FIRST FOCUS
MAKING CHILDREN & FAMILIES THE PRIORITY

Addressing the Health Care Needs of Foster Care Children

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 Medicaid children to experience emotional and psychological disorders and have more chronic medical problems. In fact, studies suggest that nearly sixty percent of children in foster care experience a chronic medical condition, and one-quarter suffer from three or more chronic health conditions.[1] In addition, nearly 70% of children in foster care exhibit moderate to severe mental health problems,[2] and 40% to 60% are diagnosed with at least one psychiatric disorder.[3]

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.

DISPROPORTIONATE EXPENDITURES FOR FOSTER CHILDREN & HEALTH CARE UTILIZATION

Although the provision of health care for foster children is mandated, many fail to receive even basic health care. In fact, a 1995 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 recent survey, HHS found that more than 30 percent of foster care cases reviewed did not demonstrate the provision of adequate services to children.[7]

Comparable findings have been reported by a number of other researchers. For instance, a study by Stahmer and colleagues found that although toddlers and pre-schoolers in child welfare exhibit significant developmental and behavioral needs, few receive services. In fact, in this sample, 41.8% of toddlers and 68.1% of pre-schoolers exhibited deficits, yet only 22.7% received services.[8] The National Survey of Child & Adolescent Well-being 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.[9] In addition, Zima and colleagues (2000) found that although 80% of children in a random sample received a psychiatric diagnosis, only half actually received mental health or special education services.[10]

Although numerous studies highlight the unmet needs of foster children, data indicate 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% of Medicaid expenditures, but represent only 3% of all enrollees.[13] 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.[14]

The High Cost of Care

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.[4] In a recent 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.[5]

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 more recent 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% of non-disabled children enrolled in Medicaid, they account for 12.3 percent of expenditures for this group.[15]

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 time greater for children in foster care that for other low-income high-risk children enrolled in Medicaid.[16, 17] In addition, according to Dr. David Rubin, a prominent researcher in this field, data from several studies have shown that up to 90% of these costs may be accounted for by 10% of children.[18]

FIRST FOCUS POLICY POSITION

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.[19] 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.

CONTINUITY IN HEALTH CARE FOR FOSTER CHILDREN

Foster care children often move from one placement to another, and are likely to experience gaps in health care coverage during transition periods. A recent 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.[20] In fact, only 7 in 10 foster care children were continuously enrolled in Medicaid in 1994.[21] Foster care children are also less likely than other vulnerable populations (i.e., adoption assistance or SSI) to be continuously enrolled in Medicaid during 12-month or 24-month periods.[22] Moreover, foster children typically have a fragmented medical history, and practitioners are faced with incomplete information and limited knowledge of their health conditions and needs. 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]

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.[24]

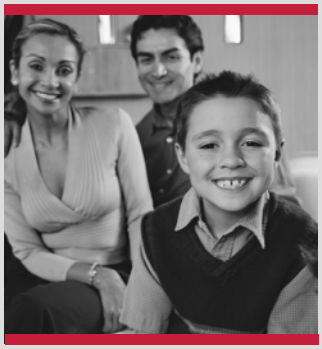
FIRST FOCUS POLICY POSITION

Disruptions in health coverage are a serious concern, especially for foster kids who have great needs. We must ensure that these children continue to maintain their eligibility and enrollment in Medicaid in times of transition. The American Academy of Pediatrics (AAP) has endorsed the concept of medical homes for children in foster care. A medical home would ensure that children receive care that is family centered, comprehensive, coordinated and continuous over time. Children and youth in foster care would receive all of their health care services from a singe health care professional. A medical home would provide continuity and ensure that children can retain a single care provider, even in times of transition. In addition, we believe medical passports can also help improve continuity in care for foster children. 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. A number of states have implemented medical passport initiatives, and we believe the federal government should continue to support the expansion of such efforts.

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% in Florida to 41% in Pennsylvania.[11] 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 (2004) found that foster children received fewer overall outpatient services than other Medicaid eligible children - but as their placements increased - were more likely to visit the emergency department and to receive a larger proportion of their overall care there than their peers.



Health Coverage Stability

A recently released 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% 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.[25] These findings highlight the dependence on Medicaid for children in the child welfare system.

ACCESS TO HEALTH CARE FOR TEENS AGING OUT OF FOSTER CARE

Teens aging out of foster care are vulnerable, and for many, access to health care is limited. In fact, several studies have highlighted high needs and lower levels of routine preventive care for adolescents - an especially at-risk subgroup in foster care.

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 are doing so. A 2007 report by the America Public Human Services Association (APHSA) found that since the enactment of the Foster Care Independence Act, 17 states have moved to extend their Medicaid programs using this provision to provide care for youth aging out.[26] In addition, five states are planning to extend their Medicaid coverage using the Chafee option. The remaining 28 states and the District of Columbia use several other programs to provide health coverage for youth aging out of the foster care system. 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.

FIRST FOCUS POLICY POSITION

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. We believe that Medicaid coverage should continue for all youth in foster care until at least the age of 21. First Focus supports efforts to expand Medicaid coverage to youth aging out of foster care and believes that federal policy is essential to ensuring continuity in care for vulnerable adolescents. A number of legislative proposals, including the Medicaid Foster Care Coverage Act (H.R.1376) and the Foster Care Continuing Opportunities Act (S. 1521) expand eligibility for Medicaid to foster care adolescents through age 21. We have expressed support for these proposals and will continue to advocate for such efforts to expand coverage to youth aging out of foster care.

ACCESS TO HEALTH CARE FOR CHILDREN IN KINSHIP CARE

Research suggests that children living in both formal and informal kinship arrangements have an increased risk of lacking health insurance. In 1996, one in three children living with a grandparent was found to have no health insurance – a sharp contrast to one in seven in the overall child population.[27] Similarly, an Urban Institute report found that only 49% of children in informal kinship care arrangements actually received the Medicaid health insurance coverage they are entitled to.[28]

In addition, Berman and Carpenter (2004) report that children in informal kinship care are less likely to receive critical preventive health care than their non-foster care counterparts. Compared to non-foster care children, those in informal kinship care were more likely to be uninsured, lack a regular source of care and to be in poor health. Children in formal kinship care had a five-fold increase in the odds of lacking health insurance as compared to children in traditional foster care. Moreover, all children in kinship care were less likely to receive mental health services than children in traditional foster care.[30]

Although all 50 states and the District of Columbia allow relative caregivers to apply for Medicaid and SCHIP coverage on behalf of a child, according to the Children's Defense Fund, kinship care families experience a number of barriers to accessing these critical programs.[31] These caregivers are often hard to reach, and children living in kinship arrangements are often overlooked in Medicaid and SCHIP outreach activities.

FIRST FOCUS POLICY POSITION

Kinship families need our support. Enhancing services, training and financial assistance for kinship care is critical to ensuring that our system of care adequately meets the needs of our most vulnerable children. In addition, Medicaid and SCHIP outreach efforts should target kinship families, and as the Children's Defense Fund recommends, we must simplify application forms and documentation requirements, provide training on eligibility rules for Medicaid and SCHIP personnel, and eliminate unnecessary requests for proof of caregivers' income and other information not essential to document eligibility.

PSYCHOTROPIC MEDICATION USE IN FOSTER CARE CHILDREN

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.[32, 33, 34]

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.

A large number of children in foster care exhibit behavioral problems, so it's not all too surprising to see high usage rates for this population. But, these kids are often prescribed several medications, the effects of which are not well known in combination. 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.[38] In the Medicaid program, children in foster care are much more likely to use psychotropic medications than children who qualify through other aid categories.[39]

A recent 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.[40]

We have a unique responsibility when it comes to foster children. Children in foster care are legal wards of the state courts or social service agencies, and it is our responsibility to ensure that every child in foster care receives the care, resources and supports he or she needs.

FIRST FOCUS POLICY POSITION

The GAO should review the practice of prescribing psychotropic medications for foster children to determine if these prescriptions are safe and cost-effective, and examine the practice of prescribing these medications to young children. We must also invest in long-term drug safety investigations, provide ongoing clinical monitoring of psychotropic medication use in children, and develop the most appropriate and effective treatments possible for children in foster care. A number of prominent researchers have recommended expanding studies of the benefits and risks of pharmaceutical treatments beyond clinical trials and into sustained studies in community-based youth populations - especially foster care and disabled youth, given the rather complicated and poorly evidenced, high-cost medication regimens these children typically receive. We strongly support such efforts to better understand the effects of psychotropic medications usage for children in foster care.

MEDICAID REGULATIONS THAT LIMIT ACCESS TO CRITICAL SERVICES FOR FOSTER CHILDREN

For children in foster care, Medicaid is an essential resource, providing critical care, services, and supports, and helping them heal and move forward on the path to recovery. Because Medicaid is a federal-state partnership, in order to receive federal matching funds, state-administered Medicaid programs must provide beneficiaries with certain mandatory services. Beyond that, states may opt to cover and are entitled to receive federal Medicaid matching funds for approved optional services. The series of regulations and policy issuances recently set forth by CMS will have a particularly devastating impact on vulnerable children. Two of the proposed regulatory changes – the targeted case-management regulation and the rehabilitative services regulation - will have a direct and devastating impact on the delivery of vital services to foster children.

Case management and targeted case management (TCM) are two optional benefits available to Medicaid-eligible individuals, and at least thirty-eight states have used the case management benefit to coordinate the critical medical, social, educational and related services foster care children need. Available data indicate that foster care children who receive TCM are more likely than those who do not to access critical medical and social services. In fact, an Urban Institute study found that TCM recipients are more likely to receive physician services (68% compared to 44%); prescription drugs (70% compared to 47%); dental services (44% compared to 24%); rehabilitative services (23% compared to 11%); inpatient services (8% compared to 4%) and clinic services (34% compared to 20%). These data are a clear indication that TCM is effective and well-utilized, serving its intended purpose.

Although CMS argues it has published an interim final regulation (CMS-2237-IFC/72 Fed. Reg. 68077) on case management and targeted case management in order to implement changes Congress made in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171, Section 6052), we believe the rule reaches well beyond what Congress intended in the DRA, and if implemented, would have a detrimental impact on beneficiaries, especially vulnerable children in foster care.

Medicaid Rehabilitation Services are another optional benefit, and include medical and remedial services provided for the reduction of a physical or mental disability, in order to help recipients reach a better level of functioning. Behavior management services, therapeutic or treatment foster care, day treatment services and family functioning interventions are considered rehabilitative services. The proposed rule (CMS 2261-P) would narrow the definition of allowable rehabilitative services eligible for federal reimbursement, and significantly limit access to therapeutic foster care, which has been quite effective in reducing psychiatric hospital stays and residential care for children with serious emotional disorders, as well as critical services provided for special needs adoptions by public or private social service agencies.

FIRST FOCUS POLICY POSITION

The House passed the Protecting the Medicaid Safety Net Act of 2008 (H.R. 5613), which would place a one-year moratorium on seven Medicaid regulations issued by the Bush Administration, including the rule on rehabilitative services and case management/targeted case management (TCM). Senate Majority Leader Harry Reid (D-NV) invoked a procedural rule that permitted the bill to come directly to the Senate floor, bypassing the committee of jurisdiction, Senate Finance. The bill faces strong opposition, both from the Administration and some Senate Republicans. We strongly support a moratorium on these regulations, and are advocating for passage of the bill in Congress. Both the planned House supplemental war appropriations bill and the Senate Appropriations Committee's war supplemental mark include a one-year moratorium on the seven Medicaid regulations issued by the Bush Administration, including delays on the rehabilitative services and case management/targeted case management (CM/TCM) rules.

Other Issues to Consider: Managed Care Models

According to the Center for Health Care Strategies, currently, at least 30 states enroll children in child welfare in managed care, and provide general medical and behavioral services through managed care arrangements.[41] 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 – such as risk adjustment approaches and taking into account the differential utilization and expenditure profile among children in foster care.

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 care for foster children.[43]

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First Focus is a bipartisan advocacy organization that is committed to making children and their families a priority in federal policy and budget decisions. To learn more visit www.firstfocus.net.