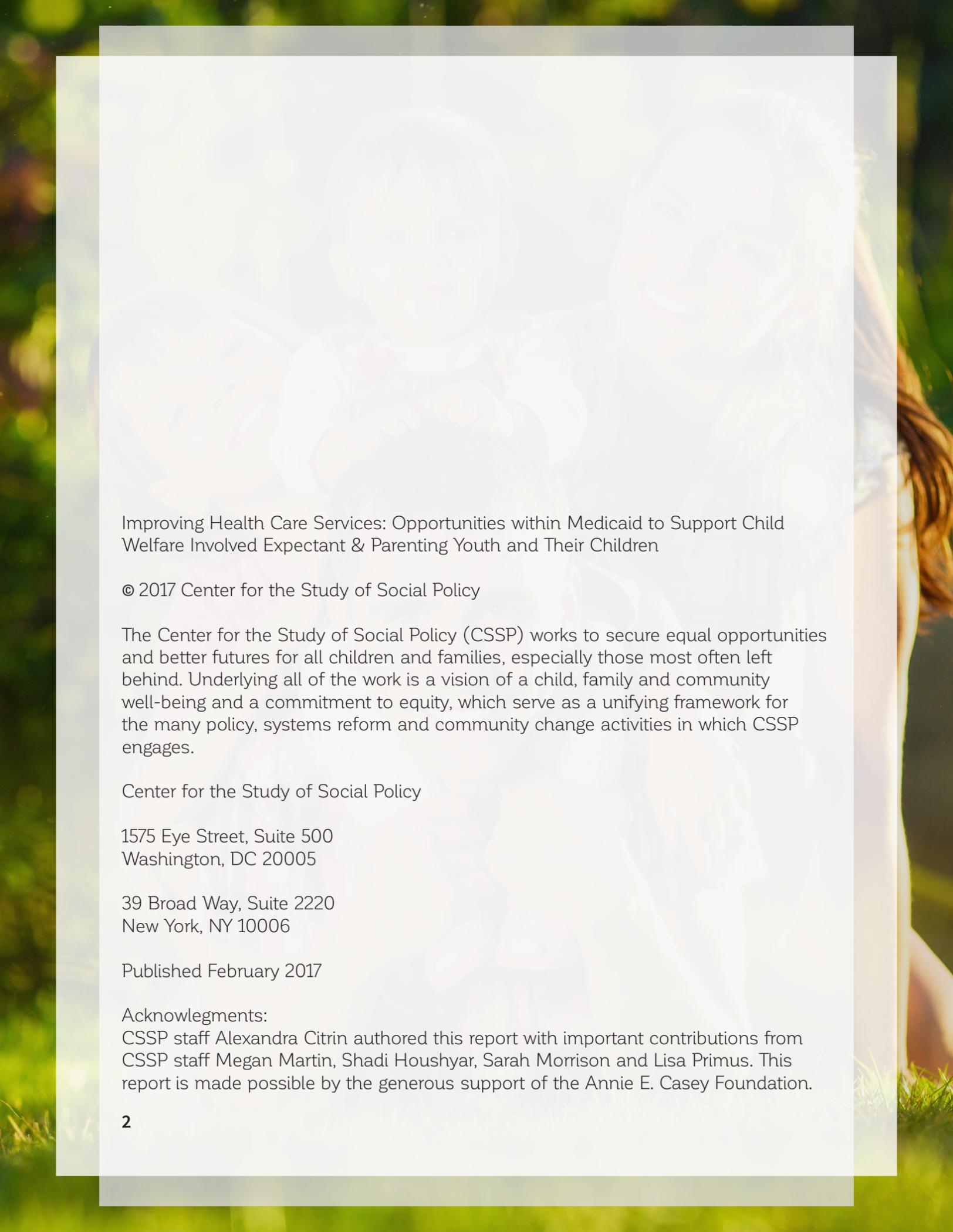




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**IMPROVING HEALTH CARE SERVICES:**  
OPPORTUNITIES WITHIN MEDICAID TO SUPPORT  
**CHILD WELFARE INVOLVED EXPECTANT AND  
PARENTING YOUTH AND THEIR CHILDREN**

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Improving Health Care Services: Opportunities within Medicaid to Support Child Welfare Involved Expectant & Parenting Youth and Their Children

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The Center for the Study of Social Policy (CSSP) works to secure equal opportunities and better futures for all children and families, especially those most often left behind. Underlying all of the work is a vision of a child, family and community well-being and a commitment to equity, which serve as a unifying framework for the many policy, systems reform and community change activities in which CSSP engages.

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Access to comprehensive, regular and reliable quality medical and behavioral health care is essential for all young people, especially for those who are expectant or parenting. Meeting the health care needs of young mothers and fathers and their children are closely associated with positive health and developmental outcomes for the child later in life.<sup>1</sup> This requires quality prenatal care and ongoing health care including post-natal care, newborn care and pediatric care, regular well-child visits, family planning, prescriptions, mental and behavioral health treatment, and treatment for sexually transmitted infections.

While national rates of adolescent pregnancy have declined, youth in foster care still have high rates of births while they are in foster care and after transitioning out of the child welfare system.<sup>2</sup> According to findings from the Midwest Evaluation – which surveyed former foster youth from Iowa, Illinois and Wisconsin during their transition to adulthood – adolescent women in foster care were 2.5 times more likely to become pregnant by age 19 than their peers not in foster care and approximately half of 21-year-old males transitioning out of foster care reported getting a partner pregnant compared to 19 percent of their non-foster care peers.<sup>3</sup>

Pregnancy and childbirth have a huge impact on the physical, mental and emotional health of young parents and their families. While many new parents face challenges associated with being a first time parent, adolescent parents in foster care face additional barriers that make it even more difficult for them – and their children – to thrive. Adolescent parents aging out of foster care are less likely to be engaged in school or work compared to their peers and often cite a need for child care as a key barrier to their participation.<sup>4</sup> In addition, compared to their peers who were never involved with the child welfare system, youth in and transitioning out of foster care experience a higher prevalence of mental health challenges and those who are expectant or parenting are at an increased risk for



prenatal and postpartum depression – which not only have an impact on the new mother but also can impact the infant’s physical and emotional development.<sup>5</sup> Specifically, across all income and age groups, mental health challenges are among the strongest risk factors for poor pregnancy outcomes for both mothers and their infants.

There are several strategies states should pursue to maximize the health and well-being of adolescent parents who have experienced foster care **and** their children. These include: (1) adopting policies and practices that recognize and seek to meet the unique, holistic needs of both young parents and their children; (2) increasing access to health care services and insurance through improving enrollment, eligibility and portability processes and policies; and (3) improving cross-systems collaboration. The specific recommendations discussed below provide states with opportunities to implement these strategies.

Figure 1.

## **Strategies to Maximize Health and Well-Being of Adolescent Parents Who Have Experienced Foster Care and Their Children**

- 1.** Adopting policies and practices that recognize and seek to meet the unique, holistic needs of both young parents and their children
- 2.** Increasing access to health care services and insurance by improving enrollment, eligibility and portability processes and policies
- 3.** Improving cross-systems collaboration



# Meet the unique, holistic needs of both young parents and their children

■ **Implement integrated care models, for example Medicaid Health Homes.**<sup>6</sup> Integrated health care models, including Medicaid Health Homes can ensure continuity of care and increase the quality of services for youth aging out of care, especially those who are expectant or parenting by addressing the interrelated health needs and concrete needs of these young families. Child welfare agencies and stakeholders should partner with state Medicaid offices to explore how these models can serve youth who have aged out of care – particularly those who are expectant and parenting – in meeting their needs as a parent and adolescent along with the needs of their child. States can apply for Health Homes to target the needs of specific groups – including those who have experienced trauma and have severe behavioral needs.

In addition to Health Homes, integrated health care approaches – including medical-legal partnerships – can improve health outcomes by addressing concrete needs.<sup>7</sup> For example, a lack of safe and stable housing, nutritional needs and financial stressors may impact a parent's physical or socio-emotional health.

■ **Coordinate all state programs to promote healthy development and well-being for both parents and children.** Promoting the healthy development of young children and families goes beyond meeting basic health needs and includes supporting the attachment between parents and children and building parental capacity. State programs – including Home Visiting, Early Head Start and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) – share a common vision of supporting young children and their parents. By coordinating access through one-stop-shops, co-location of staff and automatic Medicaid enrollment to the variety of programs to support expectant and parenting youth, Medicaid and the child welfare system can support healthy development for at least two generations – both parents and their children. Additionally, Home Visiting programs can also provide an opportunity to promote father involvement and increase their knowledge of child development through providing ongoing coaching to staff on adolescent development and engagement strategies, maintaining flexible scheduling with families and utilizing hands-on activities for fathers and children.<sup>8</sup>

## STATE EXAMPLE

In December 2016, **New York** expanded its Medicaid Health Home program to provide integrated care for children with two or more chronic medical conditions, serious emotional disturbance (SED) or complex trauma. The Health Home program provides comprehensive, person-centered care planning and coordination that is child and family-focused for all Medicaid services including those that meet identified behavioral and physical health needs. This process of identifying health needs and expanding the Health Home program involved cross-system state partners including the Department of Health, the Office of Mental Health and the Office of Children and Family Services.

## STATE EXAMPLE

Through an enhanced Medicaid reimbursement rate, **South Carolina** incentivizes CenteringPregnancy®, a health care model that utilizes individual and group care to promote healthy outcomes for parents and children. Developed by the Centering Healthcare Institute, this unique intervention includes one-on-one time with the healthcare professional as well as groups of women and/or families learning together about their child's development, discussing the challenges of parenting and developing a community of support. Currently, CenteringPregnancy® or CenteringParenting® exists in 43 states. Similar to South Carolina, states can incentivize this approach through an enhanced Medicaid reimbursement rate for current and former expectant and parenting foster youth – both mothers and fathers.

■ **Incentivize health care systems to support young people as parents and adolescents.** For young people who may have difficulty coordinating doctors, navigating complex systems and balancing multiple appointments, medical providers should be organized to serve young expectant parents in a holistic manner. Through grants and education, states can incentivize doctors to specialize in adolescent health care – encompassing both their needs as parents and as adolescents – and promote physician practices that utilize a collaborative approach to meet the needs of adolescent parents. This is particularly important for youth involved with child welfare – many of whom have experienced significant trauma and are prescribed psychotropic medications at a higher rates.<sup>9</sup> Throughout their pregnancy and as part of post-natal care, these youth require coordination of services including consistent and often specialized medication monitoring throughout their pregnancy. In addition, states can create and utilize an enhanced Medicaid reimbursement rate to incentivize the implementation of health care interventions that involve social supports – including fathers and extended family – as part of the ongoing care plan so that young people can thrive as adolescents and parents. Encouraging the involvement of social supports can create additional opportunities for both mothers and fathers to engage in co-parenting, increase their knowledge of their child's development and develop their own peer networks.

■ **Require health care providers to complete maternal depression screenings during well-child visits.** Centers for Medicare and Medicaid Services (CMS) recently issued guidance clarifying that states can allow maternal depression screenings to be claimed as a service under Medicaid's Early and Periodic Screening Diagnosis and Treatment (EPSDT) benefit. This screening is particularly important for current and former foster youth who have experienced trauma and have higher levels of mental health challenges such as untreated maternal depression, which can create additional obstacles for mothers in forming secure attachments and nurturing relationships with their children.

■ **Promote the co-location of health clinics in educational settings.** States can meet the needs of parents and youth by increasing the ability of parents to access health care services for themselves and their children in places they frequent on a regular basis – for example, education settings for adolescents and their young children. Opportunities also exist within school settings to promote collaboration between physical health clinical and school-based mental health supports to promote holistic health and well-being for young parents and their children.

# Increase access to health care services and insurance by improving enrollment, eligibility and portability processes and policies

- **Utilize an automatic enrollment process for youth prior to aging out of care.** Given that youth aging out of care are categorically eligible for Medicaid health insurance, states should use a youth's 21st birthday<sup>10</sup> as a trigger for automatic enrollment into the state's Medicaid plan to ensure continuous health care coverage for these youth. Evidence shows that passive enrollment, which does not require the youth to actively opt-in, is the most effective strategy for ensuring all eligible youth are enrolled.
- **Elect the option to cover former foster youth regardless of whether or not the youth was enrolled in Medicaid on their 18th birthday.** The Affordable Care Act (ACA) allows for states to elect to cover former foster youth regardless of their health insurance coverage on their 18th birthday. Electing this option can ensure continuous coverage for former foster youth who may have previously been on private health insurance or were not eligible for Medicaid on their 18th birthday, for example youth who did not have legal status or lawful permanent residency at the time.
- **File for a Section 1115 Medicaid Demonstration waiver to cover former foster youth regardless of the state the youth was in care.** CMS issued a final rule in November 2016 that allows states to extend eligibility to former foster youth who were in care in a different state through a Section 1115 Medicaid Demonstration.<sup>11</sup> Expectant and parenting youth deserve the same equal opportunities to relocate to pursue opportunities like work and school or to be near loved ones without being restricted to the state in which they were in foster care for fear of losing their health insurance. Currently 13 states – California, Georgia, Kentucky, Louisiana, Massachusetts, Michigan, Montana, New Mexico, New York, Pennsylvania, South Dakota, Wisconsin and Virginia – cover youth who have aged out of care in a different state. These states must apply for a Section 1115 Demonstration no later than May 21, 2017 to continue to cover these youth and future youth who fall into this group.
- **Assist former foster youth who are expectant and parenting to select the most appropriate managed care program to meet their needs when possible.** Some states require the Medicaid recipient to select a managed care plan within a designated time period otherwise they are automatically enrolled in a state-selected plan. In these states, child welfare representatives should work with youth to select the most appropriate plan while simultaneously working with Medicaid agencies to ensure that any automatic assignments for these youth are to a plan that is the most appropriate. This is particularly important for expectant and parenting youth who have specific health care needs associated with pregnancy and post-pregnancy.
- **Implement automatic enrollment criteria for all children of parenting foster youth and former foster youth who are enrolled in the state's Medicaid plan.** To promote the well-being of children of parenting foster youth and former foster youth, states should amend their Medicaid State Plans to adopt presumptive eligibility criteria for this population of children. This would ensure that children of

current and former foster youth are enrolled in a health care plan regardless of income eligibility. In addition, this would support parental decision-making capacity as parents would not have to restrict themselves from pursuing opportunities that may lift them above the income eligibility threshold to ensure their children's access to health care coverage.

■ **Allow former foster youth to maintain categorical eligibility when a young mother is pregnant even if she turns 27 during a pregnancy.** Continuous, uninterrupted health insurance is necessary to ensure that young women can access appropriate care during their pregnancy. In order to support former foster youth in accessing continuous prenatal care, states should recognize pregnancy as a trigger for young women to maintain their same Medicaid plan throughout their pregnancy, even if they turn 27 during their pregnancy.

■ **Ensure parents and their children can be on the same health care plan or linked health care plans.** Expectant and parenting foster youth are categorically eligible for health insurance, however, their child's health insurance may be provided through Medicaid or the Children's Health Insurance Program (CHIP) depending on family income. When children are also eligible for health insurance through Medicaid, states should provide options for parents and children to be on the same health care plan or on linked health care plans. When children do not qualify for Medicaid but do qualify for CHIP, states should require the state Medicaid agency and CHIP programs to coordinate care to link health care coverage if possible.

■ **Remove barriers to continuous health care for children of current and former foster youth by eliminating recertification requirements.** Requirements to recertify for Medicaid eligibility is a burden for young people who may move frequently and choose to relocate for many reasons including job or education opportunities. States should remove barriers for children of current and former foster youth by eliminating all recertification requirements until the parent's 26th birthday – the same time that parents would no longer be categorically eligible based on their former foster care status.

■ **Require Medicaid agencies to work with former foster youth transitioning to new health insurance upon turning 26 years old.**

It is particularly important for young adults to have continuous health care coverage. When a young parent is 25.5 years old, state Medicaid agencies should be required to begin working with them to ensure a seamless transition to a new health care plan to prevent any disruption in coverage. In the 34 states with a federally-facilitated Health Insurance Marketplace, states should instruct recipients of Navigator Grant Awards<sup>12</sup> to conduct outreach to former foster youth when they are 25.5 years old to support them in selecting an appropriate health insurance program.



## STATE EXAMPLES

With the implementation of the ACA, **Texas** policy supports parenting former foster youth through integrated health care coverage. As a result, when former foster youth meet income eligibility requirements, they and their children are enrolled in the same Medicaid managed care (STAR). This supports parents who now only have to navigate one health care management organization.<sup>13</sup>

**California** automatically enrolls all former foster youth in the Medi-Cal program for former foster youth upon their emancipation from foster care. Youth who have aged-out from California's foster care system are not required to submit any eligibility documents in order to receive health insurance and are able to keep their same Medi-Cal card and number. Furthermore, California does not require youth to recertify at any point prior to their 26th birthday or if they move to a new county within the state.

The Medi-Cal program for former foster youth also allows youth to select fee-for-service coverage that provides them with the ability to select their own doctors, therapists and dentists as long as the provider accepts Medi-Cal. This is particularly important for expectant and parenting youth who should have the ability to choose their preferred obstetrician-gynecologist, child's pediatrician and mental and behavioral health providers.



## WHY STATES SHOULD FOCUS ON COORDINATED CARE:

**Coordinated care** is critical to supporting the health and well-being of young families who often have to navigate complex systems in order to access resources and supports. Research shows that not only are parents more likely to ensure their child has access to the appropriate health care services when their own health needs are being met but also that parent and child health are positively impacted when a parent is enrolled in a health insurance program that supports regular access to care. For young parents who have aged out of foster care and their children, it is important for systems to support integrated health care where 1) parents can have their health care needs met in one place and 2) parents and children can have their health needs met at the same time. In May 2016, the CMS released an Informational Bulletin highlighting the importance of supporting mothers in order to promote young children's healthy development. CMS guidance clarifies that states can allow maternal depression screenings to be claimed as a service under Medicaid's EPSDT benefit. Completing this screening during a well-child visit allows for pediatricians to promote both the health and well-being of the mother and the child. In addition to supporting mothers, integrated health care models can support young fathers who are often not included in conversations regarding the health needs of their child. Beyond supporting young people in their role as parents, coordinated and integrated health care systems can also support the young person's role as a parent and their health needs as an adolescent – ensuring a holistic approach to a young person's health and well-being.

## WHY STATES SHOULD FOCUS ON ACCESS:

**Access** to health insurance is essential to ensuring expectant and parenting youth receive regular prenatal and postnatal health care to promote their health and well-being and improve birth outcomes. Any loss of health care coverage – for example due to eligibility criteria, the need to recertify or a parent moving – can have a serious impact on short-term and long-term health and well-being for both a parent and child. While ensuring access to appropriate care is important for all expectant and parenting youth, it is particularly important for current and former foster youth – many of whom have experienced trauma and have additional medical and mental health needs. To increase access to health insurance and health care services, state administrators and policymakers can support seamless enrollment processes and promote portability policies for current and former foster youth who are expectant and their children.

According to findings from the fifth wave of the Midwest Evaluation,<sup>6</sup> 41 percent of youth who had aged out of foster care reported not having health insurance compared to only 22 percent of their peers who had never been involved with the child welfare system. In response to the needs of young people aging out of foster care, regulations in the ACA now require states to provide, as of January 2014, the full Medicaid benefit<sup>6</sup> to all youth who were in foster care on, or after, their 18th birthday in their state regardless of their income. This provision applies to all youth who are currently in care and those youth who would have fit these eligibility criteria at any point since January 1, 2007. Additionally, current Medicaid regulations require eligibility to be continued automatically whenever the state has information sufficient to demonstrate continued eligibility.<sup>6</sup> For foster youth who age out of care on, or after their 18th birthday, this information can be considered sufficient to demonstrate continued eligibility and thus eliminate the need for states to conduct regular eligibility reviews. This is particularly important for young people who may move around – even within the same state – and be less likely to receive mail notification that they need to meet with a worker for a review of their eligibility.

## Improve cross-systems collaboration

■ **Require data sharing across systems.** Former foster youth who are expectant and parenting receive services from multiple systems in order to meet their health needs and those of their children including mental and behavioral health services, developmental supports and health care. To ensure comprehensive health care is provided to this population, data sharing agreements between various agencies and systems need to be in place. When working with young mothers who may be prescribed psychotropic medication, it is critical that data sharing agreements and working partnerships are in place to support the well-being of both the young person and child in the short and long-term. In addition, in order to provide for the healthy early development of young children, pediatricians would benefit from access to prenatal medical information that parents may not have or remember.

## Conclusion

Current and former foster youth often have unique and challenging health care needs based on their life experiences. These health care needs are even more complex when the young person is expecting or parenting a child. In order to promote strong, healthy families, states need to recognize the importance of providing quality medical and behavioral health care, increasing access to health insurance for both parents and their children and promoting coordinated care to ensure better outcomes for current and former foster youth and their children. As states move forward in implementing these recommendations and others, states must also invest in continuous quality improvement and learning processes to assess the effectiveness of interventions, ensure that unintended treatment disparities do not occur and improve outcomes for former foster youth who are expectant or parenting and their children.

# Endnotes

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4. Center for the Study of Social Policy. (2015). Expectant and parenting youth in foster care. (see note 2)
5. Burns et al., 2004; Courtney et al., 2011; Pecora et al., 2005 as cited in Center for the Study of Social Policy. (2015). Expectant and parenting youth in foster care. (see note 2)
6. The Affordable Care Act of 2010, Section 2703, created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions. Medicaid Health Homes are designed to coordinate care, including primary, acute, behavioral health and long-term services, for people who have two or more chronic conditions; have one chronic condition and are at risk for a second; or have one serious and persistent mental health condition. States can also target health home services geographically.
7. Medical-legal partnerships embed attorneys within health care setting to meet the holistic needs of patients and families; reduce systemic barriers to addressing health-harming social conditions; and improve policies that have an impact on population health.
8. Urban Institute. (2015). Serving Young Fathers in Home Visiting Programs: Highlights from a Research Study. Washington, DC: Sandstrom, H., Healy, O., Gearing, M., & Peters, H.E. Retrieved from: [https://www.acf.hhs.gov/sites/default/files/opre/20151124\\_serving\\_young\\_fathers\\_in\\_home\\_visiting\\_programs\\_brief.pdf](https://www.acf.hhs.gov/sites/default/files/opre/20151124_serving_young_fathers_in_home_visiting_programs_brief.pdf)
9. U.S. Government Accountability Office. (2011). Foster children: HHS guidance could help states improve oversight of psychotropic medications (Publication No. GAO-12-270T). Washington, DC: U.S. Government Printing Office.
10. In states that do not have extended foster care to 21, states should use the date the youth is no longer eligible for foster care as a trigger for automatic enrollment in the state's Medicaid plan.
11. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Program (CHIP) programs. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible, providing services not typically covered by Medicaid or using innovative service delivery systems that improve care, increase efficiency and reduce costs. Centers for Medicare and Medicaid Services. About Section 1115 Demonstrations. Retrieved from: <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html>
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