The Role of Medicaid in Meeting the Health Care Needs of Children and Youth in Foster Care

May 10, 2021

Joe Zickafoose, Mathematica
Deirdra Stockmann and Susan Ruiz, Centers for Medicare & Medicaid Services (CMS)
Catherine Heath, Children's Bureau within the Administration for Children and Families (ACF)
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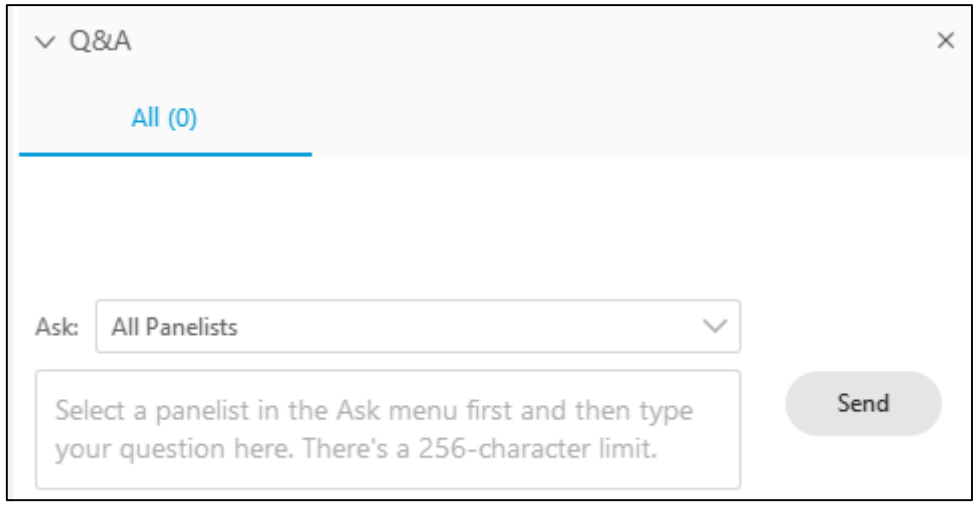
Webinar Logistics

- Phone lines are muted upon entry.
- For technical issues, select “Host” in the drop-down menu of the Q&A window.
- To submit audience questions, select “All Panelists” in the drop-down menu of the Q&A window.



Agenda

Topic	Speaker(s)
Welcome and Overview of the Foster Care Learning Collaborative: Improving Timely Health Care for Children and Youth in Foster Care	Joe Zickafoose, Mathematica Deirdra Stockmann, CMS
Federal Context for Children in Foster Care and Medicaid	Susan Ruiz, CMS Catherine Heath, Children's Bureau
Medicaid and the Unique Health Care Needs of Children and Youth in Foster Care	Kamala Allen, Center for Health Care Strategies
Virginia Spotlight: Role for Medicaid in Improving Outcomes for Children and Youth in Foster Care	Cheryl Roberts and Adrienne Fegans, Department of Medical Assistance Services Lora Smith, Virginia Department of Social Services
Questions and Discussion	Joe Zickafoose, Mathematica
Announcements and Next Steps	Laura Armistead, Mathematica

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Overview of the Foster Care Learning Collaborative:

Improving Timely Health Care for Children and Youth in Foster Care

Deirdra Stockmann, CMS

Foster Care Learning Collaborative

- **The Centers for Medicare & Medicaid Services (CMS), in collaboration with the Children's Bureau within the Administration for Children and Families (ACF), launched the Foster Care Learning Collaborative in April 2021.**
- **State Medicaid and child welfare agencies and their partners will have an opportunity to:**
  - Expand their understanding of data-driven interventions to improve timely access to care
  - Learn about the science of quality improvement

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Foster Care Learning Collaborative

- **Webinar series**
  - Webinar 1: The Role for Medicaid in Improving Outcomes for Children and Youth in Foster Care
  - Webinar 2: Establishing and Using Bidirectional Data Sharing
  - Information Session: Improving Timely Health Care for Children and Youth in Foster Care: Affinity Group Q&A
- **Improving Timely Health Care for Children and Youth in Foster Care Affinity Group**
  - Action-oriented affinity group that will support state Medicaid and child welfare agencies and their partners to improve health outcomes for the foster care population
  - Opportunity for states to expand their knowledge of policies, programs, and practices to improve timely health care for children and youth in foster care
  - Begin in June 2021 (more information available at https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/foster-care-learning-collaborative/index.html)

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Federal Context for Children in Foster Care and Medicaid

Susan Ruiz, CMS

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Federal Context for Children in Foster Care and Medicaid

Catherine Heath, Children's Bureau

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Medicaid and the Unique Health Care Needs of Children and Youth in Foster Care

Kamala Allen, Center for Health Care Strategies

CHCS Center for Health Care Strategies, Inc.

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How Children in Foster Care Become Medicaid Eligible

- Title IV-E of the Social Security Act provides funding to support safe and stable out-of-home care for children who are removed from their homes.
- There were nearly 673,000 children and youth served by the Title IV-E foster care system during FY 2019.[1]
- Title IV-E confers eligibility for Medicaid.
- Medicaid covers virtually all children in foster care.

[1] Adoption and Foster Care Analysis and Reporting System (AFCARS) FY2019 preliminary data. https://www.acf.hhs.gov/cb/report/afcars-report-27

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Medicaid Has a Responsibility

- The state assumes the same legal responsibility for care when a child is removed from the home.
- Children in foster care are a vulnerable population at risk for poor health outcomes, subject to many adverse social determinants of health.
- Ensuring timely access to a comprehensive and coordinated array of services is key to improving outcomes.
- Most states enroll the foster care population in managed care.[1]
- Child welfare agency must have a health care oversight and coordination plan developed in collaboration with the Medicaid agency.[2]

[1] 2018 Managed Care Features By Enrollment Population. Retrieved on January 12, 2021 from: https://data.medicaid.gov/Uncategorized/2018-Managed-Care-Features-By-Enrollment-Populatio/6e5c-d5iu/data.
[2] Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) and Child and Family Services Improvement and Innovation Act of 2011 (P.L. 112-34) specify the requirements.

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Who Are Children in Foster Care?

Paul is a white, 8-year-old child who lived with his mother and two siblings.

- He was removed from his home due to neglect and his mother's substance use.
- Based on the circumstances of his removal, the agency's reunification goal for him is that he go back home to live with his mother once she completes mandatory drug treatment and parenting classes.
- When he enters foster care, he is placed with a non-relative foster family. That placement is not successful, and he is placed in another non-relative foster home.
- He ultimately reunites with his mother after spending 15 months in foster care.

Physical Health Care Needs

- **Children in foster care have higher rates of physical health issues than the non-foster care population.[1,2,3]**

- **Children in foster care use more of certain categories of health care services than the non-foster care population.[3,4]**
  - Hospitalization for perinatal complications, infectious diseases, and mental health disorders are more frequent
    - Utilized more hospitalizations (18.5 vs. 12.7 per 100 patient-years) and subspecialty office/outpatient visits (173.3 vs. 113.6), but not ED or primary care visits
    - Had longer average length of inpatient stay than the general Medicaid child population
    - Had increased utilization rates and expenses ($14,372 vs. $7,082) compared to the general Medicaid child population

[1] E. L. Schor. The Foster Care System and Health Status of Foster Children, Pediatrics May 1982, 69 (5) 521-528.
[2] M. Simms et al. Health Care Needs of Children in the Foster Care System, Pediatrics October 2000, 106 (Supplement 3) 909-918.
[3] K. Turney and C. Wildeman. Mental and Physical Health of Children in Foster Care, Pediatrics November 2016, 138 (5) e20161118.
[4] M. Szilagi et al. Health Care Issues for Children and Adolescents in Foster Care and Kinship Care, Pediatrics July 2015, 10.1542/peds.2015-2656.

Oral Health Care Needs

- **Children enter foster care with high rates of dental and oral health needs, and often have not had a dental visit in the past year.[1]**
- **Younger children are less likely to have a dental visit than older children.[1]**
  - The AAP recommends that every child entering foster care have a dental evaluation within 30 days of placement. [2]
- **Approximately 35% of children and youth enter foster care with significant dental and oral health problems.[3]**
  - More likely to have experienced dental caries overall **(76% versus 59%)**
  - **5.8 times** more diagnoses of severe gingivitis
  - **1.4 times** as many root canal treatments
  - **1.3 times** more treatment-planned extractions

[1] Tracy L. Finlayson, et al., Matern Child Health J. 2018 May ; 22(5): 753–761. doi:10.1007/s10995-018-2444-y.
[2] https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Oral-Health.aspx.
[3] Morón EM, Tomar SL, Souza R, Balzer J, Savioli C, Shawkat S. Dental Status and Treatment Needs of Children in Foster Care. Pediatr Dent. 2019 May 15;41(3):206-210. PMID: 31171072.

Behavioral Health

Children in foster care have higher rates of significant behavioral health needs,[1,2] service use, and expenses than the non-foster care population.[3]

Medicaid-Enrolled Children (based on income/disability, excluding foster care)	Medicaid-Enrolled Children in Foster Care
7% of children received behavioral health services	**31%** received behavioral health services
$5,517 mean expenses for behavioral health services (for those with any behavioral health services)	**$9,318** mean expenses for behavioral health services (for those with any behavioral health services)
Of children receiving any psychotropic medication: • **24%** prescribed more than one psychotropic • **23%** prescribed antipsychotics	Of children receiving any psychotropic medication: • **47%** prescribed more than one psychotropic • **41%** prescribed antipsychotics

[1] T. Polihronakis. Mental Health Care Issues of Children and Youth in Foster Care. National Resource Center for Family Centered Practice and Permanency Planning, 2008. Found at: http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/information_packets/Mental_Health.pdf

[2] N. Williams-Mbengue. The Social and Emotional Well-Being of Children in Foster Care. National Conference of State Legislatures, May 2016. Found at: https://www.ncsl.org/research/human-services/the-social-and-emotional-well-being-of-children-in-foster-care.aspx.

[3] Pires, S., McLean, J., and Allen, K., (2018). Faces of Medicaid Data Series: Examining Children's Behavioral Health Service Use and Expenditures, 2005-2011. Center for Health Care Strategies: Hamilton, NJ.

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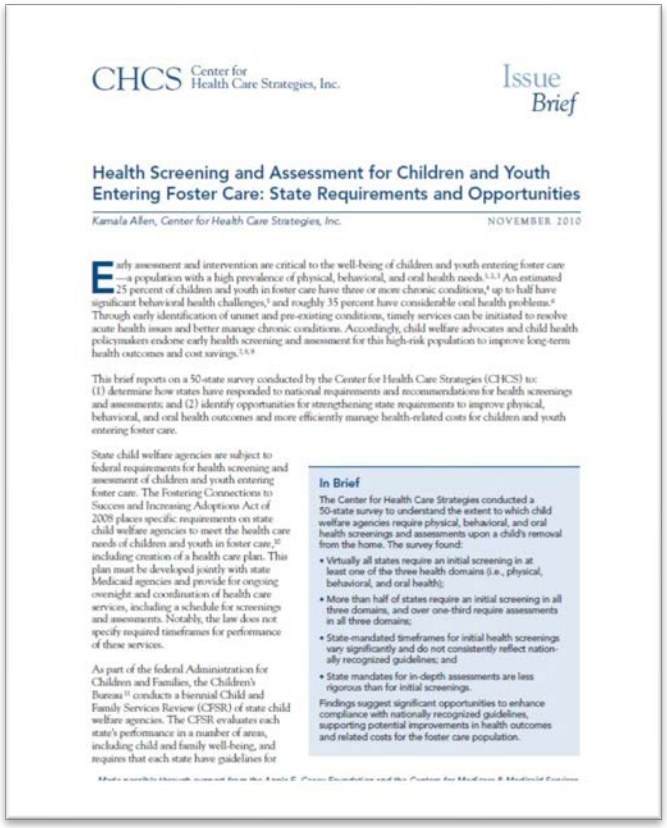
State Requirements



CHCS Center for Health Care Strategies, Inc. Issue Brief

Health Screening and Assessment for Children and Youth Entering Foster Care: State Requirements and Opportunities

Kamala Allen, Center for Health Care Strategies, Inc. NOVEMBER 2010

Early assessment and intervention are critical to the well-being of children and youth entering foster care—a population with a high prevalence of physical, behavioral, and oral health needs.[1,2,3] An estimated 25 percent of children and youth in foster care have three or more chronic conditions,[4] up to half have significant behavioral health challenges,[5] and roughly 35 percent have considerable oral health problems.[6] Through early identification of unmet and pre-existing conditions, timely services can be initiated to resolve acute health issues and better manage chronic conditions. Accordingly, child welfare advocates and child health policymakers endorse early health screening and assessment for this high-risk population to improve long-term health outcomes and cost savings.[7,8,9]

This brief reports on a 50-state survey conducted by the Center for Health Care Strategies (CHCS) to: (1) determine how states have responded to national requirements and recommendations for health screenings and assessments; and (2) identify opportunities for strengthening state requirements to improve physical, behavioral, and oral health outcomes and more efficiently manage health-related costs for children and youth entering foster care.

State child welfare agencies are subject to federal requirements for health screening and assessment of children and youth entering foster care. The Fostering Connections to Success and Increasing Adoptions Act of 2008 places specific requirements on state child welfare agencies to meet the health care needs of children and youth in foster care,[10] including creation of a health care plan. This plan must be developed jointly with state Medicaid agencies and provide for ongoing oversight and coordination of health care services, including a schedule for screenings and assessments. Notably, the law does not specify required timeframes for performance of these services.

As part of the federal Administration for Children and Families, the Children's Bureau[11] conducts a biennial Child and Family Services Review (CFSR) of state child welfare agencies. The CFSR evaluates each state's performance in a number of areas, including child and family well-being, and requires that each state have guidelines for

In Brief

The Center for Health Care Strategies conducted a 50-state survey to understand the extent to which child welfare agencies require physical, behavioral, and oral health screenings and assessments upon a child's removal from the home. The survey found:

- Virtually all states require an initial screening in at least one of the three health domains (i.e., physical, behavioral, and oral health);
- More than half of states require an initial screening in all three domains, and over one-third require assessments in all three domains;
- State-mandated timeframes for initial health screenings vary significantly and do not consistently reflect nationally recognized guidelines; and
- State mandates for in-depth assessments are less rigorous than for initial screenings.

Findings suggest significant opportunities to enhance compliance with nationally recognized guidelines, supporting potential improvements in health outcomes and related costs for the foster care population.

- **State requirements for an initial health screening for children entering foster care vary significantly.[1]**
- 47 states and the District of Columbia required an initial screening in at least one of the three health domains (physical, behavioral, and oral health).
  - 65 percent require screening across all three.
- There was wide variation in the existence and length of required timeframes for screenings (1 to 90 days).
- **The most common requirement for an initial health screening was 30 days, across all three domains.**

[1] Allen, K., Mahadevan, R. (2010) Health Screening and Assessment for Children and Youth Entering Foster Care: State Requirements and Opportunities, Center for Health Care Strategies, Hamilton, NJ.

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Managed Care and Children in Foster Care

Based on 2018 data:

- **States have taken different approaches**
  - Exclusion from managed care
  - Standard managed care plans
  - Foster care-only specialty managed care plans

- **Comprehensive managed care by the numbers**
  - Mandatory statewide: 35 states
  - Mandatory regional: 3 states
  - Voluntary statewide: 1 state
  - Voluntary regional: 2 states

[1] Managed Care Programs by State. Retrieved on May 5, 2021 from : https://data.medicaid.gov/Enrollment/Managed-Care-Programs-by-State/p9c7-tuup.

CMS FOSTER CARE LEARNING COLLABORATIVE

ROLE FOR MEDICAID IN IMPROVING OUTCOMES FOR CHILDREN AND YOUTH IN FOSTER CARE

Department of Medical Assistance Services:
Cheryl J. Roberts
Deputy of Programs and Operations
Adrienne T. Fegans
Sr. Program Administrator

Virginia Department of Social Services:
Lora Smith
Foster Care Program Manager

A SYSTEM OF COLLABORATION

VIRGINIA MEDICAID STRUCTURE

- Provides a system of high quality and cost-effective health care services to qualifying Virginians and their families
- Designated as the single state agency to administer the Medicaid and CHIP programs in Virginia
- Oversight of Medicaid policy and benefits

- Provides oversight and guidance to 120 local offices across the state
- State supervised and locally administered social services system
- Conducts Medicaid eligibility based off DMAS policies
- Administers the child welfare system

VIRGINIA MEDICAID CHILDREN IN FOSTER CARE DEMOGRAPHICS

The following demographic data is representative of children continuously enrolled in foster care (aged 2-17 years) during state fiscal year (SFY) 2019-2020

(Health ServicesAdvisory Group (HSAG), March 2021)

Category	Number	Percent
Age Category		
≤ 2 years	1,591	21.9%
3 to 5 years	1,099	15.1%
6 to 10 years	1,598	22.0%
11 to 13 years	1,030	14.2%
≥ 14 years	1,948	26.8%
Sex		
Male	3,923	54.0%
Female	3,343	46.0%
Race		
Black or African American	2,460	33.9%
White	4,669	64.3%
Other	137	1.9%

HISTORY OF FOSTER CARE IN MANAGED CARE

- The Richmond City Foster Care Pilot Program: to provide improved access to preventive and coordinated health care for children in foster care
- 2011 legislative support from the Governor and General Assembly
- 2012 General Assembly endorsement to include children in foster care and adoption assistance into managed care
- Thanks to partnership between the VA Department of Social Services (VDSS), Local Departments of Social Services (LDSS), DMAS, and the MCOs, we successfully moved over 10,000 adoptive and foster care youth into managed care statewide between 2013 - 2014

STRUCTURE OF CHILD WELFARE IN MANAGED CARE

- Enrollment into managed care through the 1915(b) waiver
- Both foster care (FC) and adoption assistance (AA) members are enrolled across all six health plans
- Health plans receive a higher capitation rate for FC/AA members as they are considered children/youth with special health care needs
- Health plans have specific contractual requirements related to this population including health risk assessments timeframes, transition planning, reporting, service utilization, care management, training, etc.

TRANSITION TO MANAGED CARE

Two managed care programs focused on the diverse needs of the populations and serving 7,470 foster care and 9,037 adoption assistance members through six statewide managed care plans

Medallion 4.0

- Serving infants, children, pregnant women, adults including most Medicaid expansion
- Acute, chronic, primary care and pharmacy services, for adults and children, and also includes SUD, and behavioral health services, excludes LTSS
- Implementation statewide August 2018

CCC Plus

- Serving older adults and disabled individuals including Medicaid-Medicare eligible
- Full continuum of services (same as Medallion) but also includes long-term services and supports (LTSS) in the community and in nursing facilities and hospice
- Implemented statewide in January 2018

Incorporating the best care networks in our state to improve access, increase cost predictability and provide a platform for future innovations

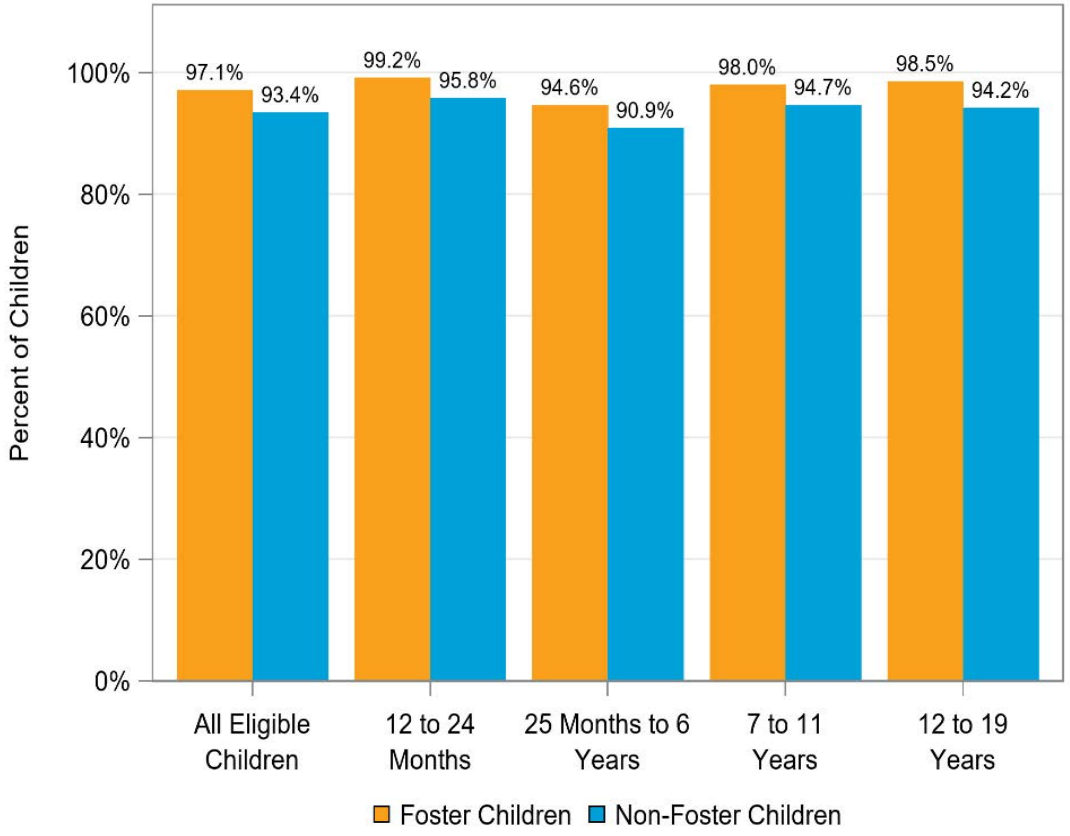
MCO CONTRACT AND CARE MANAGEMENT

- Children and youth in foster care and adoption assistance are considered "children and youth with special health care needs"
- MCOs coordinate the unique needs of members in foster care and adoption assistance and provide services that include outreach and education on medical and behavioral health benefits and the services
- MCO Care Managers support the efforts of the LDSS social worker and/or the foster care parents to ensure that members in foster care receive both a PCP and a dental visit within thirty (30) days of plan enrollment
- This effort is further enhanced through communications outlining the importance of the youth seeing a provider

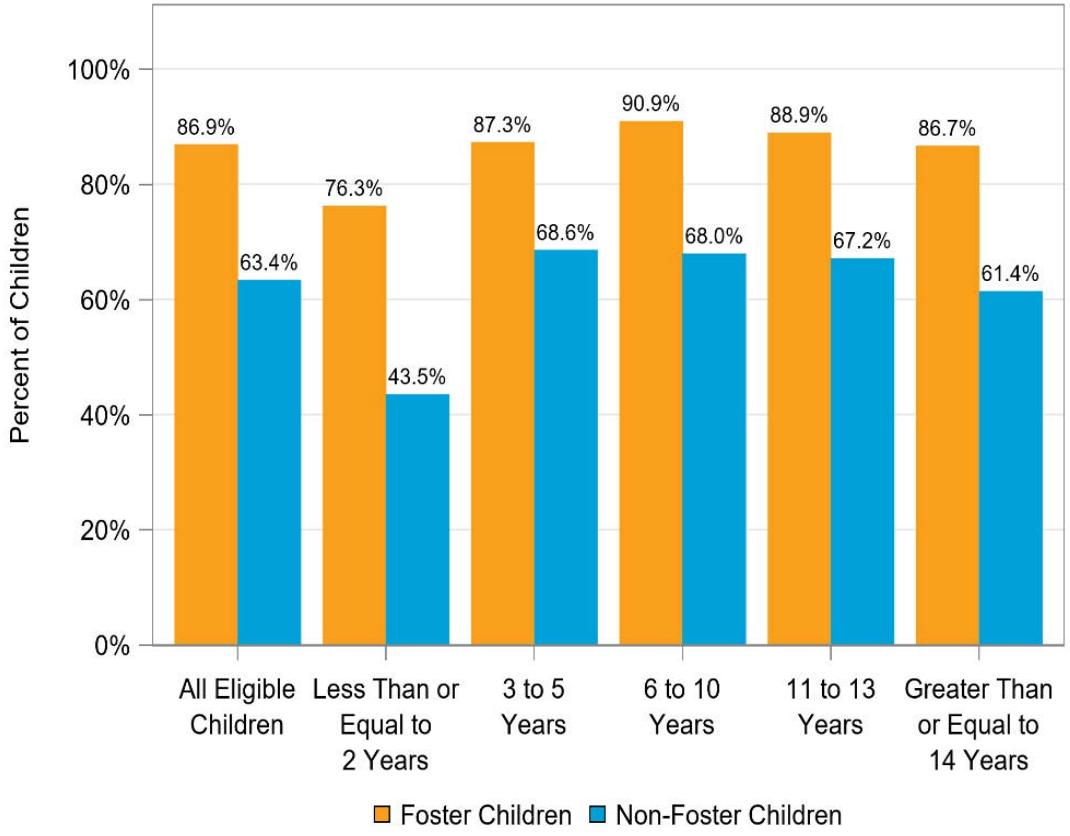
OUTCOME DATA: PCP and DENTAL

The following outcome data is representative of children continuously enrolled in foster care (aged 2-17 years) during the study period of state fiscal year (SFY) 2019-2020. The study indicator results compare utilization between children in foster care and children not in foster care. (Health Services Advisory Group (HSAG), March 2021)

Rates of Children and Adolescents' Annual Access to PCPs Among Foster Children and Non-Foster Children, by Age Category

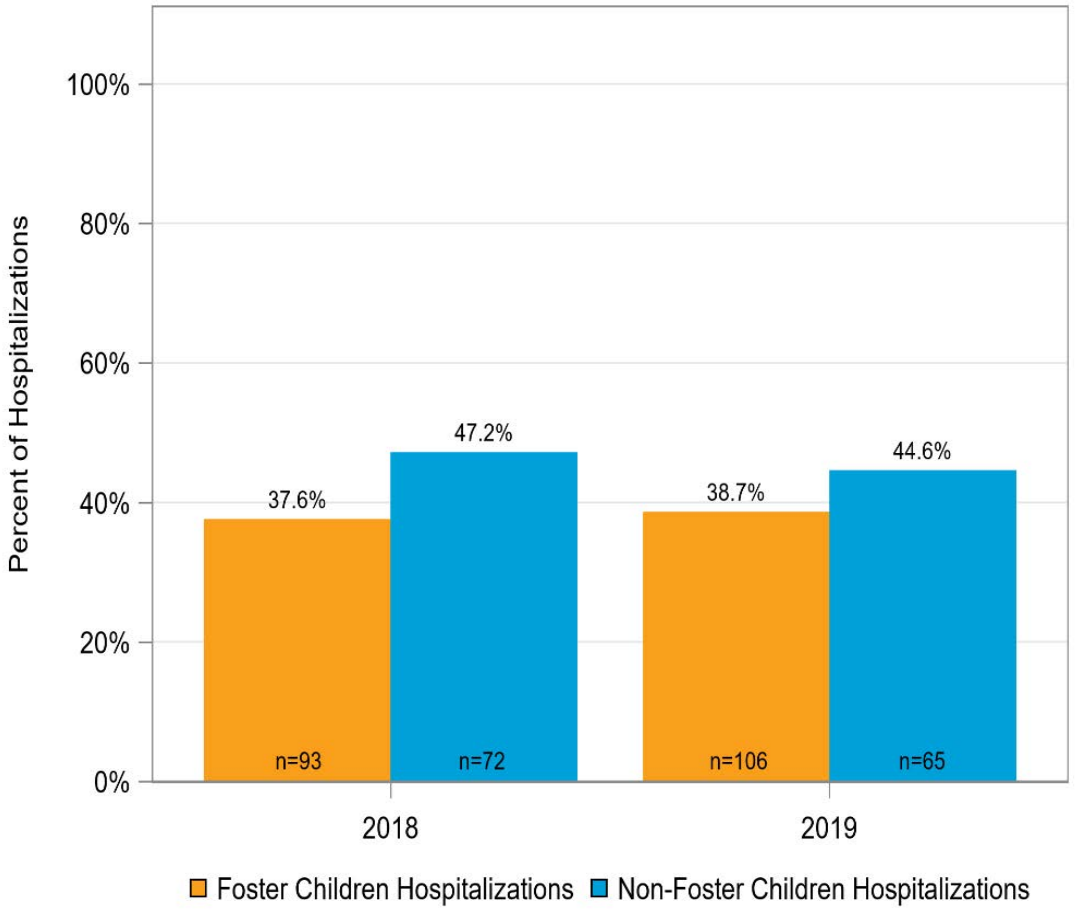


Rates of Annual Dental Visits Among Foster Children and Non-Foster Children, by Age Category

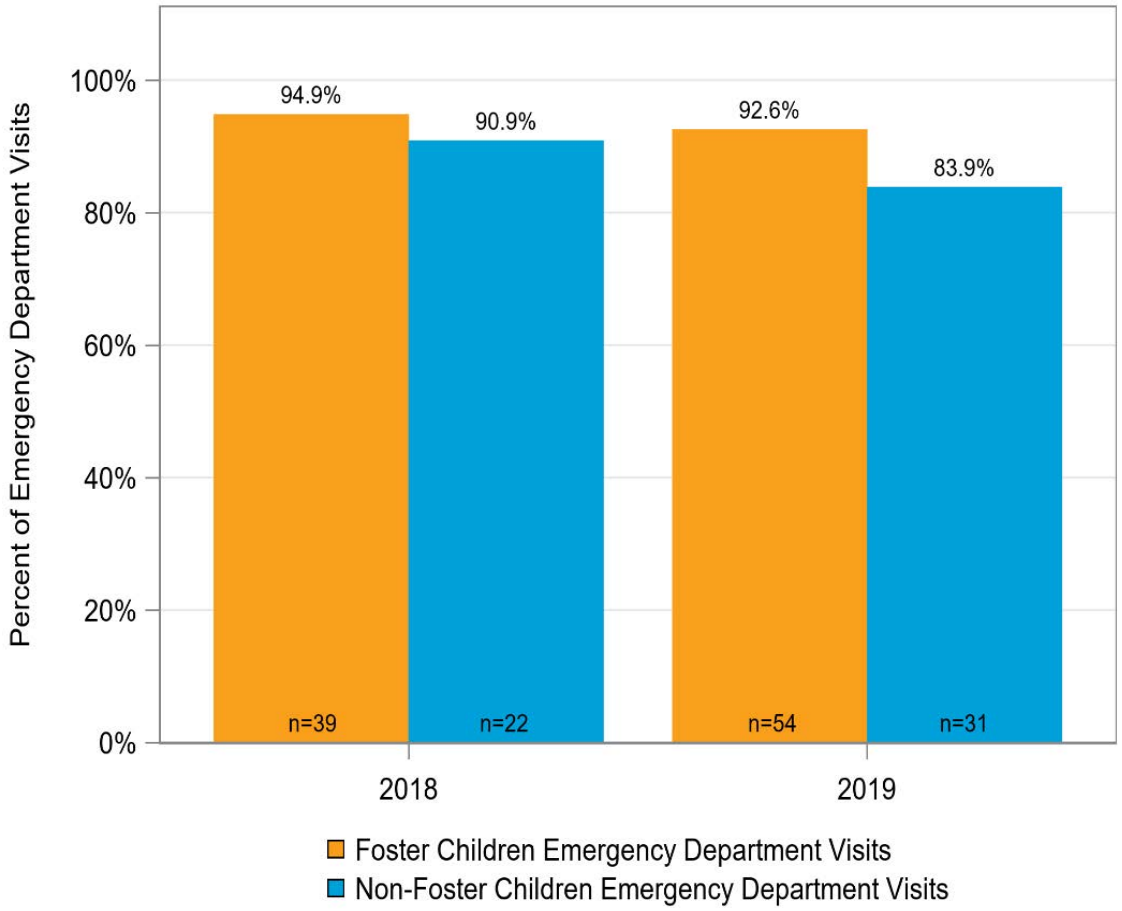


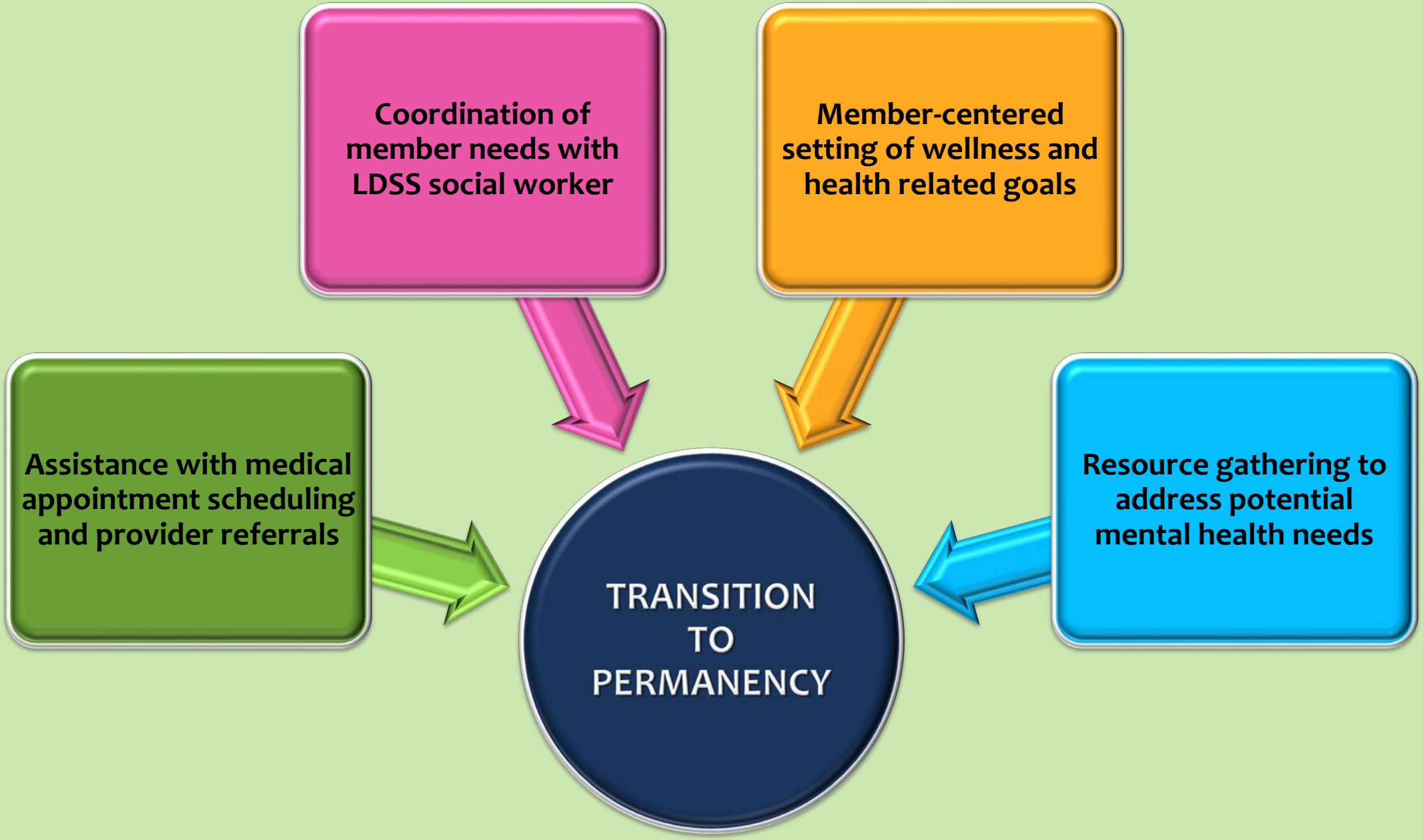
OUTCOME DATA: 7 and 30 DAY FOLLOW-UP

Rates of 7-Day Follow-Up After Hospitalization for Mental Illness Among Foster Children and Non-Foster Children, by Measurement Year



Rates of 30-Day Follow-Up After ED Visit for Mental Illness Among Foster Children and Non-Foster Children, by Measurement Year




Coordination of member needs with LDSS social worker
Member-centered setting of wellness and health related goals
Assistance with medical appointment scheduling and provider referrals
Resource gathering to address potential mental health needs
TRANSITION TO PERMANENCY

TRANSITION TO PERMANENCY

- Permanency may lead to adoption, reunification or custody to a relative
  - LDSS holds a Family Partnership Meeting prior to the transition to plan the child's move
    - Ensures the family is prepared to apply for benefits and when the coverage through foster care will end
    - Ensures services are available to the child
    - Ensures medical providers are available to the child
  - PACM provides 12 months of case management services after the finalization of an adoption from foster care
    - Coverage for adopted children remains with the locality that held custody prior to the adoption and with whom the adoption assistance agreement is with

AGING OUT

- Critical for youth aging out of care to have regular access to continuous health care including preventive medical and dental care prescriptions, mental health and behavioral counseling, and substance abuse counseling
- DMAS, State and Local DSS, and the MCOs coordinate efforts to effectively transition these members to adulthood
- MCOs notify youth in foster care who are approaching age seventeen (17) of the programs that provide continued health care coverage and convene a comprehensive treatment team meeting to discuss the services and supports the enrollee will need post-separation
- To improve the continuity of care for children in foster care, children formerly in foster care are automatically enrolled in the appropriate Medicaid group upon aging out of the foster care program

TRANSITION PROGRAMS

- **Former Foster Care** - Under the Affordable Care Act (ACA), young people in foster care who turn 18 and age out of the system are eligible for Medicaid up to age 26 - No financial eligibility requirements for this covered group

- **Fostering Futures** - Virginia's program facilitated by the Virginia Department of Social Services that utilizes federal title IV-E funding to provide foster care maintenance payments and services and adoption assistance for youth ages 18 to 21 - The program allows youth to remain in foster care and offers services and support to youth in an effort to transition them to adulthood and self-sufficiency

A SYSTEM OF COLLABORATION

DMAS CHILD WELFARE PARTNERSHIP

- DMAS engaged stakeholders to assess current needs of youth in foster care and how can the partnership address the needs
- Established 2 action groups:
  - *Care Coordination*
    - improve care coordination for youth engaged in the child welfare system
    - gain better understanding of each stakeholder's role in process to support youth
    - develop support network to enhance care coordination
  - *MCO*
    - forum for MCOs to discuss issues specific to health plans
    - opportunity to share discuss best practices

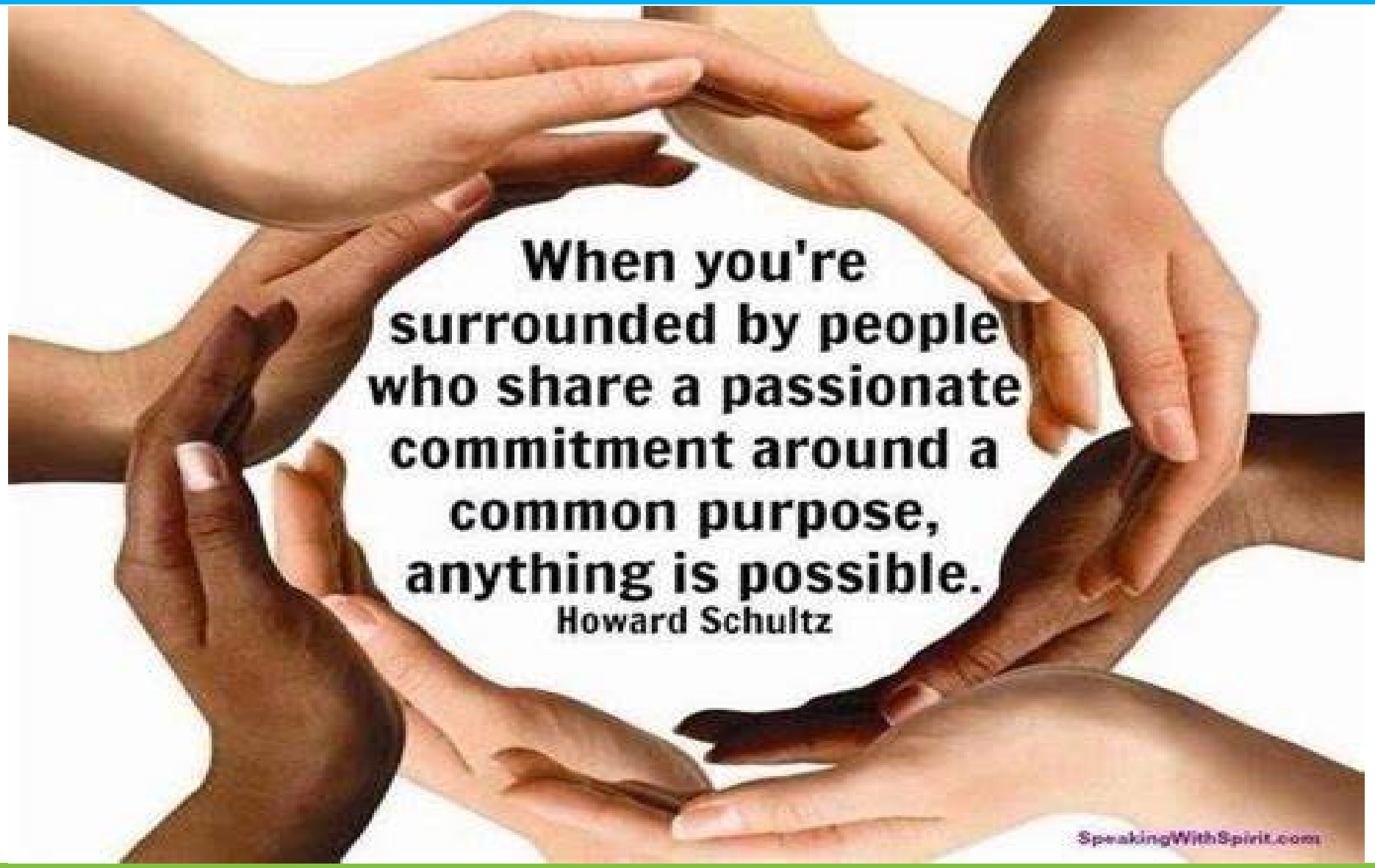
PARTNERSHIP INITIATIVES

Collaboration with Virginia State and Local Departments of Social Services

- Participate in CWAC and Three Branch
- Federal Five-Year State Plan for Child and Family Services
- Federal Family First Preservation Services Act
- Numerous training events for LDSS and LCPA staff, providers, and foster care/adoptive parents
- YouTube for LDSS staff https://youtu.be/y3jOeSursDM
- Dedicated email box and designated liaisons at each MCO
- System changes:
  - Telephone numbers
  - Auto enrollment into former foster care

MCO SPOTLIGHTS

- ***Aetna*** assisted twin infants in foster care with medical needs including helping to coordinate care during an extended NICU stay for one infant
- ***Anthem*** offered the option for foster care members graduating from high school to access Chromebooks during the COVID-19 pandemic
- ***Magellan*** assisted a youth and their foster parents with navigating health care coverage after moving to Virginia when the child had not received care in over a year
- ***Optima*** helped a local DSS office navigate medication access with a youth's provider and also continue to assist youth with GED access through vouchers and test prep
- ***United Healthcare*** launched a website, featuring education about housing, financial and employment resources, to support foster care youth transitioning out of the child welfare system
- ***Virginia Premier*** developed a video to honor families and youth impacted by the child welfare system


When you're surrounded by people who share a passionate commitment around a common purpose, anything is possible.
Howard Schultz
SpeakingWithSpirit.com

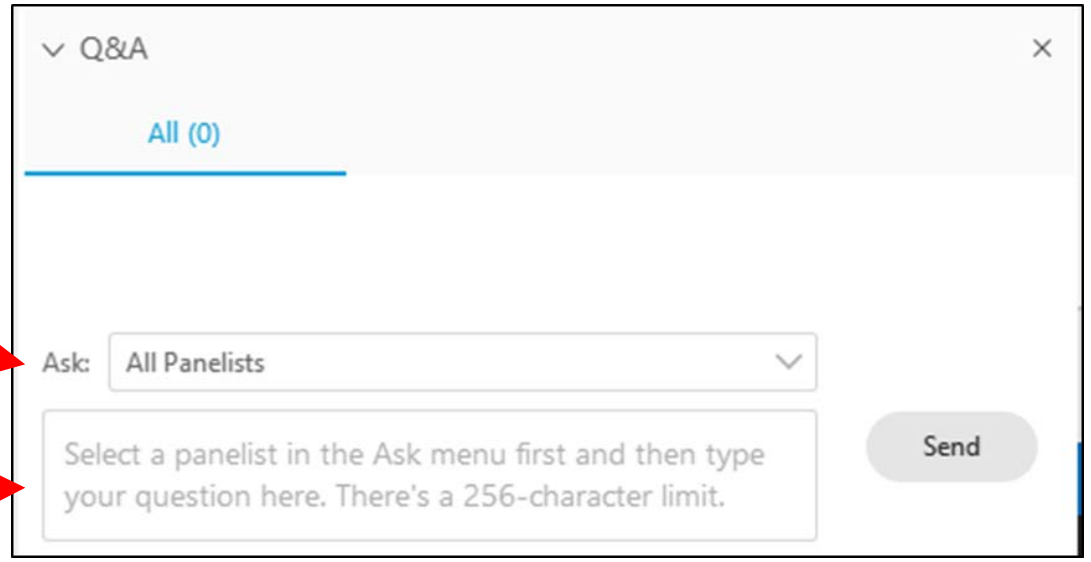
fostercare@dmas.virginia.gov

Questions and Discussion

Joe Zickafoose, Mathematica

How to Submit a Question

- **Use the Q&A function to submit questions or comments.**
  - To submit a question or comment, click the Q&A window and select All Panelists in the “Ask” field.
  - Type your question in the text box and click Send.
  - Only the presentation team will be able to see your comments.



Announcements and Next Steps

Laura Armistead, Mathematica

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Announcements and Next Steps

- **Webinar recording and slides will be posted on Medicaid.gov at** https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/foster-care-learning-collaborative/index.html
- **Upcoming webinars**
  - **May 14, 2021, 1:00 p.m. ET** Information Session: Improving Timely Health Care for Children and Youth in Foster Care Affinity Group Q&A
  - **May 24, 2021, 2:00 p.m. ET** Webinar #2: Establishing and Using Bidirectional Data Sharing
- **Register for the next webinars** https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/foster-care-learning-collaborative/index.html

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Announcements and Next Steps (continued)

- **Foster Care Affinity Group Fact Sheet available at** https://www.medicaid.gov/medicaid/quality-of-care/downloads/improvement-initiatives/foster-care-ag-factsheet.pdf
- **Foster Care Affinity Group Expression of Interest (EOI) forms are due May 28, 2021, 8:00 PM ET**
- **EOI forms are available at** https://www.medicaid.gov/medicaid/quality-of-care/downloads/improvement-initiatives/foster-care-ag-interest-form.pdf

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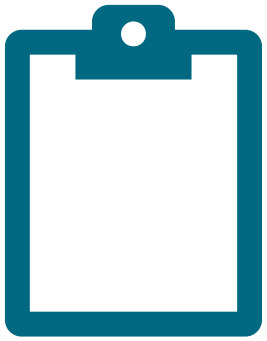
Thank you for participating!

- **Please complete the evaluation as you exit the webinar.**



- **If you have any questions, please email:**

  MACQualityImprovement@mathematica-mpr.com

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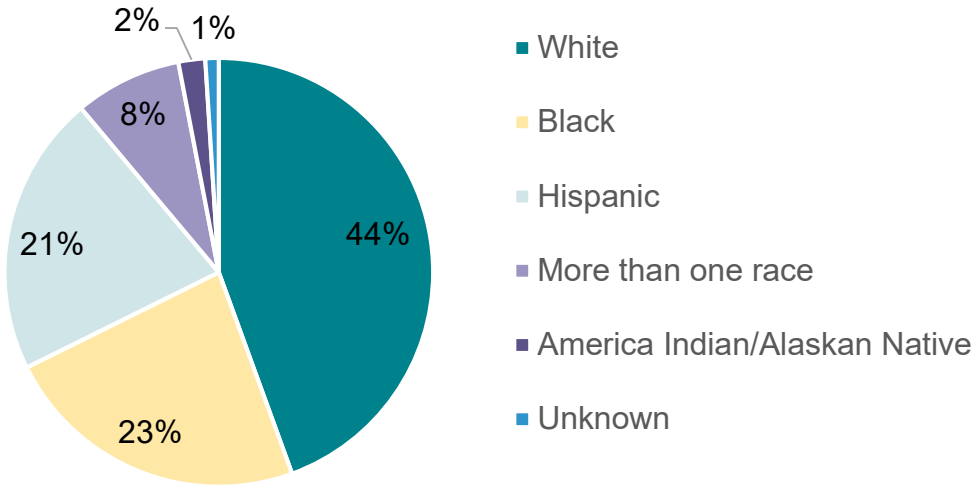
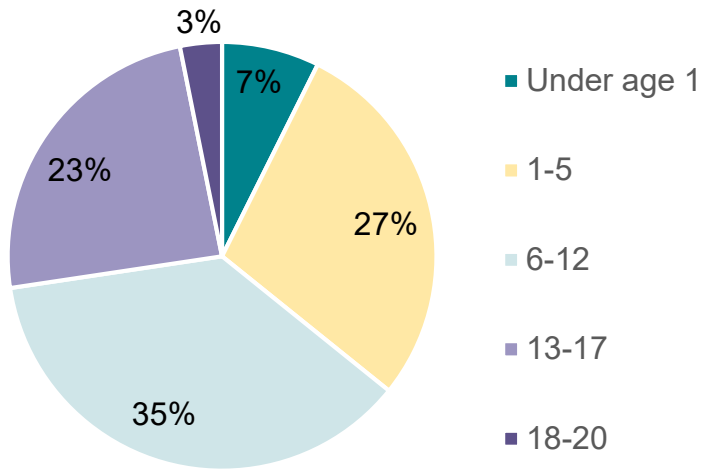
Appendix

Demographics of Children in Foster Care

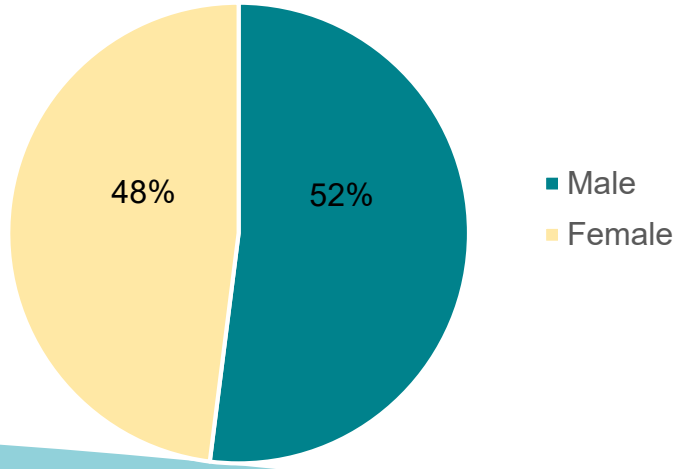
Race/Ethnicity



Age



Gender



Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measurement & Improvement

Foster Care Characteristics

- Circumstances Associated with Removal:
  - Neglect (62%)
  - Parental Drug Abuse (36%)
  - Caregiver Inability to Cope (14%)
  - Physical Abuse (13%)
  - Inadequate Housing (10%)
  - Child Behavior Problem (9%)
  - Parent Incarceration (7%)
  - Parental Alcohol Abuse (5%)
  - Abandonment (5%)
  - Sexual Abuse (4%)
  - Child Drug Abuse (2%)
  - Child Disability (2%)
  - Relinquishment (1%)
  - Parent Death (1%)