CHILDREN'S HOSPITAL ASSOCIATION

Champions for Children's Health

Children's Hospital Association Statement for the Record

U.S. Senate Committee on Finance

Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration

March 30, 2022

On behalf of the nation's more than 220 children's hospitals and the children and families we serve, thank you for holding this hearing, "Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration." As you consider policy options to ensure mental health parity and access to the full continuum of services, we urge you to recognize the tailored and dedicated mental health support and care that children, adolescents and young people need and to advance meaningful and transformational solutions.

The statistics illustrate an alarming picture for our children. Prior to the pandemic, almost half of children with mental health disorders did not receive care they needed.[1] Although the trends in pediatric mental health were worrying before the COVID-19 emergency, demand over the past two years for all levels of crisis care for children and teens has risen significantly. According to a recent study in JAMA Pediatrics, there was an alarming increase in children diagnosed with anxiety (27%) and depression (24%) between 2016 and 2020.[2] In 2021, children's hospitals reported emergency department visits for self-injury and suicidal ideation and behavior in children ages 5-18 at a 44% higher rate than during 2019.[3] There was also a more than 50% increase in suspected suicide attempt emergency department visits among girls ages 12-17 in early 2021, as compared to the same period in 2019.

Demand for care is outstripping supply, leaving far too many children waiting for needed mental and behavioral health care and "boarding" in emergency departments until an appropriate placement becomes available. This is not limited to one state or one community—children in states across the country face similar challenges accessing the necessary mental health care to address their needs.[4] Fifty percent of all mental illness begins before age 14[5] and, on average, 11 years pass after the first symptoms appear before treatments begins.[6]

Investments in the full spectrum of pediatric mental health services are critical in making immediate strides to address the crisis end of the continuum, which is overstretched right now, and prevent emergencies in the future. While the COVID-19 pandemic has certainly contributed to the crisis in child and adolescent mental health, we know that this problem and its root causes, which includes inadequate and restrictive insurance practices and a lack of a youth-specific mental health care across the full continuum of service needs, predate the pandemic.

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[1] Daniel G. Whitney and Mark D. Peterson, "US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children," *JAMA Pediatrics* 173, no. 4 (2019): 389-391, doi:10.1001/jamapediatrics.2018.5399.

[2] Lebrun-Harris LA, Ghandour RM, Kogan MD, Warren MD. Five-Year Trends in US Children's Health and Well-being, 2016-2020. JAMA Pediatr. Published online March 14, 2022. doi:10.1001/jamapediatrics.2022.0056.

[3] Children's Hospital Association (CHA), analysis of CHA PHIS database, n=38 children's hospitals.

[4] Ibid.

[5] Substance Abuse and Mental Health Services Administration (SAMHSA), Adolescent Mental Health Service Use and Reasons for Using Services in Specialty, Educational, and General Medicaid Settings, March 5, 2016.

[6] National Alliance on Mental Illness, "Mental Health Screening," accessed on Nov. 10, 2021.

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The challenges and limitations of the current mental health care system are affecting all children, but the pandemic has exacerbated and highlighted existing disparities for children of color in mental health outcomes and access to high-quality mental health care services. In 2019, the Congressional Black Caucus found that the rate of death by suicide was growing at a faster rate among Black children and adolescents, and that Black children were more than twice as likely to die by suicide before age 13, than their white peers.[7] Studies of Latino communities have found higher reported rates of depression symptoms and thoughts of suicide among Latino youth, but comparatively lower rates of mental health care utilization. The needs of children from racial and ethnic minority communities and the added barriers they frequently face in accessing needed services must be addressed in any and all approaches to strengthen mental health parity enforcement and strengthen care models.

The national state of children's mental, emotional and behavioral health is so dire that we joined the American Academy of Pediatrics and American Academy of Child and Adolescent Psychiatry in declaring a national emergency in child and adolescent mental health last fall. On the same day that we declared a national emergency, we launched the Sound the Alarm for Kids initiative to raise the visibility of the children's mental health crisis and build momentum for action. Significant investments are needed now to better support and sustain the full continuum of care needed for children's mental health. These investments will significantly impact our children and our country for the better as we avoid more serious and costly outcomes later—such as suicidal ideation and death by suicide. The emergency for our children is broadly recognized—now we need to work together on immediate action.

We applaud the committee for your attention to strengthening the Mental Health Parity and Addiction Equity Act (MHPAEA) and enhancing care integration through expanded implementation of effective models of integrated behavioral health care. We strongly encourage the committee to put forward tailored and dedicated policies and support for children and youth to better address their emotional, mental and behavioral health needs. The current mental health system for children has been under-resourced for years and now requires significant attention.

Strong enforcement of the MHPAEA is critical to the ability of children and youth to access needed mental health services without unnecessary delays due to plan limits or other requirements that are not applied to medical/surgical plans. As we note above, far too many children with mental health needs do not receive the care that they need, with children commonly waiting years to receive treatment after symptoms first appear. Problematic payer practices, including inadequate provider networks and strict utilization controls, among others, further limit children's access.

In addition, greater investments are urgently needed to develop and enhance community-based systems of care, including resources and technical assistance to support the implementation of integrated care models, care coordination services and other collaborative partnerships so children have access to the right care, in the right setting, at the right time. Children experience better outcomes when their mental and behavioral health needs are identified earlier on, and they are connected to the care they need to manage their mental and emotional health. 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. 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. Integrated care is an effective method of meeting families where they are to facilitate preventive interventions, early identification and treatment.

We appreciate the Finance Committee's attention to the need to bolster compliance with the MHPAEA and to advance care integration models that can help address mental health concerns early and comprehensively. As you

[7] Congressional Black Caucus, Ring the Alarm: The Crisis of Black Youth Suicide in America, Dec. 17, 2019.

work to develop legislative solutions, we ask you to consider the following policy priorities that will result in improved access to appropriate mental health services for children and youth, from promotion and prevention through needed treatments.

Recommendations to address mental health parity

- **Congress should give the Department of Labor (DOL) and states the tools they need to enforce parity requirements.** The DOL annual report on private health plan compliance with the MHPAEA clearly shows that health plans miss the mark on parity. The recent GAO report, Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts, similarly documented plan practices that restrict access to needed care. Though that report focuses on adults, the 43% of the nation's children who have private insurance coverage are also impacted. The violations cited in these reports mean needless delays in care or no access to care at all, particularly due to payers' non-quantitative treatment limits, not otherwise seen in medical and surgical benefits.
- **Congress should prioritize actions that address current inadequacies and inequities in reimbursement rates and policies.** Rates of reimbursement have historically been lower for mental health services in Medicaid and CHIP, as well as in 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. 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 for pediatric mental and behavioral health services to 100%. We also encourage Congress to place a priority on the examination of commercial payment policies as part of any initiatives to strengthen MHPAEA enforcement and compliance.

  In addition, 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 unnecessary insurance delays that are wholly unrelated to their mental health needs. 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 claims processing.
- **Congress should direct CMS to review how the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is implemented to ensure that children have access to the mental health services to which they are entitled.** CMS has determined that EPSDT fulfills the mental health parity requirements under the MHPAEA and requires states and Medicaid managed care plans to analyze limits placed on mental health benefits under Medicaid and CHIP. However, as the Medicaid and CHIP Payment and Access Commission has noted, the MHPAEA has not had a substantial impact on improving access to behavioral health services for the 39% of all children covered by Medicaid. Children's hospitals have noted significant gaps in access for children, particularly to the intermediate level of care—including intensive outpatient services and day programs—which can prevent hospitalizations and help transition children back to their homes and community after a hospitalization.
- **Congress should ensure that pediatric mental health network adequacy standards are sufficient to ensure that all children and youth have appropriate access to needed mental health services.** Robust pediatric network adequacy standards and assessments are a key aspect of ensuring compliance with

the MHPAEA by public and private payers. 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. Furthermore, network adequacy reviews must include assessments of claims processing policies and payment rates. 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.

- **Congress should expand MHPAEA to all children and adolescents enrolled in Medicaid fee-for-service.** By specifically requiring in statute that parity protections apply across all Medicaid payment and delivery models, Congress can help ensure that all children and youth in need of mental health services are afforded the same parity protections regardless of the state they live in. At a minimum, Congress could direct CMS to provide guidance to states on how to ensure consistent application on what is required under EPSDT to meet MHPAEA requirements, so children have timely access to the full range of mental health services without unnecessary administrative delays or arbitrary service restrictions. Even though children enrolled in Medicaid fee-for-service programs are guaranteed needed mental health services under the EPSDT benefit, state implementation has been inconsistent. Over the years, families have had to sue to receive necessary behavioral health care services, particularly recommended intensive home and community-based services to correct or ameliorate their child's disorders. Consistent application of what is required under EPSDT, regardless of Medicaid payment structure, will help ensure that children have access to the full range of mental health services, including intensive outpatient services, partial hospitalization and other stepdown levels of care that bridge inpatient care and home and community.

Recommendations to facilitate care integration and improve coordination

- **Congress must support legislative reforms and investments which improve access and quality across the full continuum of pediatric mental health services.** To address the crisis in child and adolescent mental health now and into the future, Congress must support innovative methods of enhancing service delivery to children with both public and private coverage, scale up community-based prevention and treatment services, ensure adequate capacity to provide care to children with more intensive needs and invest in the pediatric mental health workforce. We support enactment of legislation that has been introduced in the House, H.R. 4944, Helping Kids Cope Act, and H.R. 7236, Strengthen Kids' Mental Health Now Act. Both bipartisan bills would create unique programs within the Health Resources and Services Administration to fund projects to improve the availability of mental health services and supports for children based on communities' particular needs and improve recruitment, retention, training and diversity within pediatric mental health professions.

- **Congress should explore and advance payment models for all payers 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, reimbursement is a significant challenge to increasing preventive care,

standing up care coordination services, implementing integrated care models and facilitating partnerships between schools and community-based mental health professionals. Reimbursement policies that support integrated care across a variety of settings, including through telehealth and consultation services, can improve identification of mental and behavioral health needs in children and streamline connections to care. For example, schools can 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. We support S. 3864/H.R. 7076, Supporting Children's Mental Health Care Access Act, which will reauthorize the Pediatric Mental Health Care Access Grant, an important and effective program that supports care integration and early intervention in primary care through behavioral health teleconsultation. Critically, S. 3864/H.R. 7076 would also extend these programs into schools and emergency departments to serve more children across settings.

There is also a critical need to fund care coordination services that can identify and mitigate gaps within the continuum of care that often lead to children waiting for treatment they need to overcome mental health challenges. Care coordinators, in particular, provide crucial support by conducting follow-up with patients discharged from inpatient care or crisis stabilization. Professional peer support and family peer support specialists can also 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.

- **Congress should work to address payment policies that hinder access to mental health services.** Pediatricians and other primary care providers can play a critical role in early identification and intervention for children experiencing mental health symptoms and conditions. With proper training and support, some children's mental health needs can be well managed by primary care, especially when providers have access to mental health consultation services. However, public and private payers routinely exclude payment for mental health services provided by a primary care provider, putting unnecessary burden on providers prepared to conduct screenings and assessments that are convenient and beneficial to their patients. Additionally, same-day billing limitations persists in some state Medicaid plans, and children's hospitals have reported that they can prevent effective implementation of integrated care and cause delays in a patient's connection to care.

Children's hospitals are eager to partner with you to advance policies that can make measurable improvements in children's lives. Please call on us and our members as you develop these important policy improvements to stem the tide of the national emergency for children's mental health. Children need your help now.