***Sen electronically to mentalhealthcare@finance.senate.gov***

November 15, 2021

Dear Chairman Wyden and Ranking Member Crapo:

Ann & Robert Lurie Children's Hospital of Chicago (Lurie Children’s) applauds your efforts to address the mental health crisis in our nation.  We particularly appreciate your request to focus on the mental health needs of children, which will be the focus of our commentary.  Thank you for opportunity to share our perspective.

Lurie Children’s is an independent (freestanding) academic children's hospital located in Chicago, and part of the Northwestern McGaw Graduate Medical Education Consortium.  We serve as the primary pediatric partner and training center for undergraduate medical student , and health care and health science students graduate medical students.  We are the only full-service acute care independent children's hospital in Illinois, and we draw patients from our region, the nation, and many foreign countries.  Over half of our patients are insured by Medicaid or CHIP.  Half of our inpatient beds are critical care.  In short, we anchor children's health care in Illinois, particularly for low-income children, and for the full spectrum of primary, specialty, and subspecialty outpatient and inpatient services.

Mental and behavioral health challenges existed prior to the pandemic and became severe crises for children of Illinois and throughout the nation.  We are confident that you will receive many thoughtful comments on all the issues affecting so many patients in need of mental and behavioral health services.  We are focusing our comments on the most pressing problems facing children's access to mental health services~~,~~ and offering solutions that can address the problem, and have the potential to be game changers.

Our single most important message is that reimbursement for mental and behavioral health services for children is antiquated in focus, inadequate for children and families’ needs and serves as a substantial barrier to access to care and evidence-based solutions that would improve outcomes and ultimately result in cost savings.   We urge you to build a new paradigm of reimbursement under Medicaid and CHIP to address these structural barriers. This new paradigm must be aligned with the full spectrum of interventions that we know are effective for children's mental and behavioral health needs.

We often say that children are not little adults -- and this is particularly true in the mental and behavioral health arena. The behavioral and developmental needs of children -- from pregnancy, infancy, childhood, adolescence, and young adulthood require strategies that recognize that children’s mental health needs derive from a number of factors including genetic and constitutional factors as well as family and community. A child in mental health crisis, is a family in mental health crisis.

Pediatric providers are core to early identification and early intervention of behavioral health problems. Parents trust their child’s pediatric provider and see their provider as central to their child’s health care.  Pediatricians see the mental health of their patients as a key component of their patients’ overall health care needs.~~-~~- Without the integration of the primary caregivers of children in addressing their mental health needs, our ability as providers to affect outcomes is limited.   Because so many children depend upon Medicaid or CHIP for insurance, these programs must serve as critical drivers in mental health services for children.  The mental health needs of children must be addressed differently, and the evidence demonstrates that investing in the mental and physical health of children as early as possible, improves lives, outcomes, and saves later investments in serious adult mental illnesses.

**I.  Barriers to Children's Access to Mental and Behavioral Health Services**

There are numerous barriers to access to care, much of which is tied to an antiquated system of reimbursing for episodes of care and therapy, rather than interventions that will be more successful in improving care and outcomes.

1. **The Level of Reimbursement is Inadequate**. There is a gross disparity between the value and level of payment between mental health providers at all levels and physical health providers.   This is true up and down the provider structure of payment for physicians, psychologists, therapists, social workers, and other essential providers of mental health services.
   1. For example, Medicaid reimbursement for outpatient hospital-based mental health services remains woefully inadequate in Illinois making it challenging for providers to expand services for the children and adolescents who need them. In fact, some providers are reducing services due to insufficient reimbursement.
   2. Outpatient Medicaid rates for mental health services are less than half of the reimbursement rates for outpatient acute care services. Lurie Children’s has a staggering outpatient waiting list for mental health services despite all behavioral health clinicians working above their capacity. In addition, over half of these children are enrolled in the Medicaid and CHIP program. The situation is not unique to Lurie Children’s as there is significant demand for mental health outpatient services for children and adolescents across the state of Illinois. Low Medicaid reimbursement to hospitals for children and adolescent mental health has made it difficult to provide the necessary resources to meet these needs. This situation has resulted in closure of mental health outpatient and inpatient programs for children in many of our city’s leading hospitals resulting in additional barriers to accessing evidence-based care and further taxing our programs

Lurie Children’s net loss was $4.5 million for the outpatient mental health services it provided to Medicaid patients last fiscal year. Medicaid outpatient payments, inclusive of provider assessment and other supplemental payments, only cover approximately 54% of direct costs and 30% of total costs.

1. **Actually, Getting Reimbursed is Challenging**.  Quite simply, even for covered services, it is much more difficult to get paid for mental and behavioral health services.  Insurers and Medicaid programs erect paperwork, approvals, and other roadblocks to care.
   1. And there is a disparity in getting reimbursed by Medicaid and insurers who create much greater roadblocks for mental health reimbursement.

1. **Reimbursement is Not Aligned with Services**.  We have come a long way in developing systems of mental health care and interventions that are evidence based and clearly improve outcomes for children, their families, and communities.  However, Medicaid does not pay for a number of these interventions, despite their clearly demonstrated value.  And if Medicaid does pay, it pays so poorly that providers will not accept Medicaid patients.  It is sad but true that children insured by Medicaid simply lack access to many critical interventions that could dramatically change for their good their lives and those of their families.  Several examples of evidence-based interventions that are not covered or sufficiently reimbursed include the following:
   1. Parent training and education
   2. Dialectical Behavior Therapy
   3. Psych Emergency Department services, to treat acute symptoms and avoid hospitalization
   4. Intensive Outpatient Programs

**D.  Care Locations Matter.**

*1.  Outpatient Care*.  Our system is designed to pay providers to provide care in their locations -- office, outpatient, inpatient.  We need to develop a system to provides care where children **live, learn and play**, and where parents work.

*2.  Inpatient Care*.  One substantial and unnecessary barrier to providing inpatient services is the extraordinarily prescriptive requirements imposed upon hospitals.  While well intentioned, the design and structure requirements are designed not for the vast majority of children we serve, but for the few adverse outcomes that could theoretically occur.  Quite simply -- requiring pediatric hospitals to provide “Cadillac” facilities, while getting paid at “Pinto” rates, is causing many to shut down beds.  Federal, state and the Joint Commission requirements for operating psychiatric beds can be cost prohibitive.

1. **Lack of Workforce**.  As we are sure you are well aware, we simply do not have enough of every type of mental health professional to serve children.  Why?

*1.  Poor Reimbursement Drives Professionals Away from Choosing Mental Health Care*.  The disparity between mental and physical health professional remains acute in levels of payment (discussed above), and reputation -- the pay and lifestyle of a dermatologist is far greater than that of a pediatric psychiatrist.   We would highlight also the inherently more difficult challenges of providing mental health treatment to children whose minds are developing, and to teenagers who are undergoing dramatic physical and mental changes during puberty.  These make children's mental health care very challenging, and should be more highly rewarded professionally and financially, rather than the opposite which is the reality today.

 In addition to the lack of parity for mental health and behavioral health; there is also additional training required for pediatric subspecialty of child psychiatry and this is not reflected in the billing rates or pay for these professionals.

*2.  Lack of Parity in CHGME*. The high cost of professional education along the spectrum of mental health providers is another barrier and disincentive to provide pediatric mental health care.  This is particularly true for pediatric physicians.  Independent children's hospitals receive approximately $50,000 per resident, and children's hospitals that receive Medicare GME as part of an integrated adult and children’s system receive approximately $117,000 per resident.  Teaching health centers receive $130,000 per resident.  We are unaware of any independent children's hospitals that are not training above our GME caps under the CHGME program.  We need parity in funding for the pediatric residents we are already training, improved payment for subspecialist fellows in training, and we need new funding to open up more slots for psychiatrists, developmental pediatricians, psychologists, and other related providers.

Loan forgiveness for social workers and others is another way to incentivize students to enter the behavioral health field as well and providing opportunities for clinical supervisors to obtain credit/paid for supervising social workers’ post-graduate. Currently many pay out of pocket for required supervision.

**II.  Solutions to Improve Access and Outcomes for Children.**

**A.  Realign reimbursement with proven, evidence-based interventions across the full spectrum of care.**

Managed care is supposed to be preventative, but only one visit per year is covered for behavioral health.

Psych Emergency Departments could be a tremendous solution for families, but they are not reimbursed- there's no model. Most Emergency Departments decide to admit or not admit. We believe a pilot needs to allow a new model where intensive BH care occurs in the Psych Emergency y Department -- an intensive intervention right on the spot – that could avoid hospitalization and give families the tools they need to manage at home and on an outpatient basis.

Expanding partial hospitalizations is an effective treatment model. It boils down to reimbursement and funding. Additionally, dialectical behavior therapy (DBT; 2nd wave of behavioral behavior therapy) intervention is one such service that is **not**covered for children under Medicaid. Psychiatrists, social workers, and psychologists administer this service but cannot be billed in Medicaid. So, a gap in access for Medicaid kids persists.

Federal CMS could mandate that states reimburse for parental child involvement? (PCI? PCH? reimburse higher rates or enhance a match to motivate states to offer it; or directly mandate it) for these critical services. We must emphasize if there are essential services that are not offered within Medicaid they need to be covered. Is there language in Medicaid law we can cite where Medicaid is supposed to meet these needs. For example, EPSDT?

While many Joint Commission requirements are valuable, of them require hundreds of thousands of dollars to comply such as ligature requirement for inpatient psych beds. Regulations need to encourage safety and also address grave demands in need for care. Government must help. For example, one hospital paid $1 million for new anti- ligature door hardware. Lurie Children’s upgraded its door handles at great expense, too.

**B.  Prioritize Investment in Children's Mental Health Care, Especially Early Interventions that Include Parental Involvement.**

Our nation's funding of mental and behavioral health has misaligned priorities -- we should be investing in early interventions, particularly among children.  We are spending the vast majority of funding money on adults.  We should be investing in children first and foremost to prevent long-term mental health problems in adults.  Across the nation's state capitals are overwhelmed by the high costs of adult mental health needs, while children's mental health investments are largely ignored, fundamentally missing the point that many of these adults showed problems early on in childhood and adolescence.

*1.  Pay for Visits  Involving Parents*.  Most 0–5-year-old interventions are with parents (evidence-based), but Medicaid does not reimburse for parent-only visits. PCI (parent child interaction) trainings are one such example of known, effective solutions.  Reimbursing for these types of evidence-based interventions would be a game-changer for more holistically treating the child and improving the ability of parents to address the mental health needs.  Parent training care would change the face of care (for the better); it is the most robust and effective evidence-based model of care. No Medicaid reimbursements currently exist for this treatment model. Some commercial reimburses for it, but it is not the norm.  Accordingly, the only parent training that is available is provided by hospitals like Lurie Children's who rely upon philanthropic funding to do so.  For example, Parent Corps is a parenting program that is evidence- based and that provides 4 to 1 return on investment <https://www.weareparentcorps.org/>

*2.  Pay for Non-Traditional Interventions*.  There are many ways of improving access to care by bringing care and other innovative interventions to where children and their parents live, work, learn and play.   Medicaid does pay for innovative treatment but only for adults.  Assertive Community Treatment (ACT) is one example where folks treat in the community where they (patients) are to mitigate high-cost adult care (hospitalization rates, for one). Imagine an ACT team for kids!   Medicaid approaches health in an insurance-model (simple fee for service) where a problem is identified, and the medical need ("problem") is expected to be addressed and "fixed"- It lacks the necessary shift with a lens towards an intervention model.  We also need to further expand reimbursement of early intervention services delivered in non-traditional settings including schools and recreation spaces. These settings provide potential to build skills and promote mental wellness within trusting relationships that students have already. In addition, investment in the skills and expanded roles for educators, paraprofessionals, community navigators and other child serving adults can expand the potential work force including those community members who have sustained relationships with kids and families and could provide a critical link to overcome barriers to seeking treatment including stigma and lack of diversity and cultural affinity with providers.

One can easily spend a lot of money on children and not get good yields, so we need to spend resources in communities that reaches children and makes an impact with services which we know are effective (data, research, citations needed). One of the problems now is a result of for-profit over-billing ('80s and 90s'), which is a memory that is still in the system. For-profit folks exploited. Now, by contrast, we have treatments that we KNOW work with evidence that it's effective. This contributes to our current dilemma. For-profits were not beholden to clear admission criteria and results standards.

**C.  Pilot a new paradigm.**Integrated behavioral and physical health & social determinants.  Look at the kid holistically.  Enable breaking down of funding silos -- SNAP, AFDC, WIC, Foster Care.

Please contact Susan Hayes Gordon, Senior Vice President and Chief External Affairs Officer with any questions at [sgordon@luriechildrens.org](mailto:sgordon@luriechildrens.org) or 847.372.7718.

Thank you again for inviting our comments on this critical issue impacting the health and wellbeing of our nation’s children.