



NEMOURS CHILDREN'S HEALTH

November 1, 2021

The Honorable Ron Wyden
Chairman
Committee on Finance
U.S. Senate
219 Dirksen Senate Office
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
U.S. Senate
219 Dirksen Senate Office
Washington, D.C. 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of Nemours Children's Health, thank you for issuing this important request for information, and for including a section specific to the unique needs of children. As you develop a mental health legislative package, we urge you to include the policies outlined below that support the health and well-being of children and families, as well as the mental health infrastructure needed to provide them with accessible, high-quality care.

ABOUT NEMOURS CHILDREN'S HEALTH

Nemours Children's Health is one of the nation's largest multistate pediatric health systems, including two free-standing children's hospitals and a network of nearly 75 primary and specialty care practices. Nemours Children's seeks to transform the health of children by adopting a holistic health model that utilizes innovative, safe, and high-quality care, while also caring for the health of the whole child beyond medicine. Nemours Children's also powers the world's most-visited website for information on the health of children and teens, KidsHealth.org.

The Nemours Foundation, established through the legacy and philanthropy of Alfred I. duPont, provides pediatric clinical care, research, education, advocacy, and prevention programs to the children, families and communities it serves.

EXECUTIVE SUMMARY

Half of mental illness begins by the age of 14 with three-quarters being diagnosed by the age of 24. More than 45% of children diagnosed with a behavioral health disorder do not receive treatment.¹ The COVID-19 pandemic has exacerbated a host of stressors for children and families and contributed to the pediatric mental health crisis we are currently facing. Children have experienced more stress from changes in their routines, breaks in the continuity of learning and health care, missed life events, and an overall loss of security and safety.² In addition, sentinel agencies are reporting declines in referrals as fewer child-serving professionals are making reports of concern for child safety, such as the decline in referrals for concerns about maltreatment and neglect to child welfare agencies since March 2020.³ Mental health-related emergency room visits have increased by nearly 25% for children age



5-11 and by over 30% for those 12-17 years.⁴ Many children are requiring more immediate and intensive treatments, have a higher probability of admission, and are staying in the hospital longer.⁵ These challenges may result in lasting impacts on children if they do not receive appropriate supports.

Notably, children from families with lower-incomes, those from marginalized racial and ethnic groups, and those from communities underserved by health and mental health care are more likely to have a family member impacted by COVID-19, including a disproportionate rate of caregivers who have died.⁶ Preexisting inequity has important negative implications for child resilience in combination with additional COVID-related adversities.⁷ To promote rapid improvements in the mental health and overall well-being of children in the United States and to promote equity, Congress should:

- Enact policies to bolster the workforce equipped to meet children's mental, emotional, and behavioral health (MEB) needs.
- Ensure access to a continuum of services by increasing reimbursement rates for children's mental health care in Medicaid, investing in care infrastructure for children, and supporting integration of mental health care into primary care, schools, early care and education programs, and other key child-serving settings.
- Prioritize prevention and early intervention.
- Authorize innovative payment and delivery models within the Center for Medicare & Medicaid Innovation (CMMI) in order to optimize MEB health and promote whole child health across the life-course.
- Elevate coordinated policy for children in the federal leadership structure by supporting a White House Office on Children and Youth and a Federal Children's Cabinet.

QUESTIONS FROM THE COMMITTEE

In the sections below, we provide more detailed responses to the Committee's questions. We do not answer every question, and some of our recommendations may span the jurisdiction of the Finance Committee as well as the Committee on Health, Education, Labor and Pensions (HELP). Our responses draw heavily from a recent policy brief that Nemours Children's published in partnership with Mental Health America titled, "[Pediatric Mental, Emotional and Behavioral Health: Federal Policy Recommendations for Congress and the Executive Branch.](#)"

Improving Access for Children and Young People

Children are unique and should receive special consideration in mental health policy. Children are reliant on their parents or caregivers for their day-to-day and health care needs, such as identifying the need for care, 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 own mental health. Children are more likely to be involved in multiple systems of care and organizations – primary care, specialty care, sports, school, child care, 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.

Question 29: How should shortages of providers specializing in children's behavioral health care be addressed?

Enhance Reimbursement:

MEB provider shortages are more persistent and severe in pediatric health care, and these shortages are projected to worsen over time. There are many contributing factors, including low or no reimbursement for MEB health services. Commercial health insurers, Medicaid, the Children's Health Insurance Program (CHIP) and other payers historically have not provided sufficient coverage and payment for MEB services.⁸ Medicaid is the backbone of health care coverage for many children in the U.S. and the single largest payer for mental health services. Sustainable reimbursement that supports Medicaid providers is needed to enhance children's access to the full continuum of care. We recommend the following to address these challenges:

- Strengthen federal support for pediatric mental health care services by increasing Medicaid reimbursement rates for pediatric MEB health services to Medicare levels, or increasing Federal Medical Assistance Percentage (FMAP) for pediatric MEB health services to 100%.
- Provide additional FMAP for Medical Homes and advance the concept of a *High Performing Child Medical Home* that would include components that promote prevention, child development, parenting supports, behavioral health, and referrals to various service providers that can address social needs, risk factors and determinants of health. Such an approach — which includes coordinated, team-based, whole-person care models — could help to promote positive social and emotional development and potentially prevent MEB issues from arising.

Support Workforce Training Across the Care Continuum

There is an opportunity to ensure that workforce development programs support a broad base of provider types, including MEB specialists, primary care physicians,



developmental and behavioral pediatricians, nurses, social workers, community health workers, and others. Developing this capacity and integrating more providers into the MEB care model would help address the provider shortage by promoting identification of concerns and referrals from a variety of providers. Integrating behavioral health and parenting supports into a pediatric medical home can produce many opportunities for prevention, early identification, and intervention, which ultimately can help to alleviate some need for services.⁹

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 Program (CHGME) is a vital investment in our nation's pediatric workforce, supporting more than 7,000 pediatric residents annually. It supports training of front-line providers, such as pediatricians and child and adolescent psychiatrists, who play critical roles in identifying and treating mental health needs of children and youth.

We strongly recommend that the Committee:

- Support the [Helping Kids Cope Act](#) of 2021 (H.R.4944), which would create a new pediatric behavioral health workforce program within the Health Resources and Services Administration (HRSA) to support evidence-based pediatric behavioral health workforce training within ambulatory care, children's hospitals, and other pediatric health care providers. A range of providers and professionals would be eligible to receive the training, including child and adolescent psychiatrists, psychiatric nurses, psychologists, advanced practice nurses, family therapists, social workers, mental health counselors, and other practitioners. It will be important that these providers complete training in common-place evidence-based practice, and also in specialty techniques that rise to meet the need of both routine care as well as the COVID-19 era (e.g., approaches to supporting normative and complicated grief).
- 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 that was included for CHGME in Build Back Better Budget Reconciliation package advanced by the House Energy and Commerce Committee.

Support Loan Repayment Programs

Finally, the high cost of education is another contributing factor to the provider shortage. Students who graduate with psychology doctorates have a median student loan debt of \$82,000.¹⁰ Those who attain the necessary education report delays in saving for the future (73%), planning for retirement (67%), purchasing a home (57%), having children (46%), and other major life events.¹¹ The limited number



of high-quality internships is another major issue,¹² along with limits on loan repayment for providers with “too many” MEB providers in a geographic area. These limits pool all MEB providers together; they do not distinguish between adult and pediatric providers.

Policies to address these challenges should focus on developing a more diverse workforce and meeting the particular needs of Black, Indigenous, and people of color (BIPOC); Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual and Two-Spirit (LGBTQ+), and others who have historically had limited opportunities to join the field.

We strongly recommend that Congress:

- Provide additional funding for new and existing pediatric mental health workforce training and loan repayment programs such as HRSA’s Pediatric Subspecialty Loan Repayment Program, and ensuring availability for MEB providers across adult and pediatric specialties.
- Provide loan repayment incentives to increase workforce diversity across child-serving behavioral health providers that serve populations least likely to have access to culturally and linguistically responsive care, such as through the Minority Fellowship Program.
- Direct the U.S. Department of Health and Human Services (HHS) to study current wages for family and youth peer support specialists and ensure that the programs it administers, or partners with to states to administer, such as Medicaid, support fair reimbursement for peer support specialists.

Question 30: How can peer support specialists, community health workers, and non-clinical professionals and paraprofessionals play a role in improving children's behavioral health?

Youth peer specialists and family peer specialists use their lived experience with MEB needs to support others. In bright spots across the country, peer support specialists are integrated into care teams or into schools, and peer-led organizations as valued community partners. Grief counseling, rising to new importance during COVID-19, has long found benefits of peer-support in normalizing experiences for children, youth, and caregivers.¹³ Unfortunately, youth and family peer support is not systematic, and few children have access, while many peer supporters do not receive the reimbursement and support they need. The same is true for many other professionals and paraprofessionals in supporting roles, such as community health workers (CHWs).

Voluminous research indicates that when systems act to promote whole-family well-being at every developmental stage, children enjoy life-long improved mental health. Primary care, schools, early care and education programs, and other community settings all provide critical opportunities for evidence-based



prevention.¹⁴ Coordinated prevention across these settings also becomes mutually reinforcing. Congress can address these challenges by doing the following:

- Support the [Helping Kids Cope Act](#) of 2021 (H.R.4944), as recommended above. This bill would also provide funding to support training and other workforce innovations at children's hospitals, pediatric delivery settings, schools and other settings across multiple disciplines related to pediatric behavioral health. By helping to expand the workforce through supporting new roles, and training providers across the care continuum, this bill would help to address workforce shortages.
- Enact policies to ensure additional provider types, such as peer support specialists and community health workers, can receive reimbursement for providing MEB services.

Question 31: Are there different considerations for care integration for children's health needs compared to adults' health needs?

MEB health challenges impact children differently depending on a multitude of factors, including support networks and the availability of therapeutic resources. The level and type of MEB intervention needed can change over time as one ages, and as new events or circumstances arise. When children do not receive necessary intervention in a timely manner, MEB challenges often become worse and can even compound.

Support Prevention and Healthy MEB Development by Investing in Primary Care

What is unique about children is the opportunity to intervene early to shape a child's lifelong health and developmental trajectory. Evidence-based, prevention-oriented strategies, such as the [Healthy Steps](#) program, already exist to help support parents, promote resilience and positively impact the child's health trajectory while providing significant Medicaid savings.¹⁵ Congress can help primary care providers to support these evidence-based, impactful approaches by doing the following:

- Directing CMS to collaborate with states to advance patient-centered, high-performing child medical homes, and similar models that include coordinated, team-based, whole-person care and MEB supports for families with young children. As recommended above, these practice models should receive enhanced reimbursement to incentivize and sustain their implementation.
- Creating a new Primary Care Child Development Initiative within HRSA to place early childhood development specialists in pediatrician offices that serve a high percentage of Medicaid and CHIP patients. This initiative should support programs that assess the developmental milestones of children, connect families to resources, and assist families with child development issues and concerns.



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- Directing CMS to review the early and periodic, screening, diagnostic and treatment (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. CMS should provide guidance to ensure consistent application across states on what is required to ensure children are better supported at the community and family levels, addressing the social determinant challenges contributing to health disparities and a lack of healthy early development and prevention services.

Support Prevention and Healthy MEB Development through Innovative CMS Models

There is great opportunity through CMS to advance innovative, multi-sector, integrated care models that address the unique providers, settings and needs of children, with a focus on prevention. The paucity of pediatric models that can support prevention, early identification and care integration is due, in part, to the longer time horizon for which return on investment is realized. The Center for Medicare and Medicaid Innovation (CMMI), which is charged with testing these types of innovative payment and service delivery models, is required to reduce cost within a certain time horizon. Children are usually healthy, and whole child health models may result in long-term expenditure and outcome improvements that accrue to a variety of sectors beyond health care, including education, criminal justice, housing, child welfare, taxation and others. Therefore, CMMI is currently limited in its authority to test whole child health models for integrated care beyond the current model tests (such the Integrated Care for Kids (InCK) and Maternal Opioid Misuse (MOM) Models) that predominantly focus on high-cost, high needs pediatric populations. Congress should directly address these challenges by doing the following:

- Authorize and fund Whole Child Health demonstration models within the Centers for Medicaid and CHIP Services (CMCS). The models would support and test integrated, community based pediatric collaborations that align financial incentives and resources across Medicaid and other public and private programs to address the social determinants of health, improve health and reduce health disparities among pediatric populations. Models would be designed with input and engagement from community residents, Medicaid beneficiaries, and organizations, and be informed by a comprehensive needs assessment in target communities.
- Amend the statute requiring the CMMI to allow the Innovation Center to test models for children that produce both immediate and long-term benefits to a child's health and development across a range of programs and program expenditures beyond the medical care system.
- Encourage and fund cross-agency and cross-sector collaboration and data sharing. Integrated data systems and single-analysis integrated data projects, for example, are powerful tools for testing for and quantifying cross-sector



impacts. Existing data systems in health care (e.g., Health Information Exchanges), education (Statewide Longitudinal Data Systems), child welfare, and related systems can be leveraged and integrated to test innovations and approaches to comprehensive care.

Support Integration of Providers Across the Care Continuum

Another unique feature of pediatric care is that children and youth have touch points with unique sets of providers across a continuum. Care integration for children therefore involves a wide array of providers, including MEB professionals, pediatricians, early care and education providers, teachers, counselors, and other personnel, all of whom can be trained to recognize MEB concerns and provide families with referrals to an appropriate care setting.

There is an opportunity to integrate MEB health care providers into primary care and other community-based settings to ensure families can access services in the places they spend time – in schools, early care and education, primary care, at home, and in other community-based settings. To ensure children have care options that meet their needs, resources must support a range of child and adolescent-centered, community-based prevention and treatment services. Congress should:

- Advance the [Helping Kids Cope Act](#) of 2021 (H.R. 4944) which would provide funding supporting pediatric behavioral health care integration and coordination, allowing flexibility to fund a range of community-based activities such as: recruitment and retention of community health workers or navigators to coordinate care, pediatric practice integration, supporting pediatric crisis intervention, community-based initiatives such as school-based partnerships, and initiatives to decompress emergency departments.

Invest in Infrastructure

Significant capacity and infrastructure needs stymie clinical integration and limit access to MEB services overall. Investments in pediatric mental health infrastructure are critical and urgently needed to prevent children in crisis from boarding in emergency departments and to enable their swift placement in appropriate care. Children's hospitals need 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. Congress should:



- Advance the [Children's Mental Health Infrastructure Act](#) (H.R. 4943). The bill would provide funding to children's hospitals for the creation of additional pediatric care capacity for behavioral and mental health services. The funding would support costs associated with reallocating existing resources, including converting general beds to accommodate behavioral health patients, creating new capacity for "day hospital" care and supporting the associated costs of meeting safety standards to protect children and adolescents.

Question 32: How can federal programs support access to behavioral health care for vulnerable youth populations, such as individuals involved in the child welfare system and the juvenile justice system?

Children can become vulnerable to myriad poor outcomes in a variety of ways, especially with respect to MEB concerns. Experiences of adversity, especially those that interfere with family functioning or the caregiving environment (e.g., to which child welfare agencies respond), and active indicators of MEB symptoms (such as those that invoke juvenile justice involvement) are both clear risk factors. Children and families connected to these systems need health insurance, often under Medicaid and CHIP, to protect access to care among those still residing with their families, and especially for children transitioning from an out-of-home-placement back to their family.

Children, youth, and families also become vulnerable to developing MEB problems through experiences of other adversities, such as housing instability/eviction/homelessness, food insecurity, exposure to community or domestic violence, and inequitable education experiences. The current safety net lacks integration and flexibility and can be difficult to navigate. Some existing federal programs provide support to help navigate multi-system services (e.g., Early Head Start; Head Start). We believe this is a good place to start, and incorporating navigation services into additional programs for vulnerable families is warranted. Allowing all eligible children to maintain continuous 12-month eligibility and enrollment for health insurance under Medicaid and CHIP would help protect their access to care.

Deeper investments in programs targeting vulnerable children and youth – including MEB-specific programs as well as anti-poverty programs – could help prevent and mitigate the long-lasting effects of trauma and other adverse childhood experiences (ACEs). Whole child health models that aim to address behavioral health, physical health and the social determinants of health could have particular impact on vulnerable populations. We again highlight the need for statutory amendment to allow CMMI to test and fund such models.



We strongly recommend the following legislation and policy proposals to support access to behavioral health care for vulnerable children and youth. The Committee should:

- Provide 12-month continuous coverage for children eligible for Medicaid and CHIP.
- Amend the statute requiring CMMI to reduce short-term costs, as mentioned above.

Question 33: What key factors should be considered with respect to implementing and expanding telehealth services for the pediatric population?

Under the Medicaid program, states have significant flexibility to establish policies that govern the use of telehealth without federal approval, including the types of services provided through telehealth, providers that can deliver those services, allowable technology and modalities, and the reimbursement rates providers will receive. States are required to seek federal approval to replace the face-to-face assessment requirements for home and community-based services (HCBS), to pursue waivers that expand case management and some personal care services and relax cross-state licensing laws.¹⁶ While this state-by-state flexibility can be useful, it also causes wide variation, confusion, administrative burden, and sometimes gaps in care.

During the pandemic, telehealth emerged as a vital tool to increase patient access to needed services. Many states offered significant flexibility in pre-pandemic rules and restrictions, unleashing the full potential of telehealth as an effective modality of care, particularly for vulnerable families. In a [survey](#) Nemours Children's conducted, we found that, of the more than 2,000 adults across the U.S. who are parents/guardians of children under 18 years old, families with social determinants challenges were more likely to have used telehealth during the pandemic than parents who did not experience these circumstances (20% vs 14%). This group of parents also reports they are more likely to engage in ongoing, frequent use of telehealth (37% vs 14%) moving forward.

Notably, investments in telehealth have supported continuity of pediatric mental health care services amidst stay-at-home orders and forgone in-person care. At Nemours Children's, nearly 75% of all telehealth visits are now psychology and psychiatry visits, replacing in-person visits and extending our workforce. Extending and expanding telehealth for children and families also helps address regional shortages with respect to the availability of mental health care generally (e.g., in underserved rural areas), and specific competencies (e.g., evidence-based approaches to grief counseling) that are not widely available. This is a pathway to increase access and address inequity, though additional barriers including access to technology and broadband internet will remain for some families. These



infrastructure deficiencies must also be addressed. We strongly recommend the following:

- Permanently extend the telehealth flexibilities provided during the pandemic, particularly those that allow providers to care for patients across state lines.
 - One intermediate step would be to pass the [Temporary Reciprocity to Ensure Access to Treatment \(TREAT\) Act](#) (S.168/H.R.708), which would provide temporary licensing reciprocity for health care professionals for any type of services provided, within their scope of practice, to a patient located in another state during the COVID-19 pandemic.
- Support the [Enhance Access to Support Essential Behavioral Health Services \(EASE\) Act](#) (S.2112/H.R.4036) to expand the scope of required guidance, studies, and reports that address the provision of telehealth services under Medicaid, including in schools. The bill would also remove several restrictions that limit access to behavioral health telehealth services under Medicare.
- Advance the [Telehealth Improvement for Kids' Essential Services Act \(TIKES\) Act](#) (S.1798/H.R.1397), which would promote access to telehealth services for children through Medicaid and CHIP, as well as study children's utilization of telehealth to identify barriers and evaluate outcomes.

Expanding Telehealth

Telehealth is a critical tool in increasing access to a range of health services, and better leveraging the existing workforce as our nation works to address a significant shortage of providers. Amid the pandemic, when safety risks associated with in-person care were heightened, telehealth usage increased significantly with 77% of parents using telehealth, compared to 43% beforehand; and in pediatric care 79% of families used telehealth compared to 35% pre-pandemic. As mentioned previously, MEB health services at Nemours Children's shifted significantly to telehealth throughout the pandemic, and 75% of those visits are still occurring virtually.

Identifying and addressing the existing barriers to telehealth is vital to expanding telehealth access. It is equally important to understand its limitations to ensure safety, effectiveness and equity. Telehealth has the potential to help close gaps in healthcare access, quality, and outcomes. However, it is necessary to understand who is and is not using telehealth, and why. Nemours Children's Health, in partnership with Amwell, conducted a [public opinion survey](#) to inform policy and practice changes needed to help telehealth achieve its full potential. This survey, along with our many years of experience with pediatric telehealth, inform our recommendations below.



Question 21: How can Congress craft policies to expand telehealth without exacerbating disparities in access to behavioral health care?

The public opinion survey referenced previously indicated a number of important factors related to disparities in access to telehealth overall, which includes MEB health services. We found that families experiencing challenges, such as living in an unsafe community or lack of transportation, were actually more likely to use telehealth for themselves and their children than their peers without these challenges. However, the demographic breakdown of our survey respondents suggested that those reporting use of telehealth were largely white and earning at least \$50,000 per year. Overall, the survey demonstrated that families with health insurance are more likely to seek care via telehealth than families without insurance.

Further, numerous reports exist outlining the disparities in rural and underserved communities with regard to broadband, and therefore telehealth, access. Without broadband access, many types of telehealth visits (e.g. video visits) are inaccessible. Investments in broadband infrastructure are necessary and urgent. In addition, since children spend significant amounts of time in school, school-based telehealth is an important tool to help improve access to health care and increase the capacity of local health care providers to better meet the health care needs of children and youth. Studies of these programs have shown that they are providing care to children who had previously not been utilizing health services or had been underutilizing care.¹⁷

Many young children spend a significant amount of time in early care and education settings. This provides an opportunity to expand access to families with young children and to diagnose and treat or triage health care issues and improve identification of new or recurring developmental, medical, or mental health concerns among this group of children.

Examples of early care and education-based telehealth are few, but one exemplary program—the Health-E-Access program in Rochester, New York—has demonstrated the value and efficacy of delivering telehealth to children in early care and education programs, 73 percent of whom were covered by Medicaid.¹⁸ In summary, the impacts of this program include:¹⁹

- 63 percent reduction in absences from due to illness.²⁰
- Providers able to diagnose health problems as accurately via telehealth visits as in person.
- 97 percent of visits completed via telehealth; only 3 percent referred to higher level of care.
- 94 percent of the children would otherwise have gone to an ED, an urgent care facility, or a pediatric office.
- 93 percent of the time, the telehealth visit allowed the parent to stay at work or school with an estimated time savings of 4.5 hours per visit.



We strongly recommend that Congress:

- Encourage or require the creation of an Interagency Task Force to explore the potential opportunities and unique challenges associated with expanding telehealth access to early care and education settings. Such a task force should include, at a minimum, the Administration for Children and Families (ACF), the Office of Head Start (OHS), Office of Child Care (OCC), and the Center for Medicaid and CHIP Services (CMCS). Nemours is aware of many unique needs and challenges associated with the provision of health care generally, and telehealth specifically, in early care and education settings. Challenges not experienced in other care settings include but are not limited to: telepresenter licensure for early care and education staff, medication administration by early care and education staff, and policies governing mandatory release of sick children.²¹ Further exploration of existing barriers and potential solutions is needed.
- Encourage a pilot to test the impact of telehealth expansion into Head Start programs. Given that Head Start is a federally funded and regulated early learning program serving children nationwide, there is an opportunity to leverage existing infrastructure to utilize telehealth as a tool to meet existing, program-wide health care requirements. Eventually, such a pilot could test innovations that extend services beyond what is required by law. Such innovations could be scalable across the entire Head Start program and potentially benefit many underserved children.

Question 24: Are there specific mental health and behavioral health services for which the visual component of a telehealth visit is particularly important, and for which an audio-only visit would not be appropriate? For which specific mental and behavioral health services is there no clinically meaningful difference between audio-visual and audio-only formats of telehealth? How does the level of severity of a mental illness impact the appropriateness of a telehealth visit?

Audio-only visits can provide appropriate and quality care and should be included in the suite of telehealth services a provider can leverage and be paid for. Even in cases where in-person or video visits would be ideal, when faced with the prospect of audio-only intervention or no intervention at all, access to audio-only would be better. Nemours Children's has experience with visits where audio-only has been effective when our patients could not access video. For example, audio-only has been critical for families without internet and/or smart phones; families in transit; and adolescents experiencing discomfort discussing gender identity, depression and other issues while on camera. Most importantly, there may be times when a patient is experiencing a mental health crisis, and any delay of care could have serious consequences.

Yet, there are certain types of MEB diagnoses that are much better treated via the visual component of telehealth. Research indicates that up to 90 percent of



communication is nonverbal and thus, audio only visits would be quite limiting in many cases, particularly with children whose verbal skills are less developed. In addition, children with autism are best treated when they can be observed visually, as children with autism may be challenged with verbal communication. Audio-only visits with these children have the potential to miss important non-verbal cues and the ability to observe their behavior, which could reduce the effectiveness of many therapy interventions.

Question 26: Should Congress make permanent the COVID-19 flexibilities for providing telehealth services for behavioral health care (in addition to flexibilities already provided on a permanent basis in the SUPPORT for Patients and Communities Act and the Consolidated Appropriations Act, 2021)? If so, which services, specifically? What safeguards should be included for beneficiaries and taxpayers?

Nemours Children's urges Congress to make permanent the COVID-19 flexibilities for telehealth generally, and for behavioral health more specifically. Federal waivers and state flexibilities unleashed the full potential of telehealth as a safe and effective modality of care. In Nemours Children's case, we have leveraged telehealth across all our specialties, including psychology and psychiatry. The flexibilities provided during the pandemic helped our doctors and patients work together to avoid negative consequences of delayed care, whether preventive, routine or chronic.

The ability to receive reliable reimbursement for telehealth services across our specialties, including primary care and behavioral health, has been critical. Further, payment parity with in-person visits is needed.

We strongly recommend that the Committee:

- Make permanent many of the temporary policies and waivers that allowed patients to access telehealth during the COVID-19 pandemic. Examples include:
 - Expanding the places where telemedicine can be provided;
 - Expanding the providers who can provide telemedicine services.
- Work with CMS to encourage states to develop regional licensure reciprocity agreements so that patients have access to their providers and specialists during non-emergency times. State licensure compacts, while promising tools for expanding a provider's ability to practice across jurisdictions, do not achieve licensure reciprocity.
- Encourage expanded access to and use of telehealth services under Medicaid by directing 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.



Question 28: What barriers exist to accessing telehealth services, especially with respect to availability and use of technology required to provide or receive such services?

Despite the opportunity for telehealth to improve children's health, multiple systemic barriers exist within and across Medicaid programs in the U.S. This discourages many providers from offering telehealth services to Medicaid patients or extending their services across state lines, even as patients are increasingly mobile and transient. Some of these barriers include:

- Administrative, transactional, and financial burden and confusion for providers when obtaining and maintaining licensure to practice across multiple states;
- Similar burdens relating to provider licensure, and enrollment in Medicaid, across multiple states;
- Highly variable definitions, rules, laws, regulations, and billing/coding adoption across state Medicaid programs and each managed care contract within each state; and

The 2019 RAND Corporation report as well as the Medicaid and CHIP Payment and Access Commission's (MACPAC) March 2018 report entitled "Telehealth in Medicaid" cite wide variation in telehealth policies among states, state Medicaid programs and Medicaid Managed Care Organizations (MCOs) as a barrier to telehealth adoption, expansion, and state-to-state learning. The barriers outlined above represent high-level, wide-ranging challenges faced by all provider types depending on the states in which they operate. The RAND Corporation report also highlights that some of these challenges are barriers to entry altogether, meaning that willing providers cannot justify the allocation of resources to overcome these barriers given the existing policy landscape. For example, low or no reimbursement for services and/or lack of clarity around allowable services under Medicaid were cited as the key barriers to entry and program sustainability.

While some states have made progress on certain elements of telehealth policy, the patchwork of Medicaid policies, rules and regulations will remain a barrier unless the federal government acts to bring more alignment, predictability and clarity to Medicaid telehealth policy. Nemours Children's recognizes the nuance and complexity of the state-federal partnership on the Medicaid program but encourages the Committee to consider the ways in which Congress can appropriately address these challenges.

Finally, one of the major barriers for telehealth access generally, and in schools and early care and education centers specifically, is the cost of equipment, particularly as federal law restricts the ability of providers to donate equipment. Even home-based telehealth services are challenging because most payers do not cover the costs of



remote patient monitoring devices or home diagnosis/evaluation equipment. We strongly recommend that the Committee:

- Support the [EASE Act](#) (S.2112/H.R.4036) (described above).
- Advance the [TIKES Act](#) (S.1798/H.R.1397), (described above).
- Direct CMS to issue guidance providing clarity and alignment on billing codes, modifiers and/or place of service designations for telehealth and other virtual care services. State Medicaid programs and providers alike have cited confusion, wide variability, and the resulting administrative burden surrounding billing and coding as both a dissatisfier and barrier. Further, unresolved billing/coding issues sometimes result in incorrect patient bills.
- Streamline provider licensing, credentialing and enrollment across states, state Medicaid programs, and MCOs to ensure access to board certified providers, especially pediatricians and pediatric specialists. Providers cite enormous administrative and cost burdens associated with obtaining and maintaining multiple state licenses to practice medicine, multiple credentialing processes across multiple state Medicaid programs and MCOs, and the inability to enroll as a Medicaid provider across multiple state Medicaid programs via a common, singular process as burdens and barriers to entry.
 - As previously mentioned, an intermediate step would be passage of the [TREAT Act](#) (S.168/H.R.708).
 - To address the provider enrollment challenge, the Committee should include in its package the [Accelerating Kids' Access to Care Act](#) (S.1554/H.R.3089), which would require state Medicaid programs to establish a process through which qualifying out-of-state providers may enroll as participating providers without undergoing additional screening requirements.
- Allow schools and early care and education centers be considered as eligible recipients of funding for both broadband and telehealth equipment, including but not limited to remote patient monitoring devices and diagnostic/evaluation equipment.

Strengthening Workforce

Nemours Children's encourage the Committee to make significant investments in strengthening the behavioral health workforce, and urges the Committee to include pediatric considerations throughout this package. Please refer to the previous section on workforce on pages 3-7, in answer to questions 1-4 of Committee's RFI. Additional considerations are included below.

Question 5: Are there payment or other system deficiencies that contribute to a lack of access to care coordination or communication between behavioral health professionals and other providers in the health care system?



In some states, MEB services are “carved out” of the otherwise comprehensive Medicaid coverage offered to eligible enrollees, and instead offered only through certain providers with special contracts for those services. When MEB health benefits are carved out and administered through a contract with a separate insurance company, it creates obstacles for the providers and the patient/families, including:

- Care is fragmented because the health system may be contracted with the medical insurance plan and non-contracted with the behavioral health insurance plan.
- Integrated care is interrupted because carve outs do not allow a multispecialty group, like Nemours, to selectively incorporate elements of complementary behavioral health services into a comprehensive treatment plan.
- Reimbursement is not available for board certified MEB specialists providing MEB services at our hospitals and clinics, and can therefore limit access the MEB services for children who need them.

Furthermore, children and adolescents often have MEB symptoms but do not meet the criteria for a diagnosable condition, making qualifying for services challenging. For coverage under commercial insurance plans, coverage is often limited to cases when patients meet the criteria for a diagnosable condition. This precludes payment for preventive care or well behavioral care.

We strongly recommend that the Committee:

- Pursue policies to ensure MEB coverage is included in the medical plan, especially Medicaid plans, along with reimbursement for MEB services without undue restrictions in order to allow providers to treat the whole child.

Question 8: What public policies would most effectively reduce burnout among behavioral health practitioners?

Provider burnout is a significant risk under the existing policy context. Systemic barriers, many previously discussed, burden MEB providers while limiting their access to compensation. Provider burnout, if unaddressed, will exacerbate the existing shortage of MEB providers.

More specifically, the low reimbursement rate for direct patient services and the lack of reimbursement for activities related to patient care – such as consulting with other medical professional, communicating with schools, directing families to higher levels of care when appropriate – lead to very long hours. The lack of financial support for these activities means providers have to complete them beyond work hours.



We strongly recommend that the Committee:

- Pursue policies that provide and/or allow reimbursement for MEB consultation services, and direct CMS to work with partners to develop payment codes for those services for providers types across the MEB spectrum, including licensed psychologists, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists and others.

Ensuring Parity

Ensuring parity is essential for MEB health improvement. The current system, which lacks parity across a number of domains, results in limited access to care, care that is fragmented, provider burnout and contributes to provider shortages. 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 (MHPAEA). 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 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.

More specifically, parity should be achieved in payment, coverage and available reimbursement codes. In general, lack of payment parity results in MEB service reimbursement rates far below those for medical services. Lack of coverage parity results in limited access to MEB services and the inability of providers to treat the whole child. Lack of available reimbursement codes results in the inability of several provider types to bill and be reimbursed for MEB services.

Nemours Children's general recommendation on this topic is for the Committee to:

- Extend MHPAEA authority to Medicaid fee for service while increasing parity enforcement for Medicaid managed care and individual insurance marketplaces.



Question 15: How can Congress improve oversight and enforcement of mental health parity laws that apply to private plans offering coverage under the federal health programs? How can we better understand and collect data on shortfalls in compliance with parity law?

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 that 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 certain diagnoses, 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. In addition, if a multispecialty group has contracted with the medical plan, the behavioral health providers should be considered in-network even if that medical plan carves out behavioral health services to another vendor.

Finally, 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 had to seek legal recourse to receive the necessary services to treat their child's condition, including the provision of behavioral health care services.

We strongly recommend that the Committee:

- Direct CMS to develop new approaches to oversight of existing laws that protect children's rights to access services while allowing payers flexibility in implementing strategies to fill gaps in access.
- 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.

Question 17: Are there structural barriers, such as the size of the provider network, travel time to a provider, and time to an appointment, that impede access to the behavioral health care system?

There are significant barriers to access as there are not enough mental health providers to meet the demand for services. This causes long wait times for services and the need for patients to sometimes travel long distances or accept any service



they can find, even if it is a provider who does not have the expertise for that particular concern.

Further, reimbursement is so low that providers in the community often serve only self-paying patients, which contributes to health disparities. When coverage is available, commercial plans attempt to adhere to network adequacy standards for time and distance, requiring that the provider must provide access within a certain number of days, which is not always possible due to the demand. There are also contract negotiation challenges, wherein commercial plans request that the provider/group provide a huge breadth of services, which sometimes incentivizes providers to practice outside their areas of expertise.

We strongly recommend that the Committee:

- Provide funds to states to develop centralized intakes systems to link patients with appropriate providers, and help families access the care they need.
- Strengthen federal support for pediatric mental health care services by increasing Medicaid reimbursement rates for pediatric MEB health services to Medicare levels, or increasing FMAP for pediatric MEB health services to 100%.
- Provide additional Federal Medical Assistance Percentage (FMAP) for Medical Homes and advance the concept of a *High Performing Child Medical Home* that would include components that promote prevention, child development, behavioral health, and referrals to various service providers that can address social needs, risk factors and determinants of health. Such an approach - which includes coordinated, team-based, whole-person care models - could help to promote positive social and emotional development and potentially prevent MEB issues from arising

Question 18: To what extent do payment rates or other payment practices (e.g. timeliness of claims payment to providers) contribute to challenges in mental health care parity in practice?

To underscore our previous comments, we would highlight that payment rates for behavioral health providers are typically based on a fee schedule that is considerably lower than that of a medical/surgical provider. Lower rates based on these fee schedules has spillover effects on contract negotiation with payers, challenging children's hospitals to successfully contract with payers in a way that appropriately reimburses for MEB services. When negotiations are not successful for these services, access to services becomes even more limited in patient's covered provider network.

Question 19: How could Congress improve mental health parity in Medicaid and Medicare? How would extending mental health parity principles to traditional Medicare and Medicaid fee-for-service programs impact access to care and patient health?



In Delaware, for example, Medicaid behavioral health services are fragmented. Children's coverage under Medicaid managed care plans is limited to a certain number of visits per calendar year. Once that threshold is met, coverage then defaults to the traditional Medicaid benefits plan. For providers to participate the traditional Medicaid benefits portion, they must bid. Winning bidders may or may not be the same providers that provided care under a particular child's Medicaid managed care plan, resulting in fragmented, uncoordinated care until they can come back to their original provider the next calendar year.

We strongly recommend that the Committee:

- Require states to ensure behavioral health services are consistent with either the managed Medicaid plan or the traditional plan for a full calendar year.

Increasing Integration, Coordination, and Access to Care

Questions 10 & 11: What programs, policies, data, or technology are needed to improve access to care across the continuum of behavioral health services/improve patient transitions between levels of care and providers?

Unfortunately, our health, education and social services programs and systems – as well as their underlying infrastructure – function largely independently of one another, making coordination of services and data sharing difficult to achieve. These challenges strain the social safety net and place unnecessary burden on those we seek to serve. Over the past few years, CMS and HHS have taken significant steps to improve interoperability and exchange of health data. Yet, public health entities, social service organizations, and community-based organizations have not benefitted from the same level of infrastructure, coordination and investment, and often experience difficulty in sharing information with health care organizations.

In addition, as previously mentioned, centralized intake programs would help ensure patients are directed to the appropriate level of care and to a provider with appropriate expertise.

We strongly recommend that Congress:

- Support the [LINC to Address Social Needs Act](#) (S.509), which would provide states with up to \$150M for public-private partnerships to develop or enhance integrated, cross-sector solutions to better coordinate health and social services.
- Provide funds to states to develop centralized intake systems to link patients with appropriate providers, and help families access the care they need



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CONCLUSION

Nemours stands ready to leverage our expertise and relevant experiences to assist the Committee as it works to develop a comprehensive mental health legislative package. Thank you for your consideration of our recommendations, and we look forward to continued collaboration. Please do not hesitate to reach out to me at Daniella.Gratale@nemours.org or to Katie Boyer at katie.boyer@nemours.org with questions or requests for additional information.

Sincerely,

Daniella Gratale

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Nemours Children's Health

CC: The Honorable Tom Carper

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