

The Role for Medicaid in Improving Outcomes for Children and Youth in Foster Care

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Laura Armistead:

Hello everyone. We're going to get started. My name is Laura Armistead and I'm an Analyst at Mathematica. Thank you for attending today's Foster Care Learning Collaborative: Improving Timely Health Care for Children and Youth in Foster Care webinar series. This is the first webinar in the series titled: The Role for Medicaid in Improving Outcomes for Children and Youth in Foster Care. Next slide, please.

Before we begin, we wanted to cover a few housekeeping items. All participants logged into this webinar have been muted for the best sound quality possible. If you have any technical issues, please use the Q&A window located at the bottom right corner of your screen. Please select "Host" in the dropdown menu and click "Send" to let us know how we can help.

We also welcome audience questions throughout today's webinar through the Q&A window. If you'd like to submit a question, please select "All Panelists" in the dropdown menu and click "Send" to submit your question or comments. We'll be monitoring the Q&A window throughout today's webinar and we'll address as many questions as possible at the end. Lastly, we want to let everyone know that this meeting is being recorded. Next slide, please.

Now I'd like to turn it over to Joe Zickafoose from Mathematica. Joe, you now have the floor.

Joe Zickafoose:

Thanks so much, Laura. And welcome everyone. We're very excited to kick off with this first event for the CMS Foster Care Learning Collaborative. We'll start with an introduction to the learning collaborative from Deirdra Stockmann, with CMS, and then we'll hear from Susan Ruiz with CMS and Catherine Heath from the Children's Bureau to give us some help with setting the federal context for children in foster care and Medicaid. Next, Kamala Allen with the Center for Health Care Strategies will review the role of Medicaid in addressing the unique healthcare needs of children and youth in foster care.

Lastly, we'll hear about Virginia's collaboration across Medicaid and child welfare agencies from Cheryl Roberts and Adrienne Fegans with the Virginia Department of Medical Assistance Services, and Lora Smith with the Virginia Department of Social Services. We've got many speakers today to talk about some exciting topics, but we aim to leave at least ten minutes for questions and discussions at the end before Laura will close us out with announcements about upcoming events. With that, I'd like to hand it over to Deirdra Stockmann from CMS to provide an overview of the learning collaborative. Next slide, please.

Deirdra Stockmann:

Thank you so much, Joe. Hello everyone. Again, my name is Deirdra Stockmann. I'm the Technical Director for Quality Improvement at the Center for Medicaid and CHIP Services at CMS. I'm very pleased to welcome you all to the first webinar in this new learning collaborative on improving timely

health care for children and youth in foster care. This learning collaborative is one of our quality improvement initiatives at the Center for Medicaid and CHIP Services within CMS. The goal of our quality improvement work is to support state Medicaid and CHIP agencies and their partners, such as us and other state agencies, health plans, providers, advocates, to drive measurable improvement in quality of care and health outcomes for Medicaid and CHIP beneficiaries. Next slide, please.

Over the past year or so, we've had the distinct pleasure of working in collaboration with the Children's Bureau at the Administration for Children and Families to develop this learning collaborative. Over the course of this webinar series and the ensuing affinity group, we hope to provide state Medicaid and child welfare agencies with the support and tools they need to expand their understanding of data-driven interventions to improve timely access to care while learning about the science of quality improvement. To do this, we hope states will build and strengthen partnerships across state agencies, as providing the best care for children and youth in foster care depends on these agencies working together, and with their partners to meet the needs of young people and their caregivers. Next slide, please.

Briefly, before we move into the main content of the webinar today, I wanted to provide an overview of the learning collaborative. We're kicking it off today with the first webinar in the two-part series, as Laura mentioned. We'll also hold an information session about the affinity group opportunity very soon. State Medicaid and child welfare teams who are interested in taking action to improve timely care for foster youth are invited to express interest in participating in the affinity group. We'll share more details about the webinar series and how to participate in the affinity group at the end of today's webinar, so we hope you'll stick around.

With that, thank you again for joining us today. We're thrilled to see such a swell of interest in this topic. Now I'm pleased to hand it over to my colleague, Susan Ruiz, who will provide a bit more context on the Medicaid program, particularly as it pertains to children and youth in foster care. Susan.

Susan Ruiz

Thank you. My name's Susan Ruiz and I'm a Health Insurance Specialist in the Center for Medicaid and CHIP Services. Since we're joined by a number of people from child welfare agencies today, we thought it would be helpful to provide a high-level overview of Medicaid. When a child is eligible for Title IV-E foster care, they also become eligible for Medicaid. The state may have other populations of foster care, but it's Title IV-E that results in automatic eligibility for Medicaid. The Affordable Care Act created a new eligibility group for former foster children. These are young adults who have aged out of foster care and can receive Medicaid until age 26. Today, we're focused on children currently in foster care.

Medicaid provides health coverage for more 70 million people nationally, and about 40 million of those are children. It's one of the biggest items in any state budget, and yet foster children are between one and two percent of enrolled children in each state. So, this population is a small subset of overall enrollment. States administer their Medicaid programs under broad federal guidelines but states fill in the details so programs can look different from state to state. Within the guidelines, states can establish their own income limits, add optional services, set provider requirements, and decide how much providers are paid.

Since children in Title IV-E foster care are automatically eligible and because these children are in state custody, it's been the state's responsibility to ensure they receive healthcare. There's a long list of mandatory and optional benefits that states can choose to cover, physician services, inpatient and outpatient hospital services, physical and occupational therapy, nursing homes, dental services, pharmacy benefits and more. For children, most Medicaid benefits are required when medically necessary.

The Early and Periodic Screening, Diagnostic, and Treatment benefit, or EPSDT, is the Medicaid benefit for children under age 21. It requires coverage of well-child visits on a schedule adopted by the state, diagnostic services to identify conditions, and treatment of identified conditions. EPSDT is an extremely comprehensive benefit that includes all services listed in section 1905a of the Social Security Act when they're medically necessary. All of this is true regardless of your state's Medicaid delivery system.

Some states deliver services to foster children in a traditional fee-for-service system, which is where the patient finds a provider and then the provider is paid for the service rendered. Some enroll these children into, say, a managed care plan that other Medicaid children are enrolled in. That's where the patient has a choice of providers within a plan, and the plan helps to coordinate care. Some states have a dedicated foster care plan that serves exclusively foster care children, which can help serve the needs of the specific population as well as coordinate care.

Managed care plans are expected to identify individuals with special health care needs and screen new members within 90 days as well as provide care coordination. States also take varied approaches to measuring and monitoring the quality of services delivered to beneficiaries. States voluntarily report the Medicaid and CHIP Child Core Set of quality measures to CMS. These measures will become mandatory in 2024. With that, I'll hand things over to my colleague at the Children's Bureau, Catherine Heath, to talk a bit about child welfare requirements. Catherine.

Catherine Heath:

Great. Thank you so much, Susan. As Susan stated, my name is Catherine Heath and I work at the Children's Bureau. I'll just start by saying it's National Foster Care Month. So, I work for the part of Health and Human Services that deals with human services, and the Children's Bureau is the agency that administers foster care services from prevention to adoption. So, as Susan described what Medicaid is, I'm going to provide a brief overview about what is foster care.

So, when a child cannot safely remain at home, a child enters foster care and services are provided to that family and child in order to help that child return to the home that they were removed from. Most children actually return home after a short stay in foster care, and many others are placed with relatives and permanency are found for those children in foster care. In all cases, foster care is supposed to be a temporary, time-limited episode in a child's life before they find permanency with a forever family.

So, who administers foster care? Well, as it is in the Medicaid system, it's the same how our system exists. So, states, counties, and even contracted providers administer foster care services. The option of what programs and how children and families are served varies by state. That means that programs and resources can look very different.

Let me just take a moment to thank my colleagues who have been working on this project with CMS. So, I would like to thank Josh Christian Oswald, Jennifer Haight, John Hargrove, and CMS for really bringing this work to our attention, because we care about this work because we know that children and youth in foster care have experienced often complex trauma and the circumstances that often arise for them entering foster care makes for ensuring that we provide healthcare services in order to have healthcare outcomes.

We know that healthcare is important before, during, and after a child's stay in foster care. Because foster care is a time-limited – should be a time-limited episode, really thinking about that continuum of services, especially while a child is in foster care, is critically important. We know that children belong in families

and that health care supports whatever that family is going to look like, whether that is grandparents, whether they're living with kin, adopted or reunified.

So, while the work that we do around foster care in Medicaid, as mentioned before, is small, one to two percent of the population, we know that there can be variable complex and complicated administrative structures that govern how children access necessary care. And that that unnecessary confusion delay can exacerbate the problems that we're trying to solve, not only for the child but the families that we're trying to reunify. Therefore, states have been working since 2010 on an item that is given to the Children's Bureau and approved called the Health Care Oversight Coordination Plan.

This plan is required to be done in coordination with the state child welfare and Medicaid agency and in consultation with pediatricians and other experts in health care. The last Health Care Oversight Coordination Plan due from state child welfare agencies was June 30, 2019 for fiscal years 2020 to 2024. So, we know that there is already work happening in states around coordinating those services for children and youth in foster care. We look forward to this partnership and the work going forward because this is something that we are all really sure is important to making sure that children are thriving, not just while they're in foster care but afterwards and as they enter adulthood. So, with that, I'll turn it over to our next speaker, Kamala Allen.

Kamala Allen:

Thank you so much, Catherine and Susan. We are excited to be a part of this work, and I just want to say thank you for allowing us to participate today. So, my role today is really to expand on the overviews that both Susan and Catherine provided, and to lay a foundation for baseline understanding of the health care needs of children in foster care, and why Medicaid's role, both independently and as a partner with child welfare, is critical to meeting those needs.

So, Susan already gave you a little bit of a preview to this. The first question being how do children in foster care – I'm sorry, next slide, please. I should have said that. My apologies. Perfect. Thank you. So, Title IV-E, as Susan said, is the trigger for Medicaid eligibility for children in foster care. It's the largest federal funding stream for services and supports for children and families involved with the child welfare system. Foster care program funds are awarded to states, territories, and tribal organizations for the care of children who are removed from their homes, placed in foster care, and who are income-eligible based on 1996 requirements under Aid to Families with Dependent Children. There are a couple of other administrative requirements but those two are really primary determinants. Children and youth who receive Title IV-E assistance, including foster care services, among others, are automatically eligible for Medicaid, as Susan said, which makes virtually all children in foster care eligible for Medicaid. Next slide, please.

So, now that they have Medicaid eligibility, the state now assumes the same legal responsibility for care as when that child is removed from the home as the parent would have. Children in foster care, we know, are a vulnerable population. We know that there are a number of studies that have documented the high risk of poor health outcomes and poor health status for children both entering and in foster care, and those who have a history of foster care. And states have really tried to think about how to address those needs, some of them using managed care, again, as Susan said. I'll say more about that later.

The rationale, though, being that managed care can be an effective strategy to facilitate timely access to care, which is going to be one of the things that we're going to be focusing on, and it can be an effective strategy for the effective coordination of care across services and providers. We know that children in

foster care are often involved with multiple systems. So, ensuring that timely access and that coordinated array of services is key to trying to change the trajectory of some of those poor outcomes that I mentioned.

Most states do enroll the foster care population in managed care, and I have a slide later in the deck that will say a little bit more about what that looks like across the states. But as Catherine said, the point of connection through the Health Care Oversight and Coordination Plan is really a leverage point. That plan requires that the states outline how health needs identified through screenings would be monitored and treated, including the emotional trauma associated with maltreatment and removal from the home. So, there are some states where, kind of organically, that collaboration has occurred, some states where that collaboration has really come together around the coordination and the health care oversight coordination plan. And because that federally-mandated vehicle exists, it provides an opportunity for us to push that collaboration and support that collaboration between child welfare and Medicaid. Next slide, please.

So, who are children in foster care? So, what I did here is really pull data from the Adoption and Foster Care Analysis and Reporting System, or AFCARS as our colleagues on the child welfare side are so familiar with. AFCARS provide information on the foster care population, including demographics, reason for removal, placement history, goals for reunification, etc. And what I did here is create a fictional child based on the predominant characteristics of children in foster care.

What's not reflected here is the disproportionality, and that is the fact that while most children in foster care are white, children of color are disproportionately removed from their homes relative to their representation in the population. And child welfare agencies have really been trying to pay more attention and address that issue in a number of ways. But what I want to say here about the children in foster care is that they are primarily white, as I said, at about 44 percent, followed by Black children at 23 percent, and Hispanic children at 20 percent.

They're primarily young. 16 percent of children in foster care are age one or younger, with a mean age of eight years. They're slightly more likely to be male, at 52 versus 48 percent. They're most likely to have non-relative foster family homes as their most recent placement, at 46 percent, followed by kinship placement, which is placement with a family member, at 32 percent. They're most likely to have reunification with parent or primary caregivers as the most common permanency goal, with over half of children having that as their goal for permanency.

Finally, the average length of stay in foster care is just under 20 months, with a median of just over 13 months. So, you can see in that fictional child that we've created there, that the primary reason for removal is neglect and substance use. And it's probably not surprising to many of you that substance use has moved up the list in terms of its ranking as a cause of removal. Next slide, please.

So, the physical healthcare needs of children in foster care have been demonstrated to be higher than those of the non-foster Medicaid child population. They have higher rates of respiratory infection, ear infection, and vision impairment. They also use more of certain categories of health care services than others. Hospitalization is frequent, as is the use of specialty care. They have longer lengths of stays with inpatient when they are hospitalized. And they can be expected to have higher overall expenditures as a result of that.

One thing that's interesting in our background is that there are two types of services that one study found children in foster care received fewer of, and that was emergency department services and primary care, which I thought was very interesting because we might expect that if emergency department services are

high, they probably weren't getting much primary care, or vice versa. But both of those were found to be lower than the general child Medicaid population. So, there's definitely something to be examined there. Next slide, please.

Oral health is also a really important area for children in foster care. We find that when children enter foster care, they often have high rates of dental and oral health needs, and often have not had a dental visit in the past 12 months. Oral health benefits for children in foster care are covered by Medicaid under the EPSDT benefit, which Susan mentioned. Younger children are less likely to have a dental visit than older children. Across all three categories of services that I'm going to talk about, physical health, oral health, and behavioral health, the American Academy of Pediatrics recommends that children entering foster care have a screening or evaluation within 30 days, and that remains the case here.

When we look at the oral health needs of children entering foster care, approximately 35 percent of them have significant need. I've listed here what some of those are. Dental caries, which most of us refer to as cavities, that is one of the most common chronic childhood diseases. And rates of dental caries are higher for children and youth in foster care than for the non-foster care Medicaid child population, at a rate of 76 percent versus 59 percent. Then I've listed kind of the factor by which certain types of dental and oral health problems are seen in children in foster care versus those children who are not in foster care.

The third thing I want to state here is that while studies show that children enter foster care with higher rates of dental caries and lower rates of preventive dental visits, they also show that once in foster care there's evidence that the rates of preventive dental visits may be higher for children in foster care than for non-foster youth in Medicaid. That could be in part due to state requirements for screening upon placement in states where they exist, which I will speak to in just a moment. Next slide, please.

The third category of care I want to talk about as it relates to children in foster care is behavioral health. As you heard from Catherine's comments, it's not surprising that behavioral health is a primary area of need for children in foster care. They have higher rates not only of behavioral health need but also services and expense than the non-foster care population.

What I am showing here on this slide is data from our CHCS's Spaces of Medicaid study, which is a partnership that we've had with the Treatment Service Collaborative to conduct a series of analytic analyses of Medicaid claims data from 2005 to 2011. And over that period, these analyses showed that children in foster care represented, at that point, between two and three percent of the child Medicaid population, but between nine and 11 percent of that population receiving behavioral health services.

So, on the left side of the slide, what you see is – we looked at the three categories of aid eligibility for children in Medicaid, and that's income eligibility, SSI or disability eligibility, or foster care-related eligibility. On the left side of the slide, you see that the rate and expenses of different types of behavioral health services, and specifically psychotropic medication which we know is of particular importance and concern as it relates to children generally but certainly children in foster care, are significantly lower than they are for Medicaid children who are in Medicaid by virtue of their foster care status.

So, we just wanted to give you a sense of what that difference is, specifically in the area of behavioral health. So, they're more likely to receive Medicaid-financed behavioral health services. They were also more likely to have specific diagnoses, conduct, mood, anxiety, PTSD, and substance use disorders. They're more likely to be prescribed psychotropic medications, to be prescribed more than one psychotropic medication, and to be prescribed antipsychotic medication. Again, based on their needs in that service utilization, children in foster care have higher total expenditures than their non-foster care

counterparts, and a greater proportion of those expenditures were due to their use of behavioral health services. Next slide, please.

So, I mentioned a little bit ago – I was going to say come back to state requirements and the variation among state requirements for screening as children enter foster care. Those requirements vary significantly across the state. In 2010, we did a survey of all state child welfare agencies to determine what those screening and assessment requirements were. 47 states and the District of Columbia responded. All of them required some screening, an initial screening, and at least one of the three domains that I just mentioned, physical health, behavioral health, or oral health. 65 percent of those that responded require screening across all three.

The key finding, I would say, of that study is that there is significant variation. As I mentioned before, the AAP's recommendation for screening is within 30 days of placement. However, not all states have a requirement for screening, and among those that do, the requirements ranged in our study from one day at a minimum to 90 days. The most common requirement across all three of those was 30 days.

We are currently in the process of fielding this survey again. It's actually been one of the pieces that we put out in our array of resources around health care needs of children in foster care that we get the most requests for. So, we're in the process now of updating this brief. Every child welfare administrator – every state, I should say, child welfare administrator was sent a survey in the summer of last year and we're still doing follow-up where we haven't received a response.

So, what we can say right now is preliminarily, among the 27 states that have responded to-date, 30 days is still the most common timeframe for physical health and behavioral health screening requirements. We're hopeful that we can meet our response rate of 2010 and that we can have accurate information about the screening requirements and encourage you to look forward to an updated brief later this summer. Next slide, please.

Susan also mentioned managed care as one of the strategies that's used to meet the health care needs of children in foster care. Based on CMS data, states have taken different approaches, some, as Susan mentioned, fee-for-service; some have excluded children in foster care from managed care. Some states incorporate or include the foster care population within their standard managed care program. And some states have foster care-only specialty plans.

When we look at the number of states and how those 41 states are represented, 35 states have mandatory enrollment for the foster care population statewide. Three have mandatory enrollment on a regional basis. And when we look at voluntary programs, one state has a voluntary statewide program for children in foster care and two states have voluntary regional programs. As you can see, the majority of those programs are both mandatory and statewide.

As I said earlier, the opportunity managed care provides for the coordination of care and use of flexible funding offers promise for addressing complex needs of the foster care population as we've described it. However, to effectively meet those needs, managed care programs must consider the unique needs of that population, including sometimes frequent changes in geographic placements, which can have implications for managed care.

Further, I think it's important to recognize, as I said when we were talking about the demographics and the characteristics of the foster care population, because the majority of children who enter foster care have a permanency goal of being reunited with their family of origin. Attention to care transitions is

particularly important, and you'll hear more about that in Virginia's presentation. That's something that doesn't really come into play with the non-foster care population.

So, the highlight, really, of today's presentation is spotlighting Virginia, a state that's been really thoughtful about how to use managed care to meet the health care needs of children in foster care. So, it's my pleasure to turn to our colleagues from Virginia who use managed care, who center effective collaboration between managed care and child welfare, and who proactively monitor health outcomes for the foster care population. So, with that, I turn it over to Cheryl Roberts, Adrienne Fegans, and Lora Smith to talk about how they are working together to meet the health care needs of children in foster care.

Cheryl Roberts:

Thank you, Ms. Allen. I'm Cheryl Roberts and I'm the Deputy for Program and Operations for the Department of Medical Assistance Services for the Commonwealth of Virginia. I am pleased to talk to you about how we have enjoyed our journey on the foster care journey. This weekend, I got to read a book by Laura Dave and I'm going to start that way. It's called "The Last Thing He Told Me." Most of you, if you know it, it's a Reese Witherspoon Book of the Month Club. I was reading it and it was one of those action/suspense books. And because when I get like that, I want to read the end. So, I go and I'm one of those people who look at the last chapter to see how it's going to play because I'm a Hallmark person, I want to see a good ending. And I want to tell you before we begin, for Virginia, what the ending is.

And the ending is we have an opportunity. We have services. We have access to care. We have waivers. We have federal support. We have state support. And I'm asking that if you are involved in this program, if you're involved in these services, that you stay focused on protecting these children. So, ironically, the book opened in which the character said, "Protect her." And I thought about this right away and I want to start off with we're here to protect these kids. Next slide.

Foster care is a collaborative issue. I wish I had understood that from the beginning so that we didn't have some errors, because I do want to say that we are not perfect in every way. But it was a great lesson to learn. Next slide.

DMAS works very, very closely on foster care children with our Department of Social Services (DSS). DMAS is the Medicaid side. Clearly, we serve about 1.7 million members. We provide the care. We have the oversight. And then we are one of 11 states that has state-supervised and locally-administered social service systems. That's important as we're going to talk about the Virginia way. So, the Department of Social Services provides oversight and guidance to the 120 local offices. And that's why, today, we brought someone from social service to talk to us because, from the very beginning, you have to be linked together. Next slide.

We have about, on average, about 5,000 kids in foster care at any time, going up to about 7,000 now. Basically, this is the breakdown. Very consistent with the data that Ms. Allen talked about. You can see that 21 percent are kids, very young kids. And then you start to see some of them as they're beginning the aging. Same in the same demographics nationally. So, we are very much aligned. Next slide.

I'm going to spend a little more time here to talk about the history of it. So, before we get into the pilot, I do want to tell you that we made an attempt to start foster care into managed care before this one and didn't do well. This is a mistake that I think a lot of states begin with. When you're doing managed care, you're doing these massive, massive implementations. Most of the time, you think of people in big

buckets. So, you start to think of the long-term care population, your nursing home population, your kids. You start working through it. And here you really have to stop and ask the questions, the hard questions, because this is not a checkoff box. This is not the way you can just say, I'm going to bring a big group of people in.

What we learned the hard way was that you really do have to understand the logistics, how things are identified. How does the county work? What happens in terms of the trauma? Do you have the support system of the provider community? Can you get the trust of foster care parents? Can you figure out what to do with advocacy groups and other supportive groups, everything from CASA, and in our case, we have a youth commission, too. And those – all those things and all those pieces, from congregate care to transition, to court cases, you need to have a real sense of that before you really do think about moving this population into managed care. The first round we did not know that and we learned the hard way.

The second time, ironically, this is what happened in Richmond. Richmond is one of our biggest cities. The actual deputy mayor came to me because she wanted to actually exclude kids from managed care. And when I finished talking to her about all the things that managed care could do for kids, she said, I want you to move the foster care kids into managed care, and so began the pilot. All six plans wanted to be part of that pilot. Through that, we would pick an opportunity to actually learn all those things I was talking about. And that was in terms of what kind of data we were going to need, what kind of interventions we were going to need in order to make that work. The biggest thing we recognized is learning to be credible, transparent, and have trust.

So, we went to the general assembly to give our support. General assembly agreed that we would do that for foster care and the adoption assistance. Adoption assistance is after the person is in a permanent home, but they're still getting assistance from Medicaid. And we did a strong partnership with our Department of Social Services. We were linked to the hips. So, we did it regionally. We didn't go statewide in one fell swoop. We actually did regional implementations. Why? Because each region has a different niche. I'm sure everyone knows that. Different health systems. Different – every city, every state is like that. Even when I lived in New York, Brooklyn is different than the Bronx, and the same way here, Richmond is different than Northern Virginia. And you need to know how that works and what happens.

So, we spent that time and we actually went on the road to do implementation. We wanted to meet the foster care parents themselves to understand their concerns, and we wanted to meet the social workers and the eligibility workers. We were engaged in that kind of level, and that's what I recommend everyone do. Next slide.

This one is the things that you know. We're a 1915(b) Waiver state for managed care. Easy to do in terms of those pieces. I would suggest you work with your CMS rep. They know what you're doing. That way the type of questions they're asking, you'll have that information as you're working forward and do those. Health plans receive a higher capitation rate for this member. Why? Because we're asking for much more than we're asking for the average child. We're asking for a risk assessment. We're asking for transition planning. We're asking for reporting, service utilization, care management, training, and a connection to DSS. That's a key here.

We don't want the managed care to operate separately and apart, and that's understanding particularly that the child's address may be in one place and the child is located physically in another place. And the plan then has to change their systems to address that. Things like you can't have a PCP (primary care provider) that's two hours away. So, you need to make sure that the plan is very much engaged, and they have a designated person assigned to this population. Next [slide].

We have two managed care programs, the Medallion program, which has the bulk of our children, and then the CCC Plus that has basically our disabled and our chronic care population. The reason we're showing you that we had both here is because 15 percent of our foster care population, consistent with the nation, have chronic or disabling conditions that need even additional supports, like long-term care supports, in order to have a functioning and viable life. So, even as you're going through the foster care, recognize that you will have some of these children coming in, needing what we would normally consider long-term care supports. But for the bulk, they can be in whatever your normal program is in the managed care with some contingencies, meaning that you definitely want to make sure there's assessments. You want people to be dedicated. You want people to work as a collaborative. Next [slide].

In our contract, like I mentioned, we have explicit things in a section. It's a large section. Actually, Adrienne, who's going to speak at the end, created this. And we update it every year, including to make sure that their member handbooks and everything is being addressed for this population. We also work with DSS to make sure that their handbooks also bring up the managed care issues – choices of plans, choices of how to contact a plan – and also we also make sure that we're all together in working on trainings because we all want to make sure that, whether you're a worker or whether you're a foster care parent, that you understand how to access these services and how to get those services to children. Because, again, you're looking at the gamut. You're looking at well-child visits, yes, but you're also looking at behavioral health services and anything in between. So, we want to make sure that everyone is being communicated to. Next slide.

This is our data. We're proud of it. What we did was, as I mentioned, we were working with our Department of Social Services, and one of the things we realized is that we needed to work together in order to make sure that children are getting primary care services and oral health services. Primary care is really key here because, as you know, and we talk about this when we talk about children all around, it's that that's where things are identified. It's there that the PCP picks up that you need vision care. It's there that behavioral health is picked up. It's there that trauma and some other issues get picked up. It's real important that a regular primary care relationship is established and done.

And what we're proud of is that, with that effort, is that actually we're doing better. In other words, foster care children actually are seeing PCPs, even through the crises, more than our regular children. Now, our health plans are working on changing that or making them even, but that's a good thing. And look at the dental. We have a dental program. We've had it for 15 years. It's called Smiles for Children. Love it. Gets lots of great scores, but 20-percent increase in terms of oral health for our foster care kids over normal regular kids. The reason I'm proud of that is this shows you that when you work collaboratively with the workers, getting access and care, you can actually get great results.

On the other side – next slide – as Ms. Allen talked about, behavioral health is a big issue. We can talk about trauma for hours, but what I think that we look at is our atypical psychotropic drugs and also looking at hospitalizations and follow-up. One of the things that we recommend is that you use your EQRO for your data and your information. We also do an annual report with our EQRO just on our foster care children and share that with DSS. We found that that has been helpful. Again, we look at ourselves as being in a collaborative.

If you look at this data, you will see that we do fairly well, particularly on the 30-day follow-up and a commitment there. So, that shows you that if you work together, you can actually see good outcomes. Next slide. I'm going to turn it over to my partner – my partner not in crime but my partner in health, Lora. It's your turn.

Lora Smith:

Thank you, Cheryl. Hi. My name's Lora Smith and I'm the Foster Care Program Manager for the Virginia Department of Social Services. I'm going to spend the next couple of slides just talking with you about DSS's role as we transition children to permanency and ensuring that their health needs continue to be met. So, throughout the child's stay in foster care, the child's worker maintains regular communication with the MCO, and this remains critical as children are transitioned to permanency, whether the child is returning home, being adopted, or if the child's custody is being transferred to a relative. The MCO is an important resource for the family when the child is transitioning out of foster care, into permanency, and that the MCO will continue to provide assistance with scheduling appointments and providing referrals, and providing resources to support the mental health needs of the child and their overall health and wellbeing. Next slide, please.

As children are transitioning to permanency, the local DSS worker plays an integral role in supporting the child's transition. In Virginia's foster care guidance, we require that workers hold what we call a family partnership meeting prior to any placement change in foster care, which includes prior to placement with the child's parents, relatives, or an adoptive family. The purpose of the meeting is to ensure that the family is fully prepared and supported in meeting the needs of the child. The meeting includes providers working with the family but, most importantly, includes the family and their extended supports. This is the time for the team to focus on the child's medical and behavioral health needs in preparation for the transition to permanency.

Many times, when children are transitioning to permanency, the placement is in a different locality than the one that the child resided in when they were in foster care. It's crucial that the team ensures that there is no gap in services if the child's providers need to change. Additionally, as these children transition out of foster care, their parent or relative will need to reapply for Medicaid in the locality in which they live. The foster care worker ensures that the folks know how to go about doing that and the timeframe in which that needs to happen so that there's no lapse in the coverage. For adoptive children and children who participate in the Federal Kinship Guardianship Assistance Program, the locality which held custody prior to the adoption or transfer of custody under Kin-GAP and with whom the financial assistance agreement is with maintains the Medicaid approval, which, of course, helps streamline the transition and ensures that there's no gap in the child's coverage. Next slide, please.

The MCOs play a more active role in youth who are aging out of foster care to ensure that these youth continue to have access to healthcare. This includes medical, dental, mental health, and substance abuse counseling. The MCOs reach out to youth who are 17 and pull together a treatment team meeting to discuss the services and supports that the youth will need once they leave foster care. To ensure that there is no lapse in Medicaid coverage, youth who turn 18 while in foster care are automatically enrolled in the appropriate Medicaid program for youth that age out of foster care, up to age 26. The youth isn't required to do anything on their part to make this happen. Next slide, please.

In order to provide the most support possible for youth who age out of foster care, Virginia participates in extended foster care, which allows youth to remain in foster care until age 21, and access Federal Title IV-E funding. Youth who choose to remain in foster care between ages 18 and 21 are eligible for all the same services as youth under 18. Additionally, youth who were adopted at 16 or older may qualify for extended adoption assistance payments until age 21 under our Fostering Futures program. This extended financial support also applies to children who participate in our Kinship Guardianship Assistance Program.

Even if youth opt to remain in foster care, they are automatically enrolled in Medicaid under the former foster youth category as soon as they turn 18. They maintain their Medicaid eligibility until age 26, regardless of whether or not they enter our Fostering Futures program. This ensures continual coverage for these youth as they are able to leave and reenter foster care multiple times between the ages of 21. Again, this really ensures that there is a continuity of care for these youth. With that, I'm going to turn it over to Adrienne.

Adrienne Fegans:

Thank you, Lora. And I'm going to wrap up the presentation from the Virginia side. Next slide, please.

As Cheryl talked about earlier in the presentation, it truly is a system of collaboration. So, when we look specifically at the Virginia partnership, you will see who we have at the table when we're talking about working with not only our children in foster care but across the spectrum with our children that are in adoption assistance as well. So, we cross many local and state agencies and organizations. We also include our Legislative Commission on Youth as well as our Office of Children's Services. Next slide, please.

So, when we talk about partnership, one of the things that we have done in the past is we've had a collaborative where we bring many people to the table. And we have recently started that process up again, but because it was a gap in many years, what we decided to do was do an assessment of what do the current stakeholders feel are the current pressing issues regarding children in foster care. The stakeholders we brought to the table were, of course, the Virginia Department of Social Services, representatives from our local social services, our regional social services office, the Virginia Commission on Youth, our licensed child-placing agencies – that's one group that a lot of people fail to bring to the table. You have to bring the licensed child-placing agencies to the table as well. Also, our Office on Children Services as well as our managed care organizations.

From that, what we did was establish two action groups, one around care coordination, how do we meet the needs of the children who are in the child welfare system from the point of time when they come into the child welfare system all the way through into their health needs and even afterwards so if the child gets adopted and they're still eligible for Medicaid, how do we work with the adoptive parents to help them understand you still have access to other care as well.

Then we have a special group that's for the MCOs. So, they can share best practices across health plans and any opportunities to discuss issues related to data, regarding programmatic data, regarding issues that they have with receiving information from us so that they can put forth the best effort for the children in foster care. So, some of the key topics, for example, that the MCO group is looking at is the transition planning, again, the transition, as Lora talked about, to permanency as well as aging out, best practices for using data, how to streamline the assessment process, and also looking at how do we support trauma-informed care initiatives. Next slide, please.

The other part of the partnership is that we started early on. As Cheryl mentioned, right after we implemented the Richmond pilot, one of the things that we decided to do as we went statewide on a regional basis is to bring together all the partners to the table. So, we brought together state and local because one of the things we had to do on a local level was figure out how do we change – make system changes so we can correctly identify who the children are. So, that really kind of sealed our partnership.

As a result, we participate with them – when I say “them,” I mean social services. They have a Child Welfare Advisory Committee. Our agency sits on that Child Welfare Advisory Committee. Virginia, for quite a while, has been part of the Three Branch project, and DMAS has been included at the table for that. We work hand in hand with DSS. When the federal five-year state plan comes due, we actually draft the health care section of that report and work back and forth. And on a yearly basis as they have to report out, they use the data from our EQRO study, some of the data that Cheryl showed you earlier. They use that data to report out to the federal government. And then when they come in and do the actual interviews, we actually sit at the table for that interview.

We’re a part of the Family First Prevention Act. We do numerous trainings. At least once a year, we go out and we train the local DSSs on a regional basis. We bring the licensed child-placing staff to the table. We make sure we have a special session for foster care parents and adoptive parents. They have questions, too, and you really can’t ignore the engagement that we need to have to support what they need. We have created a YouTube for social workers so that, you know, as they turn over or as they want to refresh anything, they can look at YouTube. We have a dedicated email box if they have issues.

We encourage the local social services as well as the MCOs to work together in a partnership. Each MCO is required to have a dedicated liaison that can work directly with the local social services to help the needs of the child. We make sure that we have telephone numbers set up from social services so they know how to reach the child. And also, too, one of the things we do is we do an automatic enrollment process into the best aid category for the children who are aging out. Next slide, please.

This just highlights – I’m not going to read through these because I know we’re close on time – these are just some of the spotlights of what each of our six health plans has done recently during COVID to assist us with our foster care children as well as the adoptive children. Next slide, please.

So, again, it really does take the entire partnership and everyone to the table to make this a success, and to see some good outcomes. One of the things also, too, that I also want to mention is, if you’re interested in seeing the data that Cheryl talked about earlier from our EQRO, that information is posted on our Virginia website at dmas.virginia.gov. Next slide. And Joe, I’m going to turn it over to you.

Joe Zickafoose:

Thanks, Adrienne. Next slide, please.

So, now we’d be happy to take some of the questions that we’ve been getting through the Q&A. I’d like to start off by answering a very frequent question about the slides in this presentation being posted. Laura will show in just a few minutes the presentation will be posted in the coming days with the slides, the audio recording, and a transcript. So, this will all be available on the [Medicaid.gov](https://www.Medicaid.gov) website specific to the Foster Care Learning Collaborative.

I want to start off with several questions that we had for the Virginia team that I think in various ways relate to how managed care organizations and the child welfare organizations collaborate and coordinate about service delivery decisions. For example, one person was asking about how differences of opinion might be managed between the MCO and the child welfare local service agency when one might be desiring one service and another wanting a different service, and related to that, how service denials are handled.

Adrienne Fegans:

This is Adrienne. So, I might have to get you to repeat that. So, the local social services, they're split. They have eligibility workers and they have social workers. Each foster care child is assigned a family services specialist and social services actually holds custody of the child. They know that with the liaison at the MCO, they have a partner at the table that can work with them.

So, for example, if they need to find a specific type of provider or they're having issues with a foster care parent maybe receiving bills, that they can go to that MCO to work directly with that person at the MCO. But in the ultimate, it's the local social services that holds custody for that child. So, the ultimate decision is with them. The social worker is the one who actually makes the switch. So, for example, we do not have a lock-in for our foster care children. They're allowed to switch plans as many times as they need to. So, it's the social worker who gets to make that decision of which health plan the child is going to be in.

Joe Zickafoose:

Great. Thanks so much. We have another, I think, kind of cluster of questions that I'd like to direct to Catherine and to Susan about examples of children who may be in child welfare services or even some forms of foster care that are not going to show up in Medicaid, either because they are not eligible for enrollment or they may be difficult to identify in Medicaid data. Could you comment about some of those specific groups that may not be showing up in Medicaid?

Susan Ruiz:

So, this is Susan. I think there could be a number of different possibilities here, but Title IV-E is based on eligibility under the old AFDC rules. So, I believe that higher income children would not qualify for [Title] VI-E foster care but could still qualify for Medicaid. You may have children that are in some other foster care group in a state but it's not [Title] IV-E foster care. I think those are usually either higher-income children or possibly undocumented children. I think there could be a couple of different categories that they would fall into. And we hear sometimes, anecdotally, that it can be hard to identify children that are in foster care but may be eligible through a different pathway. For example, children in a state where receipt of SSI makes you automatically eligible for Medicaid. So, I think it just depends on the details. And there's a couple of different options, but I hope that gets you started and gives you a few ideas.

Joe Zickafoose:

Thanks so much, Susan. I wanted to thank everyone for joining. We had lots of great questions in the chat. And I apologize, we don't have time to address all of them. We will be capturing these questions, so folks will be able to see them in the future. I do want to hand over to Laura in these last couple minutes to let her summarize some of the other upcoming events for the Learning Collaborative, including the opportunity for states to participate directly in an affinity group, which will allow them to start to wrestle with some of these issues that were brought up today. Next slide for Laura, please.

Laura Armistead:

Thank you, Joe. We can skip ahead. So, as Joe mentioned earlier, a recording of this webinar, along with a transcript and meeting slides, will be posted on Medicaid.gov at the link shown on the slide. Our next event in the series will be this Friday, May 14th at 1:00 P.M. Eastern. This will be an informational webinar which will provide an overview of the foster care affinity group, and we'll also review the

Expression of Interest form at this time. Our final webinar will be on Monday, May 24th at 2:00 P.M. Eastern, titled Establishing and Using Bidirectional Data Sharing. You can register for both of these events at the second link shown on the slide. Next slide.

We also want to encourage everyone to please review the Foster Care Affinity Group Fact Sheet and the Expression of Interest (EOI) form on Medicaid.gov. If you're interested in participating in the affinity group, EOIs are due Friday, May 28th at 8:00 P.M. Eastern. Next slide.

Finally, when you exit the webinar, we ask that you please complete an evaluation survey. If you have any questions, you can email us at MACQualityImprovement@mathematica-mpr.com. So, I think that concludes our presentation for today. I want to thank you very much for joining us. And we hope you have a great rest of your day.