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TO: The Honorable Ron Wyden, Chairman and The Honorable Mike Crapo, Ranking Member
United States Senate, Committee on Finance

FROM: Deborah Harburger, MSW, Director, Division of Policy, Finance, & Systems Design
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RE: Request from the Senate Finance Committee for Input into Improving Access to Timely Behavioral Health Care in the United States

DATE: November 15, 2021

Thank you for the opportunity to provide input into how we can improve access to timely behavioral health care in the United States. The Institute for Innovation & Implementation (The Institute) at the University of Maryland, Baltimore School of Social Work is a national policy, finance, training, technical assistance, evaluation, and workforce development center working in 28 states to support the development, installation, and sustainability of robust, inclusive, culturally responsive, and high quality child-, youth-, and family-serving public systems.

The following recommendations are based on The Institute's more than 15 years of experience in this work across federal, state, local, and private agencies and systems, including serving as the Substance Abuse and Mental Health Services Administration (SAMHSA's) National Training and Technical Assistance Center for Children's Behavioral Health from 2013-2020. The Institute currently provides technical assistance to SAMHSA on its work related to children's crisis response systems and is engaged in multiple grants from SAMHSA, the Children's Bureau, and the Office of Juvenile Justice and Delinquency Prevention, in addition to working at the state and local levels across the United States.

We offer the following evidence-based solutions and recommendations to **improve access to behavioral health care for children and young people and to improve reimbursement mechanisms and financing**. Detail on each of these recommendations is provided below. We are available to provide additional information, resources, and examples for each of these recommendations upon request.

Thank you for the opportunity to provide recommendations and for your commitment to improving access to quality behavioral health care for children and families.

Customize public behavioral health systems to meet the needs of children and families

RECOMMENDATION 1: Require SAMHSA and the Centers for Medicare & Medicaid Services (CMS) to issue an **updated informational bulletin on providing home- and community-based services** to children, youth, young adults, and their families, outlining services and supports that should be available to all and provide consolidated resources, recommendations, and examples of financing mechanisms to support these services.

RECOMMENDATION 2: Expand and promote crisis services customized for children, youth, and youth adults, to include implementation of the 988 National Suicide Prevention Lifelife; use of the set aside in the Mental Health Block Grant for child-specific crisis response models; inclusion of mobile response

and stabilization services (MRSS) in Medicaid State Plans and Waivers, including an extension of the enhnaced Federal Medical Assistance Percentage (FMAP) thorugh 2025; and, establishing a pilot to test innovative approaches to children's crisis response systems using a model built upon the Integrated Care for Kids (InCK) Model.

Modify federal programs to support access to timely, quality, effective behavioral health care for vulnerable populations, particularly those youth involved with child welfare and juvenile justice systems

RECOMMENDATION 1: Modify the Bipartisan Budget Act of 2018 (P.L. 115-123; the Family First Prevention Services Act) to expand eligible supported services to include interventions rated by the California Evidence-Based Clearinghouse for Child Welfare; permit up to 50% of prevention services to include individualized, trauma-responsive services and supports aligned with the child's individual prevention, inclusive of housing supports, child care, medical care, employment support, and other tangible needs to strengthen the caregiver's capacity to maintain the children safely in their own homes; and, align Medicaid and Title IV-E requirements, incluidng clarifying key requirements.

RECOMMENDATION 2: Modify the Medicaid and the Children's Health Insurance Program (CHIP) to increase flexibility for children to access services through Medicaid and CHIP prior to receiving a formal diagnosis, particularly for young children; and, enable caregivers to receive necessary services without requring their child to be the recipient of the service.

RECOMMENDATION 3: Modify Title IV-E financial eligiblity for children who are in foster care to align with current poverty thresholds.

RECOMMENDATION 4: Make the provisions of Division X in P.L. 116-260, the Consolidated Appropriations Act, 2021, **permament** to support youth and young adults with foster care histories and **extend foster care through age 21** in all states and permit re-entry to youth under age 22 who left foster care after age 17.

RECOMMENDATION 5: Make the Child Tax Credit permanent.

Consider key factors related to implementing and expanding telehealth services for the pediatric population

RECOMMENDATION 1: Permit and promote the use of telehealth to improve care coordination for children, youth, and young adults with behavioral health conditions.

RECOMMENDATION 2: Continue flexibilities permitted during the COVID-19 pandemic regarding telehealth, including telephone-only telehealth with minimal administrative burden and allowing practitioners with valid licensure to provide telehealth services across state lines.

Customize public behavioral health systems to meet the needs of children and families

RECOMMENDATION 1: Require SAMHSA and the Centers for Medicare & Medicaid Services (CMS) to issue an **updated informational bulletin on providing home- and community-based services** to children, youth, young adults, and their families, outlining services and supports that should be available to all and provide consolidated resources, recommendations, and examples of financing mechanisms to support these services.

The 2013 Informational Bulletin was utilized by states and communities to develop more comprehensive, sustainable, and effective home- and community-based services for children, youth, young adults, and their families. It has been referenced in technical assistance documents and presentations[1], consulted in the development of State Plan Amendments and Title IV-E Waivers, and shared by public and private sector organizations alike to anchor best practices within their communities. States and communities look to such policy documents to assist them in assessing and modifying their service array and an updated document would be timely and helpful across the U.S.

Similar to the 2013 bulletin, this informational bulletin should:

- Outline the core home- and community-based services that should exist within every public behavioral health system for children, youth, young adults, and families, to include mobile response and stabilization services (MRSS), school-based services, intensive in-home services, individual therapy, family therapy, group therapy, psychoeducation, respite care, family and youth peer support, customized goods and services, medication-assisted treatment, and intensive care coordination using Wraparound;
- Urge the use of evidence-based and promising practices, trauma-responsive practices, and culturally humble approaches to meet community needs; and,
- Recommend financing strategies to cover these costs, both existing and new approaches.

RECOMMENDATION 2: Expand and promote comprehensive, customizsed mobile response and stabilization services for children, youth, and youth adults, to include

- Implementation of the 988 National Suicide Prevention Lifelife[2];
- Use of the set aside in the Mental Health Block Grant for child-specific mobile response models;
- Extension of the enhnaced Federal Medical Assistance Percentage (FMAP) thorugh 2025 to support increased inclusion of mobile response and stabilization services (MRSS) in Medicaid State Plans and Waivers, and,
- Establishing a pilot to test innovative approaches to children's crisis response systems using a model built upon the Integrated Care for Kids (InCK) Model.

From 2007 to 2016, pediatric psychiatric emergency department (ED) visits for children 5-17 nationwide increased significantly: visits for deliberate self-harm increased 329 percent, visits for all mental health disorders rose 60 percent, and visits for children with a substance use disorder rose 159 percent.[3] The COVID-19 pandemic has further exacerbated this crisis. Although the average number of monthly ED mental health related visits decreased during the pandemic, the proportion of ED visits for

[1] E.g., Lowther, J., Harburger, D.S., Fields, S., Zabel, M., Pires, S.A., & Allen, K. (2016). Partnering with Medicaid to Advance and Sustain the Goals of the Child Welfare System. Available from The Institute for Innovation & Implementation: https://theinstitute.umaryland.edu/media/ssw/institute/md-center-documents/Partnering-with-Medicaid-to-Advance-and-Sustain-the-Goals-of-the-Child-Welfare-System-(July-2016).pdf and Weiser, R., Spielfogel, J., & Liao, K. (2020). Planning Title IV-E Prevention Services: A Toolkit for States. Appendices. Available at https://aspe.hhs.gov/pdfreport/IV-E-prevention-toolkit-appendices.

[2] https://www.fcc.gov/suicide-prevention-hotline

[3] Lo, C.B., Bridge, J.A., Shi, J, Ludwig, L, & Stanley, R.M. (2020). Children's Mental Health Emergency Department Visits: 2007–2016. *Pediatrics* 145(6) e20191536; doi: 10.1542/peds.2019-1536.

mental health conditions significantly increased from 4 percent to 5.7 percent. Although the national rise is alarming on its own, some racial, ethnic, and historically underserved children and youth are disproportionately burdened. The suicide rate for Black children and youth increased from 2.55 per 100,000 in 2007 to 4.82 per 100,000 in 2017. Black youth under 13 years are twice as likely to die by suicide; Black males, five to 11 years, are more likely to die by suicide compared to their White peers. Suicide attempts among Black youth are rising faster than among any other racial or ethnic group.

MRSS is a child, youth, and family specific crisis intervention model for response and stabilization services within a children's crisis continuum. MRSS is designed to meet a parent/caregiver's sense of urgency when children and youth begin to demonstrate behavioral changes associated with the early phase of a crisis, commonly understood as pre-crisis. Mobile crisis services are available 24/7 and can be provided in the home or any setting where a crisis may be occurring.[4] MRSS works children and their families to resolve the crisis, identify potential triggers of future crises, develop and implement strategies to effectively de-escalate potential future crises, and avert and divert from more restrictive levels of care (ED, residential treatment, etc.), out-home-placement, and unnecessary contact with law enforcement and juvenile justice.[5]

MRSS are one example of a cost-effective alternative to the use of EDs and inpatient treatment. MRSS focuses on rapid, community-based response to non-life-threatening emotional symptoms and behaviors that are disrupting a youth's functioning; provides immediate assistance to youth and caregivers in de-escalating those symptoms and behaviors; and assists youth and caregivers with identified supports, resources, and services in their community to minimize risk, aid in stabilization, and improve life outcomes. A key distinction between crisis services for children and youth versus adults is that families are often involved in facilitating a young person's care.

In the May 2013 joint informational bulletin (discussed above), *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions*, the Centers for Medicare & Medicaid Services and the Substance Abuse and Mental Health Services Administration (SAMHSA) describe key functions and components of MRSS, including "…available 24/7 and can be provided in the home or any setting where a crisis may be occurring. In most cases, a two-person crisis team is on call and available to respond. The team may be composed of professionals and paraprofessionals (including peer support providers), who are trained in crisis intervention skills and in serving as the first responders to children and families needing help on an emergency basis. In addition to assisting the child and family to resolve the crisis, the team works with them to identify potential triggers of future crises and learn strategies for effectively dealing with potential future crises that may arise."[6]

Round-the-clock availability and the ability to respond quickly to a family's crisis is but one element of a fully developed, well-functioning MRSS. Apart from 24/7 availability, MRSS teams must demonstrate an ability to serve children and families in their natural environments; employ staff with specialized training

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[4] Manley, E., Schober, M., Simons, D., & Zabel, M. 2018. Making the case for a comprehensive children's crisis continuum of care. Alexandria, VA: National Association of State Mental Health Program Directors. Retrieved from: https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf

[5] The Institute for Innovation & Implementation. 2021. Mobile Response and Stabilization Best Practices. Available from https://files.constantcontact.com/57c33206301/8d059ee9-6862-40ef-a018-d79ee151fbcb.pdf

[6] Mann, C. & Hyde, P. 2013, May 7. Joint CMCS and SAMHSA Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions. Center for Medicaid and CHIP Services & Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. Retrieved from: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf

that emphasizing resiliency and is not adult-centric; identify and build on natural support structures while reducing reliance on unnecessary acute care; and establish a partnership with families during crisis response, through treatment planning, and into post-crisis stabilization and referral.

The exact design of MRSS should reflect the specific needs of the community to be served. Although psychiatric visits for youth six to 24 are increasing across the United States – an indicator of chronic and acute unmet mental health needs – the increases are uneven across regions; the largest increases were seen in African American and Hispanic patients even after adjusting for insurance status, but the differences varied by geographic region.[7] Similarly, a 2018 study, found a strong relationship between mental health symptoms, suicidality, and housing amongst lesbian, gay, bisexual, and transgender (LGBTQ) youth served by a community crisis center and recommended that such providers consider forming partnerships with homeless prevention partners to maintain post-crisis stabilization.[8]

988 Behavioral Health Lifeline: In 2020, the Federal Communications Commission adopted rules to establish 988 as a behavioral health lifeline, with a requirement to direct all 988 to the existing National Suicide Prevention Lifeline by July 16, 2022.[9] A recent report[10, 11] suggests that most states have not taken concrete steps to support and implement the 988 behavioral health lifeline. However, its implementation will need to be coordinated with children's MRSS and customized to respond to a crisis as identified by a child, youth, and family.[12] We recommend issuing clear federal guidance to ensure consistent implementation across states and public systems.

Mental Health Block Grant: The Mental Health Block Grant (MHBG), administered by SAMHSA, includes a set-aside of funding for children's services and, new in 2021, a separate set-aside not less than 5% of total MHBG allocation to support evidence-based crisis care programs[13]. However, this set-aside is not specific to children's services and, as outlined above, requires intentional focus to ensure services and supports are customized to meet the needs of children, youth, young adults, and their families experiencing a crisis. We recommend that there be an increase in the set-aside for evidence-based crisis care programs, specifically to support child, youth, and young adult crisis response.

Increased FMAP & Use of Medicaid: The American Rescue Plan Act (ARPA; PL-117-2) provides states with a new incentive to include MRSS in their Medicaid State Plan: Increased Federal Medical Assistance Percentage (FMAP) to 85% for covered services for 12 quarters starting in April 2022.

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[7]Kalb L.G., Stapp E.K., Ballard E.D., et al. (2019). Trends in Psychiatric Emergency Department Visits Among Youth and Young Adults in the US. *Pediatrics, 143*(4), e20182192 Retrieved from: https://pediatrics.aappublications.org/content/pediatrics/143/4/e20182192.full.pdf

[8] Rhoades, H., Rusow, J.A., Bond, D., Lanteigne, A., Fulginiti, A., Goldbach, J.T. (2018). Homelessness, Mental Health and Suicidality Among LGBTQ Youth Accessing Crisis Services. *Child Psychiatry & Human Development, 49*(4): 643–651. Retrieved from https://link.springer.com/article/10.1007%2Fs10578-018-0780-1

[9] Federal Communications Commission. (2021). *Suicide Prevention Hotline.* Available from the FCC: https://www.fcc.gov/suicide-prevention-hotline

[10] Russell, T. & Wenderoff, J. (2021). *Most states have not yet acted to support new 988 behavioral health lifeline.* Available from The Pew Charitable Trusts: https://www.pewtrusts.org/en/research-and-analysis/articles/2021/10/26/most-states-have-not-yet-acted-to-support-new-988-behavioral-health-lifeline

[11] Gulley, J., Arienti, F., Martone, K. & de Voursney, D. (2021). *Implementation of the 988 hotline: A framework for state and local systems planning.* Available from Technical Assistance Collaborative: https://www.tacinc.org/resource/implementation-of-the-988-hotline-a-framework-for-state-and-local-systems-planning/.

[12] Hoover, S., Bostic, J. (2020). Improving the Child and Adolescent Crisis System: Shifting from a 9-1-1 to a 9-8-8 Paradigm. Available from the National Association of State Mental Health Program Directors: https://www.nasmhpd.org/sites/default/files/2020paper9.pdf

[13] Hogan, M.F. (2021). *Dr. Michael Hogan discusses national funding released for crisis systems.* Available from Crisis Now: https://talk.crisisnow.com/dr-michael-hogan-discusses-national-funding-released-for-crisis-systems/

Several states received planning grants to support the development of the Medicaid State Plan Amendments, section 1115 demonstrations, or 1915(b) or 1915(c) waivers. However, states would benefit from increased time to spend the increased FMAP, given the time it takes to develop, gain Federal CMS approval of, and implement a comprehensive and high-quality Medicaid plan. Therefore, we recommend extending the period of time to be 12 quarters beginning anytime from April 2022 through April 2025.

InCK Model for MRSS: CMS has funded states and organizations to test a child-centered local service delivery and state payment model to reduce expenditures and improve quality of care for children under 21. This model aims to reduce avoidable inpatient stays and ED visits and create sustainable Alternate Payment Models through integrated care coordination and case management approaches.[14] We recommend establishing an InCK for MRSS to enable states to test innovative and sustainable approaches to implementing MRSS.

Modify federal programs to support access to timely, quality, effective behavioral health care for vulnerable populations, particularly those youth involved with child welfare and juvenile justice systems

RECOMMENDATION 1: Modify the Bipartisan Budget Act of 2018 (P.L. 115-123; the Family First Prevention Services Act, FFPSA) to:

- Expand eligible supported services to include interventions rated by the California Evidence-Based Clearinghouse for Child Welfare;
- Permit up to 50% of prevention services to include individualized, trauma-responsive services and supports aligned with the child's individual prevention, inclusive of housing supports, child care, medical care, employment support, and other tangible needs to strengthen the caregiver's capacity to maintain the children safely in their own homes; and,
- Align Medicaid and Title IV-E requirements, incluidng clarifying key requirements.

The **evidence standards** established in the law limit the interventions that are eligible for fedreal reimbursement under FFPSA. The Title IV-E Prevention Clearinghouse is working to review programs but the standards for the studies that may be considered and the threshold for the evidence mean that numerous interventions with evidence to support their positive impact are not eligible.

Families and youth would benefit significantly from having access to the interventions rated by the Title IV-E Prevention Clearinghouse as well-supported, supported, and promising *as well as* those rated by the California Evidence-Based Clearinghouse for Child Welfare as well-supported by research evidence, supported by research evidence, and promising research evidence. **The California Evidence-Based Clearinghouse for Child Welfare has 269 programs that are rated as meeting one of these three evidence standards; the Title IV-E Prevention Clearinghouse has 41 programs rated as meeting one of the three evidence standards.** This change needs to be made in the law so that states will expand the number and type of prevention services in their 5 Year Prevention Plans; without this explicit change and the guarantee of federal Title IV-E reimbursement, states are unlikely to prioritize access to such services.

The Family First Transtiion Act (PL 116-94) delayed the requirement that at least 50% of the FFPSA prevention services provided meet well-supported standards until after FY2023. However, beginning in FY2024, at least 50% of prevention services must be "well-supported," with the balance of the services meeting the "promising" or "supported" criteria. This provision does not enable states to use Title IV-E prevention funds for **individualized, trauma-responsive services** and supports to meet a particular

[14] CMS. (2021). *Integrated Care for Kids (InCK) Model.* Available from the CMS website: https://innovation.cms.gov/innovation-models/integrated-care-for-kids-model

family's needs to remain together in their own home. Families often need services related to housing, medical care, employment support, child care, or other concrete services;[15] additionally, they may identify a culturally relevant intervention that does not meet the FFPSA evidence threshold. Therefore, we strongly recommend revising the statute to permit up to 50% of total FFPSA prevention service dollars be used for individualized, trauma-responsive services and supports.

Clarification is need on **Medicaid and Title IV-E** as they relate to FFPSA. In particular, it can be unclear which entity is the payor of last resort for a child and service that is eligible under both funding mechanisms, even beyond what was provided in the 2020 Joint CMS and ACF Informational Bulletin. Additionally, states are harmed when they are unable to claim Maintenance of Effort under FFPSA for services provided under Medicaid. This incentivizes states to pay for services under FFPSA and leave those services out of their Medicaid State Plan or waivers; Medicaid is a more sustainable funding source for these services and families can access them without having to come into contact with the child welfare system. States should be rewarded for making evidence-based and promising practices available as part of their Medicaid benefit. We strongly recommend clarifying payment and permitting states to count Medicaid payments in their FFPSA maintenance of effort payments.

RECOMMENDATION 2: Modify the Medicaid and the Children's Health Insurance Program (CHIP) to increase flexibility for children to access services through Medicaid and CHIP prior to receiving a formal diagnosis, particularly for young children; and, enable caregivers to receive necessary services without requring their child to be the recipient of the service.

We endorse the recommendations from the National Association of Medicaid Directors[16] and ZERO TO THREE[17] related to this topic.

RECOMMENDATION 3: Modify Title IV-E financial eligiblity for children who are in foster care to align with current poverty thresholds.

FFPSA did not change the financial eligiblity for Title IV-E reimbursement for children who are in foster care. Children must be financially eligible to receive Aid to Families with Dependent Children (AFDC) as of July 16, 1996 for state Title IV-E agencies to claim federal reimbursement for out-of-home placements. AFDC ended in 1996 and was replaced by Temporary Aid to Needy Families (TANF), but the lookback provision remained in effect. Since 1996, states have been able to claim federal reimbursement for out-of-home placement for increasingly smaller numbers of children in foster care each year (often referred to as the penetration rate of children who meet eligibility) because of the Title IV-E Lookback.

Title IV-E has not adjusted for inflation, so fewer children are financially eligible each year.[18] This means that states must use other sources of funding to pay for out-of-home placements for otherwise eligible children. Although the goal is to limit the number of children coming into out-of-home care whenever possible, it remains necessary for some children to come into foster care for their safety. We

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[15] Rostad, W.L., Rogers, T.M., & Chaffin, M.J. (2017). *The influence of concrete support on child welfare program engagement, progress, and recurrence.* Children and Youth Services Review, 72. doi: 10.1016/j.childyouth.2016.10.014

[16] See Chapter 2 in Browning, L., Hammer, G., & Minnes, K. (2021). *Medicaid Forward: Behavioral Health.* Available from the National Association of Medicaid Directors: https://medicaiddirectors.org/wp-content/uploads/2021/02/NAMD_MedicaidForwardReport_FEB2021.pdf

[17] See Cole, P. (2020).*Building Back Better for Babies and Toddlers: A Transition Plan to Lay the Foundation for America's Future.* ZERO TO THREE. https://www.zerotothree.org/document/1815

[18] In 1996, the federal poverty threshold for a family of 4 was $15,600, while, in 2021, it is $26,500 (Assistant Secretary for Planning and Evaluation, 2020).

strongly recommend the financial eligibility for Title IV-E out-of-home placements be aligned with current poverty standards. This will enable states to maximize federal funds to provide critical services and supports to children in foster care.

RECOMMENDATION 4: Make the provisions of Division X in P.L. 116-260, the Consolidated Appropriations Act, 2021, **permament** to support youth and young adults with foster care histories and **extend foster care through age 21 in all states** and permit re-entry to youth under age 22 who left foster care after age 17.

Safety net programs are incredibly important to youth in foster care and with histories of foster care. Youth in or with a history of foster care have increased rates of behavioral health needs, which impact their ability to transition successfully into adulthood.[19], [20] Providing funds for needs like housing reduces the risk of homelessness and incarceration.[21] Division X provided enhanced funding for emergency cash assistance to youth and young adults ages 14 through age 26 who experienced foster care when they were 14 or older and increased funding to support additional costs related to obtaining a driver's license and paying for car insurance.

While some states provide extended foster care beyond age 18, this is still optional for states. Studies have shown that youth who remain in foster care beyond age 17 are less likely to experience homelessness or incarceration and are more likely to increase connection to employment and education.[22,23,24] Additionally, extended foster care may contribute to improved racial and ethnic equity in the child welfare system.[24] In states where extended foster care exists, youth face challenges to remaining in care: "Extended foster care has been underutilized as a driver of equitable outcomes for young people and needs to become more accessible across all states."[25] PL 110-351 requires that youth be enrolled in education or a related program or activity or be incapable of participating due to a medical condition in order to remain in foster care. In some states, if the youth "fail to comply" with the service agreement or are determined not to "need continued help in making the transition to self-sufficiency," the local department of social services can end services.[26] In some states, youth are not allowed to re-enter foster care and only seven states and the District of Columbia maintain eligibility for

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[19] National Conference of State Legislatures. (2019). *Mental health and foster care.* Available from the NCSL website: https://www.ncsl.org/research/human-services/mental-health-and-foster-care.aspx

[20] Greeno, E.J., Fedina, L., Lee, B.R., Farrell, J., & Harburger, D. (2019). Psychological well-being, risk, and resilience of youth in out-of-home care and former foster youth. *Journal of Child & Adolescent Trauma, 12.* doi: 10.1007/s40653-018-0204-1

[21] Prince, D.M., Vidal,S., Okpych, N., & Connell, C.M. (2019). Effects of individual risk and state housing factors on adverse outcomes in a national sample of youth transitioning out of foster care. *Journal of Adolescence, 74.* doi: https://doi.org/10.1016/j.adolescence.2019.05.004

[22] Prettyman, A. (2021). *For the Good of the Kids: Three Essays about the Economics of Child Welfare*. Dissertation. Available from Georgia State University: https://scholarworks.gsu.edu/aysps_dissertations/33

[23] Geiger JM, Okpych NJ. (2021). Connected After Care: Youth Characteristics, Policy, and Programs Associated With Postsecondary Education and Employment for Youth With Foster Care Histories. *Child Maltreatment.* doi:10.1177/10775595211034763

[24] Rosenberg, R., & Abbott, S. (2019). *Supporting older youth beyond age 18: Examining data and trends in extended foster care.* Available from the Child Trends website: https://www.childtrends.org/publications/supporting-older-youth-beyond-age-18-examining-data-and-trends-in-extended-foster-care

[25] The Annie E. Casey Foundation. (2021). *From COVID-19 Response to Comprehensive Change: Policy Reforms to Equip Youth and Young Adults in Foster Care to Thrive.* Available from the AECF website: https://assets.aecf.org/m/resourcedoc/aecf-fromcovid19responsetochange-2021.pdf

[26] Code of Maryland Annotated Regulations (COMAR). 07.02.10.12 Independent Living Aftercare Services. http://www.dsd.state.md.us/comar/comarhtml/07/07.02.10.12.htm

extended foster care to all youth in care.[27] These barriers interfere with youth remaining in foster care, particularly if they are struggling with a behavioral health disorder, are pregnant or parenting, or otherwise experiencing challenges common to young adulthood.

We recommend that the provisions of Division X are made permanent and that all states are required to extend foster care to all youth who were in foster care after the age of 14, regardless of whether they exited care at any time prior to their 22nd birthday. We also recommend that all youth be entitled to receive extended foster care regardless of whether they are in school, working, or in training.

RECOMMENDATION 5: Make the Child Tax Credit permanent.
Poverty is an important social determinant of health[28] that impacts well-being, functioning, and quality of life for children and adults. Children experiencing poverty are more likely to experience multiple risk factors, which can lead to increased mental health problems. [29, 30] The new expanded Child Tax Credit (CTC) is estimated to have kept 3.5 million children out of poverty in August 2021.[31] The CTC and the *way* it is provided (in monthly payments) may improve the financial well-being and health of many families[32]. Making the child tax credit would benefit all children, with a possible decrease in the poverty rate among Black, non-Hispanic children of an estimated 10.3%.[33] We strongly recommend that the CTC be made permanent to reduce child poverty.

Consider key factors related to implementing and expanding telehealth services for the pediatric population

RECOMMENDATION 1: Permit and promote the use of telehealth to improve care coordination for children, youth, and young adults with behavioral health conditions.

Recent research has shown that telehealth might improve help-seeking behavior in adolescents[34] and distance treatment is as effective as or even more effective than traditional, office-based therapies. [35,36] As of early 2018, 95 percent of Americans had a cellphone and 77 percent owned a smartphone, a

[27] Juvenile Law Center. (2020). Issues: Extended Foster Care. https://jlc.org/issues/extended-foster-care#review
[28] U.S. Department of Health & Human Services. (n.d.) *Social determinants of health.* Available from https://health.gov/healthypeople/objectives-and-data/social-determinants-health
[29] Hodgkinson, S., Godoy, L., Beers, L. S., & Lewin, A. (2017). Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting. *Pediatrics*, *139*. doi: 10.1542/peds.2015-1175
[30] Jakovljevic, I., Miller, A.P., Fitzgerald, B. (2016). *Children's mental health: Is poverty the diagnosis?* British Columbia Medical Journal, 58(8).
[31] Parolin, Z. & Curran, M.A. (2021). *Expanded Child Tax Credit leads to further decline n child poverty in August 2021.* Available from the Center on Poverty & Social Policy at Columbia University: https://www.povertycenter.columbia.edu/news-internal/monthly-poverty-august-2021
[32] Hamilton, L., Roll, S., Despard, M., Maag, E., & Chun, Y. (2021). *Employment, financial and well-being effects of the 2021 Expanded Child Tax Credit. Wave 1 Executive Summary: September 2021.* Available from Social Policy Institute, Washington University in St. Louis: https://socialpolicyinstitute.wustl.edu/employment-financial-wellbeing-effects-2021-ctc-report/
[33] Acs, G. & Werner, K. (2021). *How a permanent expansion of the Child Tax Credit could affect poverty.* Available from The Urban Institute: https://www.urban.org/research/publication/how-permanent-expansion-child-tax-credit-could-affect-poverty
[34] Kauer, S.D., Mangan C., and Sanci, L. (2014). Do Online Mental Health Services Improve Help-Seeking for Young People? A Systematic Review. *Journal of Medical Internet Research* 16(3). Retrieved from http://www.jmir.org/2014/3/e66/
[35] Hilty, D.M., Ferrer, D.C., Parish, M.B., Johnston, B., Callahan, E.J., and Yellowlees, P.M. (2013). The Effectiveness of Telemental Health: A 2013 Review. *Telemedicine Journal and E-Health* 19(6). Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3662387/
[36] Boydell, K.M., Hodgins, M., Pignatiello, A., Teshima, J., Edwards, H., and Willis, D. (2014). Using Technology to Deliver Mental Health Services to Children and Youth: A Scoping Review. *Journal of the Canadian Academy of*

dramatic increase since the Pew Research Center's first survey of smartphone ownership was conducted in 2011.[37] The widespread adoption of mobile technology has created opportunities to engage children and families in therapy and facilitate peer connections, extending the reach of services and supports that were previously only available in-person. The availability via mobile services is critical because many counties across the United States lack access to broadband internet.[38]

The literature indicates that adolescents embrace technology as part of their desire for privacy and autonomy: Adolescents report that telemedicine promotes transfer of power and control by allowing them to feel more comfortable about terminating the consultation; the process is more structured, resulting in a better understanding and a greater sense of shared responsibility.[39] Among the contributing factors for adolescent satisfaction with internet-based tools, adolescents report "the experience as exciting; some adolescents feel that the interaction is more visual, video-game like, and, consequently, less threatening; capacity to provide direction, along with the extra distance involved [psychological and physical]."[40]

In its March 2018 report to Congress, the Medicaid and CHIP Payment and Access Commission (MACPAC) acknowledged that "telehealth has the potential to improve access to service in underserved areas. … It can also encourage appropriate use of underutilized services, such as oral health and behavioral health services, by making it easier or more convenient to access them. … Telehealth can facilitate provider consultation and collaboration as well as enable more confidential delivery of services. For example, a patient could use a primary care office as an originating site and receive psychotherapy from a distant site, thereby avoiding the perceived stigma of visiting a mental health provider's office."[41]

We strongly recommend that states be urged to continue to use telehealth, particularly for youth and marginalized populations.

RECOMMENDATION 2: Continue flexibilities permitted during the COVID-19 pandemic regarding telehealth, including telephone-only telehealth with minimal administrative burden and allowing practitioners with valid licensure to provide telehealth services across state lines.

MACPAC's report notes that Medicaid coverage is generally not available for (1) telephonic consultation, though Oregon and Maine permit such consultation under limited circumstances; (2) provider-to-provider consultations, such as those in which child psychiatrists provide advice to pediatric primary care providers; however, four states cover such consultation, including California, Colorado, New Mexico, and Oregon, and some others use Medicaid administrative dollars, such as Wyoming;[42] and (3)

Child and Adolescent Psychiatry 23(2). Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4032077/

[37] Pew Research Center. (2018). Mobile Fact Sheet. Retrieved from http://www.pewinternet.org/fact-sheet/mobile/

[38] Federal Communications Commission. (2014). National Broadband Map. Retrieved from https://www.broadbandmap.gov/technology

[39] Grealish, A., Hunter, A., Glaze, R., and Potter, L. (2005). Telemedicine in a Child and Adolescent Mental Health Service: Participants' Acceptance and Utilization. *Journal of Telemedicine and Telehealth* 11 (1 Supplemental): 53-55. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/16035994

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[42] Wyoming Department of Health. (2007). *Equality Care News*, Bulletin 07-002. Retrieved from https://wymedicaid.portal.conduent.com/bulletins/teleheath_070503.pdf

collaborative care models in which behavioral health coordinators are embedded in primary care practices, such as in Vermont.[41,43]

The COVID-19 pandemic saw significant increases in the adoption and use of telehealth, including audio-only (telephone) and asynchronous technologies such as store and forward and remote patient monitoring. The pandemic disrupted care for children, youth, young adults and their families, including well-child visits that typically include developmental, behavioral, and psychosocial screening and assessment. This lacuna can result in serious consequences for all children, but especially so for children "affected by inequities based on race and/or ethnicity, disability, geography, socioeconomic status, and payer policies."[44]

As the pandemic wains, there will be a temptation to return to restrictive telehealth rules; we disagree and recommend retaining telehealth as a critical element in connecting children and families to care, particularly specialty care, to avoid unnecessary use of EDs and other acute care services. The American Academy of Pediatrics notes, "Telehealth is foundational to creating efficient, innovative, high-value care models in which patients get the right care at the right place at the right time, as well as investing in preventive care to reduce costly emergency department and hospital visits, all of which benefit all stakeholders in the health care system."[44]

[43] Simmons, K., Giard, M., Huebner, T., and Moore, T. (2017). Accountable Care Organizations '101' From Multi-ACOs to a Single Organization. Presentation to the Vermont House of Representatives, House Health Care Committee. Retrieved from https://legislature.vermont.gov/assets/Documents/2018/WorkGroups/House%20Health%20Care/Accountable%20Care%20Organizations/W~Kate%20Simmons%20and%20Martita%20Giard~Accountable%20Care%20Organizations%20101~1-12-2017.pdf

[44] Curfman, A.L., Hackell, J.M., Herendeen, N.E., Alexander, J.J., Marcin, J.P. et al. (2021). Telehealth: Improving Access to and Quality of Pediatric Health Care. Pediatrics 148 (3) e2021053129; DOI: 10.1542/peds.2021-053129. Retrieved from https://pediatrics.aappublications.org/content/148/3/e2021053129