



ADDRESSING THE HEALTH CARE NEEDS OF CHILDREN IN THE CHILD WELFARE SYSTEM

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As a population, children who have been abused or neglected often have a range of unique physical and mental health needs, physical disabilities and developmental delays, far greater than other high-risk populations. For instance, foster children are more likely than other children who receive their health care coverage through Medicaid to experience emotional and psychological disorders and have more chronic medical problems. In fact, studies suggest that nearly 60 percent of children in foster care experience a chronic medical condition, and one-quarter suffer from three or more chronic health conditions.^{1,2} Roughly 35 percent have significant oral health problems.³ In addition, nearly 70 percent of children in foster care exhibit moderate to severe mental health problems,⁴ and 40 percent to 60 percent are diagnosed with at least one psychiatric disorder.⁵

Although the provision of health care for foster children is mandated, many fail to receive even basic health care. In fact, a commonly cited 1995 Government Accountability Office (GAO) report found that despite regulations requiring comprehensive routine health care for foster care children, 12 percent receive no routine health care and 32 percent have

unmet needs.⁶ Moreover, in a 2005 survey, HHS found that more than 30 percent of foster care cases reviewed did not demonstrate the provision of adequate services to children.⁷ More recently, a 2009 survey found that 24 percent of foster care cases reviewed did not demonstrate the delivery of appropriate services to address children's health needs.⁸

In a study of health care utilization in Florida, California and Pennsylvania, Mathematica Policy Research found that the likelihood that foster care children received preventive check-ups ranged from 28 percent in Florida to 41 percent in Pennsylvania.⁹ The authors concluded that overall, many foster care children did not receive routine check-ups, and more over, only a small number received an assessment during the first two months of placement in foster care.

Comparable findings have been reported by a number of other researchers. For instance, a 2005 study by Stahmer and Colleagues found that although toddlers and pre-schoolers in child welfare exhibit significant



developmental and behavioral needs, few receive services.¹⁰ In fact, in this sample, 41.8 percent of toddlers and 68.1 percent of pre-schoolers exhibited deficits, yet only 22.7 percent received services.¹¹ The National Survey of Child & Adolescent Well-being (NSCAW) similarly documented that only a quarter of children exhibiting behavioral problems in out-of-home care actually received mental health services within a one-year follow-up period.¹² In addition, Zima and Colleagues (2000) found that although 80 percent of children in a random sample received a psychiatric diagnosis, only half actually received mental health or special education services.¹³

MEDICAID FOR FOSTER CHILDREN

Nearly all children in foster care and adoptive placements are eligible for Medicaid, and should have access to comprehensive health and mental health services. Children eligible for federal reimbursement for foster care expenses (Title IV-E of the Social Security Act) are categorically eligible for Medicaid, and all states exercise the option to extend Medicaid benefits to non-IV-E eligible children in foster care. In addition, children receiving federally reimbursed adoption subsidies are eligible for Medicaid.

A recent report by the Center for Health Care Strategies (CHCS) found that states are moving towards providing appropriate health and behavioral health screenings and services for foster children. In fact, their findings indicate that all but one of the responding states require an initial screening in at least one of the three health domains (i.e., physical, behavioral, and oral health).¹⁴ Even so, there is considerable room for improvement. While all responding states expect assessments to be conducted when necessary in at least one of the three domains, only 63 percent explicitly require them. Additionally, there is significant variation in the existence and length of required timeframes for conducting the screenings

and assessments — with time frames ranging from one day to 90 days for screenings, and from three days to 183 days for assessments.

Although numerous studies highlight the unmet needs of foster children, data indicates that children in foster care actually account for a significant portion of Medicaid expenditures. For instance, in some states, children in foster care account for upwards of 25-41 percent of Medicaid expenditures, but represent only 3 percent of all enrollees.¹⁵ In fact, a comprehensive analysis of health care utilization and expenditures of children in foster care found that although children in foster care represented between 1.1 and 3.3 percent of children in Medicaid at the time the study was published, they accounted for 3.6 to 7.8 percent of Medicaid expenditures.¹⁶ A report by the Urban Institute confirms that children in foster care account for a disproportionate share of Medicaid expenditures, relative to their share of Medicaid enrollment. Although they represent only 3.7 percent of non-disabled children enrolled in Medicaid, they account for 12.3 percent of expenditures for this group.¹⁷

THE HIGH COST OF HOSPITALIZATIONS

As expected, the health care costs associated with child abuse are staggering. Each year, the direct hospitalization costs associated with child abuse and neglect near \$6.6 billion, and for mental health care, \$1.1 billion. In an analysis of the economic burden of child abuse and neglect on the health care system using a sample of US community hospitals, Rovi and Colleagues (2004) found that the average total costs for hospitalization were nearly \$10,000 more for children with a diagnosis of child abuse or neglect than for other children. These children were also 9 times more likely to die during hospitalization.

While it may seem difficult to reconcile data highlighting the unmet needs of foster children and the high Medicaid expenditure rate for this population, much of this is accounted for by their disproportionate use of mental health services. In fact, mental health service use is 8-15 times greater for children in foster care than for other low-income, high-risk children enrolled in Medicaid.^{18,19} In addition, according to Rubin and colleagues (2004), data from several studies have shown that up to 90 percent of these costs may be accounted for by 10 percent of children.²⁰

Clearly children in foster care continue to experience inadequate health care. The bulk of Medicaid expenditures for this population are accounted for in mental health services, likely the greater portion expended on children with particularly chronic and severe mental health conditions. Even so, a significant number of children seem to lack access to even basic mental health services.²¹ We believe it is critical to meet the health care needs of all children in foster care. To do so, we must continue to monitor Medicaid expenditures for foster children, identify gaps in coverage, unmet needs, and barriers to access for certain subgroups, and develop cost-effective, targeted and appropriate services for this population. We need to invest in continued research on foster care health issues, including the utilization of care and the quality of care for children in foster care.

This policy brief highlights a number of critical health concerns and policies impacting children in the foster care system. We believe that in order to truly improve the provision of health care for children in foster care, we must shift our federal efforts and investments toward developing a more comprehensive approach to addressing the needs of foster children. First Focus has identified several critical issues that should be examined in any future efforts to improve health care for all children in care.

Health Information Technology: Utilizing Electronic Medical Records to Improve Care

Given that foster children typically have chronic and complex health care needs, it is essential that providers in all sectors – including health, child welfare, juvenile justice and education - have access to up-to-date, accurate and complete information in order to appropriately care for this population. Yet all too often, children in care have a fragmented medical history, and practitioners are faced with incomplete information and limited knowledge of their unique health conditions and needs.

As a result of incomplete medical records, children in foster care often receive multiple immunizations, are over-prescribed psychotropic medications, undertreated, and frequently misdiagnosed.²² In fact, research has shown that emergency room visits spike within the first few days following a placement or placement change – suggesting that foster parents are not equipped with the information they need to attend to a child's medical needs.²³

Foster care children often move from one placement to another and typically experience 1-2 changes in placement per year.²⁴ Placement instability increases the longer a child spends in the system. Placement changes are often accompanied by changes in physicians and other health care providers. This shift in placements and providers often leads to incomplete health information for children. As a result, children in care often receive incomplete or duplicate immunizations, lack adequate primary care, and fail to receive periodic developmental or mental health screenings.²⁵ Placement instability contributes to the high cost of care delivered to foster care children, combined with inadequate coordination and limited information-sharing between service providers. When children move from placement to placement, pre-existing conditions are frequently overlooked and health



problems grow more acute with each move.

Medical passports can help improve the continuity in care for foster children, allowing multiple providers to access timely information, coordinate care, and focus their efforts on addressing the needs of children in care. Medical passports are essentially abbreviated health records, and hold critical medical information about a foster child, playing a valuable role in the overall health care of children in foster care. These records include critical information, such as a listing of the child's medical problems, allergies, chronic medications, and immunization data, as well as basic social service and family history. A medical passport is designed to facilitate the transfer of essential medical information among physical and mental health professionals.

A number of states and localities, including Texas, Milwaukee, Wisconsin, Tennessee, Kansas, Sacramento, California and Arizona have developed electronic medical record systems for children in foster care or other vulnerable populations.²⁶ In Texas, the Star Health Program provides health passports and electronic health records for children in care. Star Health began serving children and young adults in care in April 2008. The goal of the initiative is to give children health care services that are coordinated, comprehensive, easy to find, and uninterrupted when the child moves. Although the Star Health Passport is not a comprehensive medical record, it makes critical medical information readily available to doctors.

In Milwaukee, reports indicate that the number of youth in residential treatment has dropped by 60 percent (down from 364 to 140 per day), and psychiatric hospitalizations have declined by 80 percent. In addition, the average overall cost of care per child has gone from more than \$5,000 per month to less than \$3,300 per month since implementing their electronic information exchange system.²⁷

Psychotropic Medication Usage: A Growing Problem

Today, one in every five children and adolescents in the U.S. is diagnosed with a mental health disorder;²⁸ yet, as a 2001 Report of the Surgeon General on Children's Mental Health highlighted, a significant number of these kids do not receive the treatment and care they desperately need.²⁹ In fact, fewer than 1 in 5 children actually receive treatment, and nearly 80 percent fail to receive specialty services.³⁰ If left untreated, a mental health problem often has devastating long-term consequences, including contact with the juvenile justice system, job loss, homelessness, and even suicide.

At the same time, prescriptions for psychotropic medications have increased dramatically for children with behavioral and emotional problems over the last 20 years, a trend evident for younger age groups—even preschoolers.^{31, 32, 33} In fact, prescription rates for atypical antipsychotics for children have increased more than fivefold over the past decade and a half. Today, atypical antipsychotics are being prescribed at a much higher rate today than ever, even though they have limited Federal Drug Administration (FDA) approval in older children and little is known of their impact on younger children.

For many children, Medicaid is a critical source of health and related support services, including both outpatient and inpatient mental health services. Medicaid supports the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program and also funds long-term mental health care for children who need more intensive or restrictive services, including hospitalizations and residential treatments. In recent years, Federal spending on prescription medications has consumed a greater portion of Medicaid budgets.



This can be partly attributed to growing Medicaid expenditures on new and more costly psychotropic medications for children – many of which have not been tested for use in children. As Jeffrey Thompson, the Chief Medical Officer of Washington State’s Medical program noted in an interview, “the number one drug class in expenditures is atypical antipsychotics in almost every state. And the fastest growing utilization is for both on and off-label use in children.” Research has shown that children enrolled in Medicaid generally experience greater chronic health conditions and impairment,³⁴ and have a higher prevalence of psychotropic medication use than those who are privately insured.^{35, 36, 37}

In fact, in one study, the rate of psychotropic drug use was nearly double among Medicaid-insured children as compared to privately insured children; and, a greater proportion of Medicaid enrolled children were given prescriptions for multiple psychotropic medications, even though fewer received outpatient mental health services.³⁸ Similarly, in a 2004 report, Safer and colleagues found that psychotropic medication usage rates are significantly higher for SCHIP participants than privately insured children.³⁹

Within the Medicaid program, certain populations are even more likely to utilize psychotropic medications. Specifically, children in foster care are much more likely to use psychotropic medications than children who qualify for Medicaid through other aid categories.^{40 41} Studies have shown that kids in foster care are prescribed psychotropic medications at a much higher rate than other children - 2 to 3 times higher.⁴² For instance, a 2003 study found that in Connecticut, while children in state custody represented only 4.8 percent of the Medicaid population, they accounted for 17.8 percent of the psychotropic prescriptions filled—a 4.5 fold higher usage rate.⁴³ Similarly, a study of children in the Los Angeles County foster care system found that

these youth had a threefold higher rate of psychotropic drug use than the broader youth population, a pattern similar to a study of a mid-Atlantic state Medicaid program. Additionally, a 2007 GAO report identified over-prescribing of psychotropic medications to foster children as one of the leading issues facing child welfare systems in the coming years.⁴⁴

In addition, youth in foster care are often prescribed two or three medications, the effects of which are not well-known in combination.⁴⁵ In a 2008 study of Texas children with Medicaid coverage, Zito and colleagues found that youth in foster care received at least three times more psychotropic drugs than other children in poor families. Zito and colleagues report that from September 2003 to August 2004, of 32,135 Texas foster care children enrolled in Medicaid, 12,189 (38 percent) were prescribed one or more psychotropic medications. In addition, 41.3 percent of a random subgroup of 472 youths received three or more psychotropic drugs daily.

Although the practice of prescribing psychotropic medications for children continues to grow, serious concerns about the safety and efficacy of use for this population have been raised. Many have expressed concerns about the safety, efficacy and long-term consequences of psychotropic medication use in children, especially younger age groups.^{35, 36, 37} Specifically, researchers have expressed concern about the effects of these medications on the developing brain, and the safety and effectiveness of medications tested in adults for alleviating behavioral and emotional symptoms in children.

For certain newer classes of drugs, medications have not been licensed for use in children. In fact, between 50% to 75% of psychotropic drugs are not approved for use in children or adolescents.⁴⁶ As a result, providers are often prescribing drugs “off-label”



(practice of prescribing meds for use other than the intended indication). To date, we have no safety data and little understanding of the long-term neurological effects of the use of atypical antipsychotics in younger children. In addition, available research suggests that use in younger children may contribute to weight gain and diabetes, can yield extrapyramidal side effects, and contribute to aggressive behaviors.⁴⁷

In 2007, State Medicaid Medical Directors and investigators from the Rutgers Center for Education and Research on Mental Health Therapeutics (CERTs) developed a plan for a collaborative project to examine the use of antipsychotic medications in children and adolescents in Medicaid. The product of the collaboration was a report from 16 states on antipsychotic medication usage in Medicaid. Among the report's findings, children in foster care (12.4 percent) were prescribed antipsychotic medications at much higher rates than other children (1.4 percent). In addition, from 2004 to 2007, the pooled antipsychotic medication use rate for children and adolescents in the 16 participating Medicaid programs increased from 1.45 percent to 1.60 percent in 2007, about a 10 percent relative increase. For foster care children and adolescents, the antipsychotic medication use rate increased (on a relative basis) by 5.6 percent between 2004 and 2007 (from 11.7 percent to 12.4 percent).⁴⁸

A September 2010 Multi-State Study on Psychotropic Medication Oversight in Foster Care conducted by the TUFTS Clinical and Translational Science Institute found that the oversight of psychotropic medication use was a high concern for state child welfare agencies. Respondents reported an increase in the use of psychotropics for youth in foster care, including: antipsychotics, antidepressants and ADHD medications, increased polypharmacy (increased medication use among young children), and an increased reliance on PRN medications (medications

administered as needed), and “blanket authorizations” in residential facilities.⁴⁹ In terms of state practices and policies, the report found that 26 states had a written policy/guideline on psychotropic medication use; 13 states were in the process of developing a policy/guideline; and 9 states had no policy/guideline on psychotropic medication use. States are moving in the direction of developing practices and policies to monitor and curb the overuse of psychotropic medications for children in foster care but clearly more work remains to be done.

Fostering Connections to Success and Increasing Adoptions Act: Health Care Provisions

Signed into law on October 7, 2008, the Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351) has led to notable improvements on behalf of children and families involved with the child welfare system-- including youth aging out of care. Fostering Connections provides states with the option to support youth aging out of foster care to the age of 21, establishes a requirement that personal transition plans for youth aging out are developed within 90 days prior to youth exiting foster care, provides extended eligibility for Independent Living Program services to children adopted or placed in kinship guardianship at age 16 or older; and extends eligibility for education and training vouchers to children who exit foster care to kinship guardianship at age 16 or older. The true impact of the legislation however, depends largely on how it is implemented.

To date, states have reported experiencing some challenges in implementing the law. Although states have experienced difficulties in implementation, many states have introduced or enacted legislation to implement various provisions of the law. With guidance from HHS, we believe more States will

pursue options set forth in Fostering Connections.

Sec. 205. Developing health oversight and coordination plans.

As part of the title IV-B plan, State and Tribal agencies are required to develop, in coordination and collaboration with the state Medicaid agency and in consultation with pediatricians and other experts, a plan for the ongoing oversight and coordination of health care services, including mental health and dental health needs, for any child in foster care. The plan must describe how initial and follow-up health screenings will be provided, health needs identified will be monitored and treated, and medical information will be updated and appropriately shared with providers. The plan must also detail the steps that are or will be taken to ensure the continuity of health care services, including a schedule for initial and follow-up health screenings; how medical information will be updated and shared; the possibility of establishing a medical home for every child in care; and what will be done to ensure the oversight of prescription medications, including psychotropic drugs. As part of the Child and Family Services Plan, the agency is required to submit a copy of the health care oversight and coordination plan, and provide an explanation of how health care experts were selected and how they and the Medicaid agency were involved in developing the health care oversight and coordination plan.

A number of states have enacted or proposed legislation related to the health provision of Fostering Connections. For instance, in California, SB 597, Chapter 339 was enacted, requiring the State Department of Social Services to - in consultation with pediatricians, health care experts, and experts in and recipients of child welfare services - develop a plan for the ongoing oversight and coordination of health care services for a child in a foster care placement. In Oklahoma, HB 1734, Chap. 338 was enacted, creating a passport program in the Department of Human Services to compile education,

medical, and behavioral health records for children in protective custody, kinship care, and foster care. The passport will accompany children so long as they remain in the custody of the department. And in Oregon, HB 3664 was enacted. The bill expands medical coverage to former foster youth who age out of Oregon's foster care system and continues coverage to age 21 (starting in May 2010). States with pending legislation include California, Minnesota, Georgia and Indiana.⁵⁰

Patient Protection and Affordable Care Act (ACA): What it Means for Foster Care Children

While most of the provisions of the ACA are not effective until January 1, 2014, the law includes several provisions that are critical for foster children and other vulnerable youth. These include:

Sec. 2004. Medicaid Coverage for Former Foster Care Children (Effective 2014)

Section 2004 expands Medicaid coverage to former foster children up to age 26. Section 2004 makes mandatory the current state option to extend Medicaid coverage up to age 26, to foster care alumni. To qualify, individuals must be under the responsibility of the state when they turn 18 (or higher age if covered by the state). In order to enroll in or maintain Medicaid eligibility, these youth must have been enrolled in Medicaid while in foster care. We expect guidance on this provision as the effective date approaches.

Under current law, The Foster Care Independence Act of 1999 (P.L. 106-169) gives states the option to expand coverage to youth who have aged out of the foster care system up to age 21. The Chafee option, enacted through P.L. 106-169, allows states to extend Medicaid coverage to former foster children ages 18 to 21, but not enough states have done so. While a



number of states have moved to extend their Medicaid programs using this provision to provide care for youth aging out, others have extended their Medicaid coverage using the Chafee option. Until now, some states have used several other programs to provide health coverage for youth aging out of the foster care system. For instance, several states have utilized Section 1115 waivers under the Medicaid program to extend care, while others offer former foster youth the opportunity to qualify for additional benefits if they remain in care or in an educational setting.

Unfortunately, there is considerable variability in access across programs, and restrictions on eligibility. In addition, a number of states only extend coverage for youth to age 19.

As a result, the majority of foster care youth receiving health care through Medicaid lose this coverage once they age out of care. In fact, the Midwest Evaluation of the Adult Functioning of Former Foster Youth Study, conducted in 2007 by the Chapin Hall Center for Children at the University of Chicago, found that only half of young adults surveyed, reported having medical insurance, and even fewer – only 39 percent – had dental insurance.⁵¹ A significant number of youth reported not having received medical care in the past year, and cited a lack of insurance as the primary reason for not accessing care.

Sec. 2951. Maternal, Infant, and Early Childhood Home Visiting Programs (Effective 2010).

Section 2951 provides \$1.5 billion over five years in mandatory funding for an innovative home visitation grant program for states. The program enjoys broad bipartisan support in Congress, the Administration and among the States and Territories. The Department of Health and Human Services (HHS), and Health Resources and Services Administration (HRSA), in collaboration with the Administration for Children and Families (ACF), recently announced the availability of

\$125 million in home visiting grants to states and eligible jurisdictions as formula-based grants. The FY 2011 grants reflect an increase over FY 2010 funding levels of at least 20%. The FY 2011 formula grants are intended to help states to continue the work begun with FY 2010 funds and allow them to establish high-quality, evidence-based home visiting programs. These positive signs all point to a promising future for the program, but monitoring will be necessary.

Sec. 2953. Personal Responsibility Education (Effective 2010).

Section 2953 provides \$75 million for personal responsibility education for FY 2010-2014. Administered by ACF, \$50 million is allocated for formula grants to states based on the size of its youth population (ages 10-19), however each state would receive a minimum of at least \$250,000. Programs must be designed to educate adolescents on abstinence, pregnancy prevention, sexually transmitted infections, financial literacy, parent-child communication, healthy life skills, adolescent development targeting at-risk populations including, homeless, foster care, teen parents, youth with HIV, and other vulnerable persons. \$10M is set aside for innovation strategies and services for high risk and vulnerable youth, such as youth in foster care, teen parents, and homeless youth. Additionally, this section provides \$3 million for tribes and \$6 million for research, training, and technical assistance.

Sec. 2955. Inclusion of information about the importance of having a health care power of attorney in transition planning for children aging out of foster care and independent living programs (Effective 2010)

Section 2955 amends the Fostering Connections to Success and Increasing Adoptions Act, specifically, the sections on the Transition Plan, the Health Care Oversight and Coordination Plan, and the John H. Chafee Foster Care Independence Program. As a result of these changes, children receiving independent living



services and/or education and training vouchers, and those who are aging out of foster care, will now be provided information about the importance of a health care power of attorney, health care proxy, or other similar document recognized under state law, as well as how to execute such a document.

Under Fostering Connections to Success and Increasing Adoptions Act, states are required to develop a personalized transition plan as directed by the youth. The transition plan process must be conducted during the 90-day period immediately prior to the date on which the child turns 18. ACA further amends this section by requiring that the transition plan include “information about the importance of designating another individual to make health care treatment decisions on behalf of the child if the child becomes unable to participate in such decisions and the child does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, and provides the child with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under State law.”^a

The Fostering Connections to Success and Increasing Adoptions Act also requires States and Tribes receiving title IV-B, subpart 1, to develop a Health Care Oversight and Coordination Plan. The state child welfare agency and the state agency that administers Medicaid must coordinate and collaborate in the development of this plan, and the plan must outline specific steps to ensure that children in foster care have their health care needs identified and appropriately met, and that their medical records are updated and shared appropriately. ACA amends this section by requiring that the plan include information about the importance of designating another individual to make health care treatment decisions on behalf of the youth

if he/she becomes unable to do so, and including information on options for health insurance, information about a health care power of attorney and a health care proxy.

ACA also requires states to certify that youth in care and former foster youth are receiving independent living services that educate the youth on the importance of designating another individual to make health care treatment decisions on behalf of the youth if he/she becomes unable to do so. ACA amends this section by requiring “a certification by the chief executive officer of the State that the State will ensure that an adolescent participating in the program under this section are provided with education about the importance of designating another individual to make health care treatment decisions on behalf of the adolescent if the adolescent becomes unable to participate in such decisions and the adolescent does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, whether a health care power of attorney, health care proxy, or other similar document is recognized under State law, and how to execute such a document if the adolescent wants to do so.”^b

Sec. 3502. Establishing Community Health Teams to Support the Patient-Centered Medical Home (Effective 2010) and Sec 2703. State Option to Provide Health Homes for Enrollees with Chronic Conditions (Effective 2011).

Section 3502 creates a program to establish and fund the creation of community health teams to support the development of medical homes by increasing access to comprehensive, community based, coordinated care. Among other requirements, health teams must demonstrate a capacity to implement and maintain electronic health record technology. Additionally, under Section 2703, the ACA provides a state option (under Medicaid) to provide health homes for enrollees

^a Patient Protection and Affordable Care Act (P.L. 111-148)

^b Patient Protection and Affordable Care Act (P.L. 111-148)



with chronic conditions. It seems that foster children could benefit from this provision. A state could potentially identify IV-E recipients as an exclusive target population due to their higher number and severity of chronic health and behavioral health conditions. A medical home would ensure that children receive care that is family centered, comprehensive, coordinated and continuous over time. A medical home would provide continuity and ensure that children can retain a single care provider, even in times of transition. Under this model, children and youth in foster care would receive all of their health care services from a single health care professional.

Improving the Provision of Behavioral Health Care in Medicaid: A Regulatory Approach

Medicaid is an essential and appropriate funding source for behavioral health care^c for vulnerable children, including those in the child welfare and juvenile justice systems and those with serious behavioral health challenges. Yet, there is wide variation in States' use of Medicaid for behavioral health services for these populations. In recent years, prior to the current Administration, Federal guidance, regulations, and administrative actions pertaining to behavioral health services have constricted the use of Medicaid for vulnerable children. In the absence of clarifying information from Center for Medicare and Medicaid Services (CMS), States are unclear or hesitant about pursuing effective home and community alternatives, and other innovative practices for this population.

The provision of behavioral health care for children in Medicaid can be vastly improved and we believe CMS can provide greater clarification of existing regulations, offer clearer and more comprehensive guidance with consistency across regions, and offer technical

assistance to States to improve care for children.

We recommend regulatory changes in several areas, including: covered services, reimbursement approaches, eligibility, and the implementation of the Fostering Connections Act.

Specifically, we believe CMS should consider the following regulatory actions:

- Clarify home and community services for children with behavioral health challenges that can be covered by Medicaid.
- Provide guidance on reimbursement practices that are the most efficient in ensuring delivery of quality care.
- Clarify on the practice of billing for co-occurring conditions and the use of mental health codes by primary care providers.
- Provide guidance on strategies to monitor and eliminate inappropriate, over-prescribing of psychotropic medications to children.
- Provide technical assistance on behavioral health care practices in Medicaid managed care.
- Clarify eligibility for Medicaid coverage of youth in juvenile justice settings.
- Alert state Medicaid agencies to the requirements of the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351).

As an example, over the past decade or so, new treatments and services for children with behavioral health challenges have been developed and researched. As a result, a substantial body of literature exists on what works best for these children. The following are three key examples of well-researched, effective services that are essential to successful treatment:

^c The term, behavioral health, includes mental health and substance abuse services.



- Therapeutic foster care, furnished as an alternative to psychiatric residential treatment facility placement
- Intensive in-home services, including Multisystemic Therapy
- Mobile response and stabilization services

These services are (or have in the past been) approved by CMS as being covered under Title XIX. In states where they are covered and used extensively, costs have decreased, particularly for the child welfare population, through reduced use of emergency rooms, psychiatric hospitalization, and psychiatric residential treatment facilities.⁵²

Therapeutic foster care (TFC) is a cost-effective alternative to a residential placement for children who cannot continue to live at home. Multidimensional Treatment Foster Care, for example, is a specific form of therapeutic foster care that has a particularly strong research base. Therapeutic foster care allows children to learn and practice appropriate behavioral and social skills in a supportive, home-like environment. Medically necessary services provided by therapeutic foster care provider agencies can include: skills training, case management, crisis management, therapy, medication management and other Medicaid rehabilitation services. Services furnished by the therapeutic foster parents themselves (provided they meet state-defined qualification requirements) should be reimbursable. These most often include skills training and case management services. States need clarification that these services may be covered as a package, with the exception of the cost of room and board, which is not reimbursable. Examples of how States may appropriately reimburse for therapeutic foster care as a package (minus room and board), would be very helpful.

Other Issues to Consider: Managed Care Models

According to the CHCS, currently, at least 30 states enroll children in child welfare in managed care, and provide general medical and behavioral services through managed care arrangements.⁵³ States can enroll children in foster care, in managed care plans under the authority of a federal waiver. In addition, the Balanced Budget Act of 1997 granted states the authority to enroll foster children in managed care voluntarily through the process of a Medicaid state plan amendment. This has allowed more states to enroll children in foster care in managed care plans. States can provide care for children in the child welfare system by creating “population carve-outs” from the general Medicaid managed care program, or by creating special managed care programs specifically for the child welfare population, or a segment of the population. As an example, Texas provides health care for all foster children in the state under one managed care system which was legislated in 2005 and initiated in 2008. And in Wisconsin, two counties have created specialized managed care programs for subsets of the child welfare population.

ROUTINE CARE

In a study of health care utilization in Florida, California, and Pennsylvania, Mathematica Policy Research found that the likelihood that foster care children received preventive check-ups ranged from 28 percent in Florida to 41 percent in Pennsylvania.⁵⁶ The authors concluded that overall, many foster care children did not receive routine check-ups, and more over, only a small number received an assessment during the first two months of placement in foster care.

In a 2004 study, Rubin and colleagues found that foster children received fewer overall outpatient services than other Medicaid eligible children, but as their placements increased, they were more likely to visit the emergency department and to receive a larger proportion of their overall care there than their peers.⁵⁷

Research suggests that Medicaid managed care policies could adversely impact service use. For instance, in a study of a nationally representative sample of children



in the child welfare system, Raghavan and colleagues (2006) found that children in counties with behavioral carve-outs under Medicaid managed care had lower odds of inpatient mental health service use.⁴² Restrictions on the use of inpatient mental healthcare resulting from behavioral carve-outs have especially devastating consequences for children in the child welfare system who typically have high rates of need and use. Mathematica Policy Research and others have recommended looking at payment mechanisms (e.g., risk adjustment approaches), and taking into account the differential utilization and expenditure profile among children in foster care.

There are however, several examples of successful managed care models for children in the child welfare system, including the Wraparound Milwaukee model. Wraparound Milwaukee is a county-based managed care program, which provides care to children in the welfare and juvenile justice systems with serious behavioral health needs. It uses capitation and case rate financing from payers, including Medicaid, mental health, child welfare and juvenile justice. Data from the program have shown that children have considerably reduced lengths of stay in intensive treatment, demonstrate improvements in clinical and functional outcomes, and have fewer school absences, among other outcomes.⁵⁴

It may be useful to consider approaches, including potentially higher capitation rates, elimination of patient cost-sharing, extensive and/or specially tailored benefits packages, relaxed prior approval requirements and monitoring of plan performance in efforts to improve managed care models for foster children.⁴³ Additionally, CHCS has identified several key considerations for states in developing managed care plans for children in the child welfare system including: developing risk-adjusted mechanisms that more appropriately reflect the high costs and elevated service

needs of children in the child welfare system, identify Medicaid-eligible non-foster children in the child welfare system, report on their utilization of services in order to ensure timely access to health care services and help avoid unnecessary placement disruptions, the use of inappropriate and costly services, appropriate data-sharing of health-related information across systems to ensure care coordination, and the provision of quality health care.⁵⁵

HEALTH COVERAGE: STABLE OR NOT?

A Mathematica Policy Research report found that although most children were enrolled in Medicaid before entering foster care, between one-third and one-half lost their Medicaid coverage within a month after leaving foster care.⁵⁸ In fact, only 7 in 10 foster care children were continuously enrolled in Medicaid in 1994.⁵⁹ Foster care children are also less likely than other vulnerable populations (e.g., adoption assistance or SSI) to be continuously enrolled in Medicaid during 12-month or 24-month periods.⁶⁰ Studies have also raised concerns about the lack of continuous health care in managed care models. For instance, a 2003 study found that children in foster care were more likely to experience diminished continuity in care compared to Medicaid managed care beneficiaries not in foster care.⁶² While these data suggest that continuity in coverage is a challenge for child welfare, more recent data indicates that foster children do maintain stable coverage over time.

A 2008 study found that the majority of children in the child welfare system do have stable health insurance coverage over time. In fact, over a three-year time period, 92 percent of children in the study maintained health insurance coverage. The study also reported an overall gain in insurance coverage over time for children in the child welfare system.⁶¹ These findings highlight the dependence on Medicaid for children in the child welfare system.

IMPROVING CHILD WELFARE DATA SYSTEMS: HEALTH AND CHILD WELL-BEING INDICATORS

While historically, child welfare systems have been responsible for ensuring the safety, permanence and well-being of children in care, child well-being is a relatively new concept in child welfare policy and practice. There are several reasons for this. As a construct, child well-being has been difficult to define and challenging to measure. Moreover, the field has failed to reach consensus as to whether child well-being is truly a mandate of child welfare. Given these challenges, child welfare systems have more often emphasized safety and permanence, and services have not been designed to promote child well-being. As a result, data on child well-being, including health, mental health and oral health outcomes are more limited.

As Webb and colleagues (2010) note, in recent years, the field is attempting to capture child well-being in its assessments of state child welfare systems. Accountability provisions under the Adoption and Safe Families Act of 1997 and federal regulation of Child and Family Service Reviews (CFSR) have given states a push to pursue a greater, service intensive focus on promoting child well-being. For instance, CFSR requires states to examine the physical, educational and mental health needs of children, and requires states to have guidelines for initial, ongoing, and/or periodic health examinations of children and youth entering foster care. Child well-being-focused components of CFSR include indicators targeting the provision of adequate services to meet children's physical and mental health needs (with items specifically examining (1) the physical health of the child and (2) mental/behavioral health of the child), and indicators assessing whether families enjoy an enhanced capacity to provide for their children's needs. Additionally, the National Survey of Child and Adolescent Well-being (NSCAW) collects data on the functioning and well-being of children who come in contact with child protective services as a result of a child maltreatment investigation.

States are beginning to demonstrate a commitment to improving the well-being of children in care, and to place greater emphasis in providing prevention services and appropriately measuring such efforts. Even so, data on child well-being outcomes, including health and mental health for children in foster care is limited. Improvements in measurement of child well-being (including health) indicators, as well as the provision of prevention services (including medical and dental evaluations and mental health screenings) are critical.

Among other recommendations, we believe the CFSR should be revised to include an indicator around developing health oversight and coordination plans (Sec. 205) as outlined in the Fostering Connections to Success and Increasing Adoptions Act, as well as an indicator on psychotropic medication usage/practices for children in foster care. In addition, CFSR data should require states to report on the provision of services to ensure that children receive quality services to meet their physical health needs, including dental and eye care; children receive quality services to meet their mental health needs; and that children receive appropriate services to meet their educational and developmental needs. The CFSR should also examine the number of children receiving critical services, including medical, dental and mental health evaluations within 60 days of entry into care.

Many advocates have suggested that it can be challenging for child welfare systems to collect data on such indicators, but that HHS can develop federal regulations and provide funding and technical assistance to help state child welfare information management systems collect child well-being data (including medical, dental and mental health data) from other existing systems within the federal health and human services arena. As an interim step – and as states continue to improve their child welfare data systems – this may be a way to gather critical information from existing data systems.



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