CCF

CENTER FOR CHILDREN AND FAMILIES

COMMUNITY CATALYST
NEW ENGLAND ALLIANCE FOR Children's Health

Georgetown UNIVERSITY
Health Policy Institute

Child Welfare and the Affordable Care Act: Key Provisions for Foster Care Children and Youth

by Brooke Lehmann and Jocelyn Guyer, Georgetown Center for Children and Families
and
Kate Lewandowski, New England Alliance for Children's Health, Community Catalyst

Introduction

Signed into law by President Obama on March 23, 2010, the Affordable Care Act (ACA) is sweeping legislation that aims to ensure that all Americans have health insurance coverage, to reduce health care costs, and to transform the delivery of health care in this country. The legislation will have important implications for many of the nation's children,[1] but, it may prove particularly significant for the over 400,000 children and youth who are part of the foster care system.[2] These children often have extensive and complex health care needs, and, as reviewed in this issue brief, the ACA includes a number of provisions that hold the promise of improving their health and well-being.

Background

According to the United States government, there were over 400,000 children and youth living in foster care in 2010, down from a peak of over half a million in the late 1990s. These are children who cannot live safely at home. Instead they are placed in foster homes, relative foster homes or "kinship care," (i.e., homes headed by a relative), group homes, institutions, or pre-adoptive homes.[3]

Summary of Key ACA Provisions of Importance to Foster Children and Youth

Medicaid coverage for former foster youth: Beginning on January 1, 2014, former foster youth will be eligible for Medicaid until they reach the age of 26, provided that they turned 18 (or older under the state's child welfare plan) and were enrolled in Medicaid while in foster care.

Maternal, infant and early childhood home visiting programs: Federal funds will help states expand home visiting programs, which are expected to prevent child abuse and neglect, and reduce the need for foster care placement.

Health homes: Medicaid programs are encouraged to create "health homes" for children and adults with chronic health conditions (including mental health conditions and substance abuse) in order to provide coordinated and person-centered health care and social services, including many services that can be of particular benefit to foster care children and youth.

Increased flexibility to provide home and community-based services (HCBS): Since 2005, states have been able to cover HCBS as a state plan option, but few states have done so. Now, as a result of the ACA, states will have greater flexibility to cover HCBS for targeted populations such as foster care children and youth.

Power-of-attorney requirement: Foster care transition plans must include information about the importance of selecting individuals to make medical decisions on one's behalf if one is unable to do so, and include information explaining the options for designating a health care proxy or power of attorney under the state's laws.

Health Status of Children and Youth in Foster Care

Often as the consequence of maltreatment, children and youth in foster care have high rates of acute and chronic medical, mental health and developmental problems, making it vitally important that they be provided with high-quality, coordinated health care.[4] Approximately 80 percent of children in foster care have a chronic medical condition, and 25 percent have three or more chronic health problems.[5] The most common chronic conditions are growth failure, asthma, anemia, and neurological problems.[6] Among preschool children in foster care, about 60 percent have developmental delays.[7] When it comes to utilization of services, children in foster care use mental health services, both inpatient and outpatient, at a rate 15-20 times higher than the general pediatric population.[8] Moreover, children and youth in foster care are an inherently transient population, often moving from one placement to another. This all too frequently leads to disjointed and generally insufficient health care.

Medicaid's Role for Children and Youth in Foster Care

Medicaid plays a vital role in the lives of children and youth in foster care by providing access to essential health care and supportive services. Nearly all children in foster care are enrolled in Medicaid, and many continue to receive Medicaid when they leave foster care for adoption or kinship care. Some of the most frequently used Medicaid services include prescription drugs, rehabilitative services, inpatient psychiatric care, inpatient hospital care, and targeted case management (i.e., case management services that help people address medical and social needs).[9] While much more work is needed to improve the quality and coordination of care provided through Medicaid, the importance of Medicaid in providing access to health services for children in foster care cannot be overstated.

Current levels of Medicaid eligibility for foster children vary considerably by state. While some states take advantage of a state option to expand Medicaid eligibility for former foster youths between the ages of 18 and 21, other states make no special provisions for them (See Table 1 for state specific data).

Key Provisions of the ACA with Implications for Foster Care Children and Youth

The key provisions of the ACA with implications for foster care children and youth are described in more detail below.

Medicaid Coverage for Former Foster Youth Up to Age 26

In general, young adults are uninsured at much higher rates than others, but lack of coverage is a particularly acute problem for former foster care youth. They often struggle to find jobs that include health benefits and, unlike many other young adults, cannot turn to their families for financial help to buy health insurance.[10] At the same time, they are more likely than their peers to report having a health condition that limits their daily activities and to be receiving psychological and/or substance abuse counseling.

To lower the uninsured rate among young adults, the ACA includes a provision allowing them to remain enrolled in a parent's employer-based coverage up to age 26. Since former foster care youth typically cannot turn to their parents for such coverage, the ACA created a parallel provision to provide equity for them in relation to their non-foster care peers. Specifically, beginning January 1, 2014, the ACA allows former foster youth who have aged out of the system to continue to receive Medicaid coverage until the age of 26. To qualify for this coverage, the former foster youth must meet the following criteria:

1. They were in the foster care system under the responsibility of the state when they reached the age of 18 (or older under the state's child welfare plan); and
2. They were enrolled in Medicaid or a waiver program[11] while in foster care.

Medicaid is available to these former foster youth even if their income otherwise would make them ineligible for coverage. The federal government will support the cost of covering these young adults by providing states with federal Medicaid matching funds at the "regular" Medicaid matching rate for their care.[12]

Regulations regarding this provision have not yet been issued, therefore many questions remain as to how this aspect of the ACA will be implemented. These include:

- Will this coverage extend to foster youth turning 18 between now and January 1, 2014 (when the provision takes effect), or must a child turn 18 after January 1, 2014 to qualify for it?
- What steps must states take to identify eligible youth and inform them of their ongoing eligibility for coverage?
- Can this provision be applied to youth who turn 18 while in the juvenile justice system but who have been or will become foster youth before reaching independence?

In the months ahead, it will be important for the federal government to address these and other key questions to ensure that the provision provides stable insurance coverage to this vulnerable population during their transition to adulthood.

States also will have a critical role to play in implementing the provision. They will need to develop efficient and effective mechanisms for former foster youth to continue their Medicaid coverage by providing a simple application process that does not involve burdensome documentation requirements.[13] In addition, states should assess applicable benefit packages to ensure that they are appropriate for the specific health needs of former foster youth. For example, program administrators could evaluate whether covered behavioral health benefits are sufficient for a population that has an especially high need for these services.

States also will have to figure out how best to inform foster parents and youth about the opportunity for former foster youth to qualify for Medicaid. Important resources for this educational process include the youth's social worker and his or her health care providers, including behavioral health care providers. In addition, the state's foster care agency and Medicaid program could jointly or separately send an easy-to-understand notice to the youth's home to notify him or her of the process for maintaining Medicaid enrollment after aging out of foster care.

Maternal, Infant, and Early Childhood Home Visiting Programs

The ACA provides $1.5 billion in funding to states over five years to expand their use of early childhood home visiting programs for at-risk families, including those with connections to the child welfare system. These programs give at-risk families the option to be visited by trained professionals who can provide them with information and support during pregnancy and throughout the first few years of a child's life.[14]

The initiatives undertaken with these new ACA funds generally must be evidence-based home visiting programs that promote improvements in outcomes such as infant, child and maternal health and well-being; parenting skills; school readiness; economic well-being; and rates of child neglect and abuse. The funds can be used for a broad array of at-risk families, but families with a history of child abuse or neglect or that have been involved with child welfare services are identified as one of the priority groups for funding. Moreover, states that use the funds are expected to demonstrate concrete progress in key areas, including in the "prevention of child injuries, child abuse, neglect or maltreatment."[15]

There are multiple ways that home visiting programs have the potential to help foster children or those at risk of foster care placement. Such programs might prevent the maltreatment that can lead to placement in foster care, help foster youth to regain placement with their families of origin, improve the experiences of children residing in foster homes, and help pregnant or parenting foster youth become better parents and avoid neglect or abuse of their own children.

The Value of Early Childhood Home Visiting Programs in Preventing Abuse and Neglect

A systematic review of the research on early childhood home visiting programs found that such approaches can prevent child maltreatment in high-risk families, with programs longer than two years having the strongest effects.[16]

Not only will the lives of the affected children be immeasurably better as a result of effective home visiting programs, but the social costs of child maltreatment also may be reduced. A recent study found that the lifetime cost of one victim of abuse and neglect was $210,012 due to adverse health, social and economic consequences. The total life-time costs of child maltreatment in the U.S. for all children abused and neglected in just one year (2008) was $124 billion.[17]

Increased Flexibility to Provide Home and Community-Based Services

The Affordable Care Act gives states new flexibility to provide home and community-based waiver services (HCBS) to targeted populations, including foster care children and youth. HCBS are services provided in an individual's place of residence or in a non-institutional setting located in the individual's immediate community. Originally conceived as a deinstitutionalization mechanism for the elderly and severely disabled, HCBS are now a growing source of services and supports for many other populations.

Until the implementation of the Deficit Reduction Act of 2005 (DRA), states could provide certain HCBS under Medicaid only if they received a waiver of otherwise applicable Medicaid rules,[18] and if the services could be provided only to individuals who would need an institutional level of care without them. Pursuant to the DRA, which created section 1915(i) of the Social Security Act, states have been able to provide HCBS as a Medicaid option, through an amendment to their state Medicaid plan, which involves a less arduous process than obtaining a waiver.

Of significance to the foster care population, 1915(i) allows states to provide HCBS to individuals before they need an institutional level of care, and can provide these services to individuals with mental health and substance use disorders. Some states have taken advantage of the 1915(i) option to provide services aimed at helping foster children. For example, Louisiana, New York, and Colorado elected to utilize the 1915(i) option to develop coordinated systems of medical and mental health care for children in their foster care systems.[19]

Only a few states have taken up the 1915(i) state plan option, however, prompting Congress to amend the provision in the ACA. The amendments allow states to expand eligibility for HCBS to individuals with higher incomes, provide additional services, target services to specific populations, and provide different services to targeted populations than to other Medicaid beneficiaries for the first five years of program operation (or longer with federal approval). With the additional flexibility offered by the ACA, it is hoped that more states will take advantage of the HCBS state option, thus allowing a greater number of children and youth within the foster care system to reap its benefits.[20]

Health Homes

Effective January 1, 2011, the ACA created a new Medicaid option and financial incentives for states to develop "health homes" for children and adult Medicaid beneficiaries who have at least two chronic conditions, including asthma, diabetes, heart disease, obesity, a mental condition or substance abuse disorder; have one chronic condition and are at risk for another; or have one serious and persistent mental health condition. Given the high risk of substance abuse and mental health diagnoses among youth and former foster youth,[21] health homes could significantly improve their care by improving access to a broad range of coordinated clinical and support services.

Pursuant to the ACA and guidance issued by the Center for Medicare and Medicaid Services (CMS), a "health home" must provide coordinated, person-centered care offering access to preventive and health promotion services; mental health and substance abuse services; comprehensive care management, care coordination and transitional care across settings; chronic disease management; individual and family supports, including referrals to community and social supports; and long-term supports and services.[22]

Of special relevance to foster youth, CMS guidance requires states to consult with the Substance Abuse and Mental Health Services Administration in designing their approaches to health homes.

Since the health home delivery structure is new, there is a dearth of research on the their effectiveness in general and on the effects of health homes for foster youth and former foster youth in particular. However, there is some evidence that similar models of coordinated care could benefit foster youths through improved access to services and decreased trips to the emergency department.[23]

Power-of-attorney requirement

The ACA requires that all foster youths' transition plans include information describing the importance of designating a person to make medical treatment decisions in the event that the youth cannot make these decisions and does not have or does not want relatives to make these decisions on his or her behalf. The transition plan must also include information explaining the options for designating a health care proxy or power of attorney

under the state's laws. These provisions are important because they will encourage youths to consider and identify someone who they want to make their health care decisions in the event that they are incapacitated.

Conclusion

The ACA provides states with a number of tools that could be helpful to foster children and former foster children. Among these, the mandatory expansion of Medicaid eligibility to include former foster youth up to age 26 (effective January 1, 2014) is probably the most significant. Advocates can encourage states to use other ACA provisions – home visiting, health homes, and the HCBS option – to improve the health and well-being of foster children and youth, as well as young adults who have "aged out" of foster care.

Endnotes

1. G. Kenney, M. Buettgens, J. Guyer et al., "Improving Coverage for Children Under Health Reform will Require Maintaining Current Eligibility Standards for Medicaid and CHIP," Health Affairs, 30: 2371-2381 (December 2011).
2. Child Welfare Information Gateway, "Foster care statistics 2010," U.S. Department of Health and Human Services, Children's Bureau (May 2012).
3. Ibid.
4. M. Inkelas and N. Halfon, "Medicaid and Financing of Health Care for Children in Foster Care: Findings from a National Survey," UCLA Center for Healthier Children, Families and Communities (September 2002).
5. M. Szilagyi, "The Pediatrician and the Child in Foster Care," Pediatrics in Review 19:39-50 (February 1998); N. Halfon, A. Mendonca, and G. Berkowitz, "Health Status of Children in Foster Care," The Archives of Pediatric Adolescent Medicine, 149:386-392 (April 1995).
6. Ibid; M.D. Simms, H. Dubowitz and M. A. Szilagyi, "Health Care Needs of Children in the Foster Care System," Pediatrics, 106:909-918 (2000).
7. Op. cit. (4).
8. M. Szilagyi, "The Pediatrician and the Child in Foster Care," Pediatrics in Review 19:39-50 (February 1998).
9. E. P. Baumrucker, A.L. Fernandes-Alcantara, E.Stoltzfus, et al., "Child Welfare: Health Care Needs of Children in Foster Care and Related Federal Issues," Congressional Research Service (February 27, 2012).
10. Ibid.
11. In certain circumstances, the federal government can grant a waiver of otherwise applicable law to permit a state to provide services outside the usual scope of Medicaid benefits or to expand eligibility beyond the usual limits.
12. The regular Medicaid matching rate refers to the percentage of Medicaid costs paid by the federal government, as opposed to the state, and ranges from 50 percent to 74 percent. It is determined by a formula designed to provide more federal support to states with lower per capita incomes.
13. Automatic enrollment of youths who age out of foster care—based on records already existing within state databases—would reduce the administrative burden on youths and eliminate the risk of gaps in coverage. States may decide that this function requires dedicated staff to oversee the process. For example, the Connecticut Department of Children and Families established a Bureau on Adolescent and Transitional Services to assist youths who leave foster care.
14. Although there are a range of different models, the typical home visitation program uses home visiting as the primary strategy for the delivery of services to families. These services can include providing information about parenting and child development, linking families to other community services and resources and providing social support. Through the efforts of the home visitor to engage and establish a strong relationship with the family, it is hoped that the program will produce short-term and intermediate positive outcomes, such as changes in parents' knowledge and behavior, decreased stress, better family functioning, and access to needed services. The long-term outcomes generally include better child health outcomes, better social and emotional support for the families, increased capacity of a parent to care for the child, and decreased abuse or neglect. For more information see D.S. Gomby, "Home Visitation in 2005: Outcomes for Children and Parents," Committee for Economic Development, Invest in Kids Working Group (July 2005).
15. The ACA's early childhood home visiting program is administered through a partnership between the Health Resources and Service Administration (HRSA) and the Administration for Children and

Authors: Brooke Lehmann and Jocelyn Guyer, Georgetown Center for Children and Families.

Kate Lewandowski, New England Alliance for Children's Health, Community Catalyst.

The Center for Children and Families (CCF) is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families. CCF is based at Georgetown University's Health Policy Institute.

For additional information, contact (202) 687-0880 or childhealth@georgetown.edu.

Community Catalyst is a national non-profit consumer advocacy organization dedicated to quality affordable health care for all. Community Catalyst's New England Alliance for Children's Health is a broad coalition of individuals and organizations dedicated to promoting access to high-quality, affordable health care for all children.

Families (ACF). To be eligible for funding, a state must engage in a series of assessment activities and apply for funding that targets specific needs identified through the assessment process. As of the time of this writing, all states and territories and the District of Columbia had received funding through this program.

16. R.A. Hahn, O.O. Bilukha, A. Crosby , et al., " First Reports Evaluating the Effectiveness of Strategies for Preventing Violence: Early Childhood Home Visitation," Morbidity and Mortality Weekly Report: Recommendations and Reports, 52: 1-9 (October 3, 2003).

17. X. Fang, D. S. Brown, C.S. Florence, et al., "The Economic Burden of Child Maltreatment in the United States and Implications for Prevention," Child Abuse and Neglect, 36(2):156-165 (February 2012).

18. These waivers (under section 1915(c) of the Social Security Act) provide a mechanism through which states are able to target various high-need populations and deliver community-based services designed specifically for them. For example, HCBS are often offered to children with autism and other developmental disorders as a way of maintaining them at home and preventing out-of-home placements (i.e., in foster care, inpatient facilities, etc.). Under a waiver, states must demonstrate that the costs of providing waiver services are no greater than they would be to provide services to the same population without a waiver.

19. For more information of each of the states' plans, see Louisiana's Coordinated System of Care Governance Board, "Coordinated System of Care- Behavioral Health Services- Children's Choice" State Plan Amendment (March 2011); New York State Office of Children and Family Services, "B2H- Bridges to Health" Waiver Program (January 2008); Colorado Department of Health Care Policy and Financing, "Children's Habilitation Residential Program Waiver".

20. Of note to those interested in expanding opportunities for children and youth in foster care are some restrictions imposed by the ACA on states using the 1915(i) option: states may no longer limit services to certain geographic regions within the state, nor are they permitted to limit the number of recipients who can receive the services.

21. Over 80 percent of youths in foster care experience behavioral, emotional, and developmental disturbances; substance use is higher among youths who have been in foster care (33.6 percent) than among youths who have never been in foster care (21.7 percent). For more information, see Children's Law Center of California, "Foster Youth and Mental Health Fact sheet," (2005), available at http://www.clcla.org/facts_mental.htm (accessed June 25, 2012); National Survey on Drug Use and Health,"Substance Use and Need for Treatment Among Youths Who Have Been in Foster Care." (February 18, 2005), available at http://www.oas.samhsa.gov/2k5/FosterCare/FosterCare.htm (accessed June 25, 2012).

22. A health home connects providers in order to streamline and enhance care. Health homes may be comprised of designated providers, teams of health professionals linked to a designated provider, or an interdisciplinary "health team." In any configuration, the health home should take a "whole-person" approach to providing clinical and non-clinical services to meet individuals' physical and psychosocial health needs and use health information technology to ensure effective information-sharing among providers. For more information, see Kaiser Family Foundation, "Medicaid's New Health Home Option," (January 2011).

23. A 2008 study described reactions to a pilot in upstate New York of a foster care "medical home" model, which bears resemblance and relevance to the health home model. Social workers in the region partnered with a pediatric primary care practice in order to deliver services that met the health care needs of the foster youths by ensuring that physicians were cognizant of the effects of trauma on child health and were connected to other community and educational resources to enhance care. The social workers reported that the partnership improved the care the foster youths received and reduced their trips to the ED. Moreover, the case workers asserted that establishing communication between themselves and physicians made their work easier and enhanced their ability to ensure that youths received appropriate services. For more information, see S. Townsend and A.K. Doyle, "Understanding Caseworker Perspectives on a Pediatric Medical Home for Children in Foster Care," Illinois Child Welfare, 4(1): 52-58 (2008).

Table 1 States that have Adopted the Medicaid Option to Cover Children Aging Out of Foster Care Up to Age 21	
State	Foster Children Up to Age 21[1]
Total	**33**
Alabama	
Alaska	
Arizona	Y
Arkansas	
California	Y
Colorado	Y
Connecticut	Y
Delaware	
District of Columbia	
Florida	Y
Georgia	Y
Hawaii	
Idaho	
Illinois	
Indiana	Y
Iowa	Y
Kansas	Y
Kentucky	
Louisiana	Y
Maine	
Maryland	Y
Massachusetts	Y
Michigan	Y
Minnesota	
Mississippi	Y
Missouri	Y
Montana	
Nebraska	Y
Nevada	Y
New Hampshire	
New Jersey	Y
New Mexico	Y
New York	Y
North Carolina	Y
North Dakota	
Ohio	Y
Oklahoma	Y
Oregon	Y
Pennsylvania	
Rhode Island	Y
South Carolina	Y
South Dakota	Y
Tennessee	
Texas	Y
Utah	Y
Vermont	
Virginia	
Washington	Y
West Virginia	Y
Wisconsin	Y
Wyoming	Y

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2011.

NOTES: 1. Data indicates whether the state has adopted the Medicaid option to cover children aging out of foster care up to age 21, referred to as the Chafee option. States listed as "yes" in this column may have used the flexibility available to them under federal law to extend Medicaid to former foster youth up to certain ages (18, 19, or 20) rather than to all such youth ages 18 to 21.

Table presents rules in effect as of January 1, 2011.