November 15, 2021

The Honorable Ron Wyden
Chairman
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Wyden and Ranking Member Crapo:

Thank you and the members of the Senate Finance Committee for the opportunity to provide comments as you explore ideas for improving access to behavioral health care for Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and Affordable Care Act (ACA) marketplace beneficiaries. We applaud the committee leadership's commitment to reducing barriers to mental health care and engagement of the broader stakeholder community. We urge you to ensure there is specific focus and tailored support for children in any mental health legislation developed by the committee and that you continue to explore strategies to address the current and future mental, emotional and behavioral health needs of children.

Children and teens are experiencing a significant mental health crisis, made worse by the stressors of the pandemic. Children's hospitals serve as a vital safety net for all children across the country. They provide care for children regardless of insurance status, including those that are uninsured, underinsured and enrolled in Medicaid. Medicaid is the single largest health insurer for children in the United States and serves as the backbone of children's health coverage. Over the course of the COVID-19 emergency, children and families have faced unprecedented challenges and the demand for pediatric mental health services has risen significantly, leaving too many children waiting for needed care. Recently, we joined pediatricians, pediatric mental health specialists, pediatric subspecialists and child and adolescent psychiatrists to declare a national state of emergency for children's mental health and sound the alarm on the mental health crisis facing children, teens and their families. Policymakers must act now.

Earlier this year, children's hospitals developed the Strengthening Kids' Mental Health Now proposal, a comprehensive set of recommendations focused on mitigating negative trends in pediatric mental health through delivery system improvements and advancing flexible solutions across the continuum of care from community-based services to specialized care provided in children's hospitals. To address these immediate and ongoing needs of children, we support the development of bipartisan legislation that takes a multi-faceted approach that addresses children's urgent mental health care needs. Such legislation should address the urgent need to build pediatric mental health care workforce capacity, strengthen and incentivize a robust and diverse pediatric clinical and non-clinical workforce, facilitate whole child and whole family care, and support inclusive and integrated systems that enable equitable access to high-quality mental health care, particularly in underserved and under-resourced areas. Specifically, we ask that the committee include policies aligned with the Strengthening Kids' Mental Health Now proposal that address the vital needs of children and pediatric providers by:

- Increasing investments to support the recruitment, training, mentorship, retention and professional development of a diverse clinical and non-clinical pediatric workforce.
- Ensuring payment models and reimbursement support clinical and non-clinical pediatric mental health providers and workers and eliminate implementation barriers hindering coordinated and integrated care.
- Improving access to mental health services, including strengthening network adequacy, expanding access to telehealth services and ensuring consistent application of Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) requirements.
- Addressing existing inequities within the pediatric mental health care system that contribute to mental health disparities in racial and ethnic minority populations and underserved communities.
- Ensure complete parity in coverage for mental health care and physical health

We look forward to working with you to implement solutions to enhance behavioral health and offer responses to the questions posed in the five priority areas identified by the committee with added information around increasing workforce capacity. While many of the recommended policies and program improvements fall within the purview of the committee, we urge you to work in partnership with your Senate colleagues on policies that fall out outside of the committee's jurisdiction but support broader efforts to improve the mental health care delivery system.

Improving Access for Children and Young People

We appreciate that the committee has recognized the need to address mental health care access for children and adolescents by soliciting comments specifically about this population. Our nation's pediatric mental health system is fragmented and insufficiently supported, which too often results in inadequate or delayed access to care for children and adolescents. The importance of investing in services and supports that promote timely access to necessary pediatric mental health care cannot be understated. As one children's hospital noted, "Every aspect of a child's life and health is different in immeasurable ways from an adult's. Often, adult health is first explored and, only after, are children considered. Identifying ways to improve children's health first sets up a generation for a lifetime."

Half of mental illness begins by the age of 14 with three-quarters being diagnosed by age 24. If children do not receive timely, developmentally appropriate treatment, challenges may become worse or compound, causing ongoing issues into adulthood. The level and type of intervention and treatment children need may change over time as they grow and age, necessitating more coordination across systems and the involvement of multiple providers. Furthermore, children and adolescents often have behavioral or mental health symptoms but do not meet the criteria for a diagnosable condition, making qualifying for services challenging. Addressing the mental health needs of children and adolescents through prevention, early intervention and support throughout the continuum of care including crisis care, inpatient and partial hospitalization and coordination across systems and providers will enable children to thrive and reach their full potential. Our policy priority must be to reduce our reliance on in-patient care. That can only be achieved by building a robust, fiscally viable community based care delivery system.

There are unique circumstances the committee should consider as it explores policy options. Children are reliant on their parents or caregivers for their day-to-day and health care needs, such as to help to identify the need for care as well as scheduling and transportation to

appointments, understanding the course of treatment and ensuring they are following through on their treatment plan. Navigating fragmented and under-resourced community-based mental health care systems can be complex and overwhelming, particularly for parents and caregivers of a child in crisis or otherwise struggling with their mental health. Children are also more likely to be involved in multiple systems of care and organizations—primary care, specialty care, sports, school, religious organizations—and there are opportunities for improved coordination and support. For example, children spend a large amount of their time in school settings and establishing effective school-based mental health programs can reduce access challenges for families. Equitable access to high-quality mental health care across settings and in underserved areas and racial and ethnic minority communities must be prioritized.

Although Connecticut has a pediatric Mobile Psychiatric Crisis program and school based mental health services, the lack of availability, limited clinical support and limited response time results in school's reliance on emergency rooms to address many behavioral health conditions that do not require emergency intervention. Unnecessary visits to hospital emergency rooms that are often overcrowded, is traumatic for both the children and their families.

Increasing Workforce Capacity

It is essential that any mental health legislation must address the current crisis in pediatric mental health care capacity. An insufficient supply of pediatric mental health professionals causes delays in access to treatment for children's mental health conditions across the continuum of care. The current workforce is strained under the stress of the mental health crisis faced by children and ongoing challenges associated with COVID-19 and provider burnout. Children's hospitals are reporting an increase in children presenting with self-harm and suicidal ideation and too many children are left boarding in emergency departments waiting for placement in appropriate care settings to become available. Some children's hospitals have had 20-40 children in their emergency departments simultaneously waiting for mental health care. Another hospital recently reported a 300% increase in the number of behavioral health admissions since April 2020. There is a national shortage of Child and Adolescent Psychiatrists. It is reported that the median number of child and adolescent psychiatrists is 11 per 100,000 children. This shortage is often mitigated by employing Psychiatric Advanced Practice Nurses. However, we are experiencing a significant challenge in recruiting psychiatrist, APRN and Clinical Social Workers. Hospital work is difficult, time consuming and offers salaries that are not competitive due to poor reimbursement.

Children's hospitals recommend that lawmakers take additional actions this year to strengthen pediatric behavioral health infrastructure and improve access to care, both immediately and in the long term. We urge Congress to provide resources to support efforts to scale up inpatient care capacity, including costs associated with the conversion of general beds to accommodate mental health patients. There is also a vital need to increase access to alternatives to inpatient and emergency department care including step-down, partial hospitalization, intensive outpatient services and day programs. These types of programs ensure that children and adolescents continue to receive intensive services and supports they need while alleviating pressure on acute care settings. We note that bipartisan legislation has been introduced in the House, H.R. 4943, the Children's Mental Health Infrastructure Act of 2021, that would provide grants to children's hospitals and other providers to increase their capacity to provide pediatric mental health services.

Congress should act quickly to relieve pressure on the existing workforce and invest in the long-term expansion of the pediatric mental health workforce across disciplines to meet growing needs. Congress should also consider how to mitigate administrative burdens that may contribute to staff burnout and frustration, such as unreimbursed coordination activities that grow with the complexity of a child's mental health condition. Congress must take steps to facilitate payment policies that support care coordination services for clinical and non-clinical mental health workers and continue its ongoing work to improve compliance with mental health parity law.

Investing in the Pediatric Mental Health Workforce

Shortages in the mental health workforce are persistent, more severe within pediatric specialties and projected to increase over time. Demand for physician and non-physician providers currently outpaces supply and this will continue, and potentially worsen, without targeted investment in the pediatric mental health workforce. Nationally, there are approximately 8,300 practicing child and adolescent psychiatrists, far fewer than needed to meet the existing and increasing demand. Shortages exist for other vital pediatric specialties and subspecialties with numerous underlying causes for these shortages. Many of our recommendations support more equitable access, including recruitment and retention policies that support racial and ethnic minorities and inclusion of historically underrepresented groups in key mental health professions, alongside locating training opportunities in medically underserved and health professional shortage areas and incentives for providers to practice in these communities. The value of diversity and representation in the mental health professional workforce cannot be stressed enough.

The specialized education and training required to work in pediatric mental health can be a barrier to entry, particularly for disciplines requiring physician training, doctorates or other advanced degrees. These programs take years to complete, and many providers accrue substantial student debt while completing their training. To reduce the financial burden of student debt carried by mental health professionals, Congress should invest additional funding in both new and existing pediatric mental health workforce loan repayment programs, such as the Pediatric Subspecialty Loan Repayment Program. Current workforce development and loan relief programs require examination to ensure that, as implemented, they remain accessible to providers in pediatric subspecialty fields, in line with congressional intent. Congress should also look at opportunities to provide additional incentives, such as grant programs or scholarships that mitigate the need for those interested in pursuing a career in the mental health field to take on a substantial amount of debt or front the cost of their education and training.

Furthermore, there is a growing gap between federal investments in physician training for the adult population and children. The Children's Hospitals Graduate Medical Education (CHGME) program is a vital investment in our nation's pediatric workforce, supporting more than 7,000 pediatric residents annually at children's hospitals. CHGME supports the training of frontline providers, such as pediatricians and child and adolescent psychiatrists, who play critical roles in identifying and treating the mental health needs of children and youth. Congress must provide robust funding for CHGME to support the pediatric physician workforce. We strongly support the $400 million provided for CHGME in the House FY 2022 L-HHS appropriations bill and the $250 million increase for CHGME included in the Build Back Better budget reconciliation package advanced by the House Energy and Commerce Committee.

Congress must also increase investments to support early outreach and recruitment of providers at all levels, training programs, retention of needed clinical and non-clinical professionals and incentives for academic medical centers to encourage the development of programs focused on mental health. These programs should be equitable and support an inclusive, diverse behavioral health workforce. Exposure to health care professions earlier in education and access to mentorship are critical tools in recruiting students to mental health fields, particularly students from minority communities who are currently underrepresented in higher education. Congress should examine current HRSA workforce programs to ensure that the full range of mental health fields are substantively included and identify opportunities to expand effective recruitment and retention policies, particularly for providers in geographically underserved areas and from minority communities.

Further, rates of reimbursement have historically been lower for mental health services in Medicaid and CHIP, as well as private insurance. Low reimbursement rates contribute to difficulty in both recruitment and retention into mental health fields and lead to fewer providers participating in Medicaid, CHIP and commercial health plans—a significant barrier to care for children. Together, the high cost of obtaining the training and credentials for pediatric mental health care professions and the low rates of reimbursement for services are impeding workforce growth. Since the Medicaid program is the single largest payer of pediatric mental health services, we recommend increasing Medicaid reimbursement rates for pediatric mental and behavioral health services to Medicare levels or increasing the federal medical assistance percentage (FMAP) for pediatric mental and behavioral health services to 100%.

Improving Integration, Care Coordination and Access to Care

Greater investments are urgently needed to develop and enhance community-based systems of care and children's access to the right care, in the right setting, at the right time. Prevention and early identification are at the foundation of an integrated system of care for children's mental health. Well-coordinated, effective systems of care meet children where they are, such as schools and pediatricians' offices, and provide universal screening to identify needs. Unfortunately, in many communities there are gaps within the continuum of care for children and adolescents and a lack of coordination between existing providers and systems. There may be added challenges, for instance consent requirements or issues around data systems sharing, for vulnerable youth populations, such as those in child welfare or justice-involved youth.

Primary care providers have regular contact and established relationships with children and their caregivers and are well positioned as the first line in identifying possible social, emotional or cognitive concerns. Integrated care, including through telehealth consultation, can improve identification of mental and behavioral health needs in children and streamline connections to care. Schools can also play a critical role in primary prevention and early identification, especially through school-based health centers and partnerships between schools and local providers, including children's hospitals. Significant resources and technical assistance are needed to stand up these partnerships in communities across the country.

At the core of a strong pediatric mental health care delivery system is a strong, interconnected network of pediatric mental health providers and supportive services that are available to deliver high-quality developmentally appropriate care. To expand and strengthen these networks at the community level, the Senate may consider H.R. 4944, the Helping Kids Cope Act of 2021, bipartisan legislation that supports flexible funding for communities to support a range of child

and adolescent-centered community-based services, as well as to support efforts to better integrate and coordinate across the continuum of care. It also supports pediatric mental health workforce development for a wide array of physician and non-physician mental health professions, to support children's long-term access to providers and services across the continuum of care.

Effectively coordinated care relies on the expertise and collaboration of both clinical and non-clinical team members to ensure children are connected to the right care and families are well supported as they navigate complex, and often patchwork, mental health care options for their child. Care coordinators in particular provide crucial support in conducting follow-up with patients discharged from inpatient care or crisis stabilization. Professional peer support and family peer support specialists can be critical members of a care team, supporting children and their caregivers with helpful insights, often from lived experience and strong community connections. Too often, this work is not reimbursable despite its value to the care relationships that benefit children and families. There is a critical need to fund care coordination services and identify gaps within the continuum of care that often leads to children waiting for treatment they need to overcome mental health challenges. Congress should explore payment models in Medicaid and CHIP that incentivize and include mechanisms to reimburse for care coordination services, community partnership and consultative services.

While there are well established evidence-based practices in providing coordinated and integrated care to facilitate access for children, there are also substantial implementation barriers that require swift action by Congress. Reimbursement is a significant challenge to increasing preventative care, standing up care coordination services, implementing integrated care models and expanding peer support. Additionally, Congress should consider how best to address the prohibition on same-day billing for both physical and behavioral health services. This limitation persists in some state Medicaid plans, and children's hospitals have reported that it can prevent effective implementation of integrated care.

Expanding Telehealth

For the past several years, children's hospitals have worked to improve access to high-quality primary and specialty care, lower costs and improve collaboration and communication among clinicians through pediatric telehealth programs. During the pandemic, telehealth emerged as a transformational method of health care delivery and a vital tool to increase patient access to needed services. Notably, investments in telehealth and waivers and flexibilities have supported continuity of pediatric mental health care services, even amidst stay-at-home orders and forgone in-person care.

Tele-mental health services have been described as an ideal application of digital health services, and mental and behavioral health visits account for a large number of overall telehealth visits at children's hospitals—up to half of telehealth visits for some hospitals. One children's health system reported that nearly 75% of their telehealth visits are psychology and psychiatry visits. As the scope of telehealth has expanded, families and kids have become more comfortable with utilizing technology for physical and behavioral health visits. Congress should develop policies that support a flexible model of services that enable children to readily access telehealth and in-person care, which is likely to result in the most convenient and cost-effective option for families, providers and payers. This includes ensuring access to s

Synchronous and asynchronous modalities including audio-only and coverage across sites of care including a child's home, school or childcare center. Increased reimbursement rates for telehealth services supported the rapid expansion of telehealth and should be continued at an appropriate level to maintain children's access to tele-behavioral health services. Many payers, including Medicaid, adopt or model their telehealth policies to align with Medicare policy. Congress should take into consideration how potential changes to reimbursement policy may impact children, including the availability of tele-mental health services for kids.

To encourage expanded access to and use of telehealth services under Medicaid, Congress should direct CMS to issue strong guidance encouraging states to sustain and improve the availability of telehealth under Medicaid during the pandemic and beyond, including coverage of audio-only services, to provide appropriate pediatric care. Additionally, we support enactment of S. 1798, the Telehealth Improvement for Kids' Essential Services (TIKES) Act, which would promote access to telehealth services for children covered by Medicaid and CHIP programs and would also study children's utilization of telehealth to identify barriers and understand outcomes and limitations. There are several other considerations, including technological limitations, language and cultural barriers, cost of cellular or internet data plans, lack of broadband access and privacy and security concerns that should be addressed to ensure that as new policies are developed, we are not replacing existing barriers to telehealth with different barriers and exacerbating health disparities.

Ensuring Parity and Access to Services

The implementation and enforcement of mental health parity requirements are essential to ensuring that children and adolescents with mental health conditions have timely access to needed care. Provisions of the Mental Health Parity Compliance Act, passed within the Consolidated Appropriations Act of 2021, were an important step towards improving private insurers' compliance with the Departments of Health and Human Services, Labor and Treasury (departments) requirements related to non-quantitative treatment limits (NQTLs) under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAE). These new requirements that plans that impose NQTLs on their mental health benefits perform a comparative analysis of the design and application of those limits will strengthen the departments' oversight of the plans and improve transparency for consumers. However, while these recent changes are critically important, there is more that can be done—both in terms of NQTLs and overall parity requirement—to ensure that children and adolescents are not denied or delayed access to needed mental health services across the continuum of care. In particular, health plans' design of provider networks and their payment policies and procedures are areas where more can be done to ensure that those practices are not impeding care.

Stronger network adequacy standards and oversight are needed in all insurance markets, including the large group, self-funded market. Those standards should include specific requirements that health plans demonstrate they contract with an appropriate number of trained mental health professionals with expertise in child and adolescent mental and behavioral health. Currently, it is not unusual for health plans to have many fewer providers at all levels of care in their mental health networks than they do in their medical/surgical networks. In addition to quantitative metrics to measure network adequacy, standards related to mental health services should prohibit the imposition of more restrictive limitations and exclusions on facility types and clinically recognized levels of care, such as residential treatment programs, or the establishment

of more stringent payment policies and procedures than those that are applied to medical/surgical benefits.

Children's hospitals often face numerous challenges navigating health plan payment policies for mental health services that are more complicated and restrictive than those imposed on medical/surgical benefits. In particular, the administrative burden associated with medical management policies, such as prior authorizations, claims processes and approvals for care transitions, often do not exist to the same extent for coverage of treatment for physical health conditions. These additional requirements are time-consuming for providers to navigate and can lead to delays in care for children and slower reimbursement for providers. Reimbursement delays due to overly burdensome utilization reviews and slow and complicated claims processing, combined with historically low reimbursement rates, are contributing factors to mental health providers not participating in private and public plans' provider networks. More oversight of payment procedures is needed to ensure that children, particularly those in mental health crisis, are not waiting for care due to payment and other related and unnecessary insurance delays that are wholly unrelated to their mental health needs.

Congress should also direct CMS to review the EPSDT requirements and how they are being implemented in the states to support access to needed mental health services and early intervention services critical to children's well-being. EPSDT provides for a broad scope of benefits for children if these services are determined by the child's health care provider to be medically necessary to correct or ameliorate physical or mental health issues. Over the years, families have sued to receive access the necessary services to treat their child's condition, including behavioral health care services, and a federal class action lawsuit was recently filed against the state of Colorado on behalf of plaintiffs and Medicaid-eligible children diagnosed with mental or behavioral health disorders who have not been provided recommended intensive home and community-based services to correct or ameliorate their disorders. CMS should provide guidance to states ensure consistent application across states on what is required so children have access to the full range of mental health services, including intensive outpatient services, partial hospitalization, day programs and other stepdown levels of care that bridges inpatient care and home and community, in addition to community-based mental health care and family support services.

Children's hospitals and their affiliated providers stand ready to partner with you as you continue your work focusing on improving access to mental health care services. Thank you for your consideration of these recommendations and your commitment to improving the health and well-being of children and adults across the country.

Sincerely,

Howard Sovronsky

Howard Sovronsky
Chief Behavioral Health Officer