October 26, 2021

The Honorable Frank Pallone
Chairman
House Committee on Energy and Commerce
Via electronic submission to Austin Flack, Policy Analyst
Austin.flack@mail.house.gov

Re: Written responses to submitted Questions for the Record (QFRs) related to the Oversight Subcommittee hearing entitled "Putting Kids First: Addressing COVID-19's Impacts on Children."

Congressman Peters,

Thank you for the thoughtful questions you submitted for the record and extending me the opportunity to respond. Please know I am at your or your staff's disposal should you have any additional follow up.

Sincerely,

Margaret G. Rush, MD, MMHC
President, Monroe Carell Jr. Children's Hospital at Vanderbilt
Professor of Clinical Pediatrics, Vanderbilt University Medical Center

1. *Discuss Centers for Medicare and Medicaid Services (CMS) definition of Qualified Residential Treatment Programs (QRTPs) as not being Institutions of Mental Disorders (IMDs).*

   I agree that it is important to provide access for temporary stays in residential treatment facilities for children in foster care with serious emotional and behavioral health disorders. Appropriate reimbursement structures directly affect the placement opportunities at such facilities. Children and adolescents who do not require the acute inpatient care of a children's hospital or inpatient psychiatric hospital may present mental and behavioral health challenges difficult to treat solely in outpatient community settings. QRTPs, by design, provide trauma-informed mental health and substance use disorder treatment on a time-limited basis in a supervised residential setting.

   As you know, the Family First Prevention Services Act (FFPSA) sought to reform many aspects of the child welfare system and established a new designation of qualified residential treatment programs (QRTPs). CMS guidance related to the FFPSA stipulate that QRTPs with more than 16

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beds are in most cases subject to the IMD exclusion for Medicaid funding purposes. Since this guidance was issued, I am aware that states have explored varied approaches to implementation of the FFPSA and designation of QRTPs. Given implementation strategies by sates are still playing out, I would urge Congress and the Medicaid and CHIP Payment and Access Commission (MACPAC) to monitor in the months to come whether an effective bed-limitation of QRTPs present a barrier to access. Congress might also take this opportunity to engage in a broader discussion on the IMD exclusion. Efforts to modernize the IMD policy and Medicaid's role in supporting inpatient behavioral health services has recent precedent, with the SUPPORT Act of 2018 allowing for limited exemption from the IMD exclusion for some Institutes of Mental Diseases caring for individuals with substance use disorders.

2a. What can Children's Hospitals do to work to address the rise in eating disorders cases given the strain on treatment capacity?

Eating disorders (EDs) are a serious mental health illness that predominantly impact adolescents and young adults (AYAs). Additionally, those with an ED diagnosis often have comorbid mental health issues such as depression, anxiety, and obsessive-compulsive disorders. If not treated appropriately, EDs contribute to physical health issues that negatively impact quality of life and long-term health. A recent study[1] has shown an increase in the number of ED-related hospitalizations, bed days, and patient/parent ambulatory requests for care above pre-pandemic baseline. As I and others mentioned in our testimonies on September 22, 2021, the infrastructure to support the mental health of children, adolescents, and adults, including those with EDs, is woefully under-resourced in this country.

Similar to other mental health diagnoses, children's hospitals are the safety-net of rescue after the systems of care have failed to prevent or treat those with EDs. Adolescents and young adults with EDs are admitted to inpatient acute care units when their ED has resulted in serious *medical* and life-threatening complications such as electrolyte and cardiovascular disturbances. Children's hospitals are the landing spot for crisis management.

Like other mental health diagnoses, there is now a greater demand than supply of accessible treatment resources and programs for EDs. There are not enough inpatient facilities to launch recovery from an ED crisis. There are not enough partial hospitalization or intensive outpatient therapy (IOP) programs for EDs. While children's hospitals could invest in the establishment of eating disorder units, this is not ideal use of space for creation of a true therapeutic environment for this chronic mental health diagnosis. With this said, children's hospitals can and should consider opportunities for building a tiered system of care that includes sufficient resources to support AYAs with EDs admitted for crisis management but more importantly focuses on ambulatory partial hospitalization and IOPs. This will require collaboration with behavioral health and nutrition experts. These are the building blocks to help contain ED symptoms and enable appropriate attention to other behavioral health comorbidities.

2b. What additional resources are needed to adequately treat eating disorders in children and adolescents?

The building of a tiered program for EDs, and frankly all mental health disorders, requires enhanced infrastructure that starts with parity in reimbursement for mental health diagnoses compared with physical diagnoses. If children's hospitals, as the safety net for crisis

management, are expected to do this, we must have both federal and state funding commitments to invest in the resources needed to build tiered systems of care, inclusive of training for a variety of healthcare providers. We must also be supported to evaluate new models of care for treatment and prevention, such as how to optimally use telehealth for increased accessibility to services.

My colleagues at the Children's Hospital Association and I continue to support the concrete steps Congress should take to help children and adolescents with EDs as well as other mental health disorders. To quote Dr. Deborah Katzman[2], "*it is time*" to rally together and do better to support young people.

References:

1. Lin JA, Hartman-Munick SM, Kells MR, Milliren CE, Slater WA, Woods ER, Forman SF, Richmond TK. The impact of COVID-19 pandemic on the number of adolescents/young adults seeking eating disorder related care. *J Adol Health*. 2021:69:660-663.
2. Katzman DK. The COVID-19 pandemic and eating disorders: a wake-up call for the future of eating disorders among adolescents and young adults. *J Adol Health*: 2021:69: 535-537.