

November 15, 2021

Senator Ron Wyden  
Chair  
Senate Committee on Finance  
Washington, DC 20510

Senator Mike Crapo  
Ranking Member  
Senate Committee on Finance  
Washington, DC 20510

Dear Senator Wyden and Senator Crapo:

On behalf of our organizations, representing a diverse array of perspectives, thank you for the opportunity to provide input on ways to promote the mental health and well-being of infants, children, adolescents, and young adults. We have witnessed soaring rates of mental health challenges among children, adolescents, and their families over the course of the COVID-19 pandemic, exacerbating the situation that existed prior to the pandemic. Children and families across our country have experienced enormous adversity and disruption. And children of color are disproportionately impacted because of inequities that result from structural racism.

This worsening crisis in child and adolescent mental health is inextricably tied to the stress brought on by COVID-19 and increasingly visible instances of racially motivated oppression and violence and represents an acceleration of trends observed prior to 2020. Rates of childhood mental health concerns and suicide rose steadily between 2010 and 2020 and by 2018 suicide was the second leading cause of death for youth ages 10-24. The pandemic has intensified this crisis: across the country we have witnessed dramatic increases in Emergency Department visits for all mental health emergencies including suspected suicide attempts.

The pandemic has struck at the well-being and stability of families. More than 140,000 children in the United States lost a primary or secondary caregiver, with youth of color disproportionately impacted. The emotional impact of losing a parent or caregiver, including trauma and grief, is often compounded with loss of material stability and economic hardship and with poor educational and long-term mental health consequences. We are already witnessing this in our practices, schools, and communities where the number of young people with depression, anxiety, trauma, loneliness, and suicidality are all increasing. We must identify strategies to meet these challenges through innovation and action, using state, local and national approaches to improve the access to and quality of care across the continuum of mental health promotion, prevention, and treatment.

**We join the American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP) and the Children's Hospital Association (CHA) in support of their recent National State of Emergency in Children's Mental Health declaration.**

We are heartened that the Senate Finance Committee recognizes the growing mental health crisis and is seeking feedback to inform legislation to address it. We encourage you to consider policies that address the key components of the continuum of mental health care from promotion and prevention to early identification, intervention, and treatment to children and youth in crisis. Our organizations have joined together to present the following policy priorities that, if adopted, would improve and enhance mental health services for children and adolescents.

Given the dire shortage of practitioners specializing in mental and behavioral health to care for infants, children, adolescents, and young adults, **the Committee should increase investments to support the**

**recruitment, training, mentorship, retention, and professional development of a diverse clinical and non-clinical pediatric workforce.** This should include new incentives and opportunities to practice in rural and underserved areas. Low payment rates to providers for the provision of behavioral health services heavily contributes to the workforce shortage. **The Committee should find ways to increase payment rates for mental and behavioral health care.**

Important research shows that the integration of mental health and primary care makes a difference for infants, children, and adolescents in terms of expanded access to mental health care, improved health and functional outcomes, increased satisfaction with care, potential for cost savings, and improved coordination among primary care clinicians and behavioral health providers in clinics and school-based settings. Integration also provides for enhanced training of the primary care clinician. Most integrated care efforts are funded through a patchwork of short-term public and private grants, limiting their reach and sustainability. **The Committee should work to develop sustainable funding models that allow for integration of mental health practitioners in a pediatric primary care practice.** Mental health care should also be coordinated through the medical home and include collaboration with mental health specialists, schools, and community supports, but currently, providers are rarely able to be paid for time spent coordinating care. **The Committee should find ways to allow providers to bill for time spent coordinating care.**

Family navigators and family support providers are key partners in addressing the spectrum of mental health needs in children and adolescents. Navigating the landscape of behavioral health care can often be difficult for families: dealing with limited provider networks, insurance, calling offices, finding appointment times are all time-consuming tasks. Family navigators, partnering with primary care and mental health, assist families in understanding and keeping up with their array of services, identifying community resources, and following up with recommendations. **The committee should provide funding for care coordinators or navigators who help families navigate the mental health system.**

Many times, emotional distress and behavioral problems are not well-differentiated in childhood (and cannot be accurately diagnosed, especially in younger children) or the condition is still evolving and hasn't risen to the level of a DSM diagnosis. In fact, one study found that 19% of children and adolescents have impaired mental health functioning and do not meet the criteria for a disorder.<sup>1</sup> While these children lack a diagnosis, they still have important mental health needs that require intervention, but behavioral health providers need to be able to specify an ICD-10 diagnostic code to bill and be paid for their time. **The Committee should find ways to allow providers to bill non-specific codes when a child does not have a diagnosable condition but has mental health needs that require care.**

Medicaid is designed to meet children's unique needs, particularly through its Early and Periodic Screening, Diagnostic, and Treatment benefit (EPSDT). Together, the Medicaid equal access provision and the EPSDT benefit should ensure that children have timely access to needed care, including mental health services. However, state Medicaid programs implement EPSDT and medical necessity determinations differently, a challenge exacerbated by the proliferation of contract with Medicaid managed care plans with varied benefit designs and coverage limitations. **Congress can take action to direct CMS to review how EPSDT is implemented in the states to support access to prevention and early intervention services, as well as developmentally appropriate mental health and substance use disorder services across the continuum of care.** In particular, specific assessment of mental health network adequacy and access to services should be included in future rulemaking regarding Medicaid enrollees' access to care through fee-for-service and

managed care programs. Congress can also request that the Medicaid and CHIP Payment and Access Commission study children's timely access to mental health care and make recommendations to Congress about future actions to bolster this essential care.

Providers are witnessing an alarming number of children and adolescents in behavioral health crisis, with emergency departments seeing increases in suicidal ideation and self-harm. From April to October 2020, hospitals across the U.S. saw a 24% increase in the proportion of mental health emergency department visits for children ages 5 to 11, and a 31% increase for children and adolescents ages 12 to 17.<sup>11</sup> Behavioral health clinicians have reported over the last several years that children and adolescents are increasingly "boarding" in emergency departments for days because they do not have sufficient supports and services. **Children and families, schools, and providers must be able to access a 24/7 crisis response system that is designed to meet their needs. Any crisis response system for children and families must be equitable and accessible, trauma-informed, and culturally appropriate with staff that are trained in child development and family-centered approaches. The system should be able to connect children and families with the appropriate next level of care to meet their needs.**

Children must be able to access care in the settings where they are, including in schools. Lack of mental health professionals in schools is a barrier to mental health care access for children and youth. Co-location of services in schools allows children and adolescents to access the care they need with less disruption to their school day, and for children in behavioral health crisis can allow for more effective interventions in school, including de-escalation. Mental health training for school staff members is also critically important for early recognition of behavioral health issues and connection to appropriate resources. **The Committee should work to identify and reduce barriers such as payment for services in schools and workforce training that prevent schools from being able to recruit and retain mental health providers on-site.**

Thank you for the opportunity to provide these comments. If we can be of further assistance, please don't hesitate to reach out to Tamar Magarik Haro at [tharo@aap.org](mailto:tharo@aap.org).

Sincerely,

American Academy of Pediatrics  
American Association of Child and Adolescent Psychiatry  
American Foundation for Suicide Prevention  
American Psychiatric Association  
American Psychological Association  
Association of Children's Residential & Community Services (ACRC)  
Association of Maternal & Child Health Programs  
Children's Defense Fund  
Children's Hospital Association  
Eating Disorders Coalition for Research, Policy & Action  
Family Voices  
First Focus on Children  
National Alliance on Mental Illness

(signatories continued on next page)

National Association for Children's Behavioral Health  
National Association of Pediatric Nurse Practitioners  
National Association of School Psychologists  
National Health Law Program  
Nemours Children's Health  
REDC Consortium  
School-Based Health Alliance  
Society for Adolescent Health and Medicine  
The Jewish Federations of North America  
The National Alliance to Advance Adolescent Health  
United Way Worldwide  
ZERO TO THREE

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<sup>i</sup> <https://pediatrics.aappublications.org/content/144/5/e20192757>

<sup>ii</sup> Leeb RT, Bitsko RH, Radhakrishnan L, Martinez P, Njai R, Holland KM. Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1675–1680. Available at: <http://dx.doi.org/10.15585/mmwr.mm6945a3>