



October 29, 2021

The Hon. Ron Wyden, Chairman
Senate Finance Committee
United State Senate
Washington, DC 20510

The Hon. Mike Crapo, Ranking Member
Senate Finance Committee
United States Senate
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

In response to your September 21, 2021, request to submit comments and proposals to improve this nation's mental health care and substance use disorder services, the Child Welfare League of America submits the following information:

Behavioral Health (Mental Health and Substance Use Services)

Accessing and addressing mental health services is a significant component and challenge within child welfare (including child protection). Thoroughly screening children and families involved with the child welfare and foster care system and providing appropriate treatment, is essential. Primary prevention efforts, family preservation, reunification, adoption, and all forms of permanence requires addressing barriers created by behavioral health needs.

Nationally, even for the general population, progress has been slow. From 1963 when President John Kennedy signed the Community Mental Health Act, which altered the delivery of mental health services, to more recent years with the 2008 enactment of the Mental Health Parity and Addiction Equity Act and the expansion of that coverage through the ACA in 2010, access to mental health services has been challenging for many Americans. It is critical that the Behavioral Health system in each state be held responsible for the provision and funding of sufficient numbers of quality services from community-based prevention, early intervention, crisis, and treatment (especially intensive home treatment for children) to meet the behavioral health needs of all children, adults, and families in the state. Child welfare has a population of parents, youth and children that may be dealing with serious mental health and substance use challenges. Despite this, the provision of mental health services through child welfare's access to Medicaid should not be the gateway for families to access these vital services. Too often the child welfare system, the juvenile justice and the education system become a default access point.

It is not effective for Child Welfare, Juvenile Justice, or Education to be the de facto mental health system. There needs to be a single point of access. The existing fragmentation that exists is untenable. The Mental Health system at large needs to be held responsible for the provision and funding of services through Medicaid using the umbrella of the EPSDT.

These two systems (CW and JJ) were not created to provide vital behavioral health services and inevitable they will be held accountable for the failures in the provision and quality of any treatment. In addition, families struggling with these issues should not have to turn to these systems as their only option to accessing critical services.

By way of example, in 2008 the state of Nebraska enacted a “baby abandonment” law as the other 49 states had done years earlier. These laws, encouraged by “Baby Abandonment” program funding that CWLA advocated for in the 1980s, are intended to offer safe harbor for new parents and safety for infants in cases where the parent is unable to care for an infant, usually shortly after birth. Most states limit this abandonment period to the first few months or days after birth and parents can safely and anonymously relinquish a child in a safe haven that can typically be a hospital or a fire department, where an infant will be safe.

In 2008, Nebraska crafted their law and did not impose an age limit on the child believing it could help some additional families under stress and parenting older children and infants. What happened was a demonstration of the need for comprehensive mental health services for families and children. Nebraska received over 35 children within a few weeks, most between the ages of ten through 17. Some parents drove from other states to relinquish a child because they could not obtain the needed services in their own communities.

As part of the federal review process called the Child and Family Services Review, each state child welfare agency must meet certain outcome measures. These outcome measures include ensuring access to and delivery of mental/behavioral health services for the children and families. The results from the last round of federal Child and Family Services Reviews of state child welfare systems reflect the challenges the state agencies have in obtaining the needed mental/behavioral health services as none of the states achieved substantial conformity with the well-being measure for this. The *Child and Family Services Reviews Aggregate Report Round 3: Fiscal Years 2015–2018* noted that one of the practice concerns for why states did not achieve substantial conformity was that “There were gaps in service provision (e.g., due to changing service providers or a lack of providers)” (JBS International, Inc., 2020 pg. 37).

All too often, instead of addressing this failure to provide services to meet these behavioral health needs, critics will argue it must be the child welfare or juvenile justice system at fault for not fully addressing these needs. Many state child welfare agencies have had class action lawsuit brought against the child welfare agency and are under current consent decrees for the child welfare agency’s failure to meet the mental/behavioral health needs of the children in their care despite the fact that it is the behavioral health system that has the authority and accountability for these services.

Nebraska acted within weeks to change their law. It should be noted, just as the CFSRs highlighted these needs, members of Congress received additional information in a 2003 report by the Government Accountability Office (GAO), that examined 19 of the 50 states and 30 counties and found that 12,700 children in these limited jurisdictions, in just one year, had been placed in child welfare or juvenile justice systems simply so they could receive mental health care.

Efforts to reduce the number of children and youth placed into foster care or the juvenile justice system must include a comprehensive way for families to access the needed continuum of culturally relevant prevention, crisis and early intervention, intensive in-home family supports and treatment services, and psychiatric inpatient behavioral health services for the child, the parent and sometimes both. These culturally relevant services must take into account the social determinants of health issues especially related to families of color that disproportionately are marginalized and do not have their needs met. They must also ensure that the providers are appropriately compensated for the additional work required to coordinate services and address these issues if we are going to make any significant changes to what is currently happening for these children and families.

This Committee must look for ways to strengthen and expand this country's system of mental health and substance use health care for the entire population which in turn can assist in reducing the children, youth and families involved with child welfare or juvenile justice systems.

To do so the Committee must address barriers, sometimes unintended, created by Medicaid and other programs under this Committee's jurisdiction and expand efforts to address ongoing challenges such as the behavioral health workforce shortage, especially child and adolescent mental health providers.

Maternal Health

Maternal mental health can have an important impact on child and adolescent health. As the National Academy of Science's study, *Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth: A National Agenda* report indicated, "Because the evidence of harm caused to children by depression in parents, and particularly in pregnant women and new mothers, is so well established, prevention researchers have long held that waiting for the onset of clinical depression before intervening is not enough and that preventing major depressive episodes at any time, but particularly during pregnancy and the postpartum period, is critical (Le et al., 2003). It is also important to note that depression is a chronic illness in which remission and relapse are common, so treatment needs to be available over the life course." (*Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth: A National Agenda*, Pg. 97)

That same report suggested the possibility that treating parental depression may be beneficial for adolescents who are at risk for or experiencing depression, "based on the growing evidence that, whether because of genes, environment, or some combination of the two, the children of depressed parents are more likely to become depressed than are children of parents who have not been depressed."

The study suggests several strategies that involve pre-natal and postpartum treatment for mothers suffering from depression or susceptible to depression.

The Committee should increase funding and efforts through the Maternal and Child Health Block grant to target additional funding to address these needs. The Committee should also pursue strategies to allow for more community driven creativity and innovation to address the needs of children and families of color and build greater evidence that will allow culturally

relevant treatment programs to be funded through the new Family First Prevention Services Act (Family First Act). However, it is critical to note that services through this new program are limited to families/parents with a child considered a candidate for foster care and these treatment initiatives must include a broader population, so all families are benefiting from these services when they need them and avoiding families ending up part of child welfare because of harm done to their children.

Similarly, the *Committee should increase funding to the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program*. Again, as noted in the National Academy study referenced above, “Home visitation has proven to be an effective intervention for preventing child physical abuse and neglect. A meta-analytic review of research on nine different home visiting models identified improved positive parenting and reduced risk for maltreatment as the most robust outcomes across programs; supervision and program fidelity monitoring were found to be significant moderators increasing these effects (Casillas et al., 2016). An RCT with longitudinal follow-up found that firstborn children of mothers with low to moderate levels of exposure to domestic violence who received home visitation through the NFP model had fewer substantiated maltreatment reports through age 15 compared with firstborn children of comparable mothers who did not receive home visitation.” (Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth: A National Agenda, National Academy of Sciences pg.100)

While some states may use Family First Act funding to expand these home visiting programs, more than the current \$377 million is needed to extend services to a larger population beyond those that qualify for Family First Act funding.

Adolescent and Youth

During this pandemic we were reminded of the mental health issues children and youth are experiencing. These pandemic-related effects compound what was already a concerning situation. Again, referencing the National Academy of Sciences study (pg. 177):

“The lifetime prevalence of any mental disorder among adolescents is estimated to be 49.5 percent (National Institute of Mental Health, 2019). Furthermore, 1 in 25 adolescents has a substance use or abuse condition (American Addiction Centers, 2019) and suicide is the second leading cause of adolescent death (Heron, 2016). However, the ratio of board-certified adolescent medicine providers to adolescents is 0.8 to 100,000 (American Board of Pediatrics, 2018) ... Thus, while behavioral medicine has emerged as a greater part of adolescent care, much work remains to be done in this area. Promotion of emotional health and prevention of depression and anxiety in this population appear to be substantial health care needs. Screening and treatment for depression are important not only for the health of adolescents but also for the well-being of their future progeny and need to be a routine part of practice.”

To reinforce the urgency of this need, on October 19, 2021, the American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP) and the Children’s Hospital Association (CHA) issued a joint statement that declared a national

emergency in children's mental health. **We endorse their series of recommendations** (and several recommendations are under the jurisdiction of this Committee):

- Increase federal funding dedicated to ensuring all families and children, from infancy through adolescence, can access evidence-based mental health screening, diagnosis, and treatment to appropriately address their mental health needs, with particular emphasis on meeting the needs of under-resourced populations.—CWLA would add that there is a need for culturally relevant evidence-based mental health screening, diagnosis, and treatment services for families and children of color to ensure that their needs are appropriately being met.
- *Address regulatory challenges and improve access to technology to assure continued availability of telemedicine to provide mental health care to all populations.*
- *Increase implementation and sustainable funding of effective models of school-based mental health care, including clinical strategies and models for payment.*
- *Accelerate adoption of effective and financially sustainable models of integrated mental health care in primary care pediatrics, including clinical strategies and models for payment.*
- *Strengthen emerging efforts to reduce the risk of suicide in children and adolescents through prevention programs in schools, primary care, and community settings.*
- *Address the ongoing challenges of the acute care needs of children and adolescents, including shortage of beds and emergency room boarding by expanding access to step-down programs from inpatient units, short-stay stabilization units, and community-based response teams.*
- *Fully fund comprehensive, community-based systems of care that connect families in need of behavioral health services and supports for their child with evidence-based interventions in their home, community, or school.*
- Promote and pay for trauma-informed care services that support relational health and family resilience.
- Accelerate strategies to address longstanding workforce challenges in child mental health, including innovative training programs, loan repayment, and intensified efforts to recruit underrepresented populations into mental health professions as well as attention to the impact that the public health crisis has had on the well-being of health professionals.
- *Advance policies that ensure compliance with and enforcement of mental health parity laws.*

We emphasize the first recommendation listed above, and the last two on promoting and paying for trauma informed services and the need to address workforce challenges.

CWLA also adds to this list that we must ***Advance policies that ensure compliance with, and enforcement of mental health parity laws and we also emphasize the importance of behavioral health systems recognizing that the needs of children and their families can't be addressed in the same way as for adults.***

Additionally, because families and children of color experience such disparities in access to health care and other services systems special attention should be given to creative solutions for serving families and their children where families would be most comfortable – this could be Family Resource Centers, Family Run Organizations, Walmart stores, etc. It is critical to shift from a medical model lens to one that is more responsive to those who we are tasked with serving.

CWLA also suggests the Committee consider similar legislation to the HR 4944 Helping Kids Cope Act, that would increase the scope of health care provider grant funding. Use of funds includes grants for recruitment and retention of health care workers, training, expanding evidence-based models, addressing surge capacity, pediatric care via telehealth, decompression of emergency departments, preventive and crisis intervention services, urgent care, school-based partnerships, and other gaps in health services. The legislation would add psychologists, psychiatrists, and other mental health professionals to the list of grant eligible health care workers. To support these activities, the legislation provides \$100,000,000 per fiscal years 2022-2026.

CWLA also urges the Committee to pay special attention through tutoring and other education assistance to address the education needs of children and student in foster care especially those of color and especially those that were challenged in their elementary school education during the pandemic. This Committee considers the reauthorization of the Title IV-B Child Welfare Services (CWS) block grant next year and this need should be addressed.

Another significant population that needs special focus within child welfare are those children and youth who identify as LGBTQ+. The National Academy of Science noted:

“For many young people, questions about their sexual orientation and gender identity become a focus as they are undergoing puberty, and for some, they arise even earlier. Those who identify as lesbian, gay, bisexual, transgender, or queer or are nonbinary (LGBTQ+) can be vulnerable for a variety of reasons that may have significant implications for their mental and emotional health.”

The process of recognizing and understanding sexual orientation and gender identity may be stressful for adolescents if they are not supported. Existing research offers insights into both risk factors for adolescents who self-identify as LGBTQ+ and factors that tend to offer protection.

Several protective factors for MEB disorders among LGBTQ+ youth have been identified. Strong evidence indicates that feeling connected, particularly with a parent, but also with nonparental adults and a positive school environment, confers protection against such risks as

non-suicidal self-injury, suicide attempts, and suicidal ideation (Taliaferro, McMorris, and Eisenberg, 2018).”

As noted by the *Every Child Deserves a Family Campaign*:

“Numerous studies show that LGBTQ+ youth experience longer stays in residential care rather than in family-like settings and greater rates of multiple placements, criminal justice involvement, hospitalization for emotional reasons, and homelessness. Indeed, foster care is a primary pathway for LGBTQ+ youth entering homelessness.

A recent survey by the Trevor Project of over 40,000 youth showed that LGBTQ+ youth in foster care had nearly three times greater odds of reporting a past-year suicide attempt compared to LGBTQ+ youth who were never in care (35% vs. 13%); these numbers were even higher for LGBTQ+ youth of color in care (38%) and highest for transgender and nonbinary youth in care (45%). LGBTQ+ youth who had been in foster care had over three times greater odds of being kicked out, abandoned, or running away due to treatment based on their LGBTQ+ identity compared to those who were never in care (27% vs. 8%); these numbers were even higher for LGBTQ+ youth of color (30%) and highest for transgender and nonbinary youth (40%).”

This Committee needs to adopt legislation (John Lewis Every Child Deserves a Family Act) to end discrimination in placement of children and youth in foster care and adoption and provide appropriate training and support for those serving these families to better support children and young people within the foster care system.

In addition, there needs to be the right family- and community-based services such as San Francisco State University’s the Family Acceptance Project© that provide the families with the support needed so the children and youth that identify as LGTBQ+ can remain with their families.

We need to develop grassroots community organizations that will be paid to provide community health workers and other “non-professionals” who possess the sensitivities to work directly with children and their families. There needs to be a whole family approach or Flourishing Family Approach© to working with youth. As we do not always look at the needs of the whole family, but in working with children, we need to address inter-generational trauma experienced by many. ***A temporary use or grant of some additional Social Services Block Grant (SSBG) funding could help target such a strategy.***

As it relates to telehealth, there should be special training for providing telehealth to youth. The therapist needs to learn to use the medium that young people use so well in the same way that they understand it so that they are able to manage the time wisely and effectively. It would likely mean developing relationships “on-line” starting with short spurts and then gradually growing the time as the youth or child is able. The therapist also needs to modulate her/his approach as it is not the same as in-person therapy with either adults or children.

Medicaid

Child welfare agencies are responsible for meeting the physical and mental health needs of all children in their custody. Virtually all children in foster care are eligible for and receive their healthcare through Medicaid. Considering the volume and intensity of the health needs of children and youth in child welfare, Medicaid must provide the physical, mental, and behavioral health services vital to their wellbeing.

Medicaid was created in 1965 along with Medicare. Medicaid provides health coverage to millions of adults, children, women who are pregnant, adults, and people with disabilities who experience low-income. It is a federal-state partnership administered by states and overseen by the federal government with the federal government paying at least half the costs of the program and some states receiving as much as 80 percent of their costs from the federal government.

Medicaid is integral in helping child welfare agencies address the prevention, early intervention, and the treatment of children in foster family homes, children with special needs in residential treatment, children who move from foster care to guardianship, and those with special needs adopted from foster care. The success of Medicaid is, therefore, integral to the success of these children. It's that simple. However, Medicaid often fails these children in its access, services, and enforcement.

Payment rates are a real barrier. Clinicians and behavioral health specialists are drastically underpaid for the nature, sensitivity, and urgency of the services they provide. These professions often provide more comprehensive care and insight than doctors who are, in the private sector, highly reimbursed.

The Committee should consider legislation such as the Medicaid Bump Act, to increase the Federal matching rate in Medicaid for behavioral health and substance abuse services and to impose accountability in order for states to receive supplementary funding that must be used exclusively for behavioral health-mental health and substance abuse-services

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT): Congress Needs to Fully Enforce

All children eligible for Medicaid under age 21 are entitled to screening under EPSDT. States must provide access to any Medicaid-coverable service in any scope, amount, duration, or frequency found medically necessary, regardless of whether the service is included in the Medicaid State Plan. States must do this without request, automatically, whenever a coverable service is requested. To know what services a child needs, implementation of the screening component of EPSDT is necessary.

According to MACPAC, over 40 million children were eligible for EPSDT services in 2014 but less than 60 percent of children who should have received at least one initial or periodic screening received one. The screening services must include five components: a comprehensive health and developmental history (assessing physical and mental health, as well as substance use disorders), an unclothed physical examination, appropriate immunizations, laboratory tests, and health education.

CMS (by Congressional directive) established a goal of an 80 percent enrollee participant ratio in EPDST in each state, per year, by federal FY 1995. Eight states achieved an 80 percent participation ratio at least once between 2006 and 2013. In FY 2014, participation ratios were highest for infants under one year, at 88 percent, but only 43 percent for 15- to 18-year-olds, and 25 percent for 19 to 20-year-olds.

EPSDT is vital to the receipt of psychiatric services. Psychiatric services are an optional service under Medicaid and must be chosen to be included in a state's Medicaid Plan. To receive inpatient, psychiatric care, it is necessary to secure a determination of medical necessity. Inpatient, psychiatric services are available in three, facility types: psychiatric hospitals, psychiatric units of general hospitals, and Psychiatric Residential Treatment Facilities (PRTFs.)

CWLA believes that Congress needs to revisit enforcement starting with the recommendations in a 2014 Office of Inspector General Report: (1) require states to report vision and hearing screenings, (2) collaborate with states and providers to develop effective strategies to encourage beneficiary participation in EPSDT screenings, (3) collaborate with states and providers to develop education and incentives for providers to encourage complete medical screenings, and (4) identify and disseminate promising state practices for increasing children's participation in EPSDT screenings and increasing providers' delivery of complete medical screenings. In addition, it will be critical that the screenings and treatment services be culturally relevant in order to ensure the children of color are being reached and appropriately screened/serviced.

Addressing the needs of the parents and families of children in child welfare

Children exist in the context of their families and for children in state care to be able to return to their families, parents and family members often need treatment and supports. Medicaid coverage needs to be available for the adults and family members that provide the framework of support for children so that the intensive family work necessary for the child's success can take place. Additionally, flexibility is needed to deliver the intensive family treatment interventions in the home and community that must take place concurrently with the individual work with the child. This work is critical to children returning to their family as soon as possible.

Treatment must also be culturally relevant. Treatment interventions for the parents, other family members, and the child must reflect and respect the family's culture in order to achieve positive, functional outcomes. There is a dearth of culturally relevant, evidence-based programs developed to meet the specific needs of families of color. It will be critical to allow flexibility in building an evidence base from grassroot programs as well as the use of more participatory and community-led research models in their development and testing.

States are establishing their crisis response systems in response to Congress's 2020 establishment of the three-digit dialing number for mental health emergencies. The legislation will enable states to provide resources to the mental health crisis line, as well as established specialized services for populations who are vulnerable, such as youth who identify as LGBTQ, minorities, veterans, and those in rural areas. It will be critical that the right follow-up response systems are in place to serve children, youth, and their families who are experiencing a mental health crisis.

This will require different, specialized services and strategies that fit and serve children- not a watered-down version of what has been established for adults. Children are not mini-adults. Their needs are unique, especially with regard to mental health. An enhanced, behavioral health response system will need to go beyond a medical model approach and to consider the social determinants of health and the stresses a family may be experiencing, especially for families of color.

It will serve no one's purpose to have a mobile response that goes out only once and considers the issue resolved. There will not always be a medical diagnosis when the crisis involves a child or youth, but the crisis response system should still have follow-up response services for the family to address the "family crisis". Medicaid should be funding models such as New Jersey's mobile response approach that also addresses the issues for the children involved with child welfare.

Allow for peer mentors without the need of a diagnosis first. Families engage sooner and stay engaged when they can connect with a family peer mentor at the beginning of their encounter with the behavioral health system. Unfortunately, Medicaid only allows the use of this type of service after there is a specific, acceptable mental health diagnosis. This leads to missed opportunities to engage families when it is urgently needed, particularly for families of color.

Medicaid should be adjusted to allow states to have family peer mentors be the "front door" for services so that families are engaged right from the very beginning, especially for families who have developed a mistrust of the child welfare system. If we are going to positively impact families and create a responsive, behavioral health system, this is one of the ways to help achieve this without the mental health diagnosis required in the medical model approach. This early intervention, family-friendly approach can effectively address the disparities embedded in our behavioral health system. These family peer mentors can and should be deemed essential workers and states should be able to draw down funding for this service under Medicaid without an established diagnosis.

Fill-In the Medicaid Coverage Gaps for Children in Child Welfare

Make Medicaid mandatory for all youth in and from foster care. Children ineligible for title IV-E- may not receive Medicaid in all states and in all circumstances, particularly interstate.

Medicaid is mandatory for children eligible for title IV-E. This guarantee and its protection under federal law is not shared by children who are ineligible for title IV-E. The provision of Medicaid, especially interstate, is not guaranteed. These children face the denial of Medicaid in some states and the reliance on a placement's eligibility for Temporary Assistance to Needy Families (TANF) in others.

Congress needs to make Medicaid mandatory for all children and youth in and from foster care, to include subsidized guardianship and subsidized adoption. All children need health care- children removed from their homes only more so. The benefit and fairness of providing Medicaid to all, child welfare populations are clear.

Create an audit system for denied cases. Currently, the Centers for Medicare and Medicaid Services only audits open cases. This provides needed, federal oversight and penalizes states for providing Medicaid in cases found ineligible. However, there is no oversight of denying Medicaid in cases found eligible. This incentivizes Medicaid denial. Those who are Medicaid eligible and erroneously denied are left to pay for Medicaid expenses out-of-pocket. This is an issue frequently faced by families of children adopted or in guardianships from child welfare. Families struggle to cover the expense of a service that was promised by a state to be provided to them through Medicaid. Once families have paid out-of-pocket, there is no federal mechanism to reimburse them. Almost invariably, the greatest expense faced by families in this circumstance are related to mental health services.

Create a system of direct, beneficiary reimbursement. The case, *Conlan v. Shewry*, was brought against the California Department of Health Care Services on the issue of direct reimbursement of out-of-pocket Medicaid expenses to beneficiaries erroneously denied Medicaid. The case was decided in favor of the plaintiffs and the court ordered the California DHCS to create a system of direct reimbursement to beneficiaries. This benefit should be made mandatory under federal law and available to all beneficiaries in all states- especially the vulnerable populations of children from child welfare. Families in crises, often mental health crises, will act swiftly to find care for their child. Placements in inpatient, mental health facilities are acute and urgent. Guarantees of coverage and payment arrangements are secondary. There is often a lack of understanding of the operation of Medicaid and coverage can be denied. Families can find that their child is eligible for services, but the services are not covered in the facility or facility type chosen. This leaves families facing enormous, out-of-pocket expenses.

Increase number of inpatient, psychiatric facilities and guarantee coverage for Medicaid beneficiaries from child welfare. States must increase the number of inpatient, mental health facilities relative to the number of youth facing this need. States must provide coverage in all, three facility types so that a child's need for a type of therapeutic setting is met. Even after confirming that the service is medically necessary, a family may not be able to find the facility type recommended for their child's care. Service setting is important for all patients and is a crucial element of the mental health treatment proscribed for a child in inpatient care. The lack of facilities and a lack of facility types has consequences. Families are forced to go to another state (interstate) to meet the needs of the child. This removes the family from physical and emotional proximity to their child who is already in psychological crises and can impact the effectiveness of and prolong treatment. Inpatient becomes de facto interstate with all, the incumbent issues of receipt for those children who are not eligible for title IV-E.

A quote from a Member of the Association of Administrators of the Interstate Compact on Adoption and Medical Assistance (AAICAMA.) The State shared the following sentence, which has at least two, embedded concerns. One is the heartbreak imposed on parents seeking inpatient, mental health care for their child and two is the lack of understanding of how EPSDT operates. "EPSDT continues to be extremely difficult for families to obtain without putting their children into a county's care in order for their Residential Treatment to be covered."

Addressing point number one: The phenomenon is well known. As we noted earlier, the GAO has reported on the practice of parents relinquishing custody of their children to child welfare or juvenile justice to access mental health care.

Addressing point number two: States believe that EPSDT is the way to obtain mental health care. Its operation as a mandatory service is often not understood by the state staff who oversee its provision. This compounds the problem of Medicaid providers not understanding the operation of Medicaid and leaves families without a state advocate to help them navigate the receipt of mental health services.

Educate states on and enforce the Medicaid mandate for interstate cooperation. Federal regulation requires states to create procedures to facilitate the provision of Medicaid services to persons in a State who are supported by another state's Medicaid Plan. As mentioned above, the receipt of inpatient, psychiatric services become a de facto, interstate operation due to the inadequate number of available facilities and an adequate number of facility types- Psychiatric Residential Treatment Facilities, in particular. Though federal law requires states to include these services in their Medicaid Plans, states do not appear to do so and there is no federal enforcement measure to compel them. *See 42 C.F.R. § 431.52 Payments for services furnished out of State.*

SSI-Adoption Assistance-Medicaid

Federal law treats categories of youth eligible for title IV-E differently and may interfere with continued access to Medicaid coverage. Some states only provide Adoption Assistance to 18. Title IV-E eligibility carries with it mandatory eligibility for Medicaid so that when Adoption Assistance ends, the basis for that Medicaid ends. Some youth may continue to need Medicaid and seek the alternate eligibility category of Supplemental Security Income (SSI) as an adult. To apply as an adult/under the adult criteria, a young person must be aged 18. This creates a problem. The application and determination process for SSI can be lengthy. This waiting period leaves a young person without the Medicaid they previously received through Adoption Assistance, and with no means to pay for their continued treatment as they await determination of eligibility for SSI.

In recognition of this obstacle to continuous, Medicaid coverage, States requested that the Social Security Administration allow youth in foster care to apply for SSI as an adult at the age of 17.5 years. This gives the determination process a six-month lead to prevent a lapse in coverage. States did not make this request for youth adopted from foster care, though they face the same obstacle. ***The Committee should amend SSI eligibility requirements to allow a young person whose Adoption Assistance will end at the age of 18 to apply early for this coverage just as youth in foster care. Administration should equally allow youth whose Medicaid is ending via Adoption Assistance to apply for SSI at the age of 17.5 years.***

Medicaid to Age 26

The ACA has expanded Medicaid coverage for young people who have aged out or exited foster care. Mirroring the provision in the ACA that allows a parent to cover their adult child on their policy to the age of 26, the ACA mandates coverage of Medicaid to the age of 26 if a young person ages out of foster care at 18. This extension of Medicaid to this population can be an

important access point for behavioral health services. Due to a problem with the way this requirement was written, if a young person moves to a new state from the state they lived in while in foster care, the new state does not have to provide this Medicaid coverage. The 2018 Health Insurance for Former Foster Youth included an amendment to this provision so that all states will have to cover these youth starting on January 1, 2023. ***CWLA believes the Committee should amend the law so that this change takes place immediately allowing Medicaid coverage to age 26 even if they relocate to another state.***

Medicaid Access Limited by Inconsistent Interpretations of policy and regulations

There have been a series of decisions by CMS over the past two decades that can encumber services to families, children, and youth in child welfare. There either needs to be greater clarity in the law/regulation or more consistent interpretation between regions. Congress needs to weigh-in in these circumstances instead of waiting for an administrative solution that sometimes never comes and results in children and families aging through the system without the help that could have been provided. In recent years these debates have focused on financing and definitional arguments over targeted case management, the use of rehabilitated services, the IMD exclusion and the use of therapeutic family/foster care.

IMD Exclusion

When Congress passed the Family First Prevention Services Act, they created a new definition for child care institution (residential) services under foster care. The new Qualified Residential Treatment Program (QRTP) requirements, as created by the Act, appear to be in conflict with Medicaid's Institute for Mental Disease (IMD) exclusion. The IMD definition under Medicaid dates to Medicaid's inception in 1965 and its goal was to limit the use of large, mental health institutions.

Some states have been receiving interpretations that a QRTP would be classified as an IMD under Medicaid policy. In that case, no child or youth while they are residing in such a level of care would be covered by Medicaid services either at the QRTP or off-site. A recent October 2021 question and answer document from CMS indicates that, for a child in an IMD, it will not impact Medicaid "eligibility." However, CMS goes on to say there will be no federal Medicaid funding for such an "eligible" child. An IMD classification could cause states to shift toward more intensive placement facilities that would not be appropriate for many children and youth who may be more appropriately placed into a QRTP. Other states may find a way to adapt, others may bypass implementing the QRTP standards, defeating the purpose of the new standards and still other states, out of necessity, will place children and youth across state lines to access needed beds. As mentioned earlier, this removes a child from their family's emotional and physical support and can adversely impact the effectiveness of the treatment intervention and prolong treatment.

The use of Title IV-E funding, as well as Medicaid, are critical components in meeting the needs of children served in the foster care system. If QRTPs are maintained by a State but are not exempted from the IMD exclusion, then the entire cost of medical, dental, behavioral, and mental health care for each child placed into QRTPs would not be reimbursable through Medicaid. The 2021 proposed budget suggested that addressing this requires a legislative correction.

The Committee should clarify the intent of the Family First Act and exempt QRTPs from the IMD exclusion allowing children in foster care up to age 18 (or 21 if foster care is extended) to have Medicaid coverage in these QRTPs. Either amend Title XIX or amend Title IV.

Therapeutic Foster Care

Therapeutic foster care, now called Treatment Family Care is therapeutic care for children and youth with special medical, psychological, emotional, and social needs who can accept and respond to the close relationships within a family setting, but whose special needs require intensive or therapeutic services.

Over the past decade states have been challenged to provide a range of funding strategies. While all states provide therapeutic care, there is no clearly defined core set of services accessible for qualified youth despite several years of legislative advocacy. Additionally, with the national awareness that children do best “in families” and the increased requirements within the Family First Act pertaining to QRTPs, more children with high behavioral health needs will be staying with their families or a foster family if necessary. Treatment Family Care addresses the high needs of these youth in home-based settings, hopefully, biological, or adoptive, but also kinship placements and non-relative foster care if needed.

As the Family Focused Treatment Association (FFTA) has explained, “A uniform, national definition would clarify an existing practice by identifying core services and adding a professional quality baseline for treatment family care programs that provide intensive, individualized treatment for seriously emotionally disturbed or otherwise troubled children in a specially trained and supported family setting. Such a definition should also provide transparency in funding for treatment services utilizing clinically validated programs and treatment protocols which are individualized for each child or youth while maintaining the authority of individual state Medicaid entities to determine medical necessity criteria coverage for other services and supports.” ***CWLA believes the Committee needs to pass existing legislation to provide a uniform national definition of therapeutic foster care under Medicaid.***

Coordination and Payor of First Resort to Family First Services

The new Family First Act offers the potential to assist children and families involved with the child welfare service. Mental health services are among the three broad categories of service that can be covered under new Title IV-E entitlement funding if these mental health services can meet the evidence-based requirements of the new law. When fully implemented, it is hoped that any child or youth considered to be a “candidate” for foster care will be able to access services (services can extend to the family). As there are not sufficient numbers of evidence-based programs tailored for child welfare related populations nor for children and families of color that are often disproportionately represented in child welfare additional models and services will need to be developed and they will have to coordinate with other parts of the U.S. mental health system.

Congress should review Medicaid mental health services currently accepted by that program and better align or recognize these services as eligible under the new Family First Act.

Congress should direct a review by HHS of Medicaid programs to examine any policies or regulatory requirements which are negatively impacting children, adults, and families of color are removed to ensure equal access to culturally relevant screening, intervention, and treatment services for populations of color and those who are marginalized.

Given that mental health has been declared a public health issue Congress should add a requirement for the Medicaid program to address the social determinants of health for all recipients to attend to this issue.

Telehealth

There is nothing like in-person care in mental health. However, telehealth is an important resource that has grown in value during this pandemic. It is a service many people prefer. They do not have to leave the comforts and security of their home, particularly at night and in poor weather; they do not have to be seen and many people are embarrassed by their appearance and find the anonymity is a comfort.

Providers initially may find the change challenging, but over time one becomes used to the new medium and develop skills, sensitivity to the sound of people's voices and the innuendo. In many regards it challenges people to be more thoughtful and reflective with their clients. The costs are much lower, but the reimbursement rates are too. Providers should be appropriately reimbursed for the value of their service, including additional amounts for the significant outreach required to coordinate the care for children, youth and families.

Telehealth has expanded the access to mental health care during the pandemic for people who might never have been able or may not have considered seeing a therapist. The level and breadth of the intervention is vast as it can cover both mental health and the psychosocial aspects of needs presented by Medicare people. It helps to remove stigma and of course the challenges for people having to going out and in the flexibility of scheduling.

The Committee should assure that Medicaid pay for telehealth as it does for in-person care. But there needs to be some mandate on payment for providers that is equitable as is for other professions. Congress should make the flexibilities developed for the pandemic permanent.

Parity Laws

The Mental Health Parity and Addiction Equity Act along with the ACA's Essential Health Benefits or EHBs requirements have provided important expansions of mental health services. These EHBs mean that exchange plans must cover ten broad categories of services: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; *mental health and substance use disorder services*, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness and chronic disease management; and pediatric services, including oral and vision care.

Congress needs to follow through on new tools to enforce the Mental Health Parity and Addiction Equity Act. As of February, of this year every health plan was to have an analysis to

show how they meet requirements. The results of audits of these reports are to make up an annual report to Congress. The Committee needs to focus annual attention and oversight of this new requirement and report so that it becomes an annual review that receives public attention.

CWLA believe the Congress needs to encourage public education campaigns through HHS, the Department of Labor and state partners such as state insurance commissioners. Online tools should be created to both educate consumers and allow consumers to file complaints. HHS should examine state progress and issue report cards. In addition, model laws should be crafted for use by states.

Substance Use

Children's exposure to parental alcohol and other drug (AOD) use—whether through prenatal exposure or environmental observation—undoubtedly puts them at risk. Substance abuse is estimated to be a factor in one- to two-thirds of cases of children with substantiated reports of abuse and neglect, and in two-thirds of cases of children in foster care. Children from families with substance abuse problems tend to come to the attention of child welfare agencies at a younger age than other children, are more likely than other children to be placed in out-of-home care and are likely to remain there longer. In addition, attention is required regarding substance use exposure for the infants since that impact may not surface until later in a young child's or adolescent's life to fully understand the effect in later developmental stages.

Foster care numbers released by HHS indicated that in 2019, 437,465 children were in foster care. The data indicates that drug abuse by the parent was the primary reason for the child's removal in 34 percent of cases along with a child's drug abuse in 2 percent of the cases.

The Assistant Secretary for Planning and Evaluation (ASPE) released a 2018 study that examined the child welfare caseload and the impact of substance use. The Relationship Between Substance Use Indicators and Child Welfare Caseloads report looked at the data at the county level. They found that hospitalizations are related to caseloads. Hospitalizations due to opioids resulted in a 2.2 percent increase in foster care entry rates compared to a 2.8 percent increase in foster care rates when the hospitalization was due to alcohol abuse. But many abuse cases may involve multiple drug problems and cases are overall more complex.

If not treated properly, parental substance abuse is troublesome; in addition to being a root cause of child abuse and neglect, often it is cyclical and intergenerational in nature. Studies have shown that children who grow up in homes plagued by alcohol and other drug use and abuse very often choose risky behavior and develop their own alcohol and other drug problems.

The Family First Prevention Services Act offers the potential to assist children and families involved with the child welfare service. Substance abuse (like mental health services) is among the three broad categories of service that can be covered under new Title IV-E entitlement funding if these prevention and treatment services can meet the evidence-based requirements of the new law. When fully implemented, it is hoped that any child or youth considered to be a "candidate" for foster care will be able to access services (services can extend to the family). But these models and services will need to be developed and they will have to coordinate with other parts of the U.S. mental health system.

Substance use treatment agencies, other service providers, courts, housing authorities, community leaders, and family members need to coordinate. In past congresses, legislation has been introduced to provide grants to state child welfare and alcohol and drug agencies to address the effects of alcohol and drug abuse on children and families who come to the attention of the child welfare system.

In 2006, Congress created nationally competitive grants with the goal of funding treatment programs. These Regional Partnership Grants (RPGs) were enacted as part of the Deficit Reduction Act of 2006. These grants, allocated through the Title IV-B PSSF program, were limited to \$40 million in the first year, decreasing to \$20 million in the fifth.

These RPGs were a good but very small start and will hopefully result in evidence-based programs that will qualify for coverage under the Family First Act. At the same time, this legislation also represented a prime example of the disproportionate approach to child welfare. The original 2006 grants started off targeting the use of methamphetamines. These areas were mainly rural and white.

CWLA believes it is time to reevaluate the Regional Partnership Grants (RPGs). While many projects have been funded since inception, no state is fully funded and in fact some states have not received any projects. Funding should be increased beyond the \$20 million annually and the Committee should consider re-crafting funds to go to each state to coordinate between child welfare services and the state substance use agency.

The Committee should consider modifications to the Family First Act to better align eligible substance use treatment services that are covered through other systems (i.e., Medicaid and state substance abuse agencies).

CWLA recommends the Committee consider legislation similar to HR 5242 the Opioid Settlement Accountability Act.

The legislation would prohibit HHS from treating any Medicaid-related funds recovered from one or more pharmaceutical companies or drug distributors with respect to opioid litigation as an overpayment but would also require funds obtained from litigation against opioid manufactures to be invested into program for opioid prevention and treatment services; health care practitioner training; first responder equipment; or social support services. CWLA would argue for a specific set-aside for children adversely effected at birth and later in childhood by substance use including neo-abstinence syndrome.

Workforce

There are 8,300 child and adolescent psychiatrists in the United States. In 1980 the Graduate Medical Education National Advisory Committee (GMENAC) recommended that this country would require between 8000 to 10,000 child and adolescent psychiatrists by the year 1990. There is a severe maldistribution of child psychiatric services rural and poor areas of the country. (American Academy of Child and Adolescent Psychiatry—AACAP).

The 8,300 practicing psychiatrists are distributed across an estimated 15 million children and adolescents in need of special expertise of such professionals (AACAP). These numbers have likely worsened since the past year and half of the pandemic.

As noted by the National Academy of Sciences study, the workforce, and its training effects the ability to provide important screening services for children and youth. As they found, “Overall rates of developmental screening and surveillance remain low (Coker, Shaikh, and Chung, 2012; Hirai et al., 2018). Barriers to success also include a paucity of behavioral training for health professionals to carry out this work in primary care settings and low levels of reimbursement for preventive and behavioral pediatric care in office-based settings.”

The workforce and its development include training, as the National Academy report stated,

“The lifetime prevalence of any mental disorder among adolescents is estimated to be 49.5 percent (National Institute of Mental Health, 2019). Furthermore, 1 in 25 adolescents has a substance use or abuse condition (American Addiction Centers, 2019) and suicide is the second leading cause of adolescent death (Heron, 2016). However, the ratio of board-certified adolescent medicine providers to adolescents is 0.8 to 100,000 (American Board of Pediatrics, 2018).”

The challenges extend to education: “While the Accreditation Council on Graduate Medical Education began requiring that pediatric resident training include one block (4 weeks) in adolescent medicine in 1997, faculty to provide comprehensive training in adolescent issues are in short supply, and pediatric residents report unmet needs in this area; many never encounter common adolescent issues in the course of their training (Ruedinger and Breland, 2017). Thus, while behavioral medicine has emerged as a greater part of adolescent care, much work remains to be done in this area.”

As noted throughout this report the need for more professional well-trained, staffed, encouraged, and supported behavioral health workforce is evident. That means we need a multi-pronged, ongoing, and long-term strategy. These strategies must include school loan forgiveness, better reimbursement, training, and integration of training between professions and a host of efforts by HHS and their umbrella agencies, the Education Department, and the Labor Department.

Although the Education Department has loan forgiveness programs this Committee should examine ways to expand the efforts or coordination of those programs with efforts by HHS. ***The Committee should examine strategies to designate certain careers as an underserved need (just as geographic and population areas in the country as designated as underserved through the Health Professional Shortage Areas program (HPSA under the Health Resources and Services Administration (HRSA).***

In addition, serious consideration should include several bills now in Congress including the Helping Kids Cope Act, that would increase the scope of health care provider grant funding. Use of funds includes grants for recruitment and retention of health care workers, training, expanding evidence-based models, addressing surge capacity, pediatric care via telehealth, decompression of emergency departments, preventive and crisis intervention services, urgent care, school-based

partnerships, and other gaps in health services. Or the Mental Health Services for Students Act that amends the Public Health Service Act, revising and extending projects relating to children while providing access to school-based comprehensive mental health programs.

Conclusion

We appreciate your efforts to address what is a truly an important challenge, the need for improvements in our mental health and substance use health care systems. This is vital to strengthening all families and we think if improvements can be made in this important part of our health care system it addresses not just child welfare but many other family-serving systems. Effective mental health and substance use services will reduce the number of children and families that come to the attention of child protection or child welfare. We appreciate the committee's outreach, and we look forward to continuing our efforts to help you address this problem in a strong bipartisan manner.

If you would like additional information, please contact John Sciamanna, Vice President, Public Policy at 410-533-5857 or jsciamanna@cwla.org

Again, many thanks for your advocacy on behalf of children.

Sincerely,

A handwritten signature in cursive script that reads "Christine James Brown".

Christine James-Brown
President/CEO, Child Welfare League of America