Chapter 4:

Access to Care for Medicaid-Enrolled Youth in Foster Care

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Key Points

- Children and youth in foster care represent less than 2 percent of all children enrolled in Medicaid, and are an especially vulnerable population. Youth in foster care have experienced neglect and abuse and other trauma, such as being removed from their home, which can contribute to poor physical, oral, and behavioral health outcomes, as well as fragmented use of health care services.
- Nearly all children in the child welfare system are eligible for Medicaid through several federal statutory pathways. Children in foster care, like all Medicaid-eligible children under the age of 21, are entitled to services under the early and periodic screening, diagnostic, and treatment (EPSDT) requirement, but studies show that children in foster care are less likely to receive mandatory EPSDT screenings. Children and youth in foster care also have substantial behavioral health needs and are at risk of being overprescribed psychotropic medications.
- Federal law requires state Medicaid agencies provide health insurance coverage to youth in foster care, and state child welfare agencies are responsible for ensuring that the health needs of children in foster care are met.
- Collaboration among agencies serving this population at the federal and state levels is important, but there are challenges to doing so, including unaligned priorities and resource constraints. At a state level, child welfare agencies must coordinate with Medicaid on aspects of foster care program design and develop health care oversight and coordination plans, which must include information about the state's approach to health screenings, treatments, and ensuring continuity of care. There is no requirement for state Medicaid agencies to consult with child welfare agencies on Medicaid program design. In addition, federal rules on interagency information sharing are limited.
- Several factors affect the ability of state agencies to meet the needs of youth in foster care, such as frequent placement transitions, availability of providers who can provide trauma-informed care particularly related to behavioral health needs, and behavioral health and oral health workforce shortages.
- Many states serve children in foster care through managed care, with most enrolling these youth in managed care organizations (MCOs) that serve the general child beneficiary population, and others using specialized MCOs that serve primarily just youth in foster care.
- States continue to address challenges by improving cross-agency collaboration and information sharing, supporting access to trauma-informed care, and by leveraging relationships with MCOs. Collaboration among Medicaid and child welfare and other agencies should be a state priority.

CHAPTER 4: Access to Care for Medicaid-Enrolled Youth in Foster Care

Children and youth in the child welfare system represent a small but highly vulnerable segment of the Medicaid-enrolled population.[1] The child welfare system serves children and families whom the state determines to need additional assistance and services to keep the children safe in their own homes or in temporary out-of-home care, also known as foster care.[2] In 2024, 328,947 children were in foster care in the United States (ACF 2025). A 2014 study found that 70 percent of children and youth were placed in foster care by court order because of abuse and neglect that occurs in the context of parental substance abuse and addiction, extreme poverty, parental mental illness, transient living situations or homelessness, extreme family violence, and parental criminal activity (Szilagyi et al. 2015). Once removed from their homes, children and youth face a heightened risk of experiencing additional trauma related to separation from familiar environments and placement instability.[3]

Congress has made resources available to the federal government and states to provide services and health care to children and youth in the child welfare system. Title IV-E of the Social Security Act (the Act) provides federal funding for child welfare assistance to low-income children who have been removed from their homes. Children receiving assistance under Title IV-E are automatically eligible for Medicaid. The Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services provides matching federal funds to states to operate their child welfare programs via a single state agency (ACF and CMS 2022).

State child welfare agencies are the legal custodians of children in foster care and are responsible for the health, safety, and well-being of these children; the agencies connect the children to a permanent and safe home if they cannot be reunited with their biological parents (§ 421 of the Act).[4] If a child is removed from their 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 (Stoltzfus 2018). The child welfare system interacts closely with the justice system (often family or juvenile court), the education system, and the health care system. Collaboration at the agency level is important to ensure children and youth in foster care are receiving appropriate and necessary care.

Children involved in the child welfare system, specifically those in foster care, have disproportionately high rates of acute and chronic physical conditions, behavioral health issues, developmental delays, and oral health concerns (Lamminen et al. 2020, Turney and Wildeman 2016, Deutsch and Fortin 2015, Szilagyi et al. 2015). In addition to the health impacts of neglect and abuse that necessitate the involvement of the child welfare system, the removal of a child from their home is a traumatic event that contributes to poor physical and behavioral health (AAP 2021a, Côté et al. 2018). Family instability, poverty, placement changes or placement instability, fragmented service delivery, and poor information sharing across systems also exacerbate these health challenges.

A range of Medicaid-covered services may be necessary and appropriate for meeting the significant health, behavioral, and other needs of children in foster care. Given the complex health needs of children in foster care, which are often a result of the trauma and maltreatment they have experienced, average Medicaid spending is much higher than that of most other children enrolled in Medicaid (MACPAC 2015a). 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., the additional spending above what would otherwise be expected) reflected 9 percent of Medicaid spending for non-disabled children (Florence et al. 2013).

The Commission has previously stated that access to and use of Medicaid services could 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 addressing inappropriate psychotropic medication use. Additionally, improved collaboration among Medicaid, child welfare, and other agencies is critically important, given that the majority of these children are eligible for Medicaid-financed services and care coordination (MACPAC 2015a). However, challenges in serving children in foster care persist due to fragmentation across financing streams and delivery systems, differences in program goals for the child welfare system and Medicaid, poor interagency coordination, and limited data sharing. Furthermore, a lack of knowledge among staff about other programs' benefits can hamper collaboration.

This chapter examines how Medicaid meets the unique needs of children and youth in the child welfare system, with a focus on those currently in foster care.[5] First, it provides background information about children and youth in foster care as well as their health status and utilization of health care. Next, it highlights key federal requirements for child welfare and Medicaid state agencies. Then, this chapter describes selected considerations for states in providing health care access to children in foster care based on our review of seven states.

Children and Youth in Foster Care

Although children and youth in foster care represent less than two percent of all children enrolled in Medicaid, they are an especially vulnerable population whose safety and well-being are the legal responsibility of the state. The number of children entering foster care has continuously declined over the last five years (ACF 2025). In 2024, the largest share, 28 percent, of children entering foster care were age 1 to 5; 20 percent, the largest share, of children exiting foster care reported that their duration in foster care was 12 to 18 months (ACF 2025). One study found that, in 2023, 39 percent of children in foster care experienced more than two placements, meaning their living arrangements changed at least three times a year (AECF 2025a).

Research shows that children from racial minority groups and children with lower socioeconomic status are more likely to be represented in the child welfare system. Three-quarters of reports to child protective services involve neglect allegations, and families in poverty are more likely to be reported for child neglect compared to families with higher incomes (Children's Bureau 2021). Children of color are more likely to be placed into foster care than white children (Minoff and Citrin 2022). In 2024, Black children comprised 25 percent of children in foster care but only 14 percent of the total child population in the United States. (ACF 2025, CDF 2023). American Indian and Alaska Native children made up three percent of those in foster care but only one percent of the total child population (ACF 2025, CDF 2023).

Health status

The physical, behavioral, and oral health needs of children and youth in foster care are complex and greater than children in the general population. These children experience social risk factors (e.g., child abuse or neglect) that adversely affect their health. Child abuse is defined as intentional harm or mistreatment (physical, sexual, or emotional). Child neglect is defined as the failure to meet a child's needs (food, shelter, supervision, medical care), and 76 percent of all confirmed maltreatment cases is from child neglect (Children's Bureau 2023). Traumatic life experiences are common among individuals in foster care, which has consequences for an individual's long-term physical and behavioral health.

Adverse childhood experiences (ACEs) are potentially traumatic events that occur before a child turns age 18 that have lasting negative physical and behavioral health consequences. Examples of ACEs include abuse, neglect, witnessing violence in the home, removal from home, and placement instability (CDC 2025). These experiences can exacerbate mental health challenges. The longer a child spends in the foster care system, the more likely they are to have three or more placements. These placement changes lead to fragmented health care and challenges with continuity of care (Casey Family Programs 2023). Studies show that children with a high ACE score, such as those in foster care, are at an increased risk

for long-term medical issues, including heart disease, stroke, cancer, respiratory diseases, diabetes, and depression (Radel et al. 2023, Merrick et al. 2019).

Physical health and developmental conditions. Children in foster care are more likely to be in poor health and have chronic conditions, such as asthma or obesity, activity limitations, learning disabilities and speech delays, developmental delays, and vision problems, compared with children in the general population (Turney and Wildeman 2016). The complex trauma histories of children who enter foster care and their limited access to appropriate health care services compound their substantial unmet health needs. Childhood trauma and adversity underlie health issues, and the ongoing loss and uncertainty in foster care may exacerbate health conditions (AAP 2021a, Szilagyi et al. 2015). Overall, 33 percent of children and youth enter into foster care with a chronic health condition; 46 to 60 percent of children younger than six years have a developmental disability (Szilagyi et al. 2015).

Other research has shown that children and youth with special health care needs are more likely to enter the foster care system, as their family is unable to meet their health care needs (Hess 2020). Because children with diagnosed disabilities need higher levels of care, they are more likely to be placed in residential treatment facilities, which may be better equipped to provide such care. They are also more likely to spend more time in foster care, experience multiple placements, and achieve permanency at lower rates than other foster care children (Sepulveda et al. 2020). In 2021, states reported they were more likely to find permanent homes for the general foster care population exiting foster care (89.6 percent) than for children with diagnosed disabilities who exited foster care (81.5 percent) (Children's Bureau 2021).

Behavioral health conditions. Children in foster care are more likely to be diagnosed with behavioral health conditions as compared to children in the general population (MACPAC 2021). Behavioral health diagnoses vary for children in foster care depending on their age, whether they are subjected to multiple child welfare investigations during their childhood, the length of time they spend in out-of-home care, and the stability of their foster care experience. Compared to children in the general population with similar socioeconomic status, children in foster care are three to four times more likely to have a diagnosis of a mental health disorder (Engler et al. 2020). In one study, children who experienced out-of-home placement in early childhood (age two to six) were twice as likely to have psychiatric diagnoses in young adulthood than peers who did not experience foster care (Côté et al. 2018). A prior review of Medicaid claims data indicates that prevalent mental health and developmental disorders among youth in foster care include attention-deficit/hyperactivity disorder (ADHD) (11.0 percent), bipolar disorders (5.6 percent), and depressive disorders (5.4 percent) (Keefe et al. 2022). Children in foster care tend to have a higher rate of suicidality than children without a history of child welfare involvement; one study found that preadolescents in foster care experience suicidality at five times the rate of suicidality in the general population (Engler et al. 2020, Taussig et al. 2014).

Oral health conditions. Children involved in the child welfare system are at a higher risk for inconsistent oral health care, leading to poor oral health outcomes (AAPD 2025, Sarvas et al. 2021, Morón et al. 2019). Children in foster care are more likely to experience dental caries and gingivitis than other children enrolled in Medicaid (Morón et al. 2019). Youth with a history of placement in foster care are 1.5 times more likely than children in the general population to have an oral health problem, with 15.6 percent of children in foster care reporting decayed teeth or cavities. They are also less likely to receive routine or acute dental care (Sarvas et al. 2021). Caregivers of children in foster care cited challenges finding dentists who accept Medicaid and, in some states, the lack of authority to consent for dental care and the lengthy process for obtaining consent from legal authorities as reasons for the delays in dental care (AAPD 2025).[6]

Health care utilization

Children and youth in foster care have lower rates of health care utilization, such as for primary care, behavioral health care, and oral care, compared to children and youth who are not (AECF 2025b). Children in foster care can experience fragmented health care when removed from their home and from placement changes while in out-of-home care. Research from

the American Academy of Pediatrics shows that interruptions in care and lower health care utilization negatively affect children's health and increase the risk of poor health outcomes (AAP 2021b).

Use of psychotropic medications. The Commission has had long-standing concerns about the use of psychotropic medication to manage the behavioral and mental health problems of children in foster care (MACPAC 2015b).[7] Limited safety and efficacy data exist on those younger than 18 using these medications, and some child welfare and behavioral health experts have concerns about inappropriate use (Keefe et al. 2023, Radel et al. 2023). Other concerns are that psychotropic medications may not address the underlying trauma or the issues at the root of challenging behaviors in some children (Zito et al. 2008). Children in foster care are three times more likely to be prescribed psychotropic medications than other Medicaid-enrolled children and are more likely to be kept on them for a longer period of time (Szilagyi et al. 2015). Nine percent of youth age 12 to 17 in the child welfare population who did not have a behavioral health diagnosis received at least one psychotropic medication, which is double the rate of beneficiaries in other Medicaid eligibility groups who do not have behavioral health diagnoses (Radel et al. 2023). Some researchers have posited that reasons for this potentially inappropriate prescribing include caregiver demand to manage disruptive behavior, provider and caregiver lack of understanding about the effects of childhood trauma on mental health, a lack of pediatric mental health professionals to provide alternative treatments (e.g., psychotherapy), and the misdiagnosis of trauma symptoms as other mental health conditions (e.g., ADHD) (Szilagyi et al. 2015).

Federal Requirements for the Child Welfare System and Medicaid

Below we describe federal child welfare and Medicaid requirements for the provision of health care for children and youth in the foster care system. As previously mentioned, child welfare agencies are responsible for ensuring that the health needs of children in foster care are met. State Medicaid agencies provide health insurance coverage for services, including under the early and periodic screening, diagnostic, and treatment (EPSDT) requirement, to address the health needs of this population.

Child welfare system

The child welfare system encompasses programs intended to preserve families; protect and promote the welfare of all children; and achieve permanency, including child abuse and neglect prevention, foster care, and subsidized adoption (§ 421 of the Act). Child welfare agencies investigate allegations of abuse and neglect and, when necessary for a child's safety, remove the child from the home and place them in foster care. ACF is responsible for developing and issuing federal regulations for state child welfare agencies to implement Titles IV-B and IV-E of the Act. 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 use the funding for services to 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 costs of providing foster care, adoption assistance, or kinship guardianship assistance for eligible children. Child welfare agencies may not use federal funds under Title IV-E to provide health care for children. Thus, these agencies rely on Medicaid funding to cover the cost of care (Stoltzfus 2018). Federal and state agencies operate these programs in partnership, with state child welfare agencies required to meet federal statutory and regulatory requirements to receive federal funds.

Coordination with state Medicaid agencies. Federal rules require state child welfare agencies to coordinate with state Medicaid programs. First, state child welfare agencies must have comprehensive operating plans that describe how they coordinate with other state agencies when developing their child welfare program. Second, state child welfare agencies must maintain information systems with accurate and current data about the program overall as well as individual children. Third, child welfare agencies must establish mechanisms for health care oversight and coordination of child welfare populations with Medicaid and clinical providers in their state (45 CFR 1357.15).

These mechanisms include child welfare agencies partnering with state Medicaid agencies to enroll foster care children in Medicaid, sharing the child's health care information with necessary parties, and in some instances, giving permission to health care providers for treatment (ACF and CMS 2022). Medicaid agencies do not have a parallel federal requirement to coordinate with their state child welfare agency when developing their Medicaid policies (e.g., through state plans and waivers).

Child and family service plans. Each state child welfare agency must develop and submit child and family service plans (CFSPs) to ACF for review and approval to receive Title IV-B grants and Title IV-E federal financial participation (§ 422-423 of the Act, 45 CFR 1357.15). Three of the 15 required CFSP elements are relevant to Medicaid and the access of these benefits: coordination of services, health care oversight and coordination plans, and case plans and case reviews. State child welfare agencies outline how services within the CFSP will be integrated and coordinated with services (e.g., social, health, education, or economic support) offered by other federal programs that serve similar populations, aiming to achieve comprehensive support for children and families while avoiding duplication and maximizing resource efficiency (45 CFR 1357.15). Additionally, each state's CFSP must include a health care oversight and coordination plan developed by the state child welfare agency in collaboration with the state Medicaid agency and in consultation with pediatricians, health care experts, and child welfare experts (§ 422(b)(15)(A) of the Act). Last, for each child they serve, state child welfare agencies must maintain individual case plans with the child's health history and current information and give the case plan to the child when they age out of foster care. Child welfare agencies must have a process in place to review, update, and provide a copy of the child's case plan to each foster parent or provider with whom the child is placed (§ 475(1)(D) of the Act).

Psychotropic medication. Federal rules require child welfare agencies to monitor and manage psychotropic medication use by children in foster care and report their findings to ACF. Federal law requires state child welfare agencies to submit health care oversight and coordination plans to ACF (as part of CFSPs) that include protocols for appropriate use and monitoring of psychotropic medications (§ 422(b)(15) of the Act). Additionally, the Family First Prevention Services Act, part of the Bipartisan Budget Act of 2018 (P.L. 115-123), amended child welfare funding streams in Titles IV-B and IV-E of the Act and requires that state child welfare agencies develop procedures that ensure children are not inappropriately diagnosed with mental illness, emotional disorders, or behavioral disorders, which can lead to inappropriate psychotropic medication prescribing.[8] State child welfare agencies must document these procedures in their health care oversight and coordination plans.

Medicaid

States rely on myriad federal authorities to design and fund Medicaid programs aimed at addressing the unique health care needs of children in foster care.

Eligibility pathways. Nearly all children in the child welfare system are eligible for Medicaid through several federal statutory pathways. Children who receive Title IV-E foster care maintenance payments are automatically eligible for Medicaid (42 CFR 435.145).[9] Children who do not qualify for state-funded foster care under Title IV-E because, for example, they receive in-home services or have family income above their state's 1996 Aid to Families with Dependent Children (AFDC) eligibility standard, are not automatically eligible for Medicaid but may be eligible through other Medicaid pathways, such as a disability-based eligibility pathway (MACPAC 2015a).[10] States may also use the Ribicoff option for Medicaid coverage, which 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). In addition, section 1902(e)(12) of the Act requires 12 months of continuous Medicaid eligibility to all eligible children younger than age 19, allowing children, including those who move in and out of foster care, to maintain access to and continuity of health care.

All states are required to provide Medicaid coverage to youth formerly in foster care until age 26, regardless of income or assets.[11] Initially, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) required states to provide such coverage to in-state former foster youth. States could also

choose to cover former foster youth who aged out of foster care in another state (CMS 2013). Later, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P.L. 115-271) made coverage of out-of-state former foster youth mandatory, which phased in beginning with youth who turned age 18 on or after January 1, 2023. SUPPORT Act requirements will apply to all former foster care youth beginning in 2031. In the interim, states can use the Section 1115 demonstration authority to extend Medicaid coverage to out-of-state former foster youth (CMS 2022). States also have the option to cover former foster care children up to age 21 through the independent foster care adolescents eligibility group, also known as the Chafee option (§1902(a)(10)(A)(ii)(XVII) of the Act and 42 CFR 435.226). 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. States may establish income criteria, may restrict eligibility to those who received assistance funded under Title IV-E, and may not cover individuals age 21 or older (MACPAC 2015a).

EPSDT. Under Section 1905(a) of the Act, all Medicaid-eligible children younger than age 21, including children in foster care, are entitled to services under the EPSDT requirement. Federal law requires Medicaid coverage of any allowable service that is determined medically necessary to ameliorate a physical or behavioral health condition, even if the services are not included in the Medicaid state plan. Services under EPSDT include comprehensive health screenings, vision and hearing services, dental services, lead screenings, immunizations, diagnostic services, and treatments for conditions discovered by any screening and diagnostic procedures. States are required to develop or adopt a schedule of recommended screenings to determine the existence of physical or mental illnesses for EPSDT-eligible children, and states must ensure children have access to these screenings (CMS 2024).[12] However, one study found that nearly 33 percent of Medicaid children in foster care did not receive at least one EPSDT screening, and slightly more than 25 percent received at least one required screening late (OIG 2015).

Most states provide enhanced services for children in foster care in both fee-for-service and managed care delivery models. Examples of such services include:

- case management;
- targeted engagement of child welfare and behavioral health partners;
- specific assessments and screenings;
- psychotropic medication monitoring;
- foster care transition services; and
- non-medical services and supports (CMS 2024).

States and the federal government share responsibility for overseeing children's access to necessary services based on the EPSDT requirement, including when provided through managed care. State Medicaid agencies must also ensure their managed care contracts clearly define plans' responsibility for covering and providing services under EPSDT, and states must monitor managed care organization (MCO) compliance with the requirement.

Psychotropic medication monitoring. State Medicaid agencies must design and implement programs to monitor and manage appropriate use of antipsychotic medications by all Medicaid-enrolled children, including children in foster care, and report to the Secretary on these efforts (§ 1902(oo)(1)(B) of the Act). Specifically, state Medicaid agencies must annually submit to the Centers for Medicare & Medicaid Services (CMS) information regarding activities completed under their monitoring and management program as part of the state's Medicaid Drug Utilization Review report (§ 1927(g)(3)(D) of the Act). States can also help reduce unmet needs for mental health care and inappropriate psychotropic medication use among child welfare–involved youth by improving timely access to community-based behavioral health treatments. Several states also require written consent by the legal guardian, court, or authorized person at the child welfare agency before psychotropic medications can be prescribed for a child in foster care; adolescents in foster care have the same rights as other teenagers to consent to mental health services without a guardian (Szilagyi et al. 2015).

Managed care. States' approaches to providing Medicaid coverage for children in the child welfare system vary, but states are now increasingly using managed care delivery systems. Although there is a statutory prohibition on mandatory enrollment of individuals in the child welfare system in managed care, states may seek approval from CMS to waive this provision (§ 1932(2)(A)(iv-v) of the Act). In 2007, 29 states used some form of managed care to deliver Medicaid to some or all children in foster care; by 2021, this number had grown to 42 states and the District of Columbia (Thompson 2022). States may use different models of managed care, such as general managed care plans, administrative service organizations (ASOs), and specialized managed care plans. States may choose to enroll children in foster care in the same general managed care plans that serve non–foster care populations and implement specific programs and policies designed to meet the needs of children in foster care. Some states may enroll children in foster care in specialized managed care plans that serve child welfare populations and other children and youth with special health care needs. Although less common, states can use ASOs instead of managed care plans (Thompson 2022).

State Medicaid agencies using managed care delivery models for children in foster care must comply with federal oversight and monitoring requirements, including CMS approval of contracts, implementation readiness review, external quality review activities, and Managed Care Program Annual Reports (42 CFR 438).[13] States must also comply with the specific approval, monitoring, and renewal requirements of the federal authority.

State Medicaid agencies and MCOs often provide children and youth in foster care enhanced benefits, which are Medicaid coverable services, such as care coordination, that have been augmented to meet their complex needs. Approaches to care coordination vary across the states and include targeted case management; integrated care coordination that connects medical, behavioral, and social services in a patient-centered approach; and intensive care coordination for children and youth with complex health care needs. A couple of states require MCOs to have a liaison between the managed care plan, behavioral health providers, and trauma-informed case managers; several states promote system-level coordination, such as routine meetings with local child welfare agencies (Thompson 2022).

Data sharing

Federal Medicaid rules allow, but do not require, state Medicaid agencies to share beneficiary information with other agencies, if it is for a purpose directly related to administration of the state Medicaid plan (§ 1902(a)(7) of the Act). These purposes include establishing eligibility, determining the amount of medical assistance, and providing services for beneficiaries (42 CFR 431.302). State Medicaid agencies wishing to exchange information with other state agencies must execute a data exchange agreement to safeguard the information to be released (42 CFR 431.306(g)). Although federal rules require managed care plans to develop and maintain systems to exchange health information with state Medicaid agencies in prescribed formats, there is no requirement that these plans configure their health information system to exchange data with the state child welfare agency (42 CFR 438.242).

Alternatively, child welfare rules require state child welfare agencies to share medical information of children in foster care with Medicaid. Through CFSPs, state child welfare agencies must coordinate with the state Medicaid agency on a methodology for updating and sharing the medical information of children in foster care (§ 422(b)(15)(A) of the Act). States may elect to develop a Comprehensive Child Welfare Information System (CCWIS). ACF regulations require that information sharing that occurs via the state's CCWIS must have 11 bidirectional data exchanges capable of information and data sharing with other state health and human service systems. State child welfare and Medicaid agencies must be able to share data with one another to effectuate Medicaid eligibility and enrollment as well as Medicaid claims and encounter processing (45 CFR 1355.52(e)). Like state Medicaid agencies, state child welfare agencies must implement safeguards regarding the data exchanged.

Challenges and Considerations for Serving Youth in Foster Care

States face several challenges in serving children in the foster care system and are pursuing a range of approaches to meet the health care needs of these children and youth. A number of factors affect the care needs of youth in foster care, which should inform the efforts of states, health plans, and providers.

Collaboration between Medicaid and child welfare agencies

Individuals interviewed for our analysis agreed that cross-agency collaboration on policy, data sharing, and health care delivery methods is ideal for serving children in foster care. They also noted that limited staff resources amid other programmatic goals and responsibilities can pose barriers to robust and consistent collaboration.

Federal collaboration. Collaboration among federal agencies serving children in foster care is important to ensure consistent agency policies that result in clear guidance to states. However, federal officials and national experts described two challenges to federal collaboration: (1) federal agencies do not coalesce around a shared set of policy priorities in the administration of the foster care program, leading to confusion among state agencies, and (2) federal officials often face constrained bandwidth to focus on collaborative efforts. However, even when federal agencies collaborate, some efforts may not have the intended effect. CMS, ACF, and the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation collaborate on issue areas that affect children in foster care, such as behavioral health, Medicaid eligibility for young adults transitioning out of foster care, and data sharing. In 2022, CMS and ACF partnered on a months-long collaboration to develop a data-sharing toolkit for child welfare and Medicaid agencies, but some states noted they were not aware of the toolkit.

Federal requirements for state agency collaboration. Federal statute requires state child welfare agencies to coordinate with Medicaid agencies and providers on specified aspects of foster care program design. However, state Medicaid agencies are not required to consult with child welfare agencies on Medicaid program design. For example, state child welfare agencies must coordinate with the state Medicaid agency to develop health care oversight and coordination plans, which are required to include information about the state's overall approach to screening schedules, treatment and monitoring, sharing of health care information, continuity of care, oversight of psychotropic medications, and avoidance of inappropriate diagnoses. These plans may include periodicity schedules that are more intensive than the general Medicaid schedule required under EPSDT.

Some state Medicaid agencies in our study indicated that they are proactively coordinating with child welfare agencies even if it is not federally required. For example, officials from Kentucky indicated that the child welfare and Medicaid agencies routinely coordinate with each other to develop initiatives focused on the child welfare population, such as increasing access to behavioral health services for children in foster care. Both agencies are under the umbrella of the state's Cabinet for Health and Family Services, which state officials noted helps their collaboration. Some of the states in our study indicated that they have taken steps to promote collaboration, including co-locating agency staff, encouraging joint participation in federal initiatives, and involving the behavioral health authority in the efforts to serve children and youth in the child welfare system. In one state in our study, state legislators attempted to mandate cross-agency collaboration for the child welfare population, but the effort failed.

State Medicaid officials reported more engagement with child welfare agencies in states that use a Medicaid specialized managed care model to provide services to children in foster care. The three states we studied that use a single, specialized MCO (Illinois, Kentucky, and West Virginia) to serve children in the child welfare system commented that coordination between the Medicaid and state child welfare agencies made it easier to implement the specialized managed care program.

Intra-state collaboration. State officials explained that cross-agency collaboration occurs most often when implementing new programs. For example, officials from New York's Medicaid and child welfare agencies collaborated before transitioning children in foster care into managed care, including convening weekly design meetings to discuss implementation plans and address potential challenges. After implementation, engagement tapered to monthly cross-agency meetings and office hours with Medicaid and child welfare staff participating to address questions from providers. New York officials also worked together to address gaps in their Medicaid provider network by implementing a special health facility license for their Voluntary Foster Care Agencies, which allowed agency clinical staff to deliver not only child welfare services for children in foster care, but also Medicaid health services, including EPSDT services (New York OCFS 2024).[14] Illinois Medicaid leaders coordinate with the state's behavioral health agency to design requirements for and implement a single, specialized MCO for children in foster care, YouthCare (YouthCare 2025a). Officials told us the state's behavioral health chief continues to participate in ongoing operational meetings.

Several state officials described a crisis orientation to collaboration, in which state agency officials work together when needed to address the extensive, and often frequent, needs of individual children in foster care. For example, state Medicaid and child welfare officials, as well as MCO personnel and providers, frequently engage with one another to identify treatment options for children in foster care with behavioral health diagnoses requiring residential or inpatient levels of care. Residential treatment services for children are behavioral health interventions intended to provide intensive clinical treatment to children with serious emotional disturbance. Qualified residential treatment programs, for example, provide time-limited trauma-informed treatment for children in foster care with behavioral health disorders (MACPAC 2025).[15] However, despite collaboration among state Medicaid and child welfare officials, the lack of available residential treatment beds may delay the receipt of needed care by children in the child welfare system. These children are often forced to wait in emergency departments or hospitals for prolonged periods of time until needed treatment becomes available.

National experts we spoke to stressed the importance of effective collaboration among state Medicaid, child welfare agencies, and MCOs. For example, child welfare agency leaders in one state provided input on the types of specialty providers included in the selected MCO's network based on their familiarity with the health care needs of children in foster care. In another state, Medicaid agency officials included child welfare agency officials in developing the contract between the state Medicaid agency and the specialized MCO; leaders from both of this state's agencies also described working together to request an expansion of the populations served under the state's waiver from CMS. Child welfare directors we spoke to in three states with specialized MCOs described asking for and receiving customized dashboards from either the state Medicaid agency or the specialized MCO for use in reporting on children in foster care.

Information sharing between Medicaid and child welfare agencies

Information sharing between Medicaid and child welfare agencies is needed to ensure access to care for children in the welfare system. The lack of federal rules related to interagency data sharing contributes to the inconsistent interpretation about which data can be shared and leads to limited data sharing between the state Medicaid and child welfare agencies. Additionally, little federal guidance exists on what data on children in foster care must be maintained in state Medicaid agency or MCO health information systems, unlike federal requirements for state child welfare agencies. Federal agency officials indicated that states have made relatively little progress with data sharing between Medicaid and child welfare agencies.

State Medicaid and child welfare agencies maintain separate health care data collection systems for children in foster care, putting them at risk of overlooked health needs, delayed routine care, interrupted treatments, and misuse of psychotropics (ACF and CMS 2022). Information technology systems maintained by state child welfare and Medicaid agencies vary in their capabilities to exchange information, leading staff to share information verbally or on paper or by entering it into a system that other

child-serving personnel are unable to access (Mark et al. 2022). State laws also vary regarding who has the authority to release medical information for children in foster care and who has the authority to consent to their treatment.

Stakeholders noted that perceived legal barriers to sharing information, technical and financial limitations (e.g., incompatible data formats and systems), and the cost of updating state information technology systems are barriers to interagency information sharing. For example, state officials indicated that confusion about and compliance concerns with the Health Insurance Portability and Accountability Act (HIPAA) and other confidentiality laws can lead to reluctance with data sharing across agencies. States use varying approaches to share data among state Medicaid and child welfare agencies, MCOs, and other agencies that may furnish services to children in foster care, such as departments of public health or behavioral health. For example, in Illinois, data are shared directly between the systems of child welfare, Medicaid, and the state's single, specialized Medicaid MCO serving children in foster care. Data are pushed daily between Medicaid and child welfare to link child information (e.g., address, phone number, caseworker) and Medicaid claims data, which are then stored in the state's Statewide Automated Child Welfare Information Systems (Illinois DCFS 2025).[16] The plan's information system includes a portal that child welfare staff can access, which includes information on screenings, assessments, care plans, referrals, and health records (e.g., medications, immunizations, lab work, and allergies).[17]

Medicaid eligibility and claims data reported to the Transformed Medicaid Statistical Information System (T-MSIS) do not differentiate children in foster care from other enrolled children who receive Title IV-E assistance (e.g., children receiving adoption assistance or in guardianship care). Consequently, some Medicaid fee-for-service and general MCO staff are unable to configure systems to efficiently produce foster care-specific reporting to share with child welfare agency staff. Officials in several states noted that they must rely on manual and time-consuming approaches to share data about children in foster care. In one state where data for children in foster care exist across several different state systems, child welfare staff pull down and send Medicaid staff a monthly flat file roster of children in foster care. This information is then matched against Medicaid claims data and sent back for staff to enter into the state's child welfare system. Interviewed state officials reported needing clearer federal expectations around data sharing, model data use agreements, and technical assistance.

Some states established data exchanges between state agencies and MCOs by using data sharing agreements. Officials in Connecticut described state statutory requirements that require Medicaid, child welfare, and behavioral health agencies to develop memorandums of understanding (MOUs), data sharing agreements, and business associate agreements to assist in coordination and sharing of data among agencies (CT § 19a-45a). In California, MCOs are required to enter into MOUs with child welfare county departments to support coordination and data sharing. The MCOs provide each county welfare agency with a dashboard with health utilization information, such as well-child visits or emergency department visits. To support implementation of these new requirements, the state Medicaid and child welfare agencies developed MOU templates for use by county agencies to ensure standardized and complete data exchange (California DHCS 2023).

The Commission has previously shared and maintains its view that collaboration between Medicaid and child welfare and other agencies should be a state priority, given that the vast majority of child welfare-involved youth are eligible for Medicaid-financed services and care coordination.

Factors that affect children in foster care

Several factors affect the health care needs of children and youth in the foster care system and the ability of state agencies to meet them. Some of the factors are unique to this population, while others affect access for all children but may have greater implications for children in foster care. These include the traumatic effects of foster care placement and placement instability, the subsequent need for trauma-informed care in particular to address behavioral health challenges, and workforce shortages.

Effects of foster care placement and placement instability. Our research and previously published research indicate that placement in foster care itself, and subsequent disruptions in placement, negatively

affect children's behavioral health and their access to consistent care. The Adoption Assistance and Child Welfare Act (P.L. 96-272) mandates that placements be in the least restrictive environment to meet the child's needs, so most children reside in foster care (28 percent) or kinship care (38 percent) rather than group homes or residential treatment facilities (9 percent) (ACF 2025, Szilagyi et al. 2015). Frequent placement transitions and changes in caregivers, who may lack information on the child's health needs and prior service use, affect continuity of care (Allen and Hendricks 2013). Beneficiary advocates stressed that continuing to reduce the number of children entering foster care is important to preserve community-based placements for children who do need to be removed from their families and to prevent placement disruptions.[18]

Some states are using evidence-based approaches that support children remaining in the home and prevent placement instability, such as mobile crisis response or intensive home-based treatment (IHBT). States are increasingly using mobile crisis response approaches to provide timely interventions in emergency situations, which may prevent a foster child from being removed from a foster family and placed in a congregate or inpatient setting. For example, New Jersey's mobile response program has significantly decreased disrupted placements; from 2014 to 2018, 95 to 97 percent of children serviced by the mobile response program were able to remain in their current living situation (Casey Family Programs 2018, New Jersey DCF 2017). Illinois state officials also described that mobile crisis response teams help streamline and improve the timeliness of behavioral health supports provided to children in foster care. Some state Medicaid programs cover IHBT, which is a community-based comprehensive service that includes crisis response, stabilization, and safety planning; psychoeducational skill building with youth; parenting and behavior management; cognitive and emotional coping with a focus on trauma-informed care; family systems therapy; and resilience and support-building interventions (Bruns et al. 2021).

In several states, Medicaid and child welfare agencies collaborate to implement therapeutic foster care programs as a strategy to create greater placement stability for certain children with complex needs. These programs can provide a higher level of support than traditional foster care, including specialized training for foster parents, to increase the likelihood that children stay in one place rather than moving several times. States consider therapeutic foster care as a means of preserving community-based placements instead of placing children in institutional settings. For example, Iowa's Medicaid and child welfare agencies started the Therapeutic Foster Home Program, which began as a pilot program and is now part of the state plan. The state enrolls children with serious emotional disturbance who live with family or a foster family in a 1915(c) waiver that provides in-home intensive behavioral health services (Iowa DHS 2024). Other state officials expressed a desire to implement similar therapeutic foster care programs in their states.

Need for trauma-informed care. The complex trauma histories of children before, during, and after placement in foster care, poor access to appropriate health care services, and the high prevalence of mental health conditions in this population necessitate having health care providers who are trained in trauma-informed care.[19] Pediatricians may need assistance from professionals trained in trauma-informed care to evaluate and diagnose children. For example, the American Academy of Pediatrics developed a practice standard it recommends for children in foster care that considers the complexity and intensity of their needs. It recommends that every child entering foster care receive a health screening within 72 hours of placement and a comprehensive health admission visit within 30 days of placement (Forkey et al. 2021). Foster care health experts recommend that children should receive trauma-informed mental health services consistent with their diagnoses. Trauma-informed, evidence-based therapies, such as parent-child interaction therapy, parent-child psychotherapy, and trauma-focused cognitive behavioral therapy, are treatments that pediatricians and therapists recommend to manage childhood trauma symptoms (Forkey et al. 2021, Szilagyi et al. 2015).

State officials highlighted that some children in foster care may have additional access issues related to their need for and lack of pediatric behavioral specialists trained in trauma-informed care. To improve access to trauma-informed care, several states have established partnerships with specific Medicaid providers to complete screenings and in some cases, provide follow-up care. For example, one state Medicaid

and child welfare agency partnered with local health care systems to develop urgent crisis centers, to serve children, including those in foster care, who are experiencing a behavioral health crisis but do not require emergency department level of care.

Workforce shortages. State Medicaid and child welfare agency officials described difficulty ensuring timely access to behavioral and oral health care for children in foster care due to provider shortages, especially in rural areas. State officials identified the lack of behavioral health providers accepting Medicaid as a challenge regardless of the Medicaid delivery system and managed care vehicle (e.g., general or specialized MCOs). State officials also noted that workforce shortages affect the states' ability to offer specialty residential care for some children in foster care. One state shared that they have attempted to ameliorate their Medicaid dental provider shortage with mobile dental vans in some regions. However, state officials noted anecdotal reports that despite these efforts for all children, children in foster care continue to not receive their oral care assessment within 30 days of entering placement, as required by the state's child welfare agency.

Specialized MCOs

Although most states using managed care for children in foster care enroll them in the same MCOs available to the general child beneficiary population, almost one-third of states (14 states and the District of Columbia) procure specialized MCOs (Thompson 2022). These specialized MCOs often cover additional benefits and exclusively serve either children and youth in the child welfare system (including children in foster care and children in subsidized adoption) or children in foster care plus other Medicaid populations with similar needs due to chronic and complex conditions. Some state officials indicated that specialized MCOs can help with care coordination and measure and track outcomes for children in foster care because these MCOs are designed to serve primarily just that population. Stakeholders shared that specialized MCOs may face the same core challenges present across all delivery systems (e.g., provider availability and network adequacy).[20]

Care coordination. Specialized MCOs hire care coordination staff with experience serving children in foster care given their membership. For example, Illinois requires an assigned care coordinator for every beneficiary enrolled in their specialized MCO who has training in serving children in the child welfare system, such as providing trauma-informed care (YouthCare 2025b). West Virginia requires that specialized MCO care managers have knowledge of children in foster care, coordinate health and social services, and ensure all members of the beneficiary's care team are informed (West Virginia DHHR 2023a). As previously mentioned, some states require MCOs to have liaisons to work with child welfare case managers to address these case managers' challenges with navigating the complex Medicaid system.

Population-specific initiatives and reporting. State and federal officials highlighted the ability of specialized MCOs to implement initiatives designed to address the needs of children in foster care and report data and outcomes for children in foster care. Quality improvement activities such as the performance improvement projects (PIPs) of specialized MCOs are focused on the youth in foster care by design.[21] Because specialized MCOs cover a narrowly defined population, PIP resources can be focused. West Virginia's specialized MCO implements PIPs designed to address specific needs of youth in foster care, youth who receive adoption assistance, and youth with serious emotional disorders. The MCO's PIPs have addressed lead screening, annual dental visits, care for adolescents, and reduction of out-of-state placements for children in foster care (West Virginia DHHR 2025, 2023b). We note that states could also require general MCOs to implement PIPs and quality improvement activities for children in foster care.

Officials from states using specialized MCOs to serve children in foster care reported that they can easily identify and address gaps with physical health and prevention services when all children in foster care are enrolled in one MCO. For example, Illinois's specialized MCO maintains a data dashboard tracking timeliness of well-child visits and immunizations and shares the dashboard with child welfare case workers, which can help them identify whether children are receiving this care (YouthCare

2025a). The specialized MCOs in Kentucky and West Virginia leverage care coordination staff to track EPSDT services. Both states require the plans' primary care providers to track EPSDT screenings for their assigned enrollees and participate in outreach to enrollees' caregivers when screenings are due (West Virginia DHHR 2023a, Kentucky CHFS 2021).

States with specialized managed care programs for children and youth in foster care collect and analyze data differently from states that have children in foster care enrolled in general managed care or fee for service (Thompson 2022). State officials indicated that their contracts sometimes require reporting from their specialized MCOs that is not required of general MCOs to capture data on specialized MCO members. Officials in another state indicated that having their entire population of children in foster care statewide enrolled in one MCO enables easier tracking of their health information, particularly if they change placements multiple times. Medicaid and child welfare officials in states using general MCOs indicated that they have limited visibility on health outcomes for enrollees who are children in foster care due to challenges in stratifying quality measures accordingly.

State administrative burden. Officials in states that enroll children in foster care in single, specialized MCOs described working with a single MCO as less administratively burdensome and simpler than having to work with multiple MCOs. One state Medicaid official indicated that having to keep track of processes and policies for just one MCO instead of multiple MCOs made it easier to work with MCO staff to resolve any issues and advocate for this population. Officials in states enrolling children in foster care into multiple general MCOs are required to navigate multiple policies and processes, which can add to administrative burden and confusion.

Next Steps

Children and youth in foster care have unique and complex health care challenges that require partnership between the state child welfare and Medicaid agencies to address. These myriad challenges include substantial behavioral health needs and risk of being overprescribed psychotropic medications, trauma associated with being removed from the home and placement instability, and fragmented care. States continue working to address these concerns—for example, by improving cross-agency collaboration and information sharing, supporting access to trauma-informed care, and leveraging relationships with the expertise of MCOs. However, cross-agency collaboration and information sharing has been limited thus far. Some states enroll youth in foster care in specialized managed care that serves a narrower population than general MCOs, which may ease certain functions (e.g., reporting). Further analysis is needed to better understand how states are leveraging specialty and general MCOs to meet the needs of children in foster care.

Endnotes

[1] States must cover infants (under age 1) and children age 1 to 18 up to 133 percent of the federal poverty limit (§§ 1902(a)(10)(A)(i)(I), (III), (VI), (VII); 1902(l)(1)(C) and (D); 1905(n); and 42 CFR 435.118). For children above the 1997 Medicaid eligibility levels, states may choose to provide Medicaid to targeted low-income children (under age 19) using funding from the State Children's Health Insurance Program (CHIP) (§ 1902(a)(10)(A)(ii)(XIV), 42 CFR 435.229). States may cover all children or a state-defined reasonable classification of children under age 21 up to the state's 1996 Aid to Families with Dependent Children (AFDC) levels (§§ 1902(a)(10)(A)(ii)(I) and (IV), 1905(a)(i), and 42 CFR 435.222).

[2] Federal regulations define the term "foster care" as 24-hour substitute care for children placed away from their parents or guardians and for whom the Title IV-E agency has placement and care responsibility. This includes but is not limited to placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, childcare institutions, and pre-adoptive homes (45 CFR 1355.20(a)).

[3] Placement instability is when a child or youth has several placement changes outside of their home. A placement change, also known as a "placement disruption," occurs when a child in foster care is moved from one foster home or setting to another. This can involve moving to a different foster family home, a group home, or a residential facility or returning to the birth family (AECF 2025b, Casey Family Programs 2023).

[4] In the child welfare context, the goal of permanency is to reunite children with their biological parents or place them with another permanent family through an adoptive or guardianship arrangement (Stoltzfus 2018).

[5] MACPAC engaged Mathematica and its subcontractor, the Innovations Institute at the UConn School of Social Work, to conduct a systematic examination of federal requirements and state delivery methods of Medicaid benefits to children in the child welfare system. Children in the child welfare system may move between foster care, residential care, kinship care, reunification with their biological family, or adoption. This research focused on children currently in foster care. This study consisted of a federal policy review, literature review, in-depth profiles of seven states' child welfare and Medicaid systems, and more than 30 interviews with federal and state stakeholders as well as subject matter experts. The seven states are California, Connecticut, Illinois, Iowa, Kentucky, New York, and West Virginia.

[6] State laws vary regarding who has the authority to release medical and dental information for children in foster care and who has the authority to consent to their treatment.

[7] Psychotropic medications are generally used to treat conditions such as depression, anxiety, schizophrenia, bipolar disorder, and attention-deficit/hyperactivity disorder (ADHD), and are an important component in the treatment of behavioral health conditions (MACPAC 2015b).

[8] The Family First Prevention Services Act also gave states the option to use child welfare funds to access specific mental health and substance use treatment and in-home parenting skills training services to prevent children from being placed in foster care.

[9] Historically, children's eligibility for the Medicaid program was closely linked to cash payments under the former federal-state Aid to Families with Dependent Children (AFDC) program, also known as "welfare," and for those with disabilities, the federal Supplemental Security Income (SSI) program. Eligibility for Title IV-E is still tied to the former AFDC program (which ended in 1996) or the SSI rules. Although Congress has made a number of changes to expand Medicaid for all children based on their low-income states, children enrolled in Title IV-E programs are automatically connected to Medicaid coverage without having to complete a Medicaid application.

[10] For example, children younger than age 19 in foster care, but not receiving Title IV-E payments, are also Medicaid eligible since only the child's income is considered when the child is living in a home that does not include a biological parent, adoptive parent, or step parent. (MACPAC 2015a).

[11] States, such as Illinois, Massachusetts, New Jersey, and Ohio, provide transition supports and family-based therapy services for kids aging out of foster care (Landers 2019).

[12] Most states have adopted the Bright Futures periodicity schedule developed by the American Academy of Pediatrics (CMS 2024).

[13] MCOs must maintain eligibility, enrollment, claims and encounter, utilization management, and grievance and appeals data in formats prescribed by the state Medicaid agency and in compliance with the CMS reporting requirements (42 CFR 438.242).

[14] Voluntary Foster Care Agencies are authorized agencies approved by New York's Office of Child and Family Services to "care for or board out children and to provide limited health-related services as defined in regulations of the department either directly or indirectly through a contract arrangement" (New York OCFS 2024). New York state licensing law, Article 29-I, authorized Voluntary Foster Care Agencies to provide core health-related services, including nursing, skill building, Medicaid treatment planning and discharge planning, clinical consultation and supervision, and managed care liaison and administration. Other limited health-related services include screening, diagnosis, and treatment services related to physical, developmental, and behavioral health.

[15] For a qualified residential treatment program to receive Title IV-E payment on behalf of a child, the child must be assessed by a qualified individual not associated with the public agency or the residential program within 30 days of placement. Within 60 days of placement, the court must consider the assessment to determine if the placement in the residential facility is necessary and approve the placement (ACF 2018).

[16] Statewide Automated Child Welfare Information Systems (SACWIS) were a federally funded, comprehensive, computerized case management tool used by state child welfare agencies to track and manage information about children and families involved in the child welfare system (Illinois DCFS 2025). On June 2, 2016, the ACF issued a new regulation that replaced the SACWIS requirements with a Comprehensive Child Welfare Information System (CCWIS). The CCWIS final rule provides state and tribal Title IV-E agencies with flexibility to determine the size, scope and functionality of its information system and does not require

states to build a CCWIS. However, for states that elect to build and operate a CCWIS, the CCWIS final rule specifies the core requirements that must be met (ACF 2016).

[17] Approved health plan staff also have access to the state child welfare agency's system and the Illinois Department of Children and Family Service's Statewide Automated Child Welfare Information System (SACWIS), which contains information regarding child intake, investigations, case management, service planning, unusual incident reporting, and child health and education information (Illinois DCFS 2025).

[18] The number of children in foster care for fiscal year (FY) 2022 decreased by nearly six percent compared to FY 2021, which is a greater decrease than the nearly four percent decrease in FY 2021 relative to FY 2020 (ACF 2025).

[19] Trauma-informed care recognizes the signs and symptoms of trauma in patients, responds by fully integrating knowledge about trauma into procedures and services, and actively seeks to prevent re-traumatization (SAMHSA 2024).

[20] One review of Medicaid MCOs across 14 states found that, on average, 12 percent of primary care physicians left the network annually, and 34 percent exited over a period of five years, with specialized networks seeing the highest turnover rate (Ndumele et al. 2018).

[21] States must require all MCOs to implement performance improvement projects (PIPs). The purpose of PIPs is to achieve substantial improvement in measurement of quality performance with objective indicators as well as to generally sustain this improvement over time (42 CFR 438.330). States must require MCOs, prepaid inpatient health plans, and prepaid ambulatory health plans to conduct clinical and non-clinical PIPs to examine access to and quality of care.

References

Administration for Children and Families (ACF), U.S. Department of Health and Human Services. 2025. *The AFCARS dashboard*. Washington, DC: ACF. https://acf.gov/sites/default/files/documents/cb/2024-afcars-dashboard-printable.pdf.

Administration for Children and Families (ACF), U.S. Department of Health and Human Services. 2018. Information memorandum to state, tribal, and territorial agencies regarding "New legislation—Public Law 115-123, the Family First Prevention Services Act within Division E, Title VII of the Bipartisan Budget Act of 2018." April 13, 2018. Washington, DC: ACF.

Administration for Children and Families (ACF), U.S. Department of Health and Human Services. 2016. Comprehensive child welfare information system. Final rule. *Federal Register* 81, no. 106 (June 2, 2016); 35450–35482. https://www.govinfo.gov/content/pkg/FR-2016-06-02/pdf/2016-12509.pdf.

Administration for Children and Families and Centers for Medicare & Medicaid Services (ACF and CMS), U.S. Department of Health and Human Services. 2022. T*oolkit: Data sharing for child welfare agencies and Medicaid.* Washington, DC: ACF and CMS. Baltimore, MD: CMS. https://www.acf.hhs.gov/sites/default/files/documents/cb/data-sharing-and-medicaid-toolkit.pdf.

Allen, K.D., and T. Hendricks. 2013. *Medicaid and children in foster care.* Hamilton, NJ: Center for Health Care Strategies. https://www.chcs.org/media/medicaid-and-children-in-foster-care.pdf.

American Academy of Pediatric Dentistry (AAPD). 2025. *Policy on care for vulnerable populations in a pediatric dental setting.* Chicago, Ill: AAPD. https://www.aapd.org/globalassets/media/policies_guidelines/p_vulnerablepopulations.pdf.

American Academy of Pediatrics (AAP). 2021a. Mental and behavioral health care needs of children in foster care. Itasca, IL: AAP. https://www.aap.org/en/patient-care/foster-care/mental-and-behavioral-health-needs-of-children-in-foster-care/.

American Academy of Pediatrics (AAP). 2021b. Fostering health: Standards of care for children in foster care. Itasca, IL: AAP. https://www.aap.org/en/patient-care/foster-care/health-care-standards/.

Annie E. Casey Foundation (AECF). 2025a. Children in foster care with more than two placements in United States. Baltimore, MD: AECF. https://datacenter.aecf.org/data/tables/8822-children-in-foster-care-with-more-than-two-placements?loc=1&loct=1#detailed/2/2-53/true/2545/any/17681.

Annie E. Casey Foundation (AECF). 2025b *Child welfare and foster care statistics.* Baltimore, MD: AECF. https://www.aecf.org/blog/child-welfare-and-foster-care-statistics.

Bruns, E.J., P.H. Benjamin, R.N Shelper, et al. 2021. Defining quality standards for intensive home based treatment programs for youth with serious emotional disorders. *Administration and Policy in Mental Health* 48, no 6: 1065–1088. https://link.springer.com/article/10.1007/s10488-021-01116-8.

California Department of Health Care Services (California DHCS). 2023. County child welfare MOU template post-release webinar. December 5, 2023. https://www.dhcs.ca.gov/Documents/MCQMD/County-Child-Welfare-MOU-Template-Post-Release-Webinar.pdf.

Casey Family Programs. 2023. *Strong families: What impacts placement stability?* Seattle, WA: Casey. https://www.casey.org/media/23.07-QFF-SF-Placement-Stability-Impacts.pdf.

Casey Family Programs. 2018. *Strong families: What is New Jersey's mobile response and stabilization services intervention?* Seattle, WA: Casey. https://www.casey.org/media/SF_New-Jersey-MRSS.pdf.

Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. 2025. About adverse childhood experiences. Atlanta, GA: CDC. https://www.cdc.gov/aces/about/index.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024. Letter from Daniel Tsai to state health officials regarding "Best practices for adhering to early and periodic screening, diagnostic, and treatment (EPSDT) requirements." September 26, 2024. https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022. Letter from Daniel Tai to state health officials regarding "Coverage of youth formerly in Medicaid (Section 1002(a) of the SUPPORT Act." December 16, 2022. https://www.medicaid.gov/federal-policy-guidance/downloads/sho22003.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013. *Medicaid and CHIP FAQs: Coverage of former foster care children.* Baltimore, MD: CMS. https://www.medicaid.gov/state-resource-center/downloads/medicaid-and-chip-faqs-coverage-of-former-foster-care-children.pdf.

Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. 2023. *Child maltreatment 2023*. Washington, DC: Children's Bureau. https://acf.gov/sites/default/files/documents/cb/cm2023.pdf.

Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. 2021. *Child maltreatment 2021*. Washington, DC: Children's Bureau. https://acf.gov/sites/default/files/documents/cb/cm2021.pdf.

Children's Defense Fund (CDF). 2023. *2023 State of America's children report: Child welfare.* Washington, DC: CDF. https://www.childrensdefense.org/tools-and-resources/the-state-of-americas-children/soac-child-welfare/.

Côté, S.M., M. Orri, M. Marttila, and T. Ristikari. 2018. Out-of-home placement in early childhood and psychiatric diagnoses and criminal convictions in young adulthood: A population-based propensity score-matched study. *The Lancet Child & Adolescent Health* 2, no. 9: 647–653. https://doi.org/10.1016/S2352-4642(18)30207-4.

Deutsch, S.A., and K. Fortin. 2015. Physical health problems and barriers to optimal health care among children in foster care. *Current Problems in Pediatric and Adolescent Health Care* 45, no.10: 286–291. https://pubmed.ncbi.nlm.nih.gov/26364980/.

Engler, A.D., K.O. Sarpong, B.S. Van Horne, et al. 2020. A systematic review of mental health disorders of children in foster care. *Trauma, Violence, & Abuse* 23, no 1: 255–264. https://doi.org/10.1177/1524838020941197.

Florence, C., D.S. Brown, X. Fang, and H.F. Thompson. 2013. Health care costs associated with child maltreatment: Impact on Medicaid. *Pediatrics* 132, no. 2: 312–318. https://publications.aap.org/pediatrics/article-abstract/132/2/312/31377/Health-Care-Costs-Associated-With-Child.

Forkey, H., A. Garner, L. Nalven, et al. 2021. *Helping foster and adoptive families cope with trauma*. Itasca, IL: American Academy of Pediatrics. https://www.aap.org/en/patient-care/foster-care/supporting-children-who-have-experienced-trauma/.

Hess, C. 2020. *State roles in preventing and improving foster care placements for children with medical complexity.* Washington, DC: National Academy for State Health Policy. https://nashp.org/state-roles-in-preventing-and-improving-foster-care-placements-for-children-with-medical-complexity/.

Illinois Department of Children and Family Services (Illinois DCFS). 2025. IllinoisConnect. Springfield, IL: Illinois DCFS. https://dcfs.illinois.gov/for-providers/illinoisconnect.html.

Iowa Department of Human Services (Iowa DHS). 2024. *Medicaid state plan amendment: Therapeutic foster care.* Des Moines, IA: Iowa DHS. https://www.medicaid.gov/medicaid/spa/downloads/IA-24-0002.pdf.

Keefe, R.J., A.D.L Cummings, A.E. Smith, et al. 2023. Psychotropic medication prescribing: Youth in foster care compared with other Medicaid enrollees. *Journal of Child and Adolescent Psychopharmacology* 33, no. 4: 149–155. https://pubmed.ncbi.nlm.nih.gov/37204275/.

Keefe R.J., A.D.L Cummings, C.S. Greeley, and B.S. Van Horne. 2022. Mental health and developmental disorder diagnoses of foster and nonfoster children enrolled in Medicaid. *Journal of Developmental and Behavioral Pediatrics* 43, no. 5: e296–e303. https://pubmed.ncbi.nlm.nih.gov/34693925/.

Kentucky Cabinet for Health and Family Services (Kentucky CHFS) 2021. *Contract with Aetna Better Health of Kentucky Insurance Company.* Frankfort, KY: Kentucky CHFS. https://www.chfs.ky.gov/agencies/dms/dpqo/Documents/Aetna.pdf.

Lamminen, L.M., J.D. McLeigh, and H.K. Roman. 2020. Caring for children in child welfare systems: A trauma-informed model of integrated primary care. *Practice Innovations* 5, no. 1: 55–64. https://doi.org/10.1037/pri0000108.

Landers, P.A. 2019. *Youth transitioning from foster care: Background and federal programs*. Washington, DC: Congressional Research Service. https://www.congress.gov/crs-product/RL34499.

Mark, T.L., M. Dolan, B. Allaire, and C. Bradley. 2023. *Linking child welfare and Medicaid data: Lessons from two states.* Washington, DC: Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/reports/ccould-lessons-learned-report.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2025. Chapter 2: Appropriate access to residential behavioral health treatment for children in Medicaid. In June 2025 *Report to Congress on Medicaid and CHIP*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2025/06/MACPAC_June-2025-Chapter-2.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021. *Access in brief: Behavioral health services for youth in foster care*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2021/08/Access-in-Brief-Behavioral-Health-Services-for-Youth-in-Foster-Care.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015a. Chapter 3: The intersection of Medicaid and child welfare. In June 2015 *Report to Congress on Medicaid and CHIP.* Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/06/Intersection-of-Medicaid-and-Child-Welfare.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015b. Chapter 5: Use of psychotropic medications among Medicaid beneficiaries. In June 2015 *Report to Congress on Medicaid and CHIP*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/06/Use-of-Psychotropic-Medications-among-Medicaid-Beneficiaries.pdf.

Merrick, M.T., D.C. Ford, K.A. Ports, et al. 2019. Vital signs: Estimated proportion of adult health problems attributable to adverse childhood experiences and implications for prevention—25 States, 2015–2017. *Morbidity and Mortality Weekly Report* 68, no.44: 999–1005. https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6844e1-H.pdf.

Minoff, E., and A. Citrin. 2022. *Systemically neglected: How racism structures public systems to produce child neglect.* Washington, DC: Center for the Study of Social Policy. https://cssp.org/wp-content/uploads/2025/03/Systemically-Neglected-How-Racism-Structures-Public-Systems-to-Produce-Child-Neglect.pdf.

Morón E.M., S.L. Tomar, R. Souza, et al. 2019. Dental status and treatment needs of children in foster care. *Pediatric Dentistry* 41, no. 3: 206–210. https://pubmed.ncbi.nlm.nih.gov/31171072/.

Ndumele C., B. Staiger, J. S. Ross, and M. Schlesinger. 2018. Network optimization and the continuity of physicians in Medicaid managed care. *Health Affairs* 37, no 6. https://doi.org/10.1377/hlthaff.2017.1410.

New Jersey Department of Children and Families (New Jersey DCF). 2017. Mobile response and stabilization service project. Trenton, NJ: New Jersey DCF. https://www.nj.gov/njfosteradopt/services/mrss.html.

New York Office of Children and Family Services (New York OCFS). 2024. *VFCA health facilities license guidelines*. Albany, NY: OCFS. https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/final_draft_vfca_health_facilities_license_guidelines.pdf.

Office of Inspector General (OIG), U.S. Department of Health and Human Services. 2015. *Not all children in foster care who were enrolled in Medicaid received required health screenings.* Washington, DC: OIG. https://oig.hhs.gov/oei/reports/oei-07-13-00460.pdf.

Radel, L., S. Lieff, C. Couzens, et al. 2023. *Behavioral health diagnoses and treatment services for children and youth involved with the child welfare system*. Washington, DC: Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/sites/default/files/documents/51f80cd88e92eae6c4fc77efada9506b/T-MSIS-Child-Welfare-Overview-Brief.pdf.

Sarvas, E.W., J.K. Eckerle, K.L. Gustafson, et al. 2021. Oral health needs among youth with a history of foster care: A population-based study. *Journal of the American Dental Association* 152, no. 8: 589–595. https://doi.org/10.1016/j.adaj.2021.03.008.

Sepulveda, K., R. Rosenberg, S. Sun, and A. Wilkins. 2020. *Children and youth with special health care needs in foster care*. Rockville, MD: Child Trends. https://cms.childtrends.org/wp-content/uploads/2020/12/CYSHCN_ChildTrends_Dec20-2.pdf.

Stoltzfus, E. 2018. *Child welfare: An overview of federal programs and their current funding*. Washington, DC: Congressional Research Services. https://www.congress.gov/crs-product/R43458.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2024. Trauma-informed approaches and programs. Rockville, MD: SAMHSA. https://www.samhsa.gov/mental-health/trauma-violence/trauma-informed-approaches-programs.

Szilagyi, M.A., D.S. Rosen, D. Rubin, et al. 2015. Health care issues for children and adolescents in foster care and kinship care. *Pediatrics* 136, no. 4: 1142–1166. https://publications.aap.org/pediatrics/article/136/4/e1142/73872/Health-Care-Issues-for-Children-and-Adolescents-in.

Taussig, H.N., S.B. Harpin, and S.A. Maguire. 2014. Suicidality among preadolescent maltreated children in foster care. *Child Maltreatment* 19, no. 1: 17-26. https://pmc.ncbi.nlm.nih.gov/articles/PMC4319651/.

Thompson, V. 2022. *How state Medicaid programs serve children and youth in foster care*. Washington, DC: National Academy for State Health Policy. https://nashp.org/how-state-medicaid-programs-serve-children-and-youth-in-foster-care/.

Turney, K., and C. Wildeman. 2016. Mental and physical health of children in foster care. *Pediatrics* 138, no. 5: e20161118. https://pubmed.ncbi.nlm.nih.gov/27940775/.

West Virginia Department of Health and Human Resources (West Virginia DHHR). 2025. 2024 *External quality review: Annual technical report*. Charleston, WV: West Virginia DHHR. https://bms.wv.gov/media/40598/download?inline.

West Virginia Department of Health and Human Resources (West Virginia DHHR). 2023a. Model purchase of service provider agreement for Mountain Health Promise. Charleston, WV: West Virginia DHHR. https://bms.wv.gov/media/24621/download?inline.

West Virginia Department of Health and Human Resources (West Virginia DHHR). 2023b. 2022 *External quality review: Annual technical report*. Charleston, WV: West Virginia DHHR. https://bms.wv.gov/media/24896/download?inline.

YouthCare, Illinois Department of Children and Family Services. 2025a. *Member handbook*. Springfield, IL: YouthCare. https://www.ilyouthcare.com/content/dam/centene/meridian/il/pdf/YouthCare_MemberHandbook_18JUN2025.pdf.

YouthCare, Illinois Department of Children and Family Services. 2025b. *Provider manual*. Springfield, IL: YouthCare. https://www.ilyouthcare.com/content/dam/centene/meridian/il/pdf/YouthCare_2025ProviderManual_Final_08-2025.pdf.

Zito, J.M., D.J. Safer, D. Sai, et al. 2008. Psychotropic medication patterns among youth in foster care. *Pediatrics* 121, no 1: 157–163. https://doi.org/10.1542/peds.2007-0212.