Pediatric Mental, Emotional and Behavioral Health

Federal Policy Recommendations for Congress and the Executive Branch

NEMOURS CHILDREN'S HEALTH | MHA Mental Health America

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Executive Summary

Throughout the COVID-19 pandemic, children have experienced 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. Children are also going through sensitive developmental periods, and these disruptions, challenges and traumas may have lasting impacts if they do not receive appropriate supports. To promote rapid improvements in the mental health and overall well-being of children in the United States and to promote equity, Congress and the Executive Branch should:

- Expand the workforce equipped to meet children's mental, emotional and behavioral health (MEB) needs through financial incentives, such as loan repayment, and increased funding for training. This should include providers across the continuum, such as specialized child behavioral health professionals, youth and family peer support specialists, and integration of behavioral health across professions — including primary care, social work and education — with a focus on 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 rural children.
- Ensure access to a continuum of services integrated into settings that are accessible to families by increasing reimbursement rates for children's mental health care in Medicaid, investing in necessary care infrastructure for children, and supporting integration of mental health care into primary care, schools and other key child-serving settings while ensuring that integrated care is sustainably funded in Medicaid.
- Prioritize prevention and early intervention by including additional funding in programs that already reach children to incorporate promotion of MEB health in the Department of Health and Human Services (HHS) and the Department of Education (ED). To respond to the particular crisis among adolescents, the Centers for Disease Control and Prevention (CDC) should establish a coordinating center to lead a national strategy and related programming to reverse the alarming trends.
- Elevate children in the federal leadership structure by establishing a White House Office on Children and Youth, a Federal Children's Cabinet, an Interdepartmental Task Force on Child Well-Being, and a White House Conference on Building Back Better for Children and Youth.
- Promote innovative payment and delivery models for optimizing MEB health across the life-course with the Center for Medicare & Medicaid Innovation (CMMI), including those that capture longer-term value and engage multiple family-serving sectors to address key issues — such as maternal depression or kindergarten readiness — and build Accountable Communities for Health for Children and Families.

This brief elaborates on these and other policies in order to set forth a vision and policy recommendations to support the healthiest generations of children.

Overview

According to the Centers for Disease Control and Prevention, “Mental health includes our emotional, psychological, and social well-being.” Among children, mental disorders are serious changes in the way they typically learn, behave or handle their emotions that can be diagnosed and begin in childhood.[2] Up to 45 percent of children diagnosed with a mental disorder do not receive treatment.[3] In addition, children growing up in poverty have higher rates of mental, behavioral and developmental disorders, but lower treatment levels.[2]

BIPOC and LBGTQ+ children face additional challenges due to services and supports that fail to meet their needs and prevention efforts that do not effectively mitigate traumas and stressors that result from structural racism and other forms of oppression.[4] While adverse childhood experiences (ACEs) are prevalent across the U.S. population and predict later health and well-being into adulthood, ACEs disproportionately impact BIPOC and LGBTQ+ children.[5,6]

As a result of the COVID-19 pandemic, children have recently 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.[7] Mental health-related emergency room visits have increased by nearly 25 percent for children age 5-11 and by over 30 percent for those 12-17 years.[8] Many children are requiring more immediate and intensive treatments, have a higher probability of admission, and are staying in the hospital longer.[9]

This brief will describe an aspirational vision for how the United States can support MEB health for children, youth and families, policy areas for action, and recommendations for how the federal government should respond. Note that this brief focuses on prevention, early intervention and treatment of MEB needs. It does not fully examine other domains of policy critical to children’s mental health and equity, such as intersections with child welfare, juvenile justice or workforce development. Future briefs will need to focus on the necessary reforms in these areas.[10]

Vision

All young people deserve to have the best possible start to life and equitable opportunities to thrive. Improving the health and well-being of children today leads to healthier adults and improves the quality of life for families for generations. As stated by Dr. Larry Moss, president and chief executive officer (CEO) of Nemours Children’s Health, “The future stability, strength and prosperity of our nation is inexorably tied to how we invest in the health and development of America’s children today.”[11] Schroeder Stribling, president and CEO of Mental Health America similarly stated, “Supporting children's healthy mental development is critical to achieving a diverse, equitable, and inclusive society." She added, "We must take action to ensure this is a national priority.” To reach these goals we must strive for the following:

- Equitable access for all children to opportunities that promote their language, motor, adaptive, cognitive, social-emotional and MEB development.
- Access to an appropriate level of evidence-based care from well-trained and culturally responsive providers close to their home at an affordable price in a personalized caring environment.
- Communities with a workforce of providers and educators well-equipped to identify and respond to their needs in all the key settings where children live, learn and play.
- Families that have the social and economic support to nurture their child’s growth and be free from preventable adverse experiences.
- Federal government policies that empower communities, schools and other institutions to promote each child’s physical, MEB health and well-being, making children’s healthy development a shared responsibility and national goal.

[1]MEB is the term used in a seminal report from the National Academy of Medicine, “Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.” National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions; O'Connell ME, Boat T, Warner KE, editors. Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Washington (DC): National Academies Press (US); 2009. Available from: https://www.ncbi.nlm.nih.gov/books/NBK32773/

Policy Areas

This section describes several policy areas of relevance to the pediatric MEB health crisis in the United States and key barriers to the provision of health care and related services.

Federal Leadership for Children and Youth

In addition to the substantive changes needed, structural change is also needed at the federal level to optimally address children's mental health and overall well-being. Single federal agencies lack the structure and mandate to create holistic change. In addition, fragmented implementation can be a major barrier to maximizing impact. A federal leadership structure for children and youth would coordinate implementation of the Executive Branch's current policies and the recommendations in this brief, provide ongoing advisement regarding implementation, and inform the development of future policies to improve the MEB health of children and youth.

Workforce

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the nation requires approximately 4.5 million more behavioral health practitioners, including 49,000 child and adolescent psychiatrists, to serve the needs of children with serious emotional disturbances and adults with Serious Mental Illness.[12] There is also a national shortage of Developmental Behavioral Pediatricians with the number of those retiring from the field outpacing those entering five to one. Finally, the continued lack of primary care providers who have knowledge of developmental behavioral pediatrics is resulting in significant missed opportunities to simultaneously address MEB health and physical health needs.[13]

As is the case in much of medicine, significant racial, ethnic and gender disparities exist in the field. A recent study found that while more than 30 percent of the United States population is Black, Latino or Native American, only 10 percent of practicing psychiatrists are of these races and ethnicities. Moreover, while women make up about half of the population, less than 40 percent of practicing psychiatrists are female.[14]

The high cost of education is one factor likely contributing to this troubling situation. Students who graduate with psychology doctorates have a median student loan debt of $82,000. Those who do attain the necessary education report delays in saving for the future (73 percent), planning for retirement (67 percent), purchasing a home (57 percent), having children (46 percent), and other major life events.[15] The limited number of high-quality internships is another major issue. Those approaching this milestone express stress and trepidation about their prospects.[16]

Some progress has been made in the use of peer support in children's mental health.[17] Youth peer specialists and family peer specialists use their lived experience with MEB needs to support others through their recovery journey. Peer-led organizations facilitate these practices into a broader array of services. In bright spots across the country, peer support specialists are integrated into care teams or into schools and peer-led organizations are valued community partners. Unfortunately, support for youth and family peer support is not systematic and few children have access, while many peer supporters do not receive the reimbursement and support that they need.

Coverage and Payment

The shortage of MEB health providers is also a driver of cost. Many prefer to work out-of-network, citing low provider reimbursement in-network, which has led to an increasing price of treatment over the last decade.[18] 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.[19] Both cost and coverage issues have resulted in fewer in-network providers and significant difficulty for families when attempting to access treatment.

The Mental Health Parity and Addiction Equity Act of 2008 offered some relief by extending federal parity protections and expanding coverage for mental and behavioral health. However, costs remain high and coverage for specific services is inconsistent. Current levels of insurance coverage vary greatly by plan and out-of-pocket costs for mental and behavioral health therapies grow every year. Some research indicates the out-of-pocket cost for outpatient behavioral health therapy is significantly higher for individuals enrolled in private, high-deductible or consumer-driven health plans, raising concerns about disparate access based on cost.[20] In addition, states have "carved out" behavioral health coverage from their Medicaid health plans, making it challenging for some families to receive their physical care and MEB care from the same entity, often resulting in fragmented, poorly coordinated care, increasing the likelihood of misdiagnosis and unnecessary referrals.[21]

Access

While millions of children across the country have MEB health issues, far too many never receive treatment, including more than 20 percent of children living with depression, 40 percent of children with anxiety and 45 percent of children with behavior disorders.[3] There are notable racial gaps in access to care as well. Of youth who had a major depressive episode (MDE) in the past year, 50.3 percent of White children reported receiving any treatment, compared to only 35.6 percent of Black youth and 36.8 percent of Hispanic youth.[22] In addition, of all children living in poverty who need mental health care, less than 15 percent receive any mental health services and even fewer complete treatment.[23] Children in rural areas are also significantly less likely to receive services than children in more urban areas.[23]

A lack of providers compounds these issues. Up to 65 percent of nonmetropolitan counties do not have a single psychiatrist. Over 60 percent of Americans live in rural areas that have been identified as designated mental health provider shortage areas by the Health Resources and Services Administration (HRSA).[24] On a positive note, evidence has been building during the COVID-19 pandemic about telehealth as a promising modality to expand access for both physical and MEB health conditions.[25]

Infrastructure

MEB health challenges impact children differently depending on a multitude of factors, including support networks and the availability of therapeutic resources. In addition, 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 treatment in a timely manner, MEB challenges often become worse and can even compound. Thus, the ideal MEB health care for children involves providing proper care in an appropriate setting based upon each child's unique situation. The types of settings include general hospitals with inpatient capacity, psychiatric-specific hospitals, residential treatment, alcohol and drug rehabilitation, day programs, outpatient settings, telehealth and others.

While some communities may offer a variety of modalities, that is not the norm especially for rural or less-resourced areas.[26] When care options remain limited, families often must choose among suboptimal care settings. For example, families may seek care at an emergency room. This can result in children "boarding" for significant periods in facilities not equipped to properly treat and respond to mental crises among children and youth.[27]

Prevention

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 (ECE) and other community settings all provide critical opportunities for evidence-based prevention.[28] Coordinated prevention across these settings also becomes mutually reinforcing. For example, schools and ECE providers can deliver programming and create environments that strengthen social and emotional skills. Some community-based programs can extend these supportive contexts to more domains of family life. In addition, integrating behavioral health into a pediatric medical home — a model of enhanced primary care — can produce numerous opportunities for prevention, early identification of symptoms of concerns, and appropriate intervention.[29]

Families

Families are often the first to notice MEB challenges among children. When they do, they must then work through numerous complex challenges, including taking time off from work, finding providers that take their insurance, knowing what type of treatment is best for their specific situation, and navigating complex medical systems to schedule appointments. Working through these issues can cause significant stress for families. In fact, those who take care of children with MEB issues are more likely to face mental health challenges themselves.[30] For these reasons, it is critical to support families, so they are in a position to support children in their care.

Recommendations

The recommendations below build on the important investments Congress and the Executive Branch have recently made. The American Rescue Plan (P.L. 117-2) and previously passed COVID-19 legislative packages included significant investments in MEB health, including $1.5 billion each for the Community Mental Health Services Block Grant (MHBG) Program and the Substance Abuse Prevention and Treatment Block Grant Program (SABG). Congress will need to sustain these investments and pursue additional policy changes to promote equity and reduce structural causes of stress and adversity for children. Federal policy must support, incentivize and sustain transformation in child- and family-serving systems so that effective prevention, early intervention and treatment become part of our nation's core policies and practices.

Federal Leadership for Children and Youth

The Executive Branch, preferably with Congressional support, should establish one or more of these leadership structures that will be critical to the implementation of the recommendations that follow:

- A White House Office on Children and Youth would elevate issues to the highest level of the government, advance a National Strategy and Goals for Children and Youth for the federal government, and regularly coordinate with an External Advisory Council and a National Family and Youth Advisory Board.
- A Federal Children's Cabinet would coordinate closely with the Office and also facilitate senior-level leadership engagement across the federal government to identify and eliminate barriers to better alignment and effective action.
- An Interdepartmental Task Force on Child Well-Being would facilitate coordination of specific and defined policy areas, such as poverty reduction, mental health and education.
- A White House Conference on Building Back Better for Children and Youth could serve as a venue to develop strategies on how to address key priorities such as childhood poverty, mental health and racial equity from across the federal government and with outside stakeholders, including policy experts, philanthropists, and the private sector.

Workforce

Create financial incentives. Congress should defray the significant educational costs required to enter the MEB field and incentivize providers to work in underserved areas.

- Congress should sustain or increase funding for the Pediatric Subspecialty Loan Repayment Program, under HRSA, which would fund up to $35,000/year in loan repayment for up to three years for pediatric subspecialists, including nonphysician mental health providers. This program was recently reauthorized by Congress as part of the CARES Act (P.L. 116-136).
- Congress should 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.
- HHS should 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.

Support workforce training. Congress should increase access to training on evidence-based practices for providers.

- Congress should pass the Helping Kids Cope Act of 2021 (H.R.4944), which would create a new pediatric behavioral health workforce program within 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. This legislation would also support pediatric behavioral health care integration and coordination within communities.
- Congress should pass the Pursuing Equity in Mental Health Act (S.1795/H.R.1475), which would improve training in culturally and linguistically appropriate care, incentivize a more diverse workforce pipeline and proactively engage BIPOC communities in mental health care. In administering these programs, particular attention should be paid to the special needs of children and families.
- Congress should expand HRSA's Behavioral Health Workforce Education and Training (BHWET) program to not only increase the supply of specialized behavioral health providers for children, but also to mainstream children's mental health promotion into general educational programs related to child-serving sectors, such as primary care and nursing, ECE, social services and education. This program should carve out funding for institutions that promote workforce diversity including Historically Black Colleges and Universities.
- Congress should dedicate additional BHWET funds to grow the family and youth peer support workforce and ensure that other federal programs serving children encourage engagement of peers and peer-run organizations.
- Congress should increase funding to expand the reach and impact of the National Child Traumatic Stress Network (NCTSN), which seeks to raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States.
- In implementing the NCTSN, SAMHSA should continue to fund the Center for Pediatric Traumatic Stress, which is a multidisciplinary intervention development center within the NCTSN that collaborates worldwide with hospitals, universities, nonprofits and government organizations to further its work in preventing and treating medical traumatic stress in health care settings.

TRAUMA-INFORMED CARE

A traumatic event is a "frightening, dangerous, or violent event that poses a threat to a child's life or bodily integrity."[31] More than two-thirds of children report at least one traumatic event by age 16.[32] From child care providers to teachers, counselors and other school personnel to health care providers, there are a number of providers who can support children and families in identifying and addressing trauma, as well as providing trauma-informed care.

In 2000, Congress created the National Child Traumatic Stress Network (NCTSN) to raise the standard of care and increase access to services for children and families who experience or witness traumatic events. The NCTSN, administered through SAMHSA, is committed to improving care and moving scientific gains quickly into practice across the U.S.[33]

CENTER FOR PEDIATRIC TRAUMATIC STRESS

The Center for Pediatric Traumatic Stress (CPTS), co-led by Children's Hospital of Philadelphia and Nemours Children's Health, addresses medical trauma that children and families experience. As part of the NCTSN, CPTS focuses on training multidisciplinary health care providers across the nation to recognize and treat children and families facing traumatic experiences associated primarily with pediatric illnesses and injuries. Key resources include a Pediatric Medical Traumatic Stress Toolkit for Health Care Providers with tools, information, brief screening and intervention guidelines, as well as parent tip sheets and child activity sheets for patients and families who may be at risk for traumatic stress.[34s]

Enhance school-based services. Schools are a vital opportunity to identify children and youth experiencing MEB challenges, provide services and make necessary referrals in concert with families.

- HHS and ED should collaborate to provide additional technical assistance on the implementation of whole-school mental health frameworks and the integration of metrics into Every Student Succeeds Act (ESSA) (P.L. 114-95) state plans so states can track progress toward greater student well-being.

- HHS and ED should provide technical assistance to states in developing ESSA plans that mainstream MEB health promotion into school settings and coordinate with Medicaid to build comprehensive systems for children. The technical assistance should promote trauma-informed and trauma-sensitive approaches to addressing problematic behaviors in schools.
- Congress should allocate additional funding under ESSA for states and schools to test and scale innovative models of promoting student and staff MEB health in schools, with a focus on those that engage youth and families in the development, implementation and evaluation of the strategies.[35]
- Congress should enact the Comprehensive Mental Health in Schools Pilot Program Act of 2021 (H.R.3549) and the Mental Health Services in Schools Act (S.1841/H.R.721), which provide different strategies for enhancing schools' capacities to respond to students' MEB needs.

Coverage and Payment

Enhance reimbursement. Medicaid reimbursement for MEB health services remains far too low and ultimately limits the number of available providers. Congress should enact one of the options below to enhance Medicaid reimbursement levels for these services.

- Option 1 – Increase Medicaid reimbursement rates for pediatric MEB health services to Medicare levels.
- Option 2 – Increase the Federal Medical Assistance Percentage (FMAP) for pediatric MEB health services to 100 percent.
  - The Medicaid BUMP Act (S.1727/H.R. 3450) would increase the FMAP to 90 percent for Medicaid expenditures for *adult and pediatric* behavioral health services including those related to mental health and substance use.

Develop value-based payment and multi-payer incentives that support providers in developing and sustaining effective MEB interventions and delivery models. States and private insurers are increasingly experimenting with value-based arrangements to incentivize better outcomes at lower costs. Unfortunately, many value-based arrangements determine cost-savings based on past spending, which, historically, reflects little spent on children's mental health care. Providers simply lose out in value-based arrangements when they try to integrate mental health care and promote access.

- The Center for Medicare & Medicaid Innovation (CMMI) should ensure mental health care for children does not count against providers in shared savings and either:
  - Waive mental health services from counting against shared savings benchmarks with particular incentives for integrated care; or
  - Account for the need to build more comprehensive mental health services in the methodology for calculating shared savings, and also incentivize providers to build out mental health care.
- To promote more investment and sustainability in prevention, health care payers should allow providers to share in some of the later expected savings (e.g., over the next five years) when they prevent mental health conditions today.[36] CMMI should test models of sharing future savings in priority areas, such as the prevention, early identification and treatment of maternal depression or the promotion of kindergarten readiness. CMMI should engage health insurers to advance aligned multi-payer approaches.[37] Such models should also include specific requirements around cross-sector collaboration to ensure that prevention approaches are comprehensive for families.
- More broadly, Congress should direct CMMI to develop and test innovative value-based payment models that support the full continuum of care necessary to promote resilience. The payment models should prevent and address the MEB distress our children face, and incentivize the development of new delivery models grounded in prevention and healthy development.

CENTER FOR MEDICARE AND MEDICAID INNOVATION MODELS

The Center for Medicare & Medicaid Innovation (CMMI) supports the development and testing of innovative health care payment and service delivery models. The Secretary of HHS has the authority to expand the scope and duration of a model, including an option to test it nationwide. CMMI's Integrated Care for Kids (InCK) and Maternal Opioid Misuse (MOM) models offer promise in delivering innovative models to children and families. InCK is a child-centered model being tested by eight awardees that aims to reduce expenditures and improve the quality of care for children served by Medicaid and CHIP. The MOM model addresses fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with opioid use disorder (OUD) by supporting the coordination of clinical care and the integration of other services for health, well-being and recovery, with a goal of improving the quality of care and reducing costs for mothers and infants. Additional CMMI models focused on children and families could bring additional innovative approaches focused on long-term social emotional health, prevention and healthy development across the country. Opportunities exist for models that focus on longer-term value and more integrally engage child-serving sections outside of health care.

Implement existing laws related to access. As noted, federal law now mandates fair and equitable coverage of mental health services under most types of public and private insurance, especially for children. Despite strong laws protecting access across the Mental Health Parity and Addiction Equity Act (MHPAEA), the Affordable Care Act and the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate of the Medicaid statute, most oversight has only addressed obvious violations such as limits on the number of therapy sessions available. More fundamental issues that undermine access — such as insufficient reimbursement rates to attract an adequate workforce of child mental health providers — have not been examined thoroughly for children's mental health care, especially for young children.

- Congress should extend MHPAEA authority to Medicaid fee for service while increasing parity enforcement for Medicaid managed care and individual insurance marketplaces.
- The Centers for Medicare and Medicaid Services (CMS) should 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.

Access

Support a more robust, accessible and comprehensive system of mental health care for children. Ideally, MEB health care providers would fully integrate into primary care and other community-based settings to ensure families can access services in the places they spend time — in schools, ECE, primary care, at home and in other community-based settings.

- Similar to Section 1003 of the SUPPORT for Patients and Communities Act (P.L. 115-271), which increased capacity for substance use treatment, Congress should direct CMS to implement Medicaid demonstrations that allow states to create regional infrastructure to support the integration of mental health services, either with in-person or virtual providers, across child-serving settings with a specific goal of achieving access to integrated care for all children.
- Congress should require states participating in demonstrations to build infrastructure for children's mental health to appropriately modify their Medicaid, health insurance, educational and ECE policies to sustain the integrated services. States should face requirements that they cover and sufficiently reimburse for integrated services in their Medicaid programs and that other policies, such as ESSA, promote the coordination needed to support children by the end of the demonstration project to receive matching funds.

Extend flexibilities and support telehealth. 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.[40]

- Congress should 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, 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.
- Congress should reduce patient telehealth access barriers, including broadband internet availability, technology access and digital literacy.
- Congress should pass 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.
- Congress should pass the Telehealth Improvement for Kids' Essential Services Act (TIKES Act) (S.1798/H.R.1397), as described below.

THE TIKES ACT

The Telehealth Improvement for Kids' Essential Services, or TIKES, Act of 2021 (S.1798/H.R.1397) is a bipartisan bill that would require the Secretary of HHS to issue guidance to states about how to increase access to telehealth under Medicaid and CHIP. It would also require a study examining data and information on the impact of telehealth on the Medicaid population, as well as another study that reviews coordination among federal agency telehealth policies and examines opportunities for better collaboration, as well as opportunities for telehealth expansion into early care and education settings.

Streamline federal policy and guidance. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), addressing access issues will require collaboration among numerous federal agencies, including CMS, SAMHSA, the Administration for Children and Families (ACF) and various state and local authorities and agencies. In addition, states are often unsure of how to utilize these federal authorities in a comprehensive way. MACPAC provides two valuable recommendations to address this challenge.

- The Secretary of HHS should direct CMS, SAMHSA and ACF to update subregulatory guidance on promoting children's MEB health in Medicaid and CHIP and provide technical assistance to states, through the Innovation Accelerator Program or another mechanism, to implement the guidance in ways that best serve the children in each state.
- The Secretary of HHS should direct a coordinated effort by CMS, SAMHSA, and ACF to provide education and technical assistance to states on improving access to home- and community-based behavioral health services for children and adolescents with mental health conditions covered by Medicaid and CHIP. In addition, the Secretary should examine options to use existing federal funding to support state-level activities to improve the availability of these services.

Infrastructure

Support facility construction to address critical needs. Congress should act to close critical access gaps in MEB health facilities.

- Congress should pass the Children's Mental Health Infrastructure Act of 2021 (H.R.4943), which would provide funding to providers that serve high numbers of Medicaid patients, including children's hospitals, for the development of additional pediatric care capacity for MEB health services. The funds would support the costs associated with new facility construction and reallocation of existing resources, including the conversion of existing general beds and development of new capacity for partial hospitalization and intensive outpatient and in-home programs to ensure children and adolescents receive appropriate, safe care in a timely fashion.
- More broadly, Congress should provide funding to create additional facility capacity across the continuum of care to ensure children have substantial outpatient, inpatient and other appropriate options.

- Congress should provide funding for the development of in-home capacity for crisis response services for children given the imminent implementation of the 988 line for mental health crises.

Prevention

Prioritize prevention in federal programs. Some federal funding mechanisms, such as SAMHSA's MHBG, do not allow funds to be used for prevention. Others, such as ESSA, allow for prevention as one of many priorities, but do not offer enough funding for states to fully incorporate it into school settings. Head Start grants have specific requirements around prevention in mental health, but do not offer enough resources for many sites to fully meet the requirements.

- Congress should amend the MHBG to allow expenditures for early intervention and preventive mental health care services for children and youth, and set aside dedicated funding for these purposes.
- HHS and ED should issue guidance and provide technical assistance to states on how to implement effective prevention strategies across federal funding programs, including how ESSA state plans can promote student well-being and attain measurable results.
- Congress and the Executive Branch should support cross-sector collaboration to reinforce effective interventions across settings. This should include technical assistance to states with regard to coordinating across state and local agencies to ensure that children receive coordinated preventive services; implementing requirements in federal funding opportunities for state agencies to collaborate when administering programs; and data sharing between health care entities, educational institutions and community-based organizations, including sharing existing templates and tools states have developed.
- Recognizing the especially alarming statistics around adolescent mental health, Congress should fund a center within CDC to coordinate the development and implementation of national goals and a national strategy to improve adolescent mental well-being and advance equity, with a focus on culturally responsive prevention and early intervention, in collaboration with centers across CDC, other federal agencies and departments, youth, experts and advocates. This funding should be sufficient to not only coordinate across existing CDC programs, but also to bolster the overall public health approach to adolescent mental health. Key to this effort should be empowering youth advocacy and engagement in all levels of decision-making.
- Congress should include funding for mental health promotion in other programs that promote the well-being of children, such as the Healthy Schools program of the CDC, adolescent health programs in ACF, and the Local School Wellness Policies required under the National School Lunch Program.

NEMOURS CHILDREN'S CHERISH PROGRAM

The Nemours Children's CHERISH (Communities Harnessing Education, Resilience, and Integrated Services for Children's Health) program promotes children's emotional health and academic readiness, and a better-trained support system of caregivers, educators and health professionals. Its goal is to mitigate the negative impact of adversity using evidence-based curricula and therapeutic modalities to guide educators, caregivers and future pediatricians in approaches that promote healthy development among young children. Early outcomes from a micro-scaled pilot test of the program are promising. Further research and testing on this and similar approaches would be beneficial.

Strengthen implementation of existing law on prevention. As a result of federal law, almost all health insurance plans, public or private, must cover items on the Bright Futures Periodicity Schedule (BFPS). The BFPS includes screening for psychosocial needs at all ages, maternal depression in the early years, and depression in adolescence, along with anticipatory guidance on promoting mental health at every well-child visit along the way. However, families receive little of this guidance, screening, and follow-up in large part because providers are not adequately funded or appropriately reimbursed for the time needed to complete these lengthy components. In addition, providers frequently have few options for referrals to follow-up care.

- HHS should set targets for full compliance with existing law on BFPS implementation, provide support and technical assistance on options for achieving compliance, and hold stakeholders accountable for chronic and continued underfunding.
- HHS should direct CMS to issue regulatory guidance regarding the implementation of benefits for children and adolescents with mental health conditions covered by Medicaid and CHIP.

- CMS should review how states are implementing EPSDT requirements and provide guidance for how to ensure children have access to appropriate behavioral health services, including increasing enforcement where current practices violate federal law.

Support early childhood development.

- Congress should create 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.
- CMS should collaborate with states to advance patient-centered, high-performing child medical homes that include coordinated, team-based, whole-person care models and MEB supports for families with young children. These practice models should receive enhanced reimbursement to incentivize and sustain their implementation.

HEALTHYSTEPS

Stable, healthy relationships are among the foundations of child health and refer to the "extent to which young children need consistent, nurturing and protective interactions with adults that enhance their learning and behavioral self-regulation as well as help them develop adaptive capacities that promote well-regulated stress response systems." HealthySteps is an evidence-based pediatric primary care program of Zero to Three grounded in relationships. It supports the health, well-being and school readiness of babies and toddlers, with an emphasis on families in low-income communities. HealthySteps specialists assist with screenings, referrals and intensive services (when needed) and provide a range of supports to families. Longitudinal results have shown that Healthy Steps participation was associated with greater security of attachment and fewer child behavior problems. HealthySteps is also effective in preventing negative child and parent outcomes and enhancing positive outcomes.

Support existing programs. Congress should support existing programs that promote prevention, early identification and intervention.

- CDC's Learn the Signs, Act Early Program focuses on mental, behavioral and developmental disorders across childhood. Funding for robust implementation in state and local public health departments would improve early identification of autism, other developmental disabilities and mental health disorders among young children. Additional funding could also support the creation of similar tools and strategies for children and youth at other developmental periods.
- HRSA's Pediatric Mental Health Care Access Program promotes behavioral health integration into pediatric primary care. Additional funding could expand the reach of the program and improve its ability to focus on culturally and linguistically appropriate care, as well as on advancing equity.
- SAMHSA's Infant and Early Childhood Mental Health Grant Program aims to integrate infant and early childhood mental health into state systems. Expanding this program would help to build more robust systems for early childhood mental health across the U.S.
- SAMHSA's Project LAUNCH Program develops greater coordination across family-serving systems to better support families of young children to meet their MEB needs so they can enter school ready to learn. Expanding this program will further develop capacity across systems to meet the diverse needs of families and promote long-term equity.

Families

In addition to supporting preventative approaches for children, this section describes additional recommendations to support families during pregnancy and the early years of a child's life.

Promote Accountable Communities for Health for Children and Families (ACHCFs). Accountable Communities for Health (ACHs) are a promising, growing movement in health care and can be defined as "community-based partnerships formed across sectors such as health care, housing, social services, public health, employment training and economic development to focus on a shared vision and responsibility for the health of the community." ACHCFs build on ACHs by intentionally taking into account the particular needs of children, with a focus on healthy MEB development. By addressing family stressors and empowering caregivers, ACHCFs offer the foundation for better MEB health across the life-course.

- Congress should provide funding to develop, implement, and sustain ACHCFs in the same way they currently focus on high-need Medicaid beneficiaries with the Social Determinants Accelerator Act of 2021 (H.R.2503).
- The Executive Branch should provide support for states to better align diverse federal funding streams to implement and sustain ACHCFs, including a next generation of InCK that more deeply engages other agencies and sectors to meet the needs of children and families.

Support pregnant people and families with young children. Evidence-based home visiting programs improve maternal and child health, prevent child abuse and neglect, promote child development and produce numerous other benefits that contribute to positive MEB health of the child and family.

- Congress should increase funding for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program by $200 million a year over five years, bringing MIECHV up to a total of $1.4 billion annually.

Treat Maternal and Paternal Postpartum Mood Disorder. Congress should increase funding for the following programs that support families.

- HRSA's Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program reduces the most common complications of pregnancy and childbirth.
  - Congress should also consider modifying this program or supporting other approaches that focus on Maternal and Paternal Postpartum Mood Disorder, a condition that affects both mothers and fathers after childbirth.
- The Maternal Mental Health Hotline is a critical resource that offers specialized support 24 hours a day to help mothers and families.

Conclusion

The COVID-19 pandemic has underscored the need to holistically address the MEB health of children, youth and families across the care continuum. Congress and the Executive Branch have responded by making important investments in critical programs. However, the federal government must build on this progress with additional policy changes to promote equity, reduce structural causes of stress and adversity for children, and achieve a future in which all children, youth and families can thrive.

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