prompt consultation with a well-trained mental health professional and interpreter services should be available in the emergency department. Standards should be established for documentation, communication, and appropriate billing and payment for inpatient and outpatient psychiatric care by mental health specialists consulting on emergency department patients (including telemedicine consults), as well as for emergency and prolonged emergency department care for children boarding in the ED. Interfacility transfer agreements should be created to refer children to care, including simplification of psychiatric bed search for patients requiring inpatient care or community mental health centers where available, to help limit ED boarding. Currently, patients face delays to get into outpatient care. The increased availability of "step down" services such as partial hospitalization and intensive outpatient programs would promote effective care transitions. Upon discharge from hospitals or emergency departments, navigators should help families connect to community services including family supports.

Community services should be expanded to include mobile crisis intervention, intensive case management, respite services, and emergency department diversion programs such as psychiatric urgent care centers. Outpatient care services should be designed to serve children and adolescents with unique needs, such as those with autism spectrum disorder, substance use disorders, and eating disorders.

Diversity, Equity, and Inclusion

The inequities that result from structural racism increase the vulnerability to emergency situations, as evidenced by the disproportionate impacts of COVID-19 on communities of color. Racism operates at the level of individual experiences of discrimination by youth of color as well as the ways in which youth of color have differential access to mental health services and diagnosis and treatment for mental and behavioral health

conditions.[11] Additionally, COVID-19 has contributed to increased racism and xenophobia against individuals who are of Asian descent. All children, regardless of their immigration status, should have access to quality care. Behavioral health equity must be accessible for vulnerable populations affected by poverty, racism, violence, and food/housing security.

LGBTQ youth are at heightened risk for changes in mental health if they are living in homes where they are not supported by their families. The pandemic may isolate them from their supports such as the local LGBTQ center or their LGBTQ friends/community. These youth may be subjected to increased physical or emotional maltreatment from a family member and not have a means to escape it.

The provider workforce must reflect the diversity of the populations they serve. Providers must be trained in diversity, equity, and inclusion, and programs that increase the number of professionals who are from underrepresented groups such as people of color and people who identify as LGBTQ should be supported. Data examining health disparities and racial/ethnic distinctions should be collected and included in quality metrics.

Culturally Sensitive Care
Along with increasing access to a diverse mental health workforce, we must increase access to culturally-sensitive care. The development, growth and validation of community-oriented models of behavioral health care that are congruent with and steeped in the traditions of marginalized faiths, cultures and traditions must be supported. For example, behavioral health programs which have Native American and tribal traditions and beliefs embedded or programs that incorporate the culture and beliefs of immigrant populations should be increased.

Special Populations/Needs
By definition, children and youth with special health care needs (CYSHCN) are "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required for children generally."[12] The 2016 National Survey of Children's Health indicated that over 40% of CYSHCN were reported to have an emotional, developmental, or behavioral issue. Children with chronic physical health or developmental conditions are at increased risk for behavioral health conditions. Common problems experienced by CYSHCN range from internalizing problems such as low self-esteem, anxiety, and depression to externalizing problems such as attention problems to aggression. As such, pediatric specialists caring for CYSHCN also indicate the need for training in behavioral and mental health to address concerns among the children and adolescents they care for.

Children and adolescents with special health needs depend on uninterrupted access to specialized medical and/or mental health services, ideally from providers trained in trauma-informed care. Interruption of services for these children can increase stress on the family and place the child at risk for losing skills. Payment structures should support in-home intensive services for children with significant mental health needs to

[11] The Impact of Racism on Child and Adolescent Health. Maria Trent, Danielle G. Dooley, Jacqueline Dougé, SECTION ON ADOLESCENT HEALTH, COUNCIL ON COMMUNITY PEDIATRICS, COMMITTEE ON ADOLESCENCE
Pediatrics Aug 2019, 144 (2) e20191765; DOI: 10.1542/peds.2019-1765
[12] Gerri Mattson, Dennis Z. Kuo, COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, COUNCIL ON CHILDREN WITH DISABILITIES; Psychosocial Factors in Children and Youth With Special Health Care Needs and Their Families. Pediatrics January 2019; 143 (1): e20183171. 10.1542/peds.2018-3171

reduce barriers to accessing care. The federal government should invest in collaborations between child-serving sectors to facilitate transitions of care for children with high needs (i.e., child welfare system, juvenile justice system, educational system); centralizing medical and social care for these children will allow them to be more easily followed and co-managed. For some children, such as children with autism, therapies that go beyond traditional talk therapy, such as music therapy, animal care therapy, dance therapy, or art therapy can be beneficial. Federally funded programs should measure the quality and outcomes of these types of therapies.

Again, the requirement to have a specific diagnosis for insurance coverage hinders the ability of many children with high need from accessing care. Children and youth who have a history of severe or complex trauma need access to high-quality mental health services to heal from their trauma. However, to access mental health services, their behaviors, and reactions to the trauma they have experienced, are diagnosed as mental disorders through the Diagnostic and Statistical Manual of Mental Disorders. The AAP recommends eliminating the requirement for a child to have a specific diagnosis to access coverage and instead create new categories such as "severe or complex trauma history" that would permit access to services. Under this designation, we recommend exploring opportunities through EPSDT and 1115 waiver authority to expand the eligible services covered to include holistic or mind-body therapies that can be more responsive to the complexity of trauma children and youth have experienced rather than through traditional psychotherapy. Providers should receive increased payment for caring for high-risk populations that require more time in a visit, such as children in foster care.

Youth in the Juvenile Justice System

For adolescents in the juvenile justice system, visits from family members may be prohibited, which may result in increased isolation, stress, and anxiety/depression in these youth. Children and adolescents in the juvenile justice system need care consistent with Bright Futures, and because of their increased risk and experience of adversity, should have routine trauma-informed social-emotional screening, referral/linkage and follow-up.

Children in Child Welfare

Children and adolescents in foster care have substantial unmet mental health needs resulting from the trauma of their experiences before and after entering foster care. Residential care often becomes a default option as the current system of mental health services does not provide access to quality care for this population, nor access to an array of services that goes beyond traditional talk therapy and psychotropic medication.
The research is clear that children fare best in families and healthy connections offer children a chance to heal from their traumas and thrive. Congress acknowledged this with the enactment of the Family First Prevention Services Act in 2018 that applies downward pressure on the full continuum of child welfare involvement; fewer children unnecessarily in congregate care and out-of-home care, and more children safely at home. The law creates new protections to ensure residential placements are appropriate, time-limited, and meet a child's treatment needs so that they do not languish in harmful settings.

Currently, some stakeholders are raising concerns about the implementation of this policy and proposing changes that would create a major federal exemption from Medicaid law that would have major unintended consequences that would lead to more children and youth placements in congregate care facilities, in contradiction with the focus of Family First. Children of color and LGBTQ+ youth, who are already at high risk for entering and lingering in congregate care and experiencing poor outcomes as a result, would be particularly harmed by removal of these protections. AAP has sent a group and individual letter opposing the *Ensuring*

Medicaid Continuity for Children in Foster Care Act (S. 2689/H.R. 5414) that would create a categorical federal exemption from Medicaid law for all QRTPs. Instead, we recommend focusing on further reducing unnecessary congregate care, improving supports to keep children safely with their families, expanding high-quality kinship and non-relative family foster care, and improving access to community-based trauma-informed mental health services for children and youth in foster care.

To realize the goals of Family First to support and strengthen families and enable them to avoid child welfare involvement, a significant investment in primary prevention services and an expansion of the types of services allowable under the Title IV-E Prevention Program are needed. Major long-term investments in primary prevention services—including access to cash assistance and concrete resources—through service lines outside the traditional child protective services system, would ensure that families can access needed concrete supports without facing the prospect of unnecessary investigation or a child needlessly entering foster care. Congress should also build upon Family First by expanding the allowable services under the Title IV-E Prevention Program to include services that address core drivers of child welfare involvement, including behavioral health services access, housing instability, and domestic violence.

Additionally, birth parents are often left to navigate the child welfare system without sufficient support. The research is clear that children fare best in families. A navigator system designed to help birth parents get access to needed supports and navigate the child welfare system is critical to helping more families successfully reunify. Birth parents need a dedicated system to ensure they know their legal rights and available services and have the opportunity to provide input to ongoing continuous quality improvement that supports the user-centered design of the child welfare system. Navigators are also an invaluable resource to increase retention and better support foster parents and kinship caregivers who can attest to feeling overwhelmed by the child welfare system. Finally, ensuring young people transitioning out of the foster care system have access to a navigator who can help connect them to mental health supports, housing, and other essential services is paramount as they navigate life on their own.

Children and adolescents in foster care should have access to mental health evaluations and therapy without requiring the consent of the guardian. Since about 40% of children in foster care are under the age of 5, substantial enhancement of support for Infant and Early Childhood Mental Health, including incorporation of the DC:0-5 in mental health systems, is needed. There should be recognition of the AAP Healthy Foster Care America standards and schedule for health (physical and mental) care, including routine screening for social-emotional development, referral/linkage as indicated, and follow-up.

Youth with Eating Disorders

Interruptions in regular access to healthy, nutritious foods and the impact of isolation and increased screen time have impacted children's health and wellbeing on both extremes. Recent CDC data show a rise in childhood obesity during the pandemic – about 22 percent of children and teens with obesity last August, up from 19 percent a year ago. Relatedly, we are also seeing dramatic increases in eating disorders, a very complicated condition that requires multi-disciplinary treatment. Adolescent medicine and child psychiatry clinicians are seeing many more cases of eating disorders that are more severe and are starting at even younger ages, even down to the age of 8 or 9. Because of the complexity of the treatment for eating disorders, it is extremely difficult to access fully comprehensive care for patients. There is a need for more services, and the training of more providers, to treat children and adolescents with eating disorders. Outpatient care services should be designed to meet the needs of this population.

Federal Resources

Interagency collaboration among the key federal agencies is essential to ensure that existing opportunities are leveraged, and funding-related gaps are identified and addressed. Collaboration across federal agencies will be key to developing a comprehensive system of care across the continuum to address mental and behavioral health needs for infants, children, and adolescents.

Sizeable federal resources have been allocated for mental health but we must ensure that this funding goes to helping children and those who care for them. Support for schools with tools to help them access Elementary and Secondary School Emergency Relief (ESSER) funds to support student and staff mental health and well-being is critically important. And we need to ensure that the Centers for Medicare and Medicaid Services is using every authority possible to increase children's access to mental health services wherever they are – at school and early childhood settings, at the pediatrician's office, and in the community.

Despite sizable federal funds being allocated to address mental health in multiple COVID-19 relief packages, pediatricians report that they are unable to access such funds to improve mental health care for children in their own practice. If accessible, funding could be used for pediatric practices to hire behavioral health specialists to provide integrated care, among other proven interventions. Value-based payment models or incentives should be used to promote integrated care. State-level administrative and technical assistance for primary care clinics, schools, and other related organizations that would like to provide integrated behavioral health services should be provided as the administrative start-up can be a significant hinderance to beginning integrated behavioral health services.

While there is a need for mental health support across the country, children in under- resourced areas on public insurance have the highest needs. Neighborhoods with high drop-out rates, increased crime rates, and lower life expectancy are the neighborhoods that need the most resources but often have the most trouble accessing them. Taskforces and regional convenings could work on place-based solutions to address social determinants of health, cross train, and share learnings in these areas.

Future resources should address behavioral health equity in the community for mental and behavioral disorders, including prevention, treatment, and recovery programs for substance use disorders, particularly in vulnerable populations affected by poverty, racism, violence, and food/housing insecurity. Funds should support integration of behavioral health in pediatric primary care through the medical home in order to better ensure children have access to appropriate care. Lastly, the federal government should invest in interventions that reduce exposure to adverse childhood experiences, including violence intervention programs, evidence-based substance use disorder services, reducing incarceration, supporting the mental health of parents/caregivers, and prevention of neglect/abuse. Data surveillance systems such as the National Violent Death Reporting System, which describes underlying circumstances contributing to suicide deaths and allows for improved allocation of resources based on patterns identified, should be funded.

Resources should be allocated to mental and behavioral health research, including the development of evidence-based innovations, guidelines, measurements, and best practices for screening tools, assessment, consultation, acute management, and follow-up care related to children's mental health crises to drive quality improvement. Further, research related to the acute management of pediatric mental and behavioral health disorders and potential prevention strategies for MBH emergencies (e.g., acute psychiatric care models in the

ED and inpatient units, psychiatric telehealth consultations for the ED, and implementation of community mobile crisis teams responding to multiple settings) should be funded.

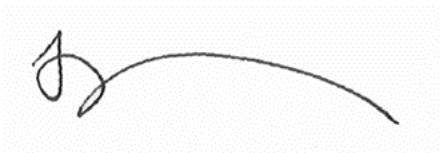
Research efforts focused on vulnerable and at-risk populations and the health inequities related to the access to care, presentation, management, and outcomes of mental and behavioral health issues, including rates and risks of suicidal ideation and attempts, in these populations (including historically disadvantaged racial and ethnic groups, LGBTQ youth, immigrants/refugees, and youth with substance use disorders, intellectual disability, low socioeconomic status, history of exposure to trauma or violence, and limited English proficiency) should be conducted with the goal of eliminating these disparities. Further, research should examine strategies to address racism and its effects on mental health.

Social Determinants of Health

Social determinants of health, such as racism, poverty, access to food, healthcare, and housing, impact the overall well-being of children, families, and communities. An upstream focus on the relationship between early childhood development and social determinants of health is needed to mitigate underlying factors contributing to child mental health problems. Pediatric primary care practices often have partnerships in place with local agencies such as food banks, transportation support, and local foundations, but these services are usually grant-funded with time or geographic limitations. Families must have access to federal and state social net programs that help meet their needs, such as housing, nutrition, insurance coverage, and income supports. A more comprehensive means to connect those in clinical practice with community supports as well as navigators who can help families sign up for assistance would help to improve mental health.

Thank you for the opportunity to provide these comments. We look forward to working with you to address barriers to accessing mental health care. If we can be of further assistance, please don't hesitate to contact Tamar Magarik Haro at tharo@aap.org.

Sincerely,



Lee Savio Beers, MD, FAAP
President

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[i] https://wonder.cdc.gov/controller/datarequest/D76;jsessionid=60B91188B5DF590441DAD31FB807

[ii] Leeb RT, Bitsko RH, Radhakrishnan L, Martinez P, Njai R, Holland KM. Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1675–1680. DOI: http://dx.doi.org/10.15585/mmwr.mm6945a3external icon

[iii] Yard E, Radhakrishnan L, Ballesteros MF, et al. Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic — United States, January 2019–May 2021. MMWR Morb Mortal Wkly Rep 2021;70:888–894. DOI: http://dx.doi.org/10.15585/mmwr.mm7024e1

[iv] https://downloads.aap.org/DOFA/CAMH%20Principles%202021%20Final%2005-04-21.pdf

[v] Children: The Hidden Pandemic. https://www.cdc.gov/coronavirus/2019-ncov/downloads/community/orphanhood-report.pdf