

November 5, 2021

Re: Request for Information to Address Unmet Mental Health Needs

Dear Chairman Wyden and Ranking Member Crapo,

On behalf of children's health researchers, clinicians, and policy experts at [PolicyLab](#) at Children's Hospital of Philadelphia (CHOP), we welcome this opportunity to respond to the U.S. Senate Committee on Finance's [request for information](#) on policy proposals to address unmet mental health needs.

We share your belief that far too often individuals across the country, particularly children and youth, struggle to access timely, quality mental health care. We also appreciate your recognition of how the COVID-19 pandemic has exacerbated unmet mental health care needs. We would go further to argue that the additional traumas and challenges faced by children, adolescents, and families during the pandemic created a perfect storm for overwhelming the already overstretched and under-resourced mental health system serving children to create a mental health crisis for this population. Additionally, the pandemic sharpened the focus on racial/ethnic inequities in our systems of care and the profound impact that health disparities and racism have on the emotional and physical well-being of communities of color.

According to the Centers for Disease Control and Prevention (CDC), between March and October 2020, the number of mental health visits for adolescents ages 12 to 17 was 31% higher than over the same period in 2019, and for children ages 5 to 11, it was up 24%. This dire situation led the American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP), and the Children's Hospital Association (CHA) to declare a national emergency in child and adolescent mental health.

Please look to the responses from CHOP and the CHA for a broader set of recommendations. However, as a complement to these responses, we offer details on areas that CHOP PolicyLab research and expertise can inform. In particular, the inputs that follow focus on four of the questions related to "Improving Access for Children and Young People."

We urge you to ensure any forthcoming mental health legislation includes a specific focus on children and to continue to explore how best to address the current and future mental health needs of children. We sought, in this feedback, to share a growing body of evidence that highlights how we can best move forward. We welcome the opportunity to discuss this feedback. Please contact Jami Young, Faculty Lead for PolicyLab's Behavioral Health Portfolio (youngjf@chop.edu) for further discussion and additional references.

Sincerely,

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Improving access for children and young people

1. How should shortages of providers specializing in children's behavioral health care be addressed?

We appreciate the Committee's recognition of the current workforce crisis and limited system capacity to serve the specialized mental health needs of children. To reiterate the scale of that problem, AACAP estimates that in 2018 there were 8,000 child and adolescent psychiatrists in the U.S. compared to a need of more than 30,000, leading to 7.5-week average wait times for treatment. The Health Resources and Service Administration (HRSA) further projects a substantial workforce shortage across the nine main mental health professions, inclusive of nurse practitioners, physician assistants, psychologists, counselors, social workers, and marriage and family therapists. These workforce shortages, which are particularly pronounced in certain geographic regions, mean that children often end up in emergency departments, waiting days or weeks for placement in settings that can meet their needs.¹ These issues are even more acute for racial and ethnic minority groups, those with emerging English proficiency and Medicaid beneficiaries.^{2,3}

As outlined in the responses from CHOP and CHA, one important solution will be training more providers, which should include strategies to incentivize existing and future providers with educational funding, loan forgiveness programs and higher pay. However, given the scale of the problem, other solutions will be needed. Below we offer complementary innovative strategies that leverage the existing workforce, nontraditional personnel and mobile technology.

Increase reimbursement rates for mental health care

Reimbursement rates for mental health services have historically been low across payer types, but particularly in Medicaid. As reimbursement rates are strongly linked to access to care, we need to address rates across the range of health care payers, but as a starting point we need to increase Medicaid's reimbursement rates. For more specific options for doing so, refer to CHA's comments.⁴ In tandem, it is imperative to ensure compliance with and enforcement of mental health parity laws.

Medicaid, the largest children's health insurer, serves as the backbone of children's health coverage and a crucial revenue source for specialty mental health care providers. The low Medicaid reimbursement rates make it exceedingly difficult for safety net providers, who operate on thin margins, to weather financial or business downturns. This has been clear during the COVID-19 pandemic, when mental health providers that rely primarily on Medicaid for payments struggled to remain open.⁵ For additional detail and evidence on addressing child mental health during the pandemic, please see PolicyLab's related policy review.⁶

Expand the workforce providing mental health services to children

It should be recognized that the mental health provider system includes licensed counselors, psychiatric nurse practitioners and physician assistants. Greater recognition of this, in

particular by state policymakers, would increase the number of professionals and the pipeline of trainees available to provide mental health services to children. Further, incorporating this full range of mental health providers in health care payer contracts is critical to support the expanded mental health workforce.⁴ To ensure quality services across professionals, these providers should be trained in evidence-based practices specific to meeting the mental health needs of children. Telehealth and technology solutions also play an important role in addressing workforce shortages. We cover this under question 4.

Additionally, engaging and supporting pediatric primary care clinicians in providing mental health services will also augment the workforce. There are several promising models, spearheaded first in Massachusetts, through which specialists provide consultation to pediatric primary care providers so these providers can initiate treatment and manage certain mental health concerns in primary care. In response to question 3, we further outline the benefits of integrating services in pediatric primary care.

In addition to expanding the current workforce with professionals with varied degrees, we recommend ensuring that pipeline programs for all mental health professionals prioritize recruitment of a racially, ethnically, socioeconomically and gender-diverse workforce. Patients and families are more readily able to engage with a mental health provider who shares important social characteristics with them. Expanding funding opportunities, including those offered by HRSA's Bureau of Health Workforce, is one way to prioritize the recruitment and training of diverse individuals across a range of mental health fields. Additionally, Congress should commit funding to workforce loan repayment programs and consider additional incentives, such as grant programs or scholarships, to ensure the development of a diverse mental health workforce.

Support long-term funding for preventive services in community settings

Preventive mental health interventions reduce morbidity and mortality and are cost-effective.⁷ Investing in evidence-based prevention programs that can be delivered in the community will reduce the burden in secondary and tertiary care settings and enable child psychiatrists and psychologists to serve those who need them most. In particular, suicide prevention programs are essential for addressing the alarming rates of suicide among children. Onsite staff can and should deliver preventive services in nonspecialty mental health locations, such as schools, primary care practices, child care settings and afterschool programs. This creates the opportunity to leverage embedded staff and trusted relationships, while also maximizing reach and impact, particularly for communities of color and other underserved populations.

Current mental health payment models do not support prevention services. We encourage increasing funding to support preventive services and developing and testing financially sustainable payment models. To this end, dedicated grant programs could further enable community-based systems of care. Increasing health care payment flexibility with new billing codes that support preventive services without a diagnosed psychiatric condition would better enable primary care providers to provide preventive care. One pathway is working with states to test innovative strategies with Medicaid's Early and Periodic Screening, Diagnostic, and

Treatment (EPSDT) services to allow youth at risk of mental health concerns but without a diagnosis to receive preventive services; we can look to Massachusetts for innovation in this area. Revisiting and realigning health insurer capitated payment rates to reflect expanded preventive services would also facilitate earlier interventions.

Build sustainable funding models for school-based services and providers

Amongst children who receive mental health services, the majority obtain these services in schools, yet funding them is a challenge.^{8,9} The Free Care Act allows states to utilize Medicaid funding for EPSDT services for children in school. Increasing the number of states (currently 15) using the EPSDT Medicaid benefit offers a route to build sustainable funding for school-based mental health services.¹⁰ Congress should consider greater support for school-based mental health services, as well as look to support innovation in braiding federal funding sources—including education, health, and substance abuse block grants and project grants, as well as the recently released Elementary and Secondary School Emergency Relief Fund—for school-based mental health services.

Ensure a focus on children as part of crisis support systems

Current state efforts to bolster crisis support systems with mobile crisis units and national suicide prevention hotlines (e.g., 988 and 211 networks) will best serve youth if these efforts include people with expertise in working with children. Involving child specialists in crisis response teams allows children to be triaged to the right level of care and avoid unnecessary trips to emergency departments. Several states were recently funded by the Centers for Medicaid and Medicare Services to plan mobile crisis units. These community-based services increase access while offsetting the burden on child psychiatrists and psychologists.¹¹ Training and ongoing support for these staff is essential to ensure they have the cultural competency to work with vulnerable youth who identify as sexual, racial and/or ethnic minorities.

2. How can peer support specialists, community health workers, and non-clinical professionals and paraprofessionals play a role in improving children's behavioral health?

The professional groups highlighted in this question are important resources for improving children's mental health. We must ensure that they receive training and ongoing consultation in evidence-based practices. Increasing and sustaining investment in these critical roles will strengthen and build the capacity of the mental health system.

Support the workforce needed by schools to offer preventive services

Youth spend most of their time in school or child care settings. Having school counselors, psychologists, social workers, and other professionals address problems there and work with students at risk of mental health difficulties can decrease the need for higher-level care, improve children's mental health and improve educational outcomes.¹² However, schools struggle to

recruit and fund these critical positions, and the COVID-19 pandemic has exacerbated these challenges. We need to ensure enough providers are in schools and reduce the current staff-to-student ratios for these essential roles. Addressing these challenges requires sustainable federal support that includes clear pathways to braided health and education funding for staffing, service delivery, as well as training and ongoing consultation in evidence-based programs.

Invest in care navigators to improve uptake of mental health services

Fewer than 50% of children referred to mental health services access them, in part because it can be complicated and confusing for families to navigate the mental health care system. Care navigators, who may be social workers, community health workers, or other non-clinical professionals, support the patient and their family in connecting with mental health care providers and resources. While care navigator models vary, families who have worked with care navigators are more likely to complete assessments and stay engaged in care.¹³ With the increasing mandates for mental health screening in the primary care setting, providers are identifying many more patients who need mental health services. This underscores the need for investing in care coordination to link these youth to services, as well as payment policies to support these coordination efforts. Congress should take steps to facilitate payment policies that support care coordination services for clinical and nonclinical mental health workers.

3. Are there different considerations for care integration for children's health needs compared to adults' health needs?

Integrating mental health care in primary and specialty care settings for both children and their caregivers will improve children's overall well-being. An important consideration for care integration is that many child mental health interventions involve parents and other family members. Additionally, directly targeting parental mental health in pediatric primary care can have many benefits, including for the child. Reforming health care payment policy to allow for and sustainably fund these services continues to be a challenge and should be prioritized.

Integrating mental health care in primary and specialty care settings improves uptake and well-being

Attending to a child's physical and mental health in the same setting offers great benefits. The primary care setting offers a critical opportunity to identify mental health needs. Most children see a primary care provider at least once per year and pediatricians are often the first to identify a mental health condition. Integrating mental health providers into primary care settings improves treatment initiation substantially and allows for a "warm handoff" between pediatrician and a specialist.¹⁴ It can also improve primary care providers' comfort and skill in addressing mental health concerns.

Specialty care is another important setting for reaching children and their families. Youth coping with complex illnesses or conditions, such as chronic kidney disease, often face mental health concerns. Integrating mental health professionals within specialty medical programs

helps children and their families cope with illness, promotes adherence to medical regimens, and improves overall health and well-being. However, these types of models are challenging to implement because of barriers posed by payment policy, including fee-for-service billing and behavioral health carveouts.

Payment reform is needed to support mental and physical care integration

Health care payment policy is a powerful lever to drive changes in care delivery and should be leveraged to support and incentivize coordinated mental health care, including preventive services in physical health care settings. As essential groundwork for this, reimbursement rates for behavioral health providers need to be consistent with physical health reimbursement.

Furthermore, public and private health care payers should create a reimbursable model for use in primary care and medical specialty clinics that covers screening, assessment, care coordination and brief evidence-based interventions. Medicaid Managed Care plans could consider higher capitation rates that reward the integration of behavioral health services.

Medicare's Behavioral Health Integration payment codes that reimburse collaborative care could serve as a model for pediatrics; North Carolina expanded these payment codes to pediatric primary care.¹⁵ Additionally, payers should be required to permit children to go out of network to receive evidence-based interventions unavailable in the local network. For example, we know from our own work with youth with eating disorders that it is rare for a Medicaid provider network to include providers trained in family-based treatment, one of the few interventions with strong evidence for the treatment of anorexia. Finally, as many evidence-based mental health interventions include family involvement such as parenting interventions and family-based models, payment models should enable and incentivize interventions that involve caregiver participation.

Treating caregivers can also improve child well-being

Caregivers are more likely to go to pediatric appointments than their own adult provider in the postpartum period.¹⁶ Perinatal mood and anxiety disorders, including postpartum depression, are common and, if left untreated, can negatively affect the parent-child relationship and, ultimately, the child's development and mental health. Evidence-based treatments exist, but too few caregivers can access care. Pediatric primary care offers a consistent, positive connection to families and their young children, while adult care can be inaccessible. Leveraging health care payment policy to finance evidence-based care delivery that can increase treatment for perinatal mood and anxiety disorders, including in pediatric primary care, has the potential to support the child and caregiver. However, attention is needed to address the complexities of privacy and managing adult health records when providing intergenerational care in a pediatric setting. For specific recommendations, see PolicyLab's briefs on "Addressing Postpartum Depression in Pediatric Settings" and "Addressing the Mental Health Needs of Teen Parents."^{17,18}

4. What key factors should be considered with respect to implementing and expanding telehealth services for pediatric population?

The COVID-19 pandemic led to a rapid expansion of telehealth and highlighted this method of care delivery as a vital tool to increase patient access to services. Although virtual visits are not a solution for everyone or every situation, telehealth makes it possible for more children to get the care they need, when they need it, right in their communities. This is particularly important for low-income families who often face financial and transportation barriers; adolescents who can consent to their own mental health treatment but do not have the support of a caregiver; youth requiring specialized care unavailable in their local community; and other vulnerable populations. Barriers to access, such as the digital divide and restrictions that prohibit telehealth services across state lines, must be addressed to fully realize the potential benefits of telehealth.

Continued coverage for telehealth services including audio only interventions

The American Psychiatric Association has long endorsed the use of video-based sessions, deeming them equivalent to in-person care. However, prior to the pandemic, insurance coverage for telehealth was inconsistent and a patchwork of state regulations has prevented its widespread use. To encourage expanded access to and use of telehealth services, including under Medicaid, Congress should direct the Centers for Medicare and Medicaid Services to issue guidance for states to sustain and improve the availability of telehealth under Medicaid during the pandemic and beyond. Regulations and payments must allow for audio-only interventions to assist those who do not have access to technology or in cases where the phone offers an additional level of privacy. It will be important that these policies ultimately support a flexible model of services that enable children to readily access telehealth and in-person care.

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