Protect Medicaid: **Critical Opportunities to Support Children, Youth and Families Involved with Child Welfare**

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Children, youth and families involved with child welfare systems depend on health care coverage and access to supports and services to not only ensure healthy development and well-being, but as a critical means to promoting positive permanency – including accessing services necessary for family reunification, to support adoption and guardianship and meet needs of older youth exiting foster care. Access to health coverage and treatment services – predominately through Medicaid – is an essential resource to ensuring positive outcomes for these children, youth and their families. When children and youth enter foster care, with few exceptions, they become eligible for Medicaid coverage.[1] For all children and youth in foster care, the state is responsible for ensuring their health care needs are comprehensively met and the state is required to submit a plan to the Department of Health and Human Services for the ongoing oversight and coordination of health care services, including medical, dental and mental health services for each child in foster care.[2]

Figure 1

Percentage of Children in Foster Care[3]	Percentage of Children in U.S. Population
24 percent African American	**14 percent** African American
25 percent Hispanic	**21 percent** Hispanic
43 percent White	**52 percent** White

Children and youth placed in foster care – 427,910 on September 30, 2015[4] – typically have multiple health care needs and experience health care challenges at a higher rate compared to their non-foster care peers. Specifically, approximately 35 percent to 60 percent of children and youth placed in foster care have at least one chronic or acute physical health condition that requires treatment, including asthma, growth failures, obesity and complex chronic illness – which represents a rate of more than 1.5 times that of children and youth not in foster care.[5] Furthermore, as a result of compounding conditions that brought them to foster care and likely exposure to trauma, as many as half to three quarters of youth in foster care suffer from mental and behavioral health challenges necessitating treatment. These health care needs continue to impact children and youth even after they have exited foster care through reunification, guardianship, adoption or aging out – with 54 percent of children adopted from foster care having a special health care need that required ongoing treatment[6] and was expected to last more than 12 months. Youth aging out of care are also almost twice as likely to have a health condition that limits their daily activity[7] and young adults who had spent their adolescent years in foster care are more than twice as likely as their peers to struggle with mental health problems.[8] Additionally, adolescent women in foster care are 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.[9]

While the future of Medicaid and the Affordable Care Act (ACA) is unknown, what is clear is that efforts to restrict Medicaid, (see CSSP's brief The Race Equity Implications of Proposals to Restrict Medicaid, the Children's Health Insurance Program [CHIP] and the Affordable Care Act [ACA]), are likely to have a significant impact on the ability of states to meet the needs of children and youth in foster care. This is doubly worrisome as states across the nation are experiencing recent increase in their foster care populations.

Changes to the current Medicaid structure, financing and eligibility parameters will have a significant impact on state and local budgets. State policymakers must take action to ensure they have the financial ability to provide quality health care services to children, youth and families involved with child welfare and funds to support the full range of services that are critical to positive child welfare safety and permanency outcomes.

Currently, states rely on Medicaid dollars to meet a wide range of needs of children and youth in foster care including preventive and routine medical and dental care, medical care case management and multiple kinds of treatment and therapeutic supports for children and youth in foster care Medicaid is a principal funding partner with state child welfare agencies, accounting for approximately eight percent of total child welfare financing in FY2014 excluding spending on basic health care for children, which is typically a state Medicaid agency expenditure. In the same year, child welfare agencies in 39 states reported spending a total of $886.2 million in federal Medicaid funds for child welfare activities – this figure does not include Medicaid-funded costs for the child welfare population borne by other public agencies.[10] States leverage their resources by matching federal Medicaid funds to serve children, youth and families. Specifically, states can utilize child welfare general revenues as a Medicaid match to expand a wide range of care coordination and home and community-based services, which can be accessed by all children who are served by child welfare systems – not just those who are Title IV-E eligible.[11] Any of the current proposals to restructure Medicaid will have a negative impact on child welfare budgets across the country – which will likely directly and negatively impact the children and youth who the state has a direct, legal responsibility to support.

In addition to having a direct, negative impact on state budgets, restricting and restructuring the ACA will likely limit states from fully meeting the needs of children, youth and families involved in child welfare. Policymakers and advocates must aggressively work to protect Medicaid financing and the ACA in order to promote equitable outcomes for children, youth and families involved with child welfare systems. Specifically policymakers can:

- Maintain Medicaid coverage for youth aging out of care;
- Implement a waiver to cover youth who age out of care in a different state;
- Elect the Chafee option; and
- Preserve the current Medicaid structure to ensure flexibility: ensure children and youth in foster care receive quality services.

Maintain Medicaid Coverage for Youth Aging Out of Care

The ACA authorized multiple opportunities to support youth who have aged out of foster care including a critical provision for advancing health equity for older youth – categorical eligibility for the full Medicaid benefit for youth who were in foster care on or after their 18th birthday in that state until age 26.[12] The current categorical eligibility was a major advancement of the last few years, providing a critical safety net to former foster youth. Without this benefit, youth leaving foster care will have no guaranteed way to assure their continuous health care coverage and may be forced to abandon treatment and services to address preventative, current and outstanding health and behavioral health needs. While some youth may continue to qualify for Medicaid in their state based on their income level or other conditions – for example pregnancy or disability – many others will lose continuous coverage and as a result, may suffer from gaps in coverage that can seriously impact health and well-being.

Implement a Waiver to Cover Youth who Age Out of Care in a Different State

The ACA provided states with the option to provide coverage to youth who aged out of their system but moved to a different state – for example a youth who was in foster care in Maryland and has chosen to move to Virginia for any reason. Youth who have aged out of foster care deserve the same equal opportunities to relocate to another state, for example to pursue employment and education opportunities or to be near loved one, without the possibility of losing their health insurance. The Centers for Medicaid and Medicare Services issued a final rule in November 2016 clarifying that in order for states to cover former foster youth who were in foster care in a different state, states must do so through a Section 1115 Medicaid waiver.[13] This option of choosing and applying for a waiver to ensure portable coverage for these youth should be pursued by the 14 states[14] who now offer this benefit and other states willing to adopt it.

Elect the Chafee Option

Under the Chafee option,[15] the ACA allows states to elect to cover former foster youth who may not have been enrolled in the Medicaid state plan on their 18th birthday – these youth may not have been Title IV-E eligible for a variety of reasons, including not having legal status or lawful permanent residency at the time. The Chafee option is more limited – providing continuous coverage for these youth until they are 21 years old and requiring that these youth are subject to income or asset requirements. Despite these limitations, electing the Chafee option is a mechanism for advancing equity for those youth who have aged out of foster care and may not otherwise have access to health care coverage, including new citizens.

RESOURCE: CSSP has issued two policy briefs on the opportunities within Medicaid to advance equity and health outcomes for youth aging out of care and expectant and parenting youth in foster care. These reports include detailed recommendations for policymakers to support well-being and healthy outcomes of these youth and their children.

Preserve the Current Medicaid Structure to Ensure Flexibility: Ensure Children and Youth in Foster Care Receive Quality Services

Medicaid allows state flexibility to implement a wide range of strategies to ensure the needs of children and youth in foster care are met – including options to provide services through managed care, Health Homes, co-located nurses, risk adjusted rates and incentive payments. This flexibility is critical to ensuring children and youth in foster care, who often exhibit complex health care needs, can be served through a wide continuum of services and providers in the community, who can adjust and wrap services around them in response to their needs.

To holistically meet the needs of children and youth in foster care, some states have utilized managed care organizations. This mechanism allows states to implement responses to target specific needs of children and youth, for example supporting dedicated child welfare health liaison staff, case managers, specialized provider networks and other services that go above the basic, managed care coverage package. Other states have implemented Health Homes, and other integrated health care approaches, to serve youth in foster care and those with intensive medical and behavioral needs. These models are beginning to demonstrate that they can improve health outcomes by comprehensively addressing a child or youth's needs, including concrete needs – which is particularly important for older youth transitioning out of foster care.[16] States have also used Medicaid funding to successfully employ nurses and other health professionals – often referred to as co-located nurses or liaisons – to ensure collaboration across systems in meeting the unique health care needs of children and youth in child welfare.[17]

To ensure children and youth in foster care have access to an array of quality service providers, many states have adopted risk-adjusted rates – higher reimbursement rates for serving children and youth in child welfare – and/or incentive payments – over and above capitation rates for Medicaid.[18] These strategies encourage providers with specialties in treating complex trauma and mental and behavioral health to serve children and youth in foster care. Additionally, targeted case management – case management for specific Medicaid groups – allows providers to dedicate time outside of 'treatment' to work with the child, caregiver and professional team in order to ensure the child's needs are holistically met.

State policymakers and administrators also can promote health and positive permanency for children and youth involved in child welfare by protecting the Medicaid expansion and ensuring coverage options for those who achieve permanency through guardianship or adoption. Specifically states should:

- Protect parents' access to critical health care services;
- Preserve Medicaid for youth exiting to guardianship; and
- Promote Medicaid for youth exiting to adoption.

Protect Parents' Access to Critical Health Care Services

Health coverage is key for parents working toward reunification with their child(ren) when removal and placement in foster care is necessary. Untreated parental mental health and substance abuse are key underlying causes of child maltreatment and neglect, which has gained additional attention due to an increase in opioid use across the country. One study found that 20 percent of parents involved with child welfare scored in the clinical range for major depression within the previous year compared to only seven percent of parents who were not involved with child welfare.[19] However, only 56 percent of parents involved with child welfare who need mental health services received treatment or medication, according to data from the second National Survey of Child and Adolescent Well-Being.[20] With the expansion of Medicaid eligibility, many more of these parents have been able to access essential mental and behavioral health services in order to prevent removal or work toward reunification. Any adjustments made to the Medicaid eligibility levels – including repeal or modification of the enhanced federal match rate[21] that has supported Medicaid expansion in many states – would lead to the loss of health insurance, and access to critical services, for many parents or a significant increase in costs for those states that choose to maintain it.[22] With such cost pressures, states would have to decide between reducing eligibility for parents and children, eliminating health care services and treatment for eligible parents and children and/or minimizing spending in every other area of their already tight budgets.

Preserve Medicaid for Youth Exiting to Guardianship

The commitment by a guardian to raise and provide a safe and stable home for a child can depend on their financial ability to meet the child's needs. For children and youth exiting foster care, including those with the highest need, their health and mental health care needs can be cost prohibitive for guardians without the help of insurance. Currently, states have the option to utilize the Guardianship Assistance pathway to access Medicaid support for relatives who assume guardianship for children who were previously in foster care. For all children who are either Title IV-E eligible or covered through the Ribicoff amendment, the Guardianship Assistance program ensures a mandatory pathway for Medicaid coverage. Children and youth who exit foster care to guardianship with a relative are at risk of losing this pathway to health care coverage. The unintended and tragic result could be fewer children and youth exiting to foster care to guardianship and increased foster care populations and costs.

Promote Medicaid for Youth Exiting to Adoption

Currently, adoptive parents receive ongoing support to meet the health care needs of children and youth who are eligible for Medicaid while in foster care through the Adoption Assistance program. This support and health care coverage is important for all adoptive parents and children, particularly so for children whose health care needs or other circumstances – including behavioral needs – are complex. The lack of supports for adoptive parents is a known factor inhibiting permanent placements for many children and youth. However, this mandatory Medicaid coverage pathway is set to be phased out in October 2017, possibly impacting the ability for parents who would like to adopt children and youth from foster care but feel unable to meet their medical care needs.

A Call to Action

As policy proposals continue to threaten Medicaid, and the outlook for CHIP reauthorization and the ACA (including Medicaid expansion) remain uncertain, advocates and policymakers can be vocal about the vital role that Medicaid, CHIP and the ACA play in ensuring that the full range of health care needs of children and youth in foster care and their families are met. Other briefs in this series highlight the role these programsd play in advancing equity and promoting the health and well-being of other populations, including young children and their families.

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Endnotes

1. Mandatory pathways for Medicaid coverage include children and youth in foster care who are Title IV-E eligible and those who are eligible based on income. For children and youth who may not be Medicaid eligible based on these mandatory pathways, optional pathways to coverage include the Ribicoff amendment, disability or other state-determined optional pathways or coverage through the Children's Health Insurance Program. Children and youth who may not be eligible for Medicaid include those without legal status and those with a countable income above 138 percent FPL. For information please see: Stoltzfus, E., Baumrucker, E., Fernandes-Alcantara, A., & Fernandzez, B. (2014). *Child Welfare: Health Care Needs of Children in Foster Care and Related Federal Issues*. Congressional Research Service.
2. This is a requirement of the Stephanie Tubbs Jones Child Welfare Services Program (Title IV-B, Subpart 1). This coordinated strategy and oversight plan must be developed through a collaborative effort of the state child welfare and state Medicaid agencies in consultation with pediatric and other health experts. Section 422(a)(15) of the Social Security Act.
3. 33 states have elected to the option to cover non-Title IV-E eligible children in foster care through an alternative pathway.
4. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2016). *The AFCARS Report Preliminary FY 2015 Estimates as of June 2016 (No. 23)*. Retrieved from https://www.acf.hhs.gov/cb/resource/afcars-report-23. U.S. Census Bureau. (2016). U.S. Census Bureau data, Children [Data file]. Retrieved from https://www.census.gov/topics/population/children.html
5. *The AFCARS Report Preliminary FY 2015 Estimates as of June 2016 (No. 23)*. (2016).
6. Congressional Research Service. (2014). *Child Welfare: Health Care Needs of Children in Foster Care and Related Federal Issues (CRS R42378)*. Retrieved from https://fas.org/sgp/crs/misc/R42378.pdf
7. U.S. Department of Health and Human Services, Office of the Assistance Secretary of Planning and Evaluation. (2009). Adoption USA: A Chartbook Based on the 2007 National Survey of Adoption Parent. Washington, DC: Vandivere, S., Malm, K., & Radel, L.
8. Chapin Hall at the University of Chicago. (2011). *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 26*. Chicago, IL: Courtney, M. E., Dworsky, A., Brown A., Cary, C., Love, K., & Vorhies, V.
9. Pecora, P., et al. (2006). Educational and employment outcomes of adults formerly placed in foster care: results from the northwest foster care alumni study. *Children and Youth Service Review, 28*, 1459-81.
10. *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 26*. (2011).
11. Child Trends. (2016). *Child Welfare Financing SFY 2014: A survey of federal, state, and local expenditures.* Bethesda, MD: Rosinsky, K., & Connelly, D. Retrieved from https://www.childtrends.org/wp-content/uploads/2016/10/2016-53ChildWelfareFinancingSFY2014.pdf
12. Center for Health Care Strategies, Inc. (2013). *Making Medicaid Work for Children in Child Welfare: Examples from the Field*. Hamilton, NJ: Pires, S., & Stroul, B. Retrieved from http://www.chcs.org/media/Making_Medicaid_

Work.pdf
13. 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. These youth must meet eligibility requirements including that they were in foster care under the responsibility of the state on the date of their 18th birthday or after; are not eligible or enrolled under an existing mandatory Medicaid eligibility group ad were enrolled in the Medicaid state plan or under a waiver while in foster care. Section 1902(10)(a)(i)VII) of the Social Security Act.
14. 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.
15. Currently 14 states – California, Georgia, Kentucky, Louisiana, Massachusetts, Michigan, Montana, New Mexico, New York, Pennsylvania, South Dakota, Utah, Virginia and Wisconsin – cover youth who have aged out of care in a different state. These states must apply for a Section 1115 no later than May 21, 2017 to continue to cover these youth and others who fall into this group.
16. 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
17. *Making Medicaid Work for Children in Child Welfare: Examples from the Field.* (2013).
18. Ibid.
19. Dolan, M., Smith, K., Casanueva, C., & Ringeisen, H. (2011). NSCAW II Baseline Report: Introduction to NSCAW II. OPRE Report #2011-27a. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation.
20. U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research, and Evaluation. (2012). *NSCAW II Wave 2 Report: Caregiver Health and Services (Report #2012-58)*. Washington, DC: Dolan, M., Casanueva, C., Smith, K., Lloyd, S., & Ringeisen, H. Retrieved from https://www.acf.hhs.gov/sites/default/files/opre/nscaw_ii_wave_2_caregiver_health_and_services_dec_2012.pdf
21. To cover adults with incomes up to 138 percent FPL, under the ACA, states receive an enhanced federal match rate at 100 percent through this year when it is reduced to 95 percent and then another reduction in 2020 to 90 percent. Current proposals to reduce the federal match rate will immediately lead to a negative impact in at least eight states – Arkansas, Arizona, Illinois, Indiana, Michigan, New Hampshire, New Mexico and Washington – which include statutory provisions to remove all individuals covered by the expansion should there be any adjustments to this rate.
22. Data cited by the Center for Budget and Policy Priorities estimate that reducing the enhanced federal match rate would cost states nearly $32 billion in 2019 if they chose to maintain coverage for previously covered adults. Center on Budget and Policy Priorities. (2017). *House Republican Proposals to Radically Overhaul Medicaid Would Shift Costs, Risks to States.* Washington, DC: Park, E., Broaddus, M., Cross-Call, J., & Schubel, J. Retrieved from http://www.cbpp.org/research/health/house-republican-proposals-to-radically-overhaul-medicaid-would-shift-costs-risks-to

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1575 Eye Street, NW, Suite 500
Washington, DC 20005

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