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March 28, 2017

Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20001

Re: Request for Information on Pediatric Alternative Payment Model Concepts

Dear Administrator Verma:

I appreciate that the Centers for Medicare & Medicaid Services (CMS) is seeking input on a draft pediatric care model concept. My comments will focus on the need for increased access among children in foster care, and children adopted from foster care, to adoption competent mental health services. I believe that there are great opportunities for Medicaid to better serve these children and families.

The Center for Adoption Support and Education (C.A.S.E.) was created in May 1998, to provide pre and post-adoption counseling and educational services to families, educators, child welfare staff, and mental health providers in Maryland, Northern Virginia, and Washington, D.C. In addition, C.A.S.E. is a national resource for families and professionals through its training, publications, and consultations. We were also selected to collaborate with the Administration for Children and Families (ACF) in the development of its National Adoption Competency Mental Health Training Initiative. From this experience, C.A.S.E. has a unique perspective on how the mental health care system can and should better address the mental health needs of children in foster care and children who are adopted from the foster care system.

The Need for Quality Mental Health Services for Children and Youth in Foster Care

There is a high level of awareness of the need to improve access to, and quality of, mental health services provided to children in foster care and adopted from foster care, as well as adopted children more broadly. As Chief Executive Officer of C.A.S.E., I was pleased to present on August 29–30, 2012 to the participants of the Substance Abuse and Mental Health Services Administration (SAMHSA) during a discussion about the science, policy, and practice related to the behavioral health challenges of children who have been adopted and their families. The interagency planning committee for the meeting included representatives from the Administration for Children and Families (ACF); Centers for Disease Control and Prevention (CDC); National Institute on Alcohol Abuse and Alcoholism (NIAAA); National Institute on Drug Abuse (NIDA);

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National Institute of Mental Health (NIMH); National Institute of Child Health and Human Development (NICHD); and SAMHSA.¹

We discussed creating a national task force for strategic planning related to adoption services, and collaboration of Medicaid and child welfare to support adoption competent training for mental health providers. It was also suggested to pursue a meeting between SAMHSA, HHS and CMS and states to examine state by state policy implications with the intended goal to develop better coordination of funding and services that could be available and accessible to adoptive families. It was further suggested to develop an in-depth policy report on possible improvements to Medicaid and access to post-adopt services, including how to address low Medicaid reimbursement rates for trained adoption competent therapists. C.A.S.E. is looking forward to participating in the development and implementation of the suggested strategies that emerged from that conference, which could include a potential collaboration with CMMI.

The TAC (Training for Adoption Competency)

To address the significant needs of adoptive and foster families, C.A.S.E. has already developed the standardized, manualized Training for Adoption Competency (TAC), an evidence-informed, intensive, post-graduate training program for clinicians. With the support of major national foundations – the Freddie Mac Foundation, the Dave Thomas Foundation for Adoption, the W.W. Kellogg Foundation, and the Annie E. Casey Foundation – C.A.S.E. developed the 72-hour training and case consultation program for licensed mental health professionals in order to expand community capacity to provide adoption competent clinical services. The TAC is currently being implemented in 17 sites across the country (see attached list), including 9 of the national Wendy’s Wonderful Kids (WWK) sites. There is a sound and growing body of evidence that the TAC is a high quality, effectively-delivered, training that increases knowledge and changes clinical practices in ways associated with adoption competency.

Prior to developing the TAC, C.A.S.E. convened nationally recognized experts – adoption practitioners, researchers, advocates, policy makers, and adoptive parents – to identify the core knowledge, skills and values competencies that mental health practitioners need to serve members of the adoption kinship network. This National Advisory Board helped develop a definition of an adoption competent mental health professional using an expert-consensus process (see text box).

¹ See <https://www.samhsa.gov/sites/default/files/children-2015-domestic-international-adoption-strategies.pdf>

Definition of an Adoption Competent Mental Health Professional

An adoption competent mental health professional has:

- The requisite professional education and professional licensure;
- A family-based, strengths-based, and evidence-based approach to working with adoptive families and birth families;
- A developmental and systemic approach to understanding and working with adoptive and birth families;
- Knowledge, clinical skills and experience in treating individuals with a history of abuse, neglect and/or trauma; and
- Knowledge, skills and experience in working with adoptive families and birth families.

An adoption competent mental health professional understands the nature of adoption as a form of family formation and the different types of adoption; the clinical issues that are associated with separation and loss and attachment; the common developmental challenges in the experience of adoption; and the characteristics and skills that make adoptive families successful.

An adoption competent mental health professional is culturally competent with respect to the racial and cultural heritage of children and families.

An adoption competent mental health professional is skilled in using a range of therapies to effectively engage birth, kinship, and adoptive families toward the mutual goal of helping individuals to heal, empowering parents to assume parental entitlement and authority, and assisting adoptive families to strengthen or develop and practice parenting skills that support healthy family relationships.

An adoption competent mental health professional is skilled in advocating with other service systems on behalf of birth and adoptive families.

Using this definition of an adoption competent mental health professional and 18 consensus-defined adoption competencies, C.A.S.E. developed the TAC to train clinicians in adoption-specific issues and interventions and build community capacity across the United States to provide adoption competent mental health services.

C.A.S.E. also has charted new territory in examining the feasibility of a national certification program for adoption competent clinicians. Recognizing that consumers often rely on objective external assessments regarding the credentials of mental health professionals whom they consult (through licensing, board certification or other means), C.A.S.E. has undertaken a broad-based feasibility study regarding such a national certification, consulting with stakeholders across the country. Currently, C.A.S.E. is developing a business plan to guide the implementation of a national credential specifically for adoption competent mental health professionals.



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The National Adoption Competency Mental Health Training Initiative

As mentioned above, C.A.S.E. was recently selected by ACF to collaborate on the National Adoption Competency Mental Health Training Initiative. Together with our partners, we are developing state-of-the-art, evidence-informed, adoption competency web-based curriculums for child welfare and mental health professionals, building upon C.A.S.E.'s nine year national initiative, the TAC (Training for Adoption Competency) program which is currently being implemented in 17 states. It is the goal of this project to work collaboratively with all States, Tribes and Territories to infuse enhanced adoption competence into the provision of mental health interventions. Yet, access to trained mental health professionals will also require innovative solutions from the principle payer of medical services for children in foster care and adopted from foster care, namely Medicaid.²

The Needs of Adoptive Families for Quality Mental Health Services

Adoptive families often report that outpatient services and, in some cases, inpatient services are not appropriate for children with foster care and adoption histories. An untrained therapist, for example, may use behavior modification techniques that do not address the underlying trauma and attachment challenges that a child is experiencing and can exacerbate a child's mental health problems. We see this situation as a direct service provider routinely. Adoptive and foster families often come to us after seeing multiple therapists who are not adoption competent, making our job more difficult as we address both the core issues of the underlying trauma and the impact of behavior modification and other techniques utilized by earlier therapists that further added to the underlying problems.

Adoptive parents consistently report that their greatest post-adoption support need is mental health services provided by someone who knows adoption. The lack of post-adoption mental health services in general, and the lack of access to adoption competent mental health services in particular, are significant barriers to recruiting adoptive families for children from the foster care system. In a national survey of 485 individuals conducted by C.A.S.E., only 25 percent of adoptive families reported that the mental health professional they saw was adoption competent. The majority of respondents did not know whether assistance in accessing or paying for mental health services was available in their state, and only about 25 percent could confirm the availability of such assistance. Further, only 19 percent reported insurance subsidies adequate to address their children's mental health needs. Many respondents reported that the number of Medicaid mental health providers is quite limited, and they were of the opinion that the majority of those who are available are not adoption competent. A great majority (81 percent) reported

² See <http://adoptionsupport.org/adoption-competency-initiatives/national-training-initiative-nti/>
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that if they had a choice, they would choose a therapist who has earned a certificate as an adoption competent therapist.

It is an unfortunate reality that children and youth in foster care, when they are able to receive mental health services, typically receive it from the least qualified professionals due to the low reimbursement rates typical of Medicaid programs. Mental health professionals often begin their careers in publicly-funded community mental health centers that accept Medicaid – where most children in foster care and children who are adopted from foster care are seen. There are significant costs associated with the limited access to quality adoption competent mental health care -- both financially and emotionally. Studies suggest that lack of appropriate mental health services contribute to higher rates of adoption disruption and dissolution for families adopting from foster care, as well as interactions with the juvenile justice system. [insert citation]

The Lack of Quality Mental Health Services for Dually-Involved Youth – Trauma and Justice

C.A.S.E. supports work to promote trauma-informed approaches to behavioral health. We recognize that, for foster and adopted children and families, there are evidence-informed approaches specific to this population that are also trauma-informed, including the Training for Adoption Competency. As policymakers seek to increase the number of trauma-specific services and trainings, we strongly urge the inclusion of trainings that will build the adoption competency of its programs and workforce.

The impact of limited quality mental health services for children and youth in foster care – whether their permanency plan is reunification with parents, guardianships with relatives, or adoption – extends broadly. Studies confirm that the lack of quality mental health services impacts the outcomes for young people dually involved in the foster care and juvenile justice systems. The Brookings Institute Center on Children and Families reported:

Although children in long-term foster care represent only a small fraction of the total child population of the United States, they represent a much bigger portion of the young people who go on to create serious disciplinary problems in schools, drop out of high school, become unemployed and homeless, bear children as unmarried teenagers, abuse drugs and alcohol, and commit crimes. A recent study of a Midwest sample of young adults aged twenty-three or twenty-four who had aged out of foster care found that they had extremely high rates of arrest and incarceration. 81 percent of the long-term foster care males had been arrested at some point, and 59 percent had been convicted of at least one crime. This compares with 17 percent of all young men in the U.S. who had been arrested, and 10 percent who had been convicted of a crime. Likewise, 57 percent of the long-term foster care females had been arrested and 28 percent had been convicted of a crime. The comparative figures for all female young adults in the U.S. are 4 percent and 2 percent, respectively.

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Former foster youth are over-represented among inmates of state and federal prisons. In 2004 there were almost 190,000 inmates of state and federal prisons in the U.S. who had a history of foster care during their childhood or adolescence. These foster care alumni represented nearly 15 percent of the inmates of state prisons and almost 8 percent of the inmates of federal prisons. The cost of incarcerating former foster youth was approximately \$5.1 billion per year.³

A study in Los Angeles County found that a quarter of youth formerly in foster care and two-thirds of dually-involved youth have a jail stay in early adulthood. The average cumulative cost of jail stays over four years ranged from \$18,430 for a youth formerly in care to \$33,946 for a dually-involved youth. The study also found that dually-involved youth were more likely than youth in care with no juvenile justice involvement to experience serious challenges including serious mental health problems, more than double the rates of those who were in foster care only.⁴ Washington State found that about one-third of the youth in the state's juvenile justice system either were or had been in the foster care system.⁵

Psychotropic Drug Use

Specific to foster care, in December, 2012, the Government Accountability Office issued a report on *Children's Mental Health: Concerns Remain About Appropriate Services for Children in Medicaid and Foster Care*. They reported that an annual average of 6.2 percent of noninstitutionalized children in Medicaid nationwide and 4.8 percent of privately insured children took one or more psychotropic medications. They also reported that 18 percent of foster children were taking psychotropic medications at the time they were surveyed, and 30 percent of foster children who may have needed mental health services did not receive them in the previous 12 months. The GAO's letter to Members of Congress stated, "Children in foster care, most of whom are eligible for Medicaid, are an especially vulnerable population because often they have been subjected to traumatic experiences involving abuse or neglect and they may suffer from generally required to cover services to screen children for mental health problems and to provide treatment for any identified conditions, we previously reported that it can be difficult for physicians to find mental health specialists to whom they can refer children in Medicaid."

³ Zill, N. (2011). *Adoption from foster care: Aiding children while saving money*. Retrieved September 10, 2013 from

http://www.brookings.edu/~media/research/files/reports/2011/5/adoption%20foster%20care%20zill/05_adoption_foster_care_zill.pdf

⁴ Conrad N. Hilton Foundation. (2011). Hilton Foundation funds groundbreaking study on outcomes among youth in both foster care and juvenile justice systems. Retrieved September 10, 2013 from

<http://www.hiltonfoundation.org/foster-care-and-juvenile-justice>

⁵ Center for Children and Youth Justice. (2012). Facts about child welfare and juvenile justice in Washington State. Retrieved September 10, 2013 from

<http://www.ccyj.org/uploads/publications/Issues%20fact%20sheet-rev.pdf>

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While we strongly support appropriate access to medications, we also believe that this report underscores an inherent and fundamental challenge in our Medicaid system around access to adoption competent mental health services.

Medicaid Challenges Impacting Children and Youth in Foster Care

As you know, children and youth in foster care and adopted from foster care face a number of challenges with Medicaid system:

- Many foster, adoptive and kinship families do not know what resources exist to help them identify and access quality mental health services in their states.
- When they access affordable mental health services, foster, adoptive and kinship families have no assurance that these services are adoption competent. They generally are given little or no choice in providers.
- There is currently no process for identifying clinicians with special adoption competent expertise, such as through a national certification or central registry of clinicians who have obtained adoption competency training.
- Medicaid clinical services are an “optional” not mandatory Medicaid service, meaning that States can choose to cover (or not) the services of psychologists, clinical social workers, outpatient mental health services, and substance abuse clinical services. As states are facing budget shortfalls, there is concern that states may opt to eliminate any optional services that they are currently covering.
- EPSDT is unevenly implemented across states, resulting in wide variances in terms of coverage of mental health services for children, particularly with respect to the delivery of treatment services following diagnosis and assessment. As one example, in California, access to EPSDT mental health services is inequitable for eligible youth across the state. Despite the alarming prevalence of treatable mental health problems among youth in foster care, only 60% of California children who enter foster care receive the medically necessary mental health services to which they are entitled. Treatment rates range from 6% in some counties to 30% in others, and from 7% to 19% among the state’s largest counties.⁶

One study by the National Institute of Mental Health found that nearly half (47.9 percent) of youth in foster care were determined to have clinically significant emotional or behavioral problems. Researchers at Casey Family Programs estimate that between one-half and three-fourths of children entering foster care exhibit behavioral or social competency problems that warrant mental health services.⁷ These children often find permanent families through adoption (ranging between 51,000 and 57,000 children each year). According to some reports, the

⁶ Alliance for Children’s Rights. (2012). *Safeguard children’s rights: Require adequate funding and accountability for EPSDT realignment*. Retrieved September 10, 2013 from http://www.youthlaw.org/fileadmin/ncyl/youthlaw/publications/yln/2012/02/EPSDT-Realign-RevV21-FINAL_1_1_.pdf

⁷ Landsverk, J. A., Burns, B. J., Stambaugh, L. F. & Rolls Reutz, J. A. (2006). Mental health care for children and adolescents in foster care: Review of research literature. *Casey Family Programs*. 9-30. adoptionsupport.org



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percentage of adopted children in residential treatment centers is reported to be between 30 and 40 percent and is even higher in centers specializing in attachment disorder treatment and developmental trauma treatment. Adoptive families are 2 to 5 times more likely to utilize outpatient mental health services, and 4 to 7 times more likely to seek care for their children in residential treatment centers.⁸

In a most recent report, clinical program directors from 59 residential treatment facilities responded to an online survey addressing the representation of adopted youth currently being served by their organization, the extent to which adoption issues are incorporated into clinical intake and treatment processes, and the training needs of clinical staff related to adoption. Results indicated that adopted youth are disproportionately represented in these programs. Although constituting slightly more than 2% of the U.S. child population, 25–30% of youth currently enrolled in these programs were adopted. The report concluded that to meet the needs of adopted youth in care, clinical and administrative staff of residential treatment programs need to become adoption clinically competent.⁹

Recommendations

I applaud your efforts to integrate health care and health-related social services to deliver family-centered care. I would further urge CMMI to play an active role in this work by promoting activities within states that address the clearly articulated barriers described above to accessing adoption competent mental health services, and by the GAO in reference to access to access to mental health services at all. Therefore, we suggest the following:

1. Effectiveness of adoption competent clinicians: We urge consideration of a pilot or demonstration project in a specified number of states/counties to enroll a target number of adoption competent clinicians (defined as successful graduates of nationally recognized adoption competent post graduate training programs that include a clinical case consultation component) as EPSDT clinical providers. Using random assignment of children, CMMI could evaluate the mental health outcomes for children in foster care with adoption goals who are served by these adoption competent clinicians through EPSDT and those who are not.
2. Effectiveness of clinical screening and testing tools by adoption competent clinicians: We urge consideration of a pilot/demonstration project in a certain number of states/counties testing the use of identified valid and reliable clinical screening and testing tools for designated conditions present in children in foster care, including those with adoption goals (such as attachment disorders, PTSD, developmental trauma) in conjunction with adoption competent clinical interventions by adoption competent

⁸ Smith, S. L. (2014, March). Keeping the promise: The case for adoption support and preservation. Donaldson Adoption Institute. Retrieved February 24, 2016, from <http://adoptioninstitute.org/publications/keeping-the-promise-the-case-for-adoption-support-and-preservation/>

⁹ See <http://dx.doi.org/10.1080/0886571X.2016.1175993>



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- clinicians. The primary focus would be on a) children in foster care being prepared for adoption; and b) children adopted from foster care receiving adoption assistance/Medicaid coverage.
3. Impact of adoption competent treatment team on psychotropic drug use: We urge consideration of a pilot or demonstration project in a certain number of states/counties in which selected children in foster care with an adoption goal (experimental group) are assigned a treatment team consisting of a psychiatrist and an adoption competent clinician who coordinate clinical care for the child. CMMI would assess the impact on the usage levels of psychotropic medications as compared to children in foster care who do not have this treatment team (comparison group).

In general, C.A.S.E. recommends a stronger research focus on the impact of integrated care models on achieving positive mental health outcomes for children in foster care and children and youth adopted from the foster care system. Studies indicate that continuous mental health treatment is beneficial for children with histories of maltreatment and foster care.¹⁰ Medicaid managed care organizations (MCO's) with adequate networks of adoption competent mental health professionals, could demonstrate more positive outcomes for foster youth. Therefore, we suggest reforms that will enhance the positive outcomes for children and youth in foster care and those adopted from foster care, the majority of whom are Medicaid eligible.

I look forward to working with CMMI in the development of a pilot or demonstration that focused on improving access to, and quality of, the mental health services provided to children in foster care. Innovative strategies to improve the lives of our most vulnerable children should not be delayed – CMMI has the authority to begin the work of promoting innovative solutions in Medicaid that will improve the well-being of children in foster care and adopted from foster care by addressing barriers to adoption competent mental health services. C.A.S.E. has already begun the process of developing the adoption competent workforce needed to test effectiveness through its Training for Adoption Competency (TAC), through its direct services in Maryland, Virginia, and Washington, DC, and through its existing partnership with ACF on the National Adoption Competency Mental Health Training Initiative. We look forward to working with CMMI on the development of incentives to ensure that Medicaid plans appropriately refer children in foster care to adoption competent clinicians.

Thank you for this opportunity to comment.

Sincerely,

Debbie B. Riley LCMFT

Debbie Riley, LCMFT, CEO
Center for Adoption Support and Education

¹⁰ Child Welfare Information Gateway. (2012). *Mental health*. Retrieved September 10, 2013 from <https://www.childwelfare.gov/systemwide/mentalhealth/>



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TAC Sites

Catholic Community Services of Southern Arizona

Catawba County Department of Social Services, Hickory, NC

Children's Home Society of North Carolina

Commonwealth Catholic Charities, Richmond, VA

Foster & Adoptive Care Coalition, MO

Four Oaks, Cedar Rapids, IA

Georgia Division of Family and Children's Services

Lilliput Children's Services, CA

Lutheran Family Services of Nebraska, NE

Right Turn, NE

Lutheran Family Services of Virginia, Richmond, VA

Massachusetts Adoption Resource Exchange (MARE), Boston, MA

Mississippi Children's Home Services, Jackson, MS

Montgomery County Job and Family Services and the Alcohol, Drug Addiction and Mental Health Services (ADAMHAS) Board, OH

The Villages of Indiana

University of Connecticut School of Social Work, West Hartford, CT

University of Minnesota, Center for Advanced Studies in Child Welfare

University of Wisconsin – Milwaukee, Helen Bader School of Social Work

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