

CHAPTER 3

The Intersection of Medicaid and Child Welfare

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Key Points

- Children and youth involved in the child welfare system have either been removed from their homes for abuse or neglect or are receiving in-home child welfare services as the result of an allegation of maltreatment. Child welfare agencies, in addition to ensuring the safety of these children, must also ensure that their health needs are met; however, they may not use federal child welfare funds under Title IV-E of the Social Security Act to do so.
- A range of Medicaid-covered services may be necessary and appropriate for meeting the significant health, behavioral, and other needs of these children. Those receiving federal child welfare assistance under Title IV-E are automatically eligible for Medicaid; those who are not receiving Title IV-E assistance may be eligible for Medicaid on another basis, such as low income or disability. Youth who have aged out of foster care also may be eligible for Medicaid, in some cases up to age 26.
- Concerns about continuity of coverage and the provision of timely and appropriate care for children involved in the child welfare system are heightened in light of their substantial health needs and complicated family situations. For example:
 - Despite high coverage rates among children with current child welfare involvement, uninsured rates increase as they age out of the system.
 - Children may experience gaps in needed care if a condition goes unidentified as they move between homes, and services may be duplicated if a caregiver or provider does not have access to their medical histories.
- Service use and access to care present other challenges as well:
 - Missed or delayed health screenings are a concern for children in foster care, some of whose caregivers may be unaware of the availability of services, resulting in health problems going undiagnosed or untreated.
 - Youth in the child welfare system have high levels of unmet need for mental health care and are at risk of inappropriate prescribing of psychotropic medications.
- Given that the vast majority of child welfare-involved children and youth are eligible for Medicaid-financed services, the importance of collaboration among agencies cannot be overstated. However, fragmentation across financing streams and delivery systems, poor interagency coordination and data sharing, and a lack of knowledge among staff about other programs' benefits can hamper collaboration.

CHAPTER 3: The Intersection of Medicaid and Child Welfare

One of the populations covered by Medicaid is the population of low-income children currently or formerly served by the child welfare system. These children and youth have either been removed from their homes for abuse or neglect or are receiving in-home child welfare services as the result of an allegation of maltreatment. Children who have been removed from their homes may be placed temporarily in foster care, but may also be permanently placed with an adoptive or kinship guardian family. Others may age out of care without having secured a permanent placement.¹ Title IV-E of the Social Security Act provides federal funding for child welfare assistance for low-income children who have been removed from their homes. State child welfare agencies are responsible for the safety and well-being of children under their care and connecting them to a permanent and safe home if they cannot be reunited with their biological parents. Agencies must also ensure that the health needs of these children are met but may not use federal funds under Title IV-E to do so.

Children involved in the child welfare system often have significant health, behavioral, social, and other needs for which a range of Medicaid-covered services may be necessary and appropriate. Children receiving assistance under Title IV-E are automatically eligible for Medicaid. However, children who are not eligible for Title IV-E services, because, for example, they receive in-home services or have family income above the established eligibility standard, are not automatically eligible for Medicaid, although many are eligible through another pathway.

In fiscal year (FY) 2011, nearly 1 million children were eligible for Medicaid based on their receipt of certain child welfare assistance (including but not limited to Title IV-E services). This population generally comprises children who have been removed from their homes. While the population is small relative to the rest of the Medicaid program—accounting for less than 1 percent of all Medicaid enrollees and about 3 percent of non-disabled child enrollees—the complex health needs of these children, which are often a result of the trauma and maltreatment they have experienced, require an array of specialized services. Moreover, their average Medicaid spending is much higher than that of most other children enrolled in Medicaid.

Some child welfare-involved children and youth are eligible for Medicaid based on family income rather than receipt of child welfare assistance. This group includes significant numbers of children who remain in their homes. They also have substantial needs but may have lower levels of health care use and spending than children living in foster care or other out-of-home placements. Because Medicaid eligibility systems do not routinely collect child welfare information as part of an income-based enrollment process, it is difficult to identify these children using Medicaid data alone.

Ensuring receipt of timely and appropriate health care for children receiving foster care or other child welfare assistance is complicated by many factors:

- frequent changes in placement that may affect continuity of care, as well as changes in caregivers who may lack information on their health needs and prior service use and whose ability to provide consent for treatment may vary;
- trauma experienced both prior to and as a result of removal from the home;
- significant behavioral health needs that may not be appropriately addressed, with over-reliance on psychotropic medications and

a shortage of providers trained to diagnose and treat childhood trauma;

- fragmentation across Medicaid, child welfare, and behavioral health financing streams and delivery systems, with a lack of intensive health care management that may be needed to supplement routine caseworker services; and
- poor interagency coordination and data sharing, with a lack of knowledge among program staff about each other's benefit programs (Allen and Hendricks 2013).

For youth who have aged out of foster care, continuity of coverage is a concern, despite the high rates of coverage among children with current child welfare involvement. Identifying and enrolling these youth in Medicaid can be challenging for states, and beneficiaries face varying state eligibility policies with regard to documentation and prior receipt of out-of-state foster care assistance. Access to and use of Medicaid services could also be improved for the child welfare population, for example, by ensuring regular health screenings and reducing unmet needs for mental health care as well as inappropriate psychotropic medication use. Improved collaboration between Medicaid, child welfare, and other agencies is critically important, given that the vast majority of these children are eligible for Medicaid-financed services and care coordination.

To provide context for these issues, this chapter begins with background on the child welfare system and the children it serves. It then describes Medicaid's role in serving this population, and it concludes with a discussion of selected Medicaid policy issues relevant for child welfare-involved youth.

Child Welfare Overview

Child welfare agencies are tasked with promoting the safety, permanency, and well-being of children. To meet these goals, these agencies provide

services to prevent the abuse and neglect of children and to ensure a child's safety within the home. They also investigate allegations of abuse and neglect, and when necessary for a child's safety, remove the child from the home and place him or her in foster care. After children are removed from the home, child welfare agencies provide maintenance payments to foster families or other caregivers, including those providing foster care in group homes or institutional settings, to help cover the cost of room and board. The agency also provides case management and permanency planning for the child.² If possible, the child will be reunited with his or her parents; if not, the goal is to place the child in another permanent family through adoption or legal guardianship. If an agency is unable to place the child with a permanent family, it will work to help him or her successfully transition to adulthood (Stoltzfus 2015a).

Most federal support for state child welfare activities is authorized under Titles IV-B and IV-E of the Social Security Act. As of FY 2015, just over \$8 billion was provided in dedicated federal funding, with states (as a condition of receiving program funds) contributing between 20 percent and 50 percent of the costs of services.³ Beyond this matching contribution, states are required to abide by federal child welfare standards. Title IV-B provides capped grants to states for a range of child welfare services. There are no federal eligibility criteria because the programs are designed to protect and promote the safety of all children, and states may elect to use the funding for services that meet the broad goals of the agency. Under Title IV-E, which is an open-ended entitlement program, states are entitled to reimbursement for some of the cost of providing foster care, adoption assistance, or kinship guardianship assistance for eligible children. States may also choose to provide support for children who, instead of returning home or finding a permanent placement, leave foster care because they age out; federal Title IV-E funding for these children is provided through a capped grant (Stoltzfus 2015a).

Characteristics of child welfare-involved children.

In FY 2013, the families of 3.2 million children were investigated or assessed for abuse or neglect. Of those, about 1.3 million received child welfare services, either in the home or in foster care. African American children and younger children comprise a disproportionate share of these children; rates of victimization are similar for boys and girls (Children’s Bureau 2015a). More than half of families investigated for child abuse and neglect had prior reports of child maltreatment. Almost one-quarter had trouble paying for basic needs. The share of families that experienced domestic violence, serious mental health problems, or active drug use was smaller (Table 3-1).

About two-thirds of the children who received services received only in-home family services to allow them to remain safe while staying with their biological families (this might include training for their parents). The remaining third were removed from their homes and received foster care services, most in a family setting (Children’s Bureau 2015a, 2014). The majority of children who

leave foster care return to their biological families, with a smaller share finding permanent adoptive or guardianship placements or aging out of care (Children’s Bureau 2014). Among children who have been removed from their homes, only a subset are eligible for Title IV-E assistance. During FY 2013, on an average monthly basis, 159,000 children were eligible for Title IV-E foster care assistance, 432,000 children received Title IV-E adoption assistance, and about 17,000 received kinship guardianship assistance (Stoltzfus 2015a).⁴ (See Figure 3-1 and Table 3-2 for additional data on the characteristics of the child welfare population.)

Medicaid’s Role for Child Welfare-Involved Children and Youth

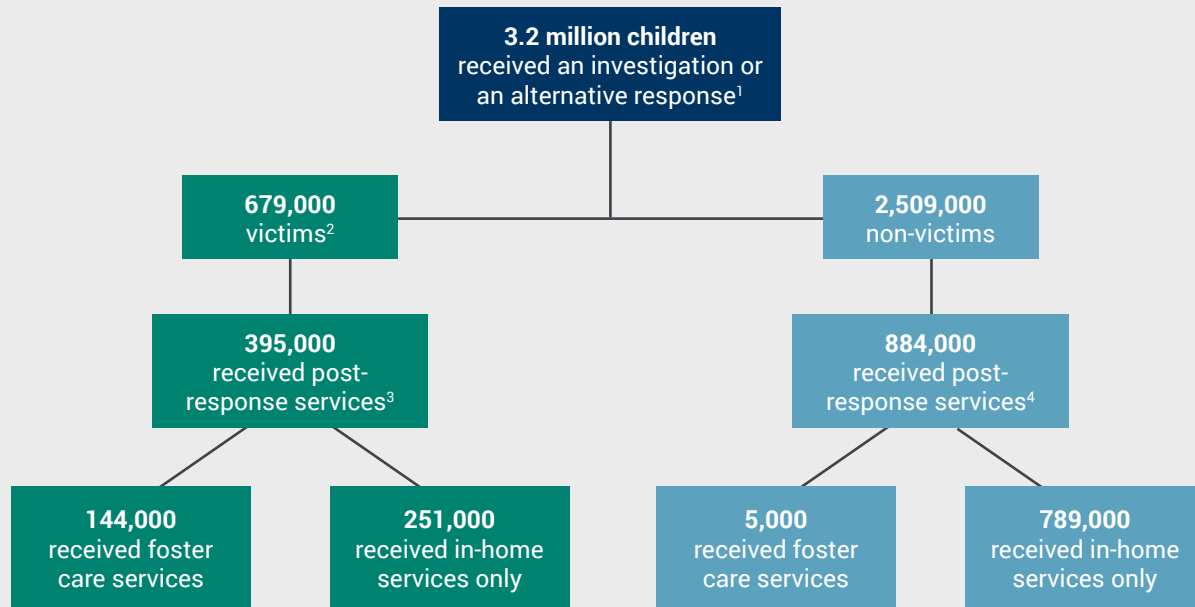
Child welfare-involved children and youth have significant health care needs and Medicaid provides a wide range of services that may address these needs. Between 31 percent and 49 percent of

TABLE 3-1. Risk Factors Associated with Families Investigated by Child Welfare Agencies

Risk factor	Percent
Family was subject of prior reports of child maltreatment	60.0%
Family experienced high levels of stress (e.g., unemployment, drug use, poverty, neighborhood violence)	50.5
Caregiver was subjected to domestic violence	27.7
Family had trouble paying for basic needs	23.8
Child had major special needs or behavioral problems	19.3
Primary caregiver had serious mental health problem	14.4
Primary caregiver had recent history of arrests	13.7
Primary caregiver involved in active drug use	10.5
Primary caregiver involved in active alcohol use	4.6
Child involved in delinquent behaviors (e.g., chronic runaway, truant)	4.5

Notes: Table based on tabulations of the National Survey of Child and Adolescent Wellbeing (NSCAW) II baseline data received from Department of Health and Human Services, Administration for Children and Families, Office of Planning Research and Evaluation. Prepared by the Congressional Research Service for the *Green Book*, a publication of the Committee on Ways and Means.

Source: Committee on Ways and Means 2014.

FIGURE 3-1. Number of Children in Families Investigated by Child Welfare Agencies, FY 2013


Among children leaving foster care in FY 2013, almost 60 percent of children were reunited with their families, almost 30 percent were placed in a permanent adoptive or guardianship home, and approximately 10 percent aged out of care without securing a permanent placement.⁵

Notes: FY is fiscal year. Unless noted, the data presented here are based on the National Child Abuse and Neglect Data System (NCANDS). As such, they will differ from the data presented from the Adoption and Foster Care Analysis and Reporting System (AFCARS). The total number of children involved in the child welfare system exceeds what is shown here for a number of reasons. For example, the overall number of children in foster care includes both children removed from their homes in FY 2013 (shown here) as well as children who entered foster care in a prior year but continued to receive services in FY 2013 (not shown here). Additionally, children whose families were not investigated in FY 2013 but received adoption or guardianship assistance or services after aging out of care are not included.

¹ In some states, reports of maltreatment may not be investigated but instead given an alternative response because the children were determined to be at low risk or for other reasons. These cases typically include the voluntary acceptance of child welfare services.

² A victim is defined in NCANDS as a child for whom the state determined that a case of maltreatment was substantiated or indicated. It also includes those identified as victims through an alternative response.

³ This count is from the 47 states that reported both foster care and in-home services.

⁴ This count is from the 45 states that reported both foster care and in-home services.

⁵ The reasons for discharge from foster care are based on Adoption and Foster Care Analysis and Reporting System (AFCARS) data for 2013 (see Table 3-2).

Source: Children's Bureau 2015a, 2015b, 2014.

TABLE 3-2. Characteristics of the Foster Care Population, FY 2013

	Number	Percent
Children in foster care on the last day of FY 2013	402,378	100.0%
Age		
< 3	86,532	21.5
3 to 5	71,005	17.7
6 to 10	86,551	21.5
11 to 15	86,566	21.5
16 to 20	71,338	17.7
Gender		
Male	210,738	52.4
Female	191,608	47.6
Race/ethnicity		
American Indian/Alaskan Native	8,652	2.2
Asian	2,114	0.5
Black or African American	98,201	24.5
Native Hawaiian/other Pacific Islander	686	0.2
Hispanic (any race)	86,993	21.7
White	168,302	41.9
Two or more races	24,935	6.2
Time in care		
< 1 month	20,901	5.2
1 to 5 months	91,425	22.7
6 to 11 months	78,963	19.6
12 to 17 months	59,105	14.7
18 to 23 months	38,614	9.6
2 years or more	113,332	28.2
Reason for discharge among children leaving foster care during FY 2013	238,280	100.0%
Reunification	121,334	51.2
Living with other relatives	19,385	8.2
Adoption	50,281	21.2
Emancipation/aging out	23,090	9.7
Guardianship	17,664	7.5
Adoptions from foster care occurring during FY 2013 with child welfare agency involvement	50,608	100.0%
Age		
< 3	14,076	27.8
3 to 5	14,837	29.3
6 to 10	13,389	26.5
11 to 15	6,661	13.2
16 to 20	1,640	3.2
Race/ethnicity		
American Indian/Alaskan Native	787	1.6
Asian	241	0.5
Black or African American	10,800	21.3
Native Hawaiian/other Pacific Islander	88	0.2
Hispanic (any race)	10,695	21.1
White	23,594	46.6
Two or more races	3,773	7.5
Relationship to adopted child¹		
Foster parent	29,428	58.1
Stepparent	53	0.1
Other relative	15,524	30.7
Non-relative	13,087	25.9

Notes: FY is fiscal year. Data are compiled from the Adoption and Foster Care Analysis and Reporting System (AFCARS) and represent children in foster care, regardless of Title IV-E status. As indicated in Figure 3-1, these children are only a subset of the total child welfare population. Components may not sum to totals due to rounding and missing data.

¹ Prior relationship categories are not mutually exclusive, and states are encouraged to select all that apply. As such, the total exceeds the number of adoptions in FY 2013, and the percentages do not sum to 100 percent.

Source: MACPAC calculations based on Committee on Ways and Means 2014 and Children's Bureau 2015b, 2014.

children in families investigated for abuse and neglect had a chronic health condition (Stein et al. 2013). The three most common health conditions were attention deficit hyperactivity disorder (ADHD) (16 percent), asthma (16 percent), and emotional problems (14 percent). Additionally, children with child welfare involvement were more likely to have fewer social skills than those in the general child population (34 percent as opposed to 16 percent), and it was estimated that over two-thirds of those 6 to 17 years old had an elevated risk for cognitive or behavioral problems (Casanueva et al. 2011). Among children eligible for Medicaid based on foster care assistance, 49 percent had diagnoses of mental health disorders and 3 percent had diagnoses of substance use disorders; for other children in Medicaid, the figures were 11 percent and less than 1 percent, respectively (SAMHSA 2013a). Child maltreatment has also been associated with increased risk of a number of longer-term health and social problems. Specifically, childhood trauma can increase alcoholism, illicit drug use, risky sexual behavior, mental health issues, including depression and attempted suicide, as well as cancer, heart, lung, and liver disease (Gilbert et al. 2009, Felitti et al. 1998).

The majority of child welfare-involved children and youth are eligible for Medicaid, either because they receive child welfare assistance or because of their low family incomes. Although it is not possible to identify the entirety of the child welfare population enrolled in Medicaid using readily available federal data (see Appendix Table 3A-1 for more information), about 1 million children were reported as ever enrolled in Medicaid based upon their receipt of child welfare assistance in FY 2011. These children accounted for less than 1 percent of all Medicaid enrollees and about 3 percent of non-disabled child enrollees. However, due to their high health needs and service use, Medicaid benefit spending for these children totaled \$5.8 billion in FY 2010, or about 2 percent of benefit spending for all enrollees and 9 percent of spending for non-disabled children (MACPAC 2015a).

Medicaid eligibility

For much of Medicaid's early history, children's eligibility for the program remained closely linked to the receipt of cash payments under the former federal-state Aid to Families with Dependent Children (AFDC) program (often referred to as welfare) and, for those with disabilities, the federal Supplemental Security Income (SSI) program. Between 1984 and 1990, Congress made a number of changes that expanded Medicaid for all children based on their low incomes alone, without regard to their eligibility for AFDC or SSI cash assistance payments. However, for children eligible for Medicaid based upon their child welfare status, ties to the former AFDC program (which ended in 1996) or SSI rules continue to apply. Specifically, children enrolled in Title IV-E programs, many of whose eligibility is based on meeting their state's 1996 AFDC standard or receiving SSI, are automatically eligible for Medicaid and connected to coverage without having to complete a Medicaid application. Those children not enrolled in Title IV-E programs may be eligible for Medicaid through another mandatory or optional pathway to enrollment, such as one based on low-income status or disability. (See Table 3-3 for specific Medicaid eligibility pathways based on Title IV-E status.)

Eligibility pathways for children who receive Title IV-E assistance. Children and youth enrolled in Title IV-E programs, including foster care, guardianship assistance, and adoption assistance, are automatically eligible for Medicaid (§1902(a)(10)(A)(i)(1) of the Act and 42 CFR 435.145). For those in foster care or those who have left foster care for legal guardianship, eligibility for Title IV-E is determined by the state welfare agency and is based upon the income and assets of the household from which the child is removed, which must meet the state's 1996 AFDC standards.

For those receiving Title IV-E adoption assistance, the eligibility criteria are slightly different, as the financial criteria are being phased out. Specifically, if the state welfare agency finds that a child in foster

care has a special need and the child meets the 1996 AFDC standards or the child qualifies for SSI (if the income standard is still applicable), the child will be eligible for Title IV-E adoption assistance.⁵ However, as of October 1, 2017, the financial criteria will no longer apply, and children will be eligible for Title IV-E adoption assistance on the sole basis of their special need (Stoltzfus et al. 2014).⁶

Eligibility pathways for children who do not receive Title IV-E assistance. While, as noted above, these non-Title IV-E children may be eligible through a non-child-welfare pathway, such as on the basis of income or disability, there are also two options that allow states to target Medicaid coverage to vulnerable child welfare populations who do not receive Title IV-E assistance. Specifically, states may use the Ribicoff option and the state-funded adoption assistance pathway. The Ribicoff option allows states to cover what is called a “reasonable category” of children, such as those who are in foster care but are not eligible for Title IV-E funding, if they meet the income limits established under AFDC (§1902(a)(10)(A)(ii)(I) of the Act and 42 CFR 435.222). Although not its only use, as of December 2013, 20 states used the Ribicoff pathway to cover non-IV-E children (Stoltzfus et al. 2014).

In addition, the optional state adoption assistance pathway allows states to provide Medicaid coverage to children who are receiving state-funded adoption assistance if they would not be able to be placed without medical assistance due to their significant health needs (§1902(a)(10)(A)(ii)(VIII) of the Act and 42 CFR 435.227). Because federal child welfare policy requires states to provide health coverage to children they have placed in state-funded adoptions, all but one state (New Mexico) has adopted this optional Medicaid pathway. However, it is likely that once the income and asset limits for Title IV-E adoption assistance have been phased out and the number of children eligible for such assistance increases, the optional Medicaid pathway for state-funded adoption assistance will be largely supplanted by the mandatory IV-E category (Stoltzfus et al. 2014).

Eligibility pathways for youth aging out of foster care. There are two designated pathways for children who have aged out of foster care—one mandatory and one optional. The mandatory category is a new pathway established by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) to align with another ACA provision that allows young adults to remain on their parents’ health insurance until age 26. It reflects the assumption that coverage through a parent’s insurance would not be available to children who reach adulthood without being reunified with their families or adopted. There is no income or asset standard for this pathway, although a youth must not be eligible for or enrolled in another mandatory Medicaid category. Therefore, some former foster youth may be enrolled on another basis of eligibility, such as being a low-income parent or pregnant woman, instead of this designated foster care pathway (CMS 2013a, 2013c). States have the option to cover former foster youth that aged out in other states, and as of January 1, 2015, 12 states have elected to do so (Brooks et al. 2015).

States also have the option to cover former foster care children up to age 21 through the Chafee option (§1902(a)(10)(A)(ii)(XVII) of the Act). In contrast to the mandatory ACA pathway, the Chafee option is less restrictive with regard to prior coverage and residence; there is no requirement for prior Medicaid enrollment or to have been in foster care in the same state in which the youth is currently residing. Also unlike the ACA pathway, states may establish income or resource criteria, may restrict eligibility to those who received assistance funded under Title IV-E, and may not cover individuals age 21 or older. As of 2012, 30 states had adopted the Chafee option (25 without an income standard) and those states must maintain this coverage until 2019, when the ACA’s maintenance of effort provision expires for children (Pergamit et al. 2012).

Continuity of health coverage. Because automatic Medicaid eligibility is tied to Title IV-E status,

TABLE 3-3. Pathways to Medicaid Eligibility by Child Welfare Population and Title IV-E Status

Type of child welfare assistance	Child is Title IV-E eligible	Child is not Title IV-E eligible
<p>Foster care assistance provides monthly maintenance payments and permanency planning for children placed in a temporary living arrangement that is intended to ensure the child’s safety and well-being after being removed from his or her home due to abuse or neglect. Less than half of all children in foster care are Title IV-E eligible.</p> <p>Guardianship assistance is a state option that provides support to relatives who assume legal guardianship for children previously in foster care. By the end of fiscal year 2014, 31 states and the District of Columbia included guardianship assistance in their Title IV-E plans.</p>	<p>Mandatory Medicaid Title IV-E pathway based on child welfare agency’s determination that child meets Title IV-E criteria:</p> <ul style="list-style-type: none"> • Child is under age 18 (up to age 21 at state option). • Home from which child was removed meets 1996 Aid to Families with Dependent Children (AFDC) need standard, and assets are limited to \$10,000. • Child meets all other Title IV-E foster care or guardianship criteria. 	<p>Mandatory or optional Medicaid pathways unrelated to child welfare, based on income or disability</p> <p>Optional Medicaid Ribicoff pathway for children that may be broad or targeted, based on the following criteria:</p> <ul style="list-style-type: none"> • Child is under age 21 (or younger, at state option) • Home from which child was removed meets 1996 AFDC income limits. • Child meets state-defined criteria for “reasonable” category of children (e.g., a child in foster care placement who is not eligible for Title IV-E funding because placement facility is not licensed).
<p>Adoption assistance provides payments to adoptive parents for ongoing support of children whose health care needs or other circumstances make them difficult to place in permanent adoptive homes. Eighty-five percent of children adopted from foster care are found to have special needs, qualifying their adoptive parents for Title IV-E assistance.</p>	<p>Mandatory Medicaid Title IV-E pathway, based on child welfare agency determination that child meets Title IV-E criteria:</p> <ul style="list-style-type: none"> • Child is under age 18 (up to age 21 at state option). • Child welfare agency determines that the child has a special need. • Home from which child was removed meets the 1996 AFDC need standard, and assets are limited to \$10,000; or child qualifies for Supplemental Security Income (SSI). <p>Note: All financial standards will be phased out by October 2017.</p>	<p>Mandatory or optional Medicaid pathways unrelated to child welfare, based on income or disability</p> <p>Optional Medicaid state adoption assistance pathway, based on the following criteria:</p> <ul style="list-style-type: none"> • Child is under age 21 (or younger, at state option). • Child does not meet applicable Title IV-E income standard, but has special need and would not be adopted without medical assistance. • Child must be eligible for or receiving Medicaid prior to adoption.
<p>In-home services are provided to children and families to protect children in their homes from abuse or neglect and to prevent their entry or re-entry to foster care using Title IV-B or other funds, such as the Social Services Block Grant (SSBG).</p>	<p>Not applicable</p>	<p>Mandatory or optional Medicaid pathways unrelated to child welfare, based on income or disability</p>

TABLE 3-3. (continued)

Type of child welfare assistance	Child is Title IV-E eligible	Child is not Title IV-E eligible
<p>Assistance for youth who have aged out of care provides financial, housing, counseling, education, employment, and other supports directly to youth using the Chafee Foster Care Independence Program or Title IV-B funds.</p>	<p>Not applicable</p>	<p>Mandatory Medicaid former foster youth pathway, based on the following criteria:</p> <ul style="list-style-type: none"> • Youth is under age 26 and aged out of foster care (either Title IV-E or non-Title IV-E) at age 18 (or older, at state option) and was receiving Medicaid. • No income or asset standard. • If youth is eligible for Medicaid under pre-Affordable Care Act (ACA) mandatory pathways, must enroll through those instead. • States have the option of covering youth who have aged out in other states. <p>Optional Medicaid Chafee pathway, based on the following criteria:</p> <ul style="list-style-type: none"> • Youth is under age 21 and aged out of foster care at age 18 (or older, at state option). • States can exclude non-Title IV-E foster youth. • States have the option to establish income and resource limits. • No requirements for youth to be enrolled in Medicaid or to have been in foster care in the same state in which they are currently residing.

Source: MACPAC and Stoltzfus 2015.

children leaving the child welfare system lose their mandatory eligibility through this pathway if they no longer receive Title IV-E funding. However, they may be eligible under another category—as a low-income child, for example. Maintaining coverage, even if the pathway changes, could help ensure ongoing care for these children’s health needs. Strong coordination across systems could help these children enroll in and maintain Medicaid coverage as their family situation changes.

Although most child welfare-involved children are covered by Medicaid, their pathway to eligibility and coverage varies by placement type. Estimates from the early 2000s indicate that of children in out-of-home care, 99 percent were covered by Medicaid, with 63 percent eligible because of their Title IV-E

status, and the remainder covered under another pathway, such as one based on their disability or low-income status. Even among children served in their homes, a majority, 84 percent, were covered under Medicaid (Libby et al. 2006).

Despite varying reasons for eligibility, children involved in the child welfare system are highly likely to remain insured. Specifically, one study found that over a three-year period, most (92 percent) of these children maintained some type of coverage even though the source of coverage (e.g., Medicaid or private) may have changed during this time period. Of those entering the child welfare system, 63 percent had Medicaid coverage, 26 percent had private insurance, and 10 percent were uninsured. After three years, the share of those with Medicaid

increased slightly to 67 percent, while the share of those who were uninsured declined to 6 percent (Raghavan et al. 2008). Coverage rates for those who have aged out of the child welfare system, however, have historically been lower. One study found, for example, that two-thirds of those aging out of foster care lost coverage at some point during the first two years following the transition (Raghavan et al. 2009). Another found that at age 26, fewer than 60 percent of youth who had aged out of foster care had insurance coverage; the majority of those who did have coverage were insured through Medicaid or the State Children's Health Insurance Program (CHIP) (Courtney et al. 2011).

States have established connections between Medicaid and child welfare agencies to ensure enrollment of children who are eligible on the basis of child welfare involvement. Almost all states have mechanisms in place to secure coverage immediately for children removed from their homes, such as through presumptive eligibility or through the co-location of agency staff (i.e., a Medicaid eligibility worker located at the child welfare agency office). For children who remain in their homes, however, responsibility for securing coverage often resides with the family, and there are fewer mechanisms in place between child welfare agencies and Medicaid to ensure coverage in such situations (Libby et al. 2006).

Other policies also affect continuity of Medicaid coverage for children with child welfare involvement. In the 23 states currently offering 12-month continuous eligibility, for example, coverage for these children will likely remain stable for at least a year (§1902(e)(12) of the Act and Brooks et al. 2015). Additionally, federal regulations require that states first attempt to renew coverage administratively. As such, for children maintaining connections to Title IV-E, the Medicaid agency should be able to renew their coverage without requiring any additional steps from the enrollees. Federal regulations also require that enrollees be screened for other Medicaid eligibility categories

prior to termination. This means that children who were categorically eligible because of their connection to the child welfare agency should be given an opportunity to enroll under another category before the state can disenroll them (42 CFR 435.916).

Given that the Title IV-E categories are subsumed by the low-income coverage categories, the question arises whether the mandatory child welfare group is still necessary. On the one hand, continuity of coverage may be eased if a child is able to enroll as a low-income child and remain enrolled as such despite child welfare involvement. This ongoing enrollment may also lead to consistent managed care enrollment, as some states have excluded children covered on the basis of child welfare from participating in mandatory managed care. On the other hand, maintaining the automatic ties to child welfare ensures that these children will be enrolled in coverage and eliminates the need for a separate Medicaid application. Additionally, although there is considerable overlap between the new mandatory eligibility pathway for youth aging out, the optional Chafee pathway may cover some youth not otherwise eligible. For example, under the Chafee option, there is no requirement for the youth to have been enrolled in Medicaid when they aged out of care (CMS 2013b).

Role of Medicaid for parents with child welfare agency contact. Caregivers, the majority of whom are parents living with their children, may also benefit from the receipt of Medicaid services. Parent caregivers are less likely to report being in good physical or mental health, and are more likely to suffer from depression, alcohol and substance abuse, and domestic violence than other types of caregivers (such as foster parents). These in-home parents also report relying on a number of services to address their family's basic living needs in addition to services required by the child welfare agency, such as parent skills training and treatment for a drug or alcohol problem. Based on data collected in 2008–2009, more than one-quarter (28 percent) of in-home parents reported receiving

mental health treatment—either inpatient or outpatient services or prescription medication, 13 percent said they received parenting skills training, and almost 3 percent reported receiving substance abuse treatment (Ringeisen et al. 2011).

Unlike their children who are eligible for Medicaid if they receive services under Title IV-E, parents do not automatically become eligible for Medicaid when their children come in contact with the child welfare system. Since many states continue to use their old AFDC standards to set Medicaid eligibility thresholds for parents, some of them may be income eligible; however, because eligibility for Medicaid as a parent requires the adult to be living with a dependent child, a parent would not be eligible if the child were removed from the home. Additionally, the expansion of Medicaid to low-income adults, a provision of the ACA that has been adopted by more than half of all states, may allow many parents in families who come to the attention of child welfare agencies to gain coverage (MACPAC 2015b). Enrollment in Medicaid provides an opportunity for a child welfare agency to facilitate access to mental health, substance abuse, or other Medicaid-supported services as needed. Even if family members are not eligible for Medicaid, services such as family therapy or parenting education may be covered by the program if they are medically necessary for a Medicaid-enrolled child and are directed exclusively to the treatment of the child (Perkins 2002).

Medicaid benefits

In light of the significant health care needs of child welfare-involved youth, a wide range of Medicaid-covered services may be necessary and appropriate to treat their physical and behavioral health conditions.

Covered benefits. For all children under age 21, whether or not they are involved in the child welfare system, Medicaid’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit requires Medicaid coverage of any

service allowed under Section 1905(a) of the Social Security Act that is determined medically necessary to ameliorate a physical or behavioral health condition (CMS 2014a). As discussed later in this chapter, however, low EPSDT screening rates are a concern for both child welfare-involved youth and the broader population of children enrolled in Medicaid. Services delivered to the family, such as family therapy and parenting education, may be covered under EPSDT, but they must be directed exclusively to the treatment of the child (Perkins 2002). The EPSDT benefit is subject to the same rules as most Medicaid services, which generally require states to offer the same coverage to all enrollees (comparability), in all geographic areas (statewideness), and through any participating provider (freedom of choice).⁷ States may use waiver authority or other statutory Medicaid provisions to cover the relatively few benefits for children that are above and beyond those required under EPSDT, such as respite services that provide parents with a temporary break from caregiving duties, or to target services in ways that might not otherwise be permitted (CMS 2014g, CMS and SAMHSA 2013).

For all children under age 18, regardless of child welfare status, there are no premiums and no cost sharing for services covered by Medicaid (42 CFR 447.56). For those age 18 or older who are receiving foster care or Title IV-E adoption assistance, the exemption from premiums and cost sharing is extended until their child welfare assistance ends.

Service delivery and care coordination. For children involved with the child welfare system, having a care coordinator who is familiar with their ongoing health needs is particularly important in light of the numerous changes in guardianship and living arrangements they may face. Child welfare agencies have specific health care oversight and coordination responsibilities for children in foster care and provide supports for other child welfare-involved youth, such as those who are receiving adoption assistance or services to help their

families avoid an out-of-home placement. However, because Medicaid is the primary payer of health care services for these children, the program's service delivery and care coordination models can play an important role for them.

State Medicaid programs are increasingly contracting with managed care plans to provide a given set of benefits defined by the state. In this arrangement, plans generally take responsibility for provider networks, care coordination activities, utilization management policies, and provider payments. In most cases, the plans are paid a per-member-per-month capitation rate and are at risk of financial loss if their costs exceed their payments from the state. In 2012, eight states had mandatory managed care enrollment of children in foster care (which may include an ability to opt out at any time), while other states had voluntary enrollment or specifically excluded these children from managed care (Gonyea et al. 2015, CMS 2014c). Depending on the circumstances, states may have specific managed care policies and plans may have particular design features aimed at child welfare-involved youth and other children with special health care needs. Examples include the use of dedicated child welfare liaison staff, case managers, and specialized provider networks; establishment of family and community group relationships; and risk adjustment of state payments to plans to reflect higher service use and spending for enrollees with complex conditions (Allen 2008). However, inclusion of these features varies within and across states. For example, a state may require that all of its Medicaid managed care plans meet heightened requirements for children in foster care and other children with special needs, that they enroll these children in a subset of plans that are certified to meet particular requirements, or that they use pediatric special needs plans that have been designed to serve specific child populations (Dutton et al. 2013).

Another approach to service delivery taken by many states is to implement some version of a medical or health home that uses teams of providers to

coordinate care and assist Medicaid beneficiaries in accessing services.⁸ States that meet specific Medicaid health home requirements for individuals with chronic conditions—such as children with serious emotional disturbance, including child welfare-involved youth—can receive two years of 90 percent federal match for health home services provided to those individuals (Moses et al. 2014, CMS 2010).⁹ However, as with other Medicaid services, in order to avoid duplication of effort, states must take care to differentiate the case management services provided by child welfare agencies from those provided by a health home. In addition, customized approaches may be needed for child welfare-involved youth whose needs extend beyond traditional office-based services to include specialty behavioral health care provided in family or community settings, as well as coordination with child welfare agencies, the juvenile justice system, schools, and other systems and institutions (CHCS 2014). Policies regarding Medicaid's role in facilitating access to these services vary from state to state.

Medicaid service use

In 2010, the share of children eligible for Medicaid on the basis of foster care assistance who used any type of Medicaid service was 89.3 percent, which is comparable to the 85.0 percent share of other children enrolled in Medicaid (SAMHSA 2013a).¹⁰ However, the amount and types of services used by the child welfare population differ substantially from services used by their peers. For example, children eligible for Medicaid based on foster care assistance had longer inpatient stays than other children in Medicaid (31 days compared to 6 days); this may be due in part to their use of residential treatment centers and other rehabilitation facilities that may provide care for an extended period of time (SAMHSA 2013a).

Additionally, among Medicaid-enrolled children with at least one visit in 2010, those eligible based on foster care assistance had many more outpatient visits per year (an average of 27) compared to

other children (an average of 9) (SAMHSA 2013a). This differential may be driven in part by ongoing contact with behavioral health professionals, given that nearly half (48.2 percent) of children enrolled in Medicaid based on foster care assistance used outpatient services for which mental health was the primary diagnosis, compared to a much smaller share (12.8 percent) of other children in Medicaid (SAMHSA 2013a). Additional data indicate that the share of children in Medicaid with a behavioral health diagnosis is nearly as high among those who are eligible for the program based on child welfare assistance as it is among those who are eligible based on a disability (see Chapter 4).

Among children enrolled in Medicaid on the basis of foster care assistance who used behavioral health services in 2005, individual therapy was the most common outpatient treatment, with 61 percent using it.¹¹ This was followed by psychotropic medications (49 percent); screening, assessment, and evaluation services (41 percent); medication management visits (28 percent); and family therapy or education and training (20 percent) (Table 3-4). In contrast, a smaller share of these children received non-traditional services that are often family-centered and provided in home- and community-based settings, such as therapeutic foster care (3 percent) and intensive care coordination services through a wraparound model (1 percent). However, due to differences in coding and billing across states, the use of non-traditional services may be understated if they are embedded in other categories, such as psychosocial rehabilitation (Pires et al. 2013b).

In addition, about one-quarter of children enrolled in Medicaid based on child welfare assistance have psychotropic drug prescriptions filled during the year (see Chapter 5). Among children who are enrolled in Medicaid based on foster care assistance, about half of those with psychotropic drug use have prescriptions filled from two or more psychotropic drug classes and nearly 20 percent have prescriptions filled from three or more drug classes. These medications could be

taken simultaneously or at different points during the year (Pires et al. 2013b). One source that examined concurrent use indicates that 13 percent of these children took three or more psychotropic medications at the same time (GAO 2012). Although estimates vary from about 20 to more than 30 percent, a substantial number of children in foster care using psychotropic medications do not receive identifiable behavioral health services in addition to such medication (Pires et al. 2013b, GAO 2012).¹² Others may receive both medication and behavioral health services, but could benefit from more applicable or evidence-based therapies (GAO 2014). (See Chapter 5 for an examination of psychotropic medication use and spending.)

Medicaid eligibility systems do not routinely collect child welfare information as part of the income-based enrollment process, although some states do use such information to create flags that identify children with special needs (Allen et al. 2012). Therefore, using Medicaid data alone, it is difficult to identify child welfare-involved youth for whom Medicaid eligibility is based on family income rather than their receipt of child welfare assistance. These children, many of whom remain in their homes while receiving child welfare services, may have lower levels of health care use and spending than children in foster care or other out-of-home placements. For example, while 80 percent of children in foster care are estimated to have mental health needs, one study found that 48 percent of the overall child welfare population had mental health needs due to emotional or behavioral disorders and that only 16 percent used mental health services (GAO 2012, Burns et al. 2004). In addition, among the overall child welfare population, an estimated 14 percent take psychotropic medications, a much smaller share compared to children in foster care (Raghavan et al. 2005).

TABLE 3-4. Children in Medicaid Using Behavioral Health Services by Service Type and Basis of Eligibility, 2005

Service type	Foster care ¹	TANF or low income	SSI or disabled	Total
Outpatient treatment (primarily individual)	61.3%	53.0%	46.6%	53.1%
Psychotropic medication	49.3	37.9	61.2	43.8
Screening/assessment/evaluation	41.4	42.4	34.8	40.9
Medication management	27.7	18.9	30.6	22.3
Family therapy/family education and training	20.2	19.8	17.3	19.4
Substance use outpatient	13.6	10.4	8.7	12.4
Psychological testing	12.7	8.3	10.4	10.5
Psychosocial rehabilitation	11.5	11.5	16.5	13.8
Targeted case management	10.0	5.9	9.2	7.6
Group therapy	9.1	7.1	8.0	8.7
Initial service planning	8.4	8.4	10.8	9.3
Case management	7.6	8.0	12.0	8.8
Residential treatment/therapeutic group homes	6.1	2.7	5.0	3.9
Inpatient psychiatric treatment	5.1	2.8	3.8	3.5
Crisis intervention and stabilization (non-emergency room)	4.5	3.1	3.9	3.6
Partial hospitalization/day treatment	4.2	2.7	4.6	3.3
Behavior management consultation and training	4.1	3.4	5.5	7.1
Substance use screening and assessment	3.6	3.1	1.8	3.1
Therapeutic foster care	3.0	0.3	0.7	0.8
Mental health consultation	2.5	2.8	4.6	3.3
Therapeutic behavioral support	2.4	0.4	0.9	1.1
Wraparound	1.1	0.8	2.4	2.9
Substance use, inpatient	0.3	0.3	0.2	0.3
Respite	0.3	0.2	0.4	0.3
Supported housing	0.2	0.2	0.2	0.2
Emergency room	0.2	0.1	0.1	0.1
Transportation	0.1	0.0	0.2	0.1
Home-based (e.g., in-home services)	0.1	0.1	0.1	0.1
Activity therapies	0.1	0.1	0.1	0.1
Multisystemic therapy	0.1	0.0	0.0	0.0
Peer services	0.0	0.0	0.3	0.1
Telehealth	0.0	0.0	0.0	0.1

Notes: TANF is Temporary Assistance for Needy Families. SSI is Supplemental Security Income. Analysis based on Medicaid Analytic eXtract (MAX) data. Includes children with at least one claim for behavioral health services, with or without psychotropic medications use; does not include children with psychotropic medications use and no other behavioral health service claim. See source for full information on data and methods.

¹ Source refers to children with a foster care basis of eligibility. However, additional children eligible for Medicaid based on adoption or certain other child welfare assistance are included in the MAX data analyzed, which are derived from Medicaid Statistical Information System (MSIS) data reported by states to the federal government (see Appendix Table 3A-1).

Source: Pires et al. 2013b.

Medicaid spending for children eligible based on child welfare assistance

Spending on Medicaid benefits for children enrolled based on child welfare assistance totaled \$5.8 billion in FY 2010, or about 2 percent of benefit spending for all enrollees and 9 percent of spending for non-disabled children (MACPAC 2015a). Medicaid benefit spending per child enrolled on the basis of child welfare assistance was \$5,767, compared to \$2,000 per non-disabled child and \$14,216 per child under age 21 enrolled on the basis of disability (MACPAC 2015a). Managed care, including both comprehensive and limited-benefit plans (such as those specializing in behavioral health), accounted for 18 percent of the Medicaid benefit spending for children enrolled based on child welfare assistance in FY 2010, up from 9 percent in FY 2001 (Stoltzfus et al. 2014).

The broader population of children in Medicaid who are identified as maltreated or as being at risk of maltreatment (defined as those who are investigated or assessed by local child protective services agencies regardless of whether their case was substantiated) have higher costs than children who do not come into contact with the child welfare system. Specifically, one study estimated that children who were maltreated or at risk of being maltreated incurred Medicaid expenditures that were on average more than \$2,600 higher per child per year than the expenditures for children not maltreated or at risk of being maltreated. The authors estimated that these higher costs (i.e., additional spending above what would otherwise be expected) reflected 9 percent of Medicaid spending for non-disabled children (Florence et al. 2013).

Medicaid and child welfare agencies' division of responsibilities for children's health

As noted earlier, child welfare agencies are required to ensure that the health needs of children in foster care are met, but they may not expend

Title IV-B or Title IV-E funds to meet these needs. The state Medicaid agency accepts the Title IV-E determinations of eligibility and funds a wide range of medical, behavioral health, and supportive services for these youth. Medicaid, however, may not pay for room and board costs associated with care in family, group home, or residential treatment settings because these costs are paid for by state child welfare agencies, either through Title IV-E or another funding source.

The child welfare agency is also responsible for regularly reviewing and updating the agency's health record for each child in foster care (§475(1)(C) and 5(D) of the Act). In addition, through Title IV-B, a state must ensure that the child welfare and Medicaid agencies develop a plan for the oversight and coordination of health care services for children in foster care (§422(b)(15) of the Act).¹³ Such plans are intended to identify and respond to the health needs—including mental and dental health—of children in foster care, and must outline the schedule for initial and follow-up health screenings and how any needs identified through the screenings will be addressed.¹⁴

Health oversight plans must also describe how to update and share relevant health information for children in foster care, and how to ensure continuity of care for them. Plans must list the necessary steps that ensure the health needs of youth are addressed if they are transitioning out of the child welfare system. Since 2011, health oversight plans are also required to include details on the oversight of prescription psychotropic medications (Stoltzfus et al. 2014).¹⁵ There is no specific requirement for a health oversight plan for child welfare-involved children who are not in foster care, but many who are receiving adoption assistance would previously have been in foster care, and children who are receiving services to help their families avoid an out-of-home placement may obtain a general needs assessment as part of their contact with the child welfare agency.

As children enter the system, the child welfare agency has overall responsibility for ensuring that their health, behavioral, and social needs are met. The agency conducts a broad child-and-family needs assessment as part of the investigation and develops a case plan to ensure that the child is placed in a safe home and that services are provided to the child, the parents, and the foster parents (if applicable) to improve the conditions within the home to either prevent the child's removal or enable reunification (§475(1) of the Act and 45 CFR 1356.21(g)).

A clinician typically carries out the physical and mental health screenings and assessments. The American Academy of Pediatrics (AAP) recommends that children be seen by a health care professional for a health screening within 72 hours of placement, although ideally within 24 hours of removal. Within 30 days, children should have a comprehensive mental health, developmental, educational, and dental health evaluation and get a follow-up appointment within 60 to 90 days (AAP 2005, Allen 2010).¹⁶

However, as of 2010, not every state was meeting these guidelines. Nearly all states require physical health screenings and about two-thirds require physical, behavioral, and oral health screenings. Many states do require more thorough, in-depth assessments when necessary, but only 35 require assessments across all three areas. Finally, there is wide variation in terms of whether states have established timelines for the screenings and assessments as well as the length of any prescribed time frame (Allen 2010).

Selected Policy Issues

There are concerns about continuity of coverage and receipt of timely and appropriate care for all children enrolled in Medicaid, but concerns about children involved in the child welfare system are heightened in light of their substantial health needs. While studies indicate that continuity of

coverage for children currently involved in the child welfare system is high, for youth who have aged out of care, coverage rates are much lower. Identifying these youth and enrolling them in Medicaid can be challenging, and beneficiaries face an array of different state eligibility policies regarding documentation and prior out-of-state foster care placements. In addition, there may be gaps in needed care if a condition goes unidentified as a child moves between homes or duplication of services because a provider is unaware that a screening or assessment has been conducted.

Service use and access to care present other challenges. Missed health screenings are a concern for children in foster care, and state Medicaid agencies can do more to inform caregivers about the availability of services. States can also help to reduce unmet needs for mental health care and inappropriate psychotropic medication use among child welfare-involved youth by implementing explicit Medicaid coverage policies for care that expands beyond traditional services such as outpatient therapy, residential treatment, and prescription drugs. In addition, the importance of collaboration between Medicare and child welfare and other agencies cannot be overstated, given that the vast majority of child welfare-involved youth are eligible for Medicaid-financed services and care coordination.

Implementation of the new pathway for youth aged out

As discussed earlier, coverage rates for young adults who have aged out of the child welfare system have historically been lower than coverage rates for children currently involved in the child welfare system or young adults the same age, but with no involvement in the child welfare system.¹⁷ Although the new mandatory Medicaid eligibility pathway for former foster youth established under the ACA should increase coverage, problems with implementation could affect the size of these gains.

Identifying and enrolling these youth can be challenging. As youth age out of the system, child welfare agencies are required to develop a transition plan that includes specific options related to health insurance coverage, but there is no requirement that the agency ensure enrollment in Medicaid or another coverage source (Stoltzfus 2014). For those who have already aged out, the process of connecting to Medicaid may be more difficult and require targeted outreach. Additionally, caseworkers (in both child welfare and Medicaid agencies) and youth themselves may be unaware of the new coverage pathway and the requirements for application. A recent examination of the implementation of the Chafee option found that few Medicaid staff were knowledgeable about the pathway, in part, because it represented such a small share of the overall Medicaid program (Pergamit et al. 2012). As such, education for both agency staff and youth involved in the system will be important.

In order to be eligible as a former foster youth under the pathway discussed above, these young adults must not be eligible for or enrolled in another mandatory category. States must therefore confirm that an applicant is not eligible as a low-income child, parent, or pregnant woman prior to enrollment on the basis of being a former foster youth, a requirement that will also need to be met at renewal (CMS 2013a).¹⁸ If the state can check existing data sources, such as for income, the former foster youth may have their eligibility renewed administratively without having to submit any additional information.

The level of documentation required from the youth in order to enroll varies. States have a great deal of flexibility regarding verification of former foster care status, for example, by accepting self-attestation of the youth's status (42 CFR 435.956). The regulations also specify that the paper documentation cannot be required unless electronic data to verify the individual's status as a former foster care individual is not available. States that do not currently have an electronic data source could use the enhanced federal matching

rate (90 percent) to develop such a system as discussed in more detail below. In states relying on documentation for verification of former foster care status, the requirement may be more cumbersome and may result in lower coverage and retention rates, especially for those formerly in foster care who have already left the system and may not have easy access to documentation. For example, under the Chafee option, youth in states that required documentation at renewal had lower recertification rates than youth in states that did not require documentation (Pergamit et al. 2012).

Finally, coverage may not be available to youth who have aged out of care if they move between states. In proposed regulations, the Centers for Medicare & Medicaid Services (CMS) has interpreted the statute to allow, but not require, states to cover former foster youth from other states (CMS 2013a, 2013c).¹⁹ As of January 2015, only 12 states had adopted this option (Brooks et al. 2015). While sharing former foster care status across states may be difficult, states may have a flag on those who are eligible for Medicaid on the basis of Title IV-E within their systems that could facilitate such an exchange. However, this flag only includes those children eligible on the basis of Title IV-E status, and not all those with foster care involvement who would be covered through the new pathway. As found in the managed care environment and discussed elsewhere, it has been challenging for Medicaid to identify all children in foster care (Allen et al. 2012). To facilitate coverage of these youth, CMS could revise its interpretation of the requirement in the final rule, or Congress could amend the statute to require coverage for youth who have aged out in any state or provide incentives for states to cover these youth.

Receipt of EPSDT screenings

Routine screening services that are required under Medicaid's EPSDT benefit for all individuals under age 21 are separate from child welfare agency-directed screenings that children may receive if they are removed from their homes. These periodic

EPSDT benefit screenings are key to identifying physical and behavioral health conditions and for referring children to follow-up treatment, but are commonly delayed or missed for children in foster care. The Office of Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS) recently reported that nearly a third of children in foster care who were enrolled in Medicaid did not receive at least one required EPSDT health screening, and that just over a quarter received at least one required screening late (OIG 2015).²⁰ Low EPSDT screening rates are also an issue for the broader population of children enrolled in Medicaid (OIG 2014, 2010).

In interviews with officials from several states, the most frequently cited barriers to receipt of preventive screenings for the overall population of children covered by Medicaid were cultural or family attitudes and circumstances, although problems with provider access and incorrect beneficiary contact information were also noted (OIG 2010). For children in foster care, several OIG reports found that some caregivers were not familiar with the Medicaid program's covered services or its schedule for EPSDT examinations, indicating that better communication regarding Medicaid coverage may be warranted. (See individual reports for states listed in OIG 2005.) Although the OIG indicated that health oversight and coordination for children in foster care is a child welfare agency responsibility, state Medicaid agencies may go beyond the federal minimum requirement to notify parents and caregivers within 60 days of an eligibility determination about the availability of EPSDT services (OIG 2015, 2010).

Coverage for behavioral health and other specialized services and providers

Based on data collected in 2009–2011, nearly one-third (30 percent) of children in foster care with a potential mental health need had not received any mental health services in the past year or since

the start of their living arrangement, if less than 12 months (GAO 2012). In addition, numerous studies have cited concerns about inappropriate prescribing of psychotropic drugs for child welfare-involved youth (see Chapter 5). The EPSDT benefit requires Medicaid to cover a wide range of services for children—including those that may reduce the need for psychotropic medications—when they are deemed medically necessary, but actual receipt of those services depends on the degree to which states have policies and infrastructure in place to facilitate access.

State Medicaid coverage of behavioral health care that extends beyond traditional services such as outpatient therapy, residential treatment, and psychotropic medication may increase as evidence regarding the clinical, functional, family, and cost impacts of non-traditional or alternative services grows (Pires et al. 2013a). Examples of alternative services for children in the child welfare system include intensive care coordination (often provided through what is referred to as a wraparound model, or ICC/wraparound), family and youth peer supports, mobile crisis response and stabilization teams, intensive in-home services for children remaining with their families, therapeutic foster care for those in out-of-home placements, and trauma-informed screenings and therapies (Davis and Maul 2015, Simons et al. 2014, Boyd 2013, Pires and Stroul 2013). States may also work to ensure that their provider networks include qualified trauma-informed pediatric mental health professionals and other individuals who are knowledgeable about the child welfare population (ACF et al. 2013, AAP 2013). In the case of preventive services, such as home visiting and parenting education programs, CMS recently clarified that a broad set of providers are eligible to receive Medicaid funding as long as their services are recommended by licensed practitioners; regulations previously permitted funding only for preventive services that were delivered by licensed practitioners themselves (CMS 2013b, TFAH and Nemours 2013). Because Medicaid funding is only available for services that are not the legal

obligation of another program or payer, states must take care to differentiate responsibility and costs for services where there may be overlap between required child welfare agency functions and available Medicaid benefits. Medicaid's targeted case management and health home benefits are examples of services for which coordination and overlapping responsibilities must be addressed.

The Medicaid EPSDT benefit has been the subject of litigation brought against states, due in part to variation in state interpretation and implementation of the benefit's requirements (Perkins 2009). In practice, a child's access to Medicaid services—even services that have been identified through an EPSDT screening as medically necessary—may be affected when states lack explicit coverage policies for specific treatments (for example, in provider manuals that contain service descriptions and billing codes), when they impose payment restrictions on covered benefits (including the types of providers who may bill for a service), or when they have shortages of participating clinicians who specialize in particular physical or behavioral health issues. Informational and technical assistance resources are available to states at the federal level to improve behavioral health services (including a variety of guidance letters issued to states in recent years), but it is each state's policies that ultimately govern Medicaid payment of specific services for children and youth with behavioral and other health needs (CMS and SAMHSA 2015, 2013; SAMHSA 2013b; ACF et al. 2013, 2011).

Even when the services Medicaid covers are clearly defined, children in managed care might not receive all of their services through a single plan. Receiving services through a combination of managed care and fee-for-service coverage can be confusing and difficult to navigate. In addition, if provider networks change, child welfare-involved youth may experience disruptions in care or lose access to providers who are most familiar with their needs as they transition between managed care plans (for example, when they move between homes in

different locations) or between fee-for-service and managed care coverage (for example, when they are excluded from managed care enrollment while in foster care but mandatorily enrolled after exiting foster care to reunite with family) (Dutton et al. 2013).

States generally cannot provide certain benefits only to children involved with the child welfare system, despite their high levels of need and potential to benefit from specialized care. Instead, services must be based on individual assessments of medical necessity, and all children with similar health needs must be provided the same level of assistance on a statewide basis. For example, if a state Medicaid program covers therapeutic foster care, which places children who have severe behavioral health issues with specially trained foster families supported by licensed clinical staff, then the state must also indicate how similar services are covered for children who have not been removed from their homes.²¹ The ability to offer specific benefits to the child welfare population is one reason that states may maintain non-Medicaid funding of certain services (see discussion of financing later in this chapter).

Care coordination

Although child welfare agencies are ultimately responsible for monitoring and oversight of the health of children receiving their assistance, Medicaid investments can play a key role given that most of these children are eligible for Medicaid-financed services and care coordination.

As noted earlier, 90 percent federal match is available for Medicaid health homes for individuals with chronic conditions, including children with serious behavioral health needs, but this enhanced match is limited to two years and an increase in state funding is required to maintain the benefit at a regular matching rate beyond that point. Care coordination services may also be covered by Medicaid under other statutory authorities. For example, several states use different Medicaid and

non-Medicaid funding authorities to provide similar services involving ICC/wraparound, an approach that incorporates a dedicated care coordinator working with a small number of children and families to holistically address their health and social needs (Simons et al. 2014, CHCS 2013). Massachusetts, New Jersey, and Wyoming provide ICC/wraparound services financed by Medicaid through the program's targeted case management benefit. Louisiana, Michigan, and two counties in Wisconsin use Medicaid managed care authorities. Others with established ICC/wraparound programs, including Nebraska and one county in Ohio, do not currently employ Medicaid funding for those programs.

Cross-agency collaboration

While collaboration across systems may be required for Medicaid beneficiaries receiving ICC/wraparound services, collaboration at the agency level is also needed to improve care for the broader population of child welfare-involved youth. For example, Tennessee's Department of Child Services and TennCare, the state Medicaid agency, have an interagency agreement with specific provisions to coordinate the enrollment of and ongoing provision of health services to all children in state custody (Allen and Hendricks 2013). In Michigan, staff members in community mental health agencies receive training on serving children in child welfare, often from child welfare agency staff or foster parents; child welfare agency staff, in turn, receive training from mental health agencies on various behavioral health services and the specifics of the state's Medicaid home and community-based services waiver for children with serious emotional disturbances (Pires et al. 2013a).

Specific efforts have also been undertaken to address inappropriate psychotropic drug use. These include a quality improvement collaborative among six states to develop and implement new approaches to psychotropic medication use, as well as the establishment of a federal interagency working group, the provision of guidance to states,

and a summit that convened state directors of child welfare, Medicaid, and mental health agencies (see Chapter 5). The President's budget for FY 2016 also proposes a joint Administration for Children and Families and CMS effort that would provide funding to encourage evidence-based psychosocial interventions and reduce over-prescription of psychotropic drugs, which could be achieved in part through explicit coverage of specialized behavioral health services by state Medicaid programs.

Financing

In order to maximize the availability of funding for services provided to child welfare-involved youth, state dollars previously allocated for child welfare programs may be used as nonfederal share to draw down federal Medicaid funding (Pires and Stroul 2013). In Arizona and Michigan, for example, the child welfare system contributed funds to the Medicaid behavioral health system as Medicaid match, allowing the state to draw down additional federal Medicaid dollars to generate more resources for services. New Jersey identified behavioral health services previously supported solely with state dollars that could be incorporated into the Medicaid plan, allowing the state to capture federal funding for these services. Although Medicaid funding is available for a wide variety of services, it can only pay when third parties—including public programs that are not explicitly designated as payers of last resort after Medicaid (such as Ryan White HIV/AIDS, Title V Maternal and Child Health Block Grant, Indian Health Service, and Individuals with Disabilities Education Act programs), private insurers, and certain other entities—do not have a legal obligation to do so (CMS 2014d, 2014f). As a result, states may only claim federal Medicaid funding for services that are not the specific responsibility of a child welfare agency. This limitation is in addition to the requirement that states abide by Medicaid's rules for comparability, statewideness, and freedom of choice noted earlier.

In light of these requirements, states may wish to retain non-Medicaid financing of certain services provided to child welfare-involved youth. Reasons include a desire to provide services to targeted groups of children, to vary services by locality within the state, and to use a limited set of health care providers who specialize in the needs of the child welfare population—all of which may be possible under Medicaid waiver authority, but difficult to achieve without Medicaid and child welfare agency collaboration.

Data availability and sharing

For children eligible for Medicaid on the basis of child welfare assistance, Medicaid agencies accept child welfare determinations of eligibility. State Medicaid agencies can facilitate data sharing by taking advantage of Medicaid's 90 percent federal match for upgrades to both the Medicaid and non-Medicaid components of integrated eligibility systems. Such upgrades require considerable planning and resources, and only a small number of states may be actively considering the inclusion of child welfare agency systems in their plans for integration.²² Prior to the ACA, the majority (45) of state Medicaid eligibility systems were integrated with assistance programs such as the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF). As states implemented new ACA eligibility determination and enrollment processes for Medicaid and upgraded or built new eligibility systems, many delinked Medicaid from these other programs due to the large scale of the changes. As of January 2015, 19 states had integrated systems that administered eligibility for Medicaid and other benefit programs and another 12 indicated that they planned to phase in other assistance programs in 2015 or beyond (Brooks et al. 2015).

In April 2015, CMS issued a proposed rule that would permanently extend the availability of 90 percent federal match for the development of new eligibility and enrollment systems (currently set to expire at the end of 2015) and 75 percent match

for their ongoing operations (CMS 2015). CMS also announced an extension through 2018 of a waiver of cost allocation rules that ordinarily require other human services programs, such as child welfare agencies, to share with Medicaid the cost of building integrated eligibility systems. However, the other programs are still responsible for costs associated with non-Medicaid functions that are specific to their particular needs (CMS 2014e).

Other data sharing efforts relate to electronic health records (EHRs), which are used to facilitate electronic health information exchange among health care providers and to provide foster parents and emancipated youth with a complete record of health conditions and service use (Carillo and Ashton 2013). State and local agency staff may also be involved in health information exchange (TCP 2014a, TCP 2014b). Such information can help inform the types of care that may be needed and can help avoid unnecessary services, such as duplicative diagnostic tests and immunizations. Reports by the OIG indicate that foster parents do not always receive information on the medical conditions and previous service use of the children in their care, a problem that could be mitigated in part through EHR and health information exchange efforts (OIG 2005).

However, given the complexity of laws governing the providers and entities who may legally share health information and the situations in which written consent may be required, some have suggested that better models for allowing treatment teams to share information on child welfare-involved youth and other children enrolled in Medicaid are needed (Thorpe and Rosenbaum 2013). Technological issues also need to be addressed because EHR portals may sometimes allow access by only one individual and only to a child's full record, making it difficult to share appropriate levels of information with the multiple caseworkers and caregivers who may have responsibility for the child over time (Szilagyi 2015).

Conclusion

The needs of child welfare-involved youth are substantial, and state Medicaid programs play a major role in meeting those needs along with child welfare agencies, the juvenile justice system, schools, and other systems and institutions. The Commission supports continued federal oversight and guidance in this area, and encourages states to evaluate how Medicaid policy changes could help to improve the health and well-being of child welfare-involved children and youth. This is a complex area, but given the vulnerability of these children, MACPAC will continue to assess ways in which their care needs could be better addressed by Medicaid.

The Commission also recognizes that the broad challenges Medicaid faces in providing timely, appropriate, and coordinated care for these children are not unique. For example, as noted in this chapter, low EPSDT screening rates are a concern for the overall population of children enrolled in Medicaid. In addition, as described in Chapter 4, the share of Medicaid beneficiaries with behavioral health conditions is large, and many beneficiaries—particularly nonelderly adults with serious mental illness—report not receiving needed mental health services. And similar to child welfare-involved youth who may receive services through multiple programs, beneficiaries who are dually eligible for Medicaid and Medicare make up another population for whom fragmented financing and delivery systems may increase costs and lead to poor health outcomes (MACPAC 2015c, 2015d). As the Commission monitors these issues, it will continue to highlight the needs of particularly vulnerable populations—including child welfare-involved children and youth—and consider areas where Medicaid policy recommendations may be warranted.

Endnotes

- ¹ Youth are considered to have aged out of foster care if they are in care as of their 18th birthday or up to their 21st birthday, at state option.
- ² The goal of permanency is to ensure that children have a stable and loving family. In the child welfare context, this could mean reuniting them with their biological parents or placing them with another permanent family either through an adoptive or guardianship arrangement.
- ³ This \$8 billion represents federal dollars dedicated to child welfare purposes only. States also use other sources of federal funds, such as Temporary Assistance to Needy Families (TANF) and Social Services Block Grant (SSBG), to provide significant support (as much as \$5.3 billion) to child welfare activities. The federal matching rate for state child welfare spending varies depending upon the source. For example, states need to match at least 25 percent of spending for the Stephanie Tubbs Jones Child Welfare Services Program, with a larger share required if the agency does not meet certain performance standards (Stoltzfus 2015a).
- ⁴ Children are most often ineligible for Title IV-E funding due to the income in the home from which they are removed or because they are placed with an unlicensed caretaker (typically a relative). These children must be provided most of the same protections as those eligible for Title IV-E, but are not entitled to a monthly maintenance payment, and do not have guaranteed Medicaid eligibility. Estimates suggest that between 40 and 50 percent of children in foster care settings are receiving Title IV-E maintenance payments and about three-quarters of children adopted from foster care are receiving Title IV-E payments (ACF 2015, DeVooght et al. 2014).
- ⁵ Among the children leaving foster care for adoption, 44,000 (85 percent) were determined to have special needs. The primary special needs conditions include: member of a sibling group (31 percent), a medical condition or mental, physical or emotional disability (24 percent), age (16 percent), and racial or ethnic origin (10 percent) (Stoltzfus 2015b).
- ⁶ Phasing out of the income, asset, and deprivation tests began in FY 2010. States are phasing out the standards

primarily based on age as well as for any child who has been in foster care for at least 60 continuous months. As of FY 2015, the tests do not apply to a child who has been determined to have a special need who is at least 6 years old. Siblings of children who meet the age or length of stay criteria are also exempt from the income standard if they are placed in the same home as their sibling.

⁷ For individuals in managed care plans the choice of providers may be limited to those in the plan's network, but individuals generally must be offered a choice of at least two managed care plans when enrolling.

⁸ Other examples include primary care case management (PCCM) programs that assign beneficiaries to primary care providers who provide varying levels of assistance with locating, coordinating, and monitoring services in exchange for a small monthly capitation fee, and accountable care organization (ACO) models whose definitions vary but generally reflect provider-based organizations that assume responsibility for clinical and financial outcomes for a defined population (CMS 2014b). These models are not mutually exclusive and may include a variety of contracting and payment arrangements between states, providers, and other entities. For example, managed care plans may pay PCCM fees or use medical homes, and states may use managed care plans and PCCM programs in different geographic areas.

⁹ Specifically, a state may receive 90 percent match for the first eight quarters beginning on the effective date of its health home state plan amendment.

¹⁰ The SAMHSA analysis refers to children with a foster care basis of eligibility. However, it is possible that additional children eligible for Medicaid based on adoption or certain other child welfare assistance were included in the MarketScan data obtained from states, as is the case with federal Medicaid Statistical Information System (MSIS) data reported by states to the federal government (see Appendix Table 3A-1).

¹¹ The source for this figure and those that follow (Pires et al. 2013b) refers to children with a foster care basis of eligibility. However, additional children eligible for Medicaid based on adoption or certain other child welfare assistance are included in the Medicaid Analytic eXtract (MAX) data analyzed, which are derived from Medicaid Statistical

Information System (MSIS) data reported by states to the federal government (see Appendix Table 3A-1).

¹² The 20 percent figure is based on Figure 1 in GAO 2012 and reflects the share of children in foster care with a potential mental health need whose only mental health treatment was administration of medications (9 percent) divided by the share who had either medications only or a combination of medications and services (42 percent). The more than 30 percent figure is based on Exhibit 37 in Pires et al. 2013b and reflects the share of children enrolled in Medicaid based on foster care assistance with psychotropic drug prescription fills who received exclusively physical health services (21 percent) or indeterminate services that were not clearly identifiable as behavioral health or physical health (11 percent).

¹³ The Health Oversight and Coordination Plan was established through section 205 of the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351). Requirements related to youth transitioning out of care were added by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), and provisions that require protocols for the use of psychotropic drugs were added by the Child and Family Services Improvement and Innovation Act (P.L. 112-34).

¹⁴ This differs from the periodicity schedule established under the Medicaid EPSDT benefit, which is required for all Medicaid enrollees. The child welfare-developed schedule of screenings and assessments applies only to those children served by the child welfare agency and would apply regardless of whether the child was enrolled in Medicaid. However, the state child welfare agency may base these guidelines on those that govern EPSDT benefits.

¹⁵ The Administration for Children and Families (ACF) also conducts biennial reviews of child welfare agencies that require each state to have guidelines for initial, ongoing, and periodic health screenings for children entering foster care.

¹⁶ Guidelines have also been developed by the Child Welfare League of America and the American Academy of Child and Adolescent Psychiatry.

¹⁷ Young adults have historically been the most likely to be uninsured. In 2010, the rate of uninsurance among individuals age 19–25 was 29.8 percent. This rate has

declined significantly to 27.7 percent, since implementation of the policy to allow young adults to remain on their parents' health insurance coverage until age 26 (ASPE 2012).

¹⁸ The regulation implementing the provisions regarding the new ACA eligibility pathway for former foster youth to be covered up to age 26 has not yet been finalized.

¹⁹ This interpretation is based on a reading of Section 1902(a)(10)(IX)(cc) of the Act, which says that states must cover children who were in foster care under the responsibility of the state.

²⁰ An earlier OIG report indicated that not only Medicaid claims data but also child welfare case files were required to accurately assess EPSDT performance among children in foster care because neither source was likely to contain a complete picture of their service use (OIG 2005).

²¹ For example, the Centers for Medicare & Medicaid Services recently requested that California provide more information about how a proposed Medicaid state plan amendment for therapeutic foster care would allow for comparable treatment of children not in foster care (CDHCS 2015).

²² These states include New Mexico and Oklahoma (Shaw et al. 2015) and California (Morales and Woolsey 2014). Current state child welfare information systems (Statewide Automated Child Welfare Information System (SACWIS) and its next generation) require Medicaid eligibility information, and they are moving toward greater interoperability with Medicaid systems; if Medicaid systems permit queries through SACWIS, child welfare workers would be able to access health information, albeit with a need to do so in a way that ensures appropriate privacy protections and translates the information into a usable format (Raghavan 2015).

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APPENDIX 3A: Child Welfare Population Identified in Selected Data Sources

TABLE 3A-1. Population Identified in Child Welfare Versus Federal Medicaid Data

Federal child welfare data	Federal Medicaid data
<p>National Child Abuse and Neglect Data System (NCANDS)</p> <ul style="list-style-type: none"> • Reports the total population of children in families investigated for child abuse and neglect and whether they received post-response services • Includes the number of children removed to foster care following the child welfare response and the number who received only in-home services <p>Federal Adoption and Foster Care Analysis Reporting System (AFCARS)</p> <ul style="list-style-type: none"> • Reports any child who is: <ul style="list-style-type: none"> – under the “placement and care” responsibility of the state child welfare agency (generally as ordered by a state court); and – living in a foster care setting (foster family home or congregate) on a 24-hour basis • Does not count children formally discharged from foster care due to adoption or to legal guardianship or due to age <p>Federal data on Title IV-E reported by states</p> <ul style="list-style-type: none"> • States submit quarterly expenditure and average monthly caseload data • Reports the subset of children receiving Title IV-E foster, adoption, and guardianship assistance 	<p>Medicaid Statistical Information System (MSIS)</p> <ul style="list-style-type: none"> • Data reported by states for FY 1999 to present • Medicaid basis of eligibility is labeled as foster care but includes any child who is eligible via: <ul style="list-style-type: none"> – mandatory Title IV-E assistance pathway, including children in foster care and children who left care for adoption or guardianship; – optional state adoption assistance pathway for special needs under an agreement not involving IV-E; – special needs covered by state foster care payments not involving IV-E;¹ or – optional Chafee pathway for former foster youth up to age 21. • Does not clearly identify those who are not eligible based on child welfare assistance (such as children who are in foster care but not eligible for Title IV-E or state-funded special needs adoption assistance and those receiving in-home services) • Does not clearly identify mandatory former foster children up to age 26 • State option to report separate basis of eligibility categories used for T-MSIS, including pathway for mandatory former foster youth <p>Transformed MSIS (T- MSIS)</p> <ul style="list-style-type: none"> • Reporting expected to begin in 2015 • Similar to MSIS but will include separate basis of eligibility categories for mandatory IV-E, mandatory former foster youth up to age 26, optional adoption assistance, and optional Chafee pathways¹

Note: As shown in this table, federal Medicaid data only identify those involved in the child welfare system if they are eligible based on certain types of child welfare assistance, generally reflecting children who have been removed from their homes, rather than the entirety of the child welfare population. See Table 3-3 for more information on Medicaid eligibility pathways for child welfare-involved youth.

¹ The MSIS reference to children with special needs covered by state foster care payments not involving Title IV-E does not appear in the T-MSIS categories.

Source: MACPAC compilation based on CMS 2014h, 2012; Children’s Bureau 2015a, 2015b, 2014; and ACF 2013.