



Child Welfare: Health Care Needs of Children in Foster Care and Related Federal Issues

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Summary

Approximately 662,000 children spend some time in foster care each year. Most enter care because they have experienced neglect or abuse by their parents. Between 35% and 60% of children entering foster care have at least one chronic or acute physical health condition that needs treatment. As many as one-half to three-fourths show behavioral or social competency problems that may warrant mental health services. Many health and mental health needs persist. A national survey of children adopted from foster care found that 54% had special health care needs and research on youth who aged out of foster care shows these young adults are more likely than their peers to report having a health condition that limits their daily activities and to participate in psychological and substance abuse counseling.

The Social Security Act addresses some of the health care needs of children in, or formerly in, foster care through provisions in the titles pertaining to child welfare (Titles IV-B and IV-E) and to the Medicaid program (Title XIX). Under child welfare law, state child welfare agencies are required to have a written plan for each child in foster care that includes, among other items, the child's regularly reviewed and updated health-related records. In addition, state child welfare agencies, in cooperation with state Medicaid agencies, must develop a strategy that addresses the health care needs of each child in foster care. Upon aging out of foster care, youth must receive from the state child welfare agency a copy of their health record and information about health insurance options and designating other individuals to make health care decisions on their behalf if they are unable to do so on their own.

States are not permitted to use federal child welfare program funds to pay medical expenses of children in care or those who left foster care due to their age or placement in a new permanent family. However, states can (and do) receive reimbursement through Medicaid to pay a part of the medical expenses, including well-child visits and other benefits, for many of these children and youth. Most children in foster care are eligible for Medicaid under mandatory eligibility pathways, meaning that states must provide coverage because these children meet low-income and other eligibility criteria. Children in foster care who are not eligible under mandatory pathways generally qualify for Medicaid because the state has implemented one or more optional eligibility categories allowing coverage. Further, some children who leave foster care for legal guardianship remain eligible for Medicaid on a mandatory basis, as do most children with state-defined "special needs" who leave foster care for adoption. The income and resources of the child's guardian or adoptive parent are not considered under this eligibility pathway. Separately, youth who age out of foster care may be eligible for Medicaid through one of the mandatory eligibility pathways that are available to adults generally. States also have the option of providing Medicaid to youth up to the age of 21 if they aged out of foster care. However, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended and largely upheld by the U.S. Supreme Court in *National Federation of Independent Business v. Sebelius*) requires all states (as of January 1, 2014) to provide Medicaid to young people under the age of 26 who aged out of foster care. Unlike most other Medicaid pathways, coverage must be provided without regard to the youths' income and assets. This new pathway parallels another ACA requirement that directs health insurance companies to continue coverage of children up to age 26 who are enrolled in their parents' health care plans.

ACA made additional changes to assist adults in obtaining private health insurance, and young adults leaving foster care may benefit from these changes. ACA may also include new opportunities for providing health insurance to child welfare-involved children and their families, such as those children in foster care who are vulnerable to losing Medicaid upon returning home.

Contents

Introduction.....	1
Major Findings.....	2
Children in, or Formerly in, Foster Care.....	4
Health Care Needs.....	5
Child Welfare Programs: Overview.....	6
Child Welfare Policy: Health Needs of Children in, or Leaving, Foster Care.....	7
Health Care Records.....	7
Health Care Oversight and Coordination Planning.....	8
Health Care Power of Attorney	10
Medicaid Program: Overview of Benefits and Eligibility	11
Medicaid Benefits for Children in, or Formerly in, Foster Care.....	13
Medicaid Eligibility for Children and Families with Current or Past Child Welfare Involvement.....	16
Children in Foster Care	17
Mandatory Pathways.....	17
Optional Pathways.....	18
Medicaid Eligibility in Practice.....	19
Young Adults Who Were Formerly in Foster Care.....	20
Mandatory Pathways.....	20
Mandatory Pathway Effective in 2014	20
Optional Pathway	21
Medicaid Eligibility in Practice.....	22
Children Who Leave Foster Care for Adoption or Guardianship.....	22
Mandatory Pathway.....	22
Optional Pathways.....	24
Interstate Application	25
Possible Coverage for Child Welfare-Involved Families	25
Children and Families Served in the Home.....	25
Families of Children Entering Foster Care.....	26
Private Health Insurance Reforms Affecting the Child Welfare Population.....	27
Selected Private Health Insurance Reforms under ACA	28
“Immediate” Health Insurance Reforms and Programs	28
Health Insurance Reforms and Programs Effective in 2014	30
Issues and Challenges	31
Cross-Agency Collaboration	31
Communicating Across Programs	33
Disruptions in Medicaid Coverage for Children in Foster Care and Leaving Care	34
Implementation of the New Pathway for Young Adults Formerly in Foster Care.....	35
Varying Income Counting Rules Across Medicaid Eligibility Pathways	36
Balancing State Fiscal Constraints	37
Accessing Private Health Insurance	37

Tables

Table A-1. Comparisons of Select Outcomes Between Young Adults in the Midwest Study and Young Adults in the Add Health Study	43
Table A-2. Presence of Certain Health and Mental Health Conditions Among All Children, All Adopted Children, and Children Adopted from Foster Care	46
Table B-1. Major Mandatory and Optional Medicaid Pathways for Current and Former Foster Children and Youth.....	48

Appendices

Appendix A. Research on the Health Needs of Current and Former Foster Children and Youth.....	39
Appendix B. Medicaid Pathways for Current and Former Foster Children and Youth	48

Contacts

Author Contact Information.....	55
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Introduction

Children who are placed in foster care are at a higher risk of having a medical, social, or behavioral disability than children in the general population. The abuse or neglect most experience before entering foster care can create physical and mental health issues, and the trauma of being removed from their parents may also incline children in foster care to social or behavioral health concerns.¹ The Social Security Act addresses some of the health care needs of children in foster care—through provisions in titles pertaining to child welfare (Titles IV-B and IV-E) and those in the title pertaining to the Medicaid program (Title XIX). Federal child welfare policy expects state child welfare agencies to maintain health care records of children in foster care and to develop a strategy that addresses the health care needs of each child. States must provide Medicaid coverage to children who are eligible for the Title IV-E federal foster care program or, if applicable, eligible through other Medicaid eligibility pathways.

Beginning on January 1, 2014, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) creates a new mandatory Medicaid pathway, for young adults up to age 26 if they were in foster care at age 18. This new mandatory coverage category for youth aging out of foster care is distinct from the ACA expansion requirements in Section 2001 of ACA that are related to coverage for most childless, non-pregnant and non-elderly adults who were previously ineligible for Medicaid and have incomes below 133% of the federal poverty level.² The U.S. Supreme Court held in *National Federation of Independent Business (NFIB) v. Sebelius*³ that states must have a genuine choice to accept or reject the new ACA expansion funds and requirements that come with those funds. A state's choice whether or not to cover the Section 2001 ACA expansion group cannot be tied to the loss of all Medicaid funding. The Supreme Court's decision leaves enforcement of other provisions of ACA intact, including the new coverage group created by ACA for youth aging out of foster care. Accordingly, all states are expected to comply with the new mandatory coverage category for youth who have aged out of foster care as of January 1, 2014. ACA made additional changes outside of Medicaid to assist adults in obtaining private health insurance, which may benefit young adults who age out of foster care and families who are served by child welfare agencies.

The report begins with a discussion of major findings. It then briefly describes the foster care population and their unique health-related issues. Next is an overview of the federal programs and policies in three areas—child welfare, Medicaid, and private health insurance—that directly or indirectly address some of the health care needs of such children and young adults. The report concludes with a discussion of issues pertaining to these federal policies. **Appendix A** discusses selected research on the health care needs of children in foster care and those who leave foster

¹ U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation, National Survey of Child and Adolescent Well-Being (NSCAW), “Estimates of Supplemental Security Income Eligibility in Out-of-home Placements,” Research Brief No. 12 (undated).

² Section 2001 of ACA contains requirements related to the Medicaid expansion group discussed by the U.S. Supreme Court in *NFIB v. Sebelius*. Section 2004, as amended by Section 10201 of ACA, contains requirements related to Medicaid coverage for youth who age out of foster care.

³ 567 U.S. ____ (2012), available at <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>. See also CRS Legal Sidebar, Health and Medicine, “Conditioning Federal Grants after *NFIB v. Sebelius*,” posted July 3, 2012, by Kathleen S. Swendiman and “To Be or Not to Be a ‘New Program?’ What Does *NFIB v. Sebelius* Mean for Implementation of the Medicaid Expansion Provision?,” posted July 7, 2010, by Kathleen S. Swendiman.

care due to age or placement in a permanent adoptive family. **Appendix B** summarizes the major mandatory and optional Medicaid eligibility pathways for current and former foster children.

Children and Families Currently or Previously Involved With Child Welfare

This report refers to four distinct populations of children and families who receive (or previously received) services or assistance from the state child welfare agency:

- Children who have been removed from their homes due to abuse and neglect, or because their parents are unable to care for them. These children are under the care and supervision of the state and are placed in a foster care home, group home, or other setting. This report also touches on the health care needs of the parents of these children.
- Children who leave foster care for placement with a new permanent family via adoption or guardianship.
- Young adults who have reached the state age of majority and exited foster care. For the purposes of this report, this category includes those young adults who are under the age of 26.
- Children who come into contact with child protective services, but are not removed to foster care, and their parents.

Major Findings

- Approximately 35% to 60% of children placed in foster care have at least one chronic or acute physical health condition that needs treatment, including growth failure, asthma, obesity, vision impairment, hearing loss, neurological problems, sexually transmitted diseases, and complex chronic illnesses. As many as one-half to three-fourths show behavioral or social competency problems that may warrant mental health services. Studies indicate that many health and mental health care issues persist and that—relative to their peers in the general population—children who leave foster care for adoption and those who age out of care continue to have greater health care needs.
- Federal child welfare policy includes health-related provisions. For example, child welfare agencies must ensure that the health care records of children in foster care are periodically reviewed and updated. In addition, states must develop a strategy that addresses the health care needs of each child in foster care including, among other things, health care screenings and oversight of prescription medicines. States must also ensure that young people aging out of foster care are provided a copy of their health records, and information about health insurance options and designating other individuals to make health care decisions on their behalf in the event that they are unable to do so.
- States provide Medicaid to virtually all children in foster care through mandatory and optional coverage pathways. Additionally, the large majority of children who leave foster care for adoption are enrolled in Medicaid on a mandatory basis, as are some children who leave care for legal guardianship with kin. Under the primary Medicaid eligibility pathways for children adopted from foster care (and some leaving to kinship guardianship), the income and assets of the adoptive parents or guardians are not considered. In addition, beginning on January 1, 2014, ACA creates a new mandatory pathway for

young adults up to age 26 if they were in foster care at age 18. Their income and assets will not be considered when determining Medicaid eligibility. This ACA provision is distinct from the ACA expansion group, which was included in a separate section of ACA and was discussed in the U.S. Supreme Court decision *NFIB v Sebelius*. All states are expected to comply with the new requirement to provide coverage for youth aging out of foster care.

- ACA made additional changes outside of Medicaid to assist childless adults and children and their families (e.g., children in foster care who are vulnerable to losing Medicaid upon returning home) in obtaining private health insurance. In addition, private health insurance reforms were enacted to prohibit insurance industry practices such as excluding coverage for preexisting health conditions and setting lifetime limits on the dollar value of essential health benefits. A number of ACA's insurance reforms become effective in 2014. These provisions are designed to provide protection to potentially vulnerable groups with a high prevalence of preexisting conditions, which could include youth previously in foster care.
- ACA also requires states to establish "American Health Benefits Exchanges" by January 1, 2014. Exchanges will not be insurers but will provide qualified individuals and small businesses access to private health insurance plans. In general, the exchange plans will provide comprehensive coverage and meet all applicable market reforms specified in ACA. To make exchange coverage more affordable, eligible individuals may receive premium assistance in the form of tax credits and cost-sharing subsidies. These provisions may provide new opportunities for young adults who age out of foster care and/or families who are served by child welfare agencies to access private health insurance.
- While federal law provides protections to address the health needs of children in foster care, significant challenges remain. For example, federal child welfare law requires cooperation between state child welfare and Medicaid agencies to ensure that the health needs of children in foster care are properly identified and treated; however, there has been little federal guidance on how cooperation should occur. Given the distinct roles played by the child welfare and Medicaid agencies, understanding precisely what cooperation means and how it should occur remains a question.
- Beginning in 2014, ACA requires states to extend Medicaid coverage to certain individuals under the age of 65 with income up to 133% of the federal poverty level (FPL) (i.e., the ACA expansion group). However, on June 28, 2012 the U.S. Supreme Court held in *NFIB vs. Sebelius* that the federal government cannot terminate current Medicaid federal matching funds if a state refuses to expand its Medicaid program to include the ACA expansion group. If a state accepts the new ACA Medicaid expansion funds, it must abide by the new expansion coverage rules, but a state can refuse to participate in the expansion without losing any of its current federal Medicaid matching funds. Therefore not all states may include this mandatory coverage group in their Medicaid program. However, in states that elect to include the ACA expansion group in their state plans, the expansion may enable more family members with children in foster care—or otherwise involved with child welfare—to qualify for Medicaid. While ACA includes enhanced federal matching funds to assist states with some of the costs associated with anticipated program growth, states will

likely face challenges in balancing the costs associated with Medicaid's future expanded role and ongoing state fiscal pressures.

Children in, or Formerly in, Foster Care

Children in foster care are children that the state has removed from their homes and placed in another setting that provides round-the-clock care (e.g., foster family home, group home, child care institution).⁴ Placement in foster care means that a judge has determined that the child's removal from his or her home was necessary because the home was "contrary to the welfare" of the child and, accordingly, the judge has given responsibility for the child's "care and placement" to the state child welfare agency.⁵ The large majority of children enter foster care because of neglect or abuse at the hands of their parents. However, in some instances a child's behavior may also be a reason for entry into foster care; this is more often true for older children.⁶

During FY2010, some 662,000 children spent at least one day (24 hours) in foster care and 254,000 left the system, resulting in more than 408,000 of those children remaining in care on the last day of that fiscal year.⁷ Although there is some variation at the state level, the national foster care caseload has been in decline for at least a decade, with the number of children remaining in foster care on the last day of FY2010 decreasing by close to 160,000 from its recorded high of 567,000 in FY1999.

Foster care is intended to be a temporary placement for children, and a primary goal of child welfare agencies is to expeditiously find a permanent family for them. For most children who enter foster care, permanency is achieved through reunification with their parents (after services have been provided to make this a safe and appropriate permanency outcome). When reunification is not possible or appropriate, however, children must remain in care until a new permanent adoptive family, legal guardian, or "fit and willing" relative can be identified. For some children, no permanent family is identified. These children age out of care when they reach the state's age of majority—typically age 18, or a later age when the state chooses to end custody (usually no later than age 21).

Of the approximately 254,000 children or youth who left foster care custody during FY2010, most of these children or youth—almost six out of every 10 (59%)—returned to their biological parents or went to live with another "fit and willing" relative while another 25% left care for new

⁴ For child welfare purposes, child refers to an individual under the age of 18 except in states that choose to extend foster care up to age 19, 20, or 21. For Medicaid purposes, the term child is not specifically defined in statute, but the term child generally refers to individuals under the age of 19. However, some of the Medicaid eligibility pathways specifically permit states to extend coverage to individuals up to age 19, 20, or 21. Likewise, some Medicaid benefits are defined in terms of age. For example, early and periodic, screening, diagnostic and treatment (EPSDT) services are limited to most Medicaid beneficiaries under the age of 21.

⁵ A few children enter foster care under a "voluntary placement agreement" between their parents and the state child welfare agency. In these cases, *federal* child welfare policy would not require any court involvement in the placement until 180 days at least or 12 months at most.

⁶ U.S. House of Representatives, Committee on Ways and Means, *Green Book 2008*, Table 11-41 and Chart 11-7. (Hereafter, *Green Book 2008*)

⁷ U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, "Trends in Foster Care and Adoption, Based on Foster Care Data Reported by States as of June 15, 2011," http://www.acf.hhs.gov/programs/cb/stats_research/afcars/trends_june2011.pdf.

permanent homes via adoption or legal guardianship. However, another 11% aged out of foster care custody without reunification or placement in a new permanent family.⁸ The number of youth who age out of foster care each year increased over the past decade, rising from just over 20,000 in FY2002 to a high of nearly 30,000 in FY2008. During FY2010, the number of youth aging out of care declined to less than 28,000. However, this number continued to represent a historically high share (11%) of all exits during the year.⁹ Some research into foster care caseload trends suggests that the number of children aging out of foster care may decline and then stabilize in the near future, primarily due to a predicted decrease in the number of children in foster care ages 10 through 17.¹⁰

Health Care Needs

Between 35% and 60% of children and youth entering foster care have at least one chronic or acute physical health condition that needs treatment.¹¹ Chronic problems include, for example, growth failure, asthma, obesity, vision impairment, hearing loss, neurological problems, gastroesophageal reflux, sexually transmitted diseases, and complex chronic illnesses. An even greater estimated share of these children and youth entering foster care—between one-half and three-fourths—have behavioral or social competency problems that may warrant mental health services. This rate of physical and mental health issues is “significantly higher” than what would be expected in the comparable general population of children and youth, although it is somewhat more comparable to children living in families with income below the poverty level.¹² Children who leave foster care often carry with them significant health and mental health needs. A national survey of children adopted from foster care found that 54% had special health care needs,¹³ which means they have one or more conditions (expected to last 12 months or more) that required ongoing need for more medical, mental health, or educational services than is usual for most children of the same age.¹⁴ Another study found that young adults who aged out of foster care at age 18 or soon thereafter were more likely than their peers generally to report having a health condition that limits their daily activities and to participate in psychological and substance abuse counseling. They were also less likely to have health insurance.¹⁵ Research on the health care

⁸ Additionally, in FY2010 more than 1,500 youth (1% of exits) who had run away from their foster care placement were released by courts from state foster care responsibility. Another 2% left care because they were transferred to another agency (i.e., juvenile justice, etc.). HHS, ACF, ACYF, CB, *AFCARS Report #18*.

⁹ HHS, ACF, ACYF, CB, *AFCARS Report #12*, and *AFCARS Report #18*.

¹⁰ Fred Wulczyn and Linda Collins, “A 5-Year Projection of the Number of Children Reaching Age 18 While in Foster Care,” Chapin Hall Center for Children, University of Chicago, 2010, <http://www.chapinhall.org/research/report/5-year-projection-number-children-turning-age-18-while-foster-care>.

¹¹ This is based on single state studies and data from a nationally representative survey. John Landsverk, Director, Child and Adolescent Services Research Center, Rady Child’s Hospital, San Diego, “Health Care for Children in Foster Care,” written testimony submitted for Subcommittee on Income Security and Family Support, House Committee on Ways and Means hearing, July 19, 2007.

¹² Ibid. See also Barbara Burns, et. al “Mental Health Need and Access to Mental Health Services by Youth Involved with Child Welfare: A National Survey,” *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 43, no. 8 (August 2004), pp. 960-970.

¹³ Sharon Vandivere, Karin Malm and Laura Radel, *Adoption USA: A Chartbook Based on the 2007 National Survey of Adoption Parents*, U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary of Planning and Evaluation (ASPE), Washington, DC, 2009, pp. 21-23.

¹⁴ Ibid, p. 23.

¹⁵ The studies do not posit that foster care, per se, is associated with the challenges former foster youth face in adulthood. In fact, children tend to have a range of challenges upon entering care. Fred Wulczyn et al. *Beyond Common* (continued...)

needs and status of children in foster care, those who have aged out of foster care, and those who have left foster care for adoption is described further in **Appendix A**.

Child Welfare Programs: Overview

The majority of federal child welfare policy and funding is provided via programs authorized in Title IV-B and Title IV-E of the Social Security Act.¹⁶

Under two formula grant programs included in Title IV-B—the Stephanie Tubbs Jones Child Welfare Services program and the Promoting Safe and Stable Families program—the federal government provides funds to state child welfare agencies for provision of a wide range of child welfare-related services to children and families. Overall, the focus of those services is to support and strengthen families (whether biological, adopted, or extended) in ways that ensure children’s safety, permanence (with a stable family), and well-being. Funding is provided on a discretionary or capped entitlement basis and states may generally choose to serve any child or family they believe would benefit from these services.¹⁷ The exact number of children and families served via these programs is not known. However, most are believed to access services following an investigation or other child protection agency response to an allegation of child abuse or neglect. In FY2010, state child protection agencies conducted some 2.0 million child abuse and neglect investigations or assessments, involving some 3.6 million children. Many states mandate provision of any services needed during the investigation. In addition, roughly 1 million of these children received services after the conclusion of the investigation—either in the home (79% of those receiving post-investigation services) or via removal to foster care (21%).¹⁸

The Title IV-E program has three main components: foster care, adoption assistance, and kinship guardianship assistance. States that choose to operate a Title IV-E program (all states do) must provide foster care maintenance payments to each eligible child in foster care and must enter into an adoption assistance agreement with parents of each eligible adopted child.¹⁹ States are not required to provide kinship guardianship assistance to eligible children who leave foster care for placement with a legal (relative) guardian. However, states may elect to offer this assistance (in which case any child eligible for kinship guardianship, as defined in the state’s Title IV-E plan, must be served). Not all children in foster care and not all those leaving care for guardianship or adoption are eligible for federal assistance under Title IV-E, and eligibility for Title IV-E varies by each of these components. (The various Title IV-E eligibility criteria are summarized, below, in the context of Medicaid eligibility.) Funding for the Title IV-E program is authorized as an

(...continued)

Sense: Child Welfare, Child Well-Being, and the Evidence for Policy Reform (New Brunswick: AldineTransaction, 2005), p. 116. (Hereafter, Wulczyn et al., *Beyond Common Sense*.)

¹⁶ CRS Report RL34121, *Child Welfare: Recent and Proposed Federal Funding*, by Emilie Stoltzfus.

¹⁷ CRS Report R41860, *Child Welfare: Funding for Child and Family Services Authorized Under Title IV-B of the Social Security Act*, by Emilie Stoltzfus.

¹⁸ HHS, ACF, ACYF, Children’s Bureau, *Child Maltreatment 2010* (December 2011). A child is counted each time an investigation regarding that child occurred or a post-investigation service was provided on that child’s behalf. Therefore, some children are included more than once in these counts.

¹⁹ Throughout this report, the child welfare agency that administers the Title IV-E program is referred to as the “state” child welfare agency. “States” with an approved Title IV-E plan include all 50 states, the District of Columbia, and Puerto Rico. In addition, effective October 1, 2009, tribes are permitted to seek approval of a Title IV-E plan and to operate a Title IV-E program.

open-ended entitlement; states are entitled to federal reimbursement for a part of each eligible cost incurred on behalf of an eligible child.²⁰ In FY2010, close to 614,000 children received Title IV-E assistance on an average monthly basis, more than two-thirds of these children (70%) had exited foster care for adoption and were receiving adoption assistance.²¹

Finally, under the Chafee Foster Care Independence Program (Section 477, Title IV-E of the Social Security Act) state child welfare agencies receive funds to provide independent living services—such as mentoring, tutoring, substance abuse prevention, and preventive health services—to youth who are expected to age out of foster care (without placement in a new permanent family), those who have recently aged out, and those who left foster care for adoption or kinship guardianship at age 16 or older. Services are expected to improve these youths' ability to transition from foster care custody to successful adulthood. Funding is providing on a discretionary and capped entitlement basis.²²

Each of these child welfare programs is jointly funded by the state and the federal government, and many program details are determined at the state level. The Children's Bureau within the U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Administration on Children, Youth, and Families (ACYF), administers these child welfare programs at the federal level; individual state child welfare agencies administer them on a day-to-day basis.

Child Welfare Policy: Health Needs of Children in, or Leaving, Foster Care

As a condition of receiving federal funds dedicated to child welfare purposes, states must meet federal requirements related to planning for and administering services to children and families, and they must provide certain protections for children in foster care. Child welfare policy does not permit states to use federal child welfare program funds (under Title IV-B or Title IV-E) to pay medical expenses of children in care or those who leave foster care due to their age. However, federal child welfare policy requires child welfare agencies to respond to certain health-related requirements.

Health Care Records

Federal law requires that the state child welfare agency have a written plan for each child in foster care, including certain health-related records. These records must include the names and addresses of the child's health providers, a record of the child's immunizations, information about the child's medication, and any other relevant health information concerning the child.²³ These records must be reviewed, updated, and supplied to a child's foster care parent or provider at the

²⁰ For more information on the Title IV-E program generally, see *Green Book 2008*, pp. 11-41 to 11-84 at <http://democrats.waysandmeans.house.gov/media/pdf/111/s11cw.pdf>.

²¹ Based on state FY2010 Title IV-E claims as compiled by HHS, ACF, Office of Legislative Affairs and Budget. Of the 613,929 children receiving Title IV-E assistance on an average monthly basis, 429,233 received adoption assistance, 181,078 received foster care maintenance payments, and 3,618 received kinship guardianship assistance.

²² For more information, see CRS Report RL34499, *Youth Transitioning from Foster Care: Background and Federal Programs*, by Adrienne L. Fernandes-Alcantara.

²³ Section 475(1)(C) of the Social Security Act.

time of each foster care placement. Additionally, a copy of the record must be provided to a youth at the time he/she leaves care due to age.²⁴

Health Care Oversight and Coordination Planning

As part of the requirements that demonstrate compliance with the Stephanie Tubbs Jones Child Welfare Services Program (Title IV-B, Subpart 1), states must submit a state plan for child welfare services that includes a coordinated strategy and oversight plan to ensure access to health care, including mental health services and dental care, for all children in foster care. This coordinated strategy and oversight plan must be developed via a collaborative effort between the state child welfare agency and the state agency that administers Medicaid, in consultation with pediatric and other health care experts, as well as experts in, or recipients of, child welfare services.²⁵

²⁴ Section 475(5)(D) of the Social Security Act.

²⁵ Section 422(a)(15) of the Social Security Act. In guidance issued in July 2010, HHS noted that the state child welfare agency has flexibility in implementing this requirement and in deciding whether to implement a single, agency-wide health care monitoring entity or to put in place another mechanism to oversee the health care of children in care. As part of the plan, the state must include a schedule for health screenings that mirrors or incorporates elements of existing professional guidelines for physical, mental, and dental health screenings, and standards of care into the plan. The guidance emphasizes that states should pay particular attention to the use of psychotropic medicines by children in care. HHS, ACF, ACYF, CB, “Guidance on Fostering Connections to Success and Increasing Adoptions Act,” ACYF-CB-PI-10-11, July 9, 2010. In October 2011, P.L. 112-34 amended the plan requirements to explicitly require protocols to address psychotropic medication and, separately, plans to meet identified needs resulting from emotional trauma experienced by children before (and as a result of) entering foster care.

Health Care Oversight and Coordination Planning Requirements

States must develop a plan for the ongoing oversight and coordination of health care services for any child in foster care. The plan must be developed in coordination and collaboration with the state child welfare agency and state Medicaid agency, and in consultation with pediatricians, other experts in health care, and experts in and recipients of child welfare services. It must ensure a coordinated strategy to identify and respond to the health care needs of children in foster care placements, including mental health and dental health needs and must outline

- a schedule for initial and follow-up health screenings that meet reasonable standards of medical practice;
- how health needs identified through screenings, including emotional trauma associated with a child's maltreatment and removal from home, will be monitored and treated;
- how medical information for children in care will be updated and appropriately shared, which may include the development and implementation of an electronic health record;
- steps to ensure continuity of health care services, which may include the establishment of a medical home for every child in care;
- the oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications;
- how the state actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children; and
- steps to ensure that the components of the transition plan development process (required under Section 475(5)(H)) that relate to the health care needs of children aging out of foster care are met, including the requirements to include options for health insurance, to provide information about a health care power of attorney, health care proxy, or other similar document recognized under state law; and to provide the child with the option to execute such a document.

Source: Section 422(b)(15) of the Social Security Act.

Little guidance has been provided on how coordination is to occur in the development of this health care oversight plan generally. However, with regard to psychotropic medication and otherwise meeting the mental health needs of children in foster care (both required components of the plan), three HHS agencies—the Administration for Children and Families (ACF), Centers on Medicare and Medicaid (CMS), and the Substance Abuse and Mental Health Services Administration (SAMHSA)—sent a joint letter to the directors of each state child welfare, Medicaid, and mental health agency in November 2011. The letter discussed actions being taken at the three federal agencies to “support effective management” of prescription medication for children in foster care and the need for their counterpart state agencies to address this issue. Further, it announced that CMS, ACF, and SAMHSA are scheduled to convene state directors of child welfare, Medicaid, and mental health agencies in 2012 to address use of psychotropic medications for children in foster care as well as the mental health needs of children who have experienced maltreatment. According to the letter, “State Medicaid/CHIP agencies and mental health authorities play a significant role in providing continuous access to and receipt of quality mental health services for children in out-of-home care. Therefore it is essential that State child welfare, Medicaid, and mental health authorities collaborate in any efforts to improve health, including medication use and prescription monitoring structures in particular.”²⁶

²⁶ George Sheldon, Acting Assistant Secretary, ACF; Donald Berwick, Administrator, CMS; and Pamela Hyde, (continued...)

Health Care Power of Attorney

One of the health care oversight provisions directs states to ensure that each young person aging out of foster care is provided information about designating other individuals to make health care decisions on their behalf in the event that they are unable to do so themselves, and about how to execute what is known as a power of attorney document.

A health care power of attorney (or health care proxy) is a document that lays out the circumstances under which health care decisions can be made for a person if he or she is unable to make or communicate those decisions.²⁷ The document designates an individual (sometimes referred to as an “agent”) who can make decisions on that person’s behalf. The agent can be anyone that the individual chooses; the agent does not have to be a relative. The power of attorney form can be tailored to an individual’s circumstances, although states have generic forms that can be used.²⁸

The health care oversight provision on health care power of attorney references the transition planning requirement under Title IV-E of the foster care program. The transition plan requirement directs states to develop a plan for (and with) any youth in foster care for whom the state’s responsibility is expected to end because the youth has reached the state’s age of majority (i.e., age 18 or a later age, up to 21, at state option). The plan must be developed during the 90-day period immediately prior to the date on which the youth is expected to age out of foster care, and it must include specific options on housing, health insurance, education, local opportunities for mentors and continuing support services, and workforce supports and employment services.²⁹

Beginning with FY2011, the transition plan must include information about the importance of designating another individual to make health care treatment decisions on behalf of the youth if he or she becomes unable to participate in these decisions *and* does not have a relative who would be authorized to make these decisions under state law, or he or she does not want that relative to make those decisions. In addition, the transition plan must provide the youth with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under state law. States must meet related requirements under the Title IV-E Chafee Foster Care

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Administrator, SAMHSA, to “State Director,” November 23, 2011, <http://www.childwelfare.gov/systemwide/mentalhealth/effectiveness/jointlettermeds.pdf>.

²⁷ A health care power of attorney is different from a living will, which allows an individual to express his or her wishes concerning life-sustaining procedures but does not specify who should make decisions on the individual’s behalf if needed. For further information, see CRS Report R40235, *End-of-Life Care: Services, Costs, Ethics, and Quality of Care*, coordinated by Kirsten J. Colello.

²⁸ Laws pertaining to health care power of attorney are specific to each state. Generally, if an adult becomes ill and incapacitated, and no health care power of attorney has been executed, then state law will determine how medical decisions will be made. Some states specify certain individuals, such as a spouse or other relative, who would be authorized to make decisions on the person’s behalf. In other states, where a law may provide other criteria for such a decision, a spouse or relative is still likely to have an important role. In a situation where there are no relatives, a hospital may petition a court to have someone appointed to make decisions for the incapacitated patient. Further, in an emergency situation, a doctor or hospital can treat the person without consent or input from anyone else in order to save his or her life.

²⁹ HHS/ACF/ACYF/Children’s Bureau encourages child welfare agencies to use transition planning to build on earlier efforts to assist young people in making the transition from foster care, including through the case planning process and permanency hearings. HHS, ACF, ACYF, CB, “Guidance on Fostering Connections to Success and Increasing Adoptions Act,” ACYF-CB-PI-10-11, July 9, 2010. According to HHS, the component of the plan pertaining to health care power of attorney for youth aging out of foster care will be addressed in future guidance.

Independence Program (CFCIP).³⁰ As part of their application for these funds, states must certify that they meet requirements pertaining to health care power of attorney.

A health care power of attorney may be especially important for young people aging out of care when they do not have a relative upon whom they can rely to make decisions if they become incapacitated. Even if former foster youth maintain relationships with kin, these relationships may be tenuous. A prospective study that is tracking young people who emancipated from care in three Midwest states found that at ages 25 or 26, roughly one-third to one-half of the former foster youth surveyed reported being “very close” or “somewhat close” to their biological mother (52.0%), biological father (30.8%), grandparents (46.2%), or “other relatives” (38.8%).³¹ (Comparable data were not reported for youth generally.) This suggests that a significant share of former foster youth in the study did not have strong relationships with at least some of their relatives after having been out of care for at least a few years.

Medicaid Program: Overview of Benefits and Eligibility

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term care, covering more than 68 million people in FY2010.³² The Medicaid program is jointly funded by states and the federal government and many program details are determined at the state level. The Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) is responsible for Medicaid program administration at the federal level, but individual state Medicaid agencies administer their own programs on a day-to-day basis.

Benefits

In general, states provide mandatory benefits (e.g., inpatient hospital services; early and periodic screening, diagnostic and treatment (EPSDT) services,³³ physician services; and pregnancy-related services) and state-selected optional benefits (e.g., prescribed drugs, routine dental care, case management services, and inpatient psychiatric care for the elderly and individuals under age 21) to their Medicaid beneficiaries. These are referred to as “traditional” Medicaid state plan benefits. States define the specific features of each covered benefit within broad federal guidelines. For example, states may place different limits on the amount of inpatient hospital services a beneficiary can receive in a year (e.g., up to 15 inpatient days per year in one state versus unlimited inpatient days in another state). For these reasons, there is great variability across states in terms of their Medicaid benefit coverage.

³⁰ For further information, see CRS Report RL34499, *Youth Transitioning from Foster Care: Background and Federal Programs*, by Adrienne L. Fernandes-Alcantara.

³¹ Mark E. Courtney et al., *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 26*, Chapin Hall Center for Children, University of Chicago, 2011, <http://www.chapinhall.org/research/report/midwest-evaluation-adult-functioning-former-foster-youth> (Hereinafter, Courtney et al., *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 26*.)

³² For more information on the Medicaid program, see CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz.

³³ For more information on EPSDT, see discussion in the text below.

As an alternative to providing all of the mandatory and selected optional benefits under traditional Medicaid, the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) gave states the option to enroll state-specified groups in benchmark and benchmark-equivalent benefit packages.³⁴ Within certain federal guidelines, benchmark packages may provide generally more-limited benefits than “traditional Medicaid.”³⁵ The DRA of 2005 also gave states the option to impose premiums or other cost sharing requirements for some Medicaid beneficiaries.³⁶

Eligibility

Federal Medicaid law defines over 50 distinct population groups as being potentially eligible for state Medicaid programs. Some eligibility groups are mandatory, meaning that all states with a Medicaid program must cover them; others are optional. For most groups to qualify for coverage, applicants’ incomes, and sometimes their resources or assets, must meet program financial requirements. Medicaid eligibility is also subject to categorical restrictions—generally, it is available only to the elderly, persons with disabilities, members of families with dependent children, and certain other pregnant women and children.

Section 2001 of ACA added a new mandatory³⁷ coverage group to the Medicaid statute to include certain individuals (under the age of 65) with income at or below 133% of the federal poverty level (FPL) (effectively 138% of FPL as a result of the 5% income disregard)³⁸ by January 1, 2014, or sooner at state option.^{39,40} On June 28, 2012, the United States Supreme Court issued its

³⁴ Section 1937(a)(2)(viii) of the Social Security Act. When certain conditions are met, states can also offer premium assistance for health insurance offered through employer-based plans for Medicaid children and their parents. Section 1115 of the Social Security Act provides states with flexibility to test benefit package and service delivery innovations with approval from the Secretary of HHS.

³⁵ Benchmark packages must include the same benefits offered under (1) the Blue Cross/Blue Shield preferred provider plan under the Federal Employees Health Benefits Program (FEHBP), (2) a plan offered to state employees, (3) the largest commercial health maintenance organization (HMO) in the state, and (4) other coverage appropriate for the targeted population approved by the Secretary of the Department of Health and Human Services (HHS). Benchmark-equivalent coverage must have the same actuarial value as one of the benchmark plans. The benchmark equivalent coverage includes, for example, (1) inpatient and outpatient hospital services; (2) physician services; (3) lab and x-ray services; (4) well-child care, including immunizations; and (5) other appropriate preventive care (designated by the Secretary). Such coverage must also include at least 75% of the actuarial value of coverage under the benchmark plan for vision care and hearing services.

³⁶ States may require certain beneficiaries to share in the cost of Medicaid services, although there are limits on the amounts that states can impose, the beneficiary groups that can be required to pay, and the services for which cost-sharing can be charged. See CRS Report RS22578, *Medicaid Cost-Sharing Under the Deficit Reduction Act of 2005 (DRA)*, by Elicia J. Herz.

³⁷ The ACA expansion group resides in Section 1902(a)(10)(A)(i) of the Medicaid statute, which also lists the eight other mandatory eligibility groups. Historically, states that participated in the Medicaid program were required to cover these mandatory groups in order to receive federal matching funds.

³⁸ Federal poverty guidelines are based on family size and are recalculated periodically (usually on an annual basis) to keep pace with inflation. Under the FY2012 federal poverty guidelines, 133% of FPL for a family of one (living in one of the 48 contiguous states) was roughly \$14,856 and 138% FPL for a family of one was roughly \$15,415. See *Federal Register*, January 26, 2012, at <http://aspe.hhs.gov/poverty/12poverty.shtml>.

³⁹ For a more detailed discussion, see the CRS Congressional Distribution Memo, *Selected Issues Related to the Effect of NFIB v. Sebelius on the Medicaid Expansion Requirements in Section 2001 of the Affordable Care Act*, by Kathleen S. Swendiman and Evelyne P. Baumrucker. Also, see CRS Legal Sidebar, Health and Medicine, “Conditioning Federal Grants after NFIB v. Sebelius,” posted July 3, 2012, by Kathleen S. Swendiman available at <http://www.crs.gov/analysis/legalsidebar/pages/details.aspx?ProdId=117>, and “To Be or Not to Be a ‘New Program?’ What Does NFIB v. Sebelius Mean for Implementation of the Medicaid Expansion Provision?,” posted July 7, 2010, by Kathleen S. Swendiman available at <http://www.crs.gov/analysis/legalsidebar/pages/details.aspx?ProdId=121>.

decision in *National Federation of Independent Business v. Sebelius*. The Court held that the federal government cannot terminate current Medicaid federal matching funds if a state refuses to expand its Medicaid program to include non-elderly, non-pregnant adults under 133% of the federal poverty level. If a state accepts the new ACA Medicaid expansion funds, it must abide by the new expansion coverage rules, but, based on the Court's opinion; it appears that a state can refuse to participate in the expansion without losing any of its current federal Medicaid matching funds. The Court's decision only limited the Secretary of Health and Human Service's enforcement mechanism; it did not specifically affect, change, or limit any other Medicaid or ACA provisions.

In general, it is possible for an individual to qualify for Medicaid under multiple eligibility pathways. In these cases, eligibility determinations are to be made in a manner consistent with simplicity of administration and in the best interests of the beneficiary.⁴¹ Further, states cannot deny Medicaid coverage to individuals with completed applications, or terminate existing coverage, until all avenues of eligibility have been explored and evaluated. For individuals who would be eligible under more than one category, Medicaid regulations specify that the individual will be determined eligible for the category he or she selects.⁴²

Medicaid Benefits for Children in, or Formerly in, Foster Care

Regardless of the Medicaid eligibility pathway used, children in foster care, those who have left foster care for adoption or guardianship, and those who have aged out of care are generally entitled to the same set of "traditional" Medicaid state plan services available to other categorically needy children enrolled in a given state's Medicaid program. Central among these benefits is a provision in the law requiring that children receive all medically necessary services authorized in federal statute through the EPSDT program. The EPSDT program—which is a required benefit for nearly all Medicaid beneficiaries under the age of 21⁴³—covers health screenings and services, including assessments of each child's physical and mental health development; laboratory tests (including lead blood level assessment); appropriate immunizations; health education; and vision, dental, and hearing services. The screenings and services must be provided at regular intervals that meet "reasonable" medical or dental practice standards.⁴⁴ States are required to provide all federally allowed treatment to correct problems identified through screenings, even if the specific treatment needed is not otherwise covered under a given state's Medicaid plan.⁴⁵

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⁴⁰ For more information on the Medicaid and CHIP provisions in ACA, see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*.

⁴¹ Section 1902(a)(19) of the Social Security Act.

⁴² See 42 C.F.R. Section 435.404. For individuals who would be eligible under more than one category, the state may assign eligibility based on a predetermined eligibility hierarchy, but ultimately the individual gets to select the category under which he or she enrolls.

⁴³ EPSDT is not a mandatory benefit for the medically needy, although states that choose to extend EPSDT to their medically needy population must make the benefit available to all individuals under age 21.

⁴⁴ Social Security Act §1905(r) of the Social Security Act.

⁴⁵ This means states may be required to cover some services for children that would be optional or not covered at all for (continued...)

While EPSDT is a critical benefit for children covered by Medicaid, tracking receipt of the covered services is complicated by the diverse range of licensed providers (e.g., medical doctor, nurse practitioner, dentists, and others) that may offer the services, as well as the wide range of locations in which the screenings or other services may be provided (ranging from well-child clinics to Head Start programs and many other locations).⁴⁶ A recent investigation by the HHS Office of Inspector General (OIG) found that many Medicaid-eligible children did not receive all the EPSDT services⁴⁷ and this is consistent with earlier studies by the HHS OIG showing inconsistent receipt of basic health care services for children in foster care.⁴⁸

The primary data source for tracking receipt of EPSDT services is separate from the overall Medicaid claims data reported to CMS,⁴⁹ and more recent administrative data on receipt of EPSDT services by children in foster care were not available. Analysis of overall Medicaid claims data,⁵⁰ however, suggests several widely adopted optional Medicaid services are particularly important to children who are coded for Medicaid eligibility purposes as “foster care children.”⁵¹ Specifically, in FY2008 just over 46% of all Medicaid fee-for-service spending for children coded as children in foster care (which includes many who were adopted from foster care) was associated with the following top five service-spending categories: (1) prescription drugs (\$743 million); (2) rehabilitative services (which are medical or remedial services to restore

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adults.

⁴⁶ Eligible EPSDT providers and service locations are detailed in CMS, *State Medicaid Manual*: Part 5: Early and Periodic Screening Diagnostic and Treatment Services, Section 5124, pp. 5-19.

⁴⁷ HHS, OIG, “Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services,” May 2010 (OEI-05-08-00520). The report cited a need for improved documentation of certain screenings as well as better provider knowledge of what a screening entails (among other things) as ways to improve services. In December 2010, CMS convened a National EPSDT Improvement Workgroup to help identify areas for improvement of EPSDT and to work at the federal level and with states to improve both children’s access to EPSDT services and the quality of the data reporting on receipt of those services. See <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html>.

⁴⁸ Between 2003 and 2005, HHS conducted studies of health care use of children in foster care in eight states. For an overview, see HHS, OIG “Children’s Use of Health Care Services While in Foster Care: Common Themes,” Memorandum to Susan Orr, Associate Commissioner for the Children’s Bureau, Administration for Children and Families, and Dennis G. Smith, Director of Centers for Medicare and Medicaid Services, from Brian Ritchie, Acting Deputy Inspector General for Evaluation and Inspections, July 2005 (OEI-07-00-00645).

⁴⁹ The primary data source used to track Medicaid EPSDT services is Form CMS-416. States use this from to report aggregate EPSDT statistics on an annual basis, including services provided under both fee-for-service and managed care arrangements. CMS Form 416 records the number of children (by age group) who are eligible for EPSDT services; have received child health screening services; are referred for corrective treatment; have received dental services; are enrolled in managed care; and/or are screened for blood lead tests.

⁵⁰ These claims data are reported via the Medicaid Statistical Information System (MSIS), which may be analyzed using the Medicaid Analytic Extract (MAX). A CMS Questions and Answers document advises MSIS and MAX data users not to rely on the “Type of Service” or “Program Type” data elements to identify EPSDT or other preventive services delivered to children, “... users are warned that there is substantial variation across states in terms of exactly which services are identified as EPSDT services in MSIS reporting. At one extreme, some states report only screening services as EPSDT services. Referrals and treatments are included in MSIS and MAX, but they may not be identified as EPSDT services. At the other extreme, some states identify a wide array of services (including screening, referrals and treatments) as EPSDT services.” For more information, see https://questions.cms.hhs.gov/app/answers/detail/a_id/9228/~/is-it-possible-to-identify-early-and-periodic-screening-diagnosis-and-treatment.

⁵¹ For purposes of Medicaid eligibility categories, “foster care children” include some (but not all) children in foster care, most children who are adopted from foster care, and certain children who have aged out of foster care. See **Appendix A**, footnotes for further discussion of the children categorized as “foster care” children for Medicaid purposes.

a recipient to his or her best possible functional level) (\$660 million); (3) inpatient psychiatric care services (\$509 million); (4) inpatient hospital care services (\$501 million); and (5) targeted case management (which are case management services provided to a specific subpopulation of Medicaid enrollees to help them identify needed, medical, social, or other services, locate providers, and monitor and evaluate receipt of services) (\$302 million).⁵² (See **Appendix A** for more information on this analysis.)

Use of both rehabilitative services and targeted case management (TCM) for children in, or formerly in, foster care has been the subject of legislative and/or regulatory activity in the past decade. As described below, Congress has generally acted to preserve access to these benefits for children in foster care and those who leave foster care for adoption (under a Title IV-E agreement).⁵³ However, recent survey data appear to show that state child welfare agencies have reduced their use of these Medicaid funding options.

As part of the Deficit Reduction Act of 2005 (P.L. 109-171), Congress acted to both clarify what case management services include, and, with specific regard to children in foster care, the services that could not be supported via Medicaid's TCM benefit. The statute provides that Medicaid TCM *may not* be used to support direct delivery of medical or other social services, including foster care services, which include (but are not limited to) research gathering and completion of documentation required by the foster care program, assessing adoption placements, recruiting or interviewing potential foster care parents, serving legal papers, home investigation, providing transportation, administering foster care subsidies, and making placement arrangements.⁵⁴ Subsequently, CMS released an interim final rule on case management and TCM that was intended to implement these specific changes and, particularly, to clarify use of TCM for children in foster care and other Medicaid-eligible groups. Critics of the December 2007 interim rule, which included child welfare advocates and state administrators, argued that it was more restrictive than Congress intended, would result in cuts to necessary TCM services, and would increase state administrative costs. Congress enacted several temporary moratoria on its full implementation. Ultimately, the Obama Administration expressed some of these same concerns about the interim final rule and responded by rescinding parts of it to address most or all of these concerns.⁵⁵

As part of that same 2009 announcement, the Obama Administration rescinded, in whole, a proposed regulation that appeared to limit rehabilitative services for children in foster care, among other Medicaid enrollees. Similar to the TCM rule, Congress had acted on more than one occasion to temporarily prohibit CMS from implementing the proposed rehabilitative services rules and it further adopted a Sense of Congress (P.L. 111-5, Section 5003) indicating that CMS should never finalize the proposed rehabilitative services rule.⁵⁶

⁵² Based on CRS analysis described in **Appendix A**. These findings from FY2008 claims data are generally consistent with an analysis of FY2001 Medicaid claims for “foster care” children that was conducted by the Urban Institute. See Rob Geen, Anna Sommers, and Mindy Cohen, “Medicaid Spending on Foster Children,” Urban Institute, August 2005.

⁵³ See CRS Report RL34426, *Medicaid Targeted Case Management (TCM) Benefits*, by Cliff Binder; and CRS Report RL34432, *Medicaid Rehabilitation Services*, by Cliff Binder.

⁵⁴ Section 1915(g)(2)(A)(iii) of the Social Security Act. See also Conference Report to accompany S. 1932 (H.Rept. 109-362), Deficit Reduction of 2005, pp. 320-323 and CRS Report RL33155, *Child Welfare: Foster Care and Adoption Assistance Provisions in Budget Reconciliation*, by Emilie Stoltzfus.

⁵⁵ *Federal Register*, June 30, 2009, pp. 31183-31196. CRS Report RL34764, *Select Bush Administration Medicaid Rulemakings: Congressional and Administrative Actions*, by Elicia J. Herz and Vanessa K. Burrows.

⁵⁶ *Ibid.*

As ultimately resolved then, this legislative and regulatory activity appears to preserve states' ability to use Medicaid funding under the TCM and rehabilitative services option for children in foster care largely as it existed prior to the enactment of the DRA of 2005. However, states reported a 37% decline in child welfare agency spending of Medicaid dollars—primarily for these two Medicaid options (as well as Medicaid-funded therapeutic foster care)—between state fiscal year 2006 and state fiscal year 2010.⁵⁷ Among the 46 states able to report these data in both years, spending declined from \$1.6 billion in state fiscal year 2006 to \$1.0 billion in state fiscal year 2010.⁵⁸

Separately, while the DRA of 2005 gave states the option to impose premiums or other cost sharing requirements for some Medicaid beneficiaries and to enroll some in benchmark or benchmark-equivalent coverage plans, Congress acted to ensure that these options did not apply to children in foster care. Instead, children in foster care (like most other nondisabled Medicaid-eligible children) must remain free of any beneficiary cost-sharing requirements⁵⁹ and states are not permitted to require mandatory enrollment of children in foster care in benchmark or benchmark-equivalent benefit packages, which typically cover fewer services than traditional Medicaid benefit packages.⁶⁰

Medicaid Eligibility for Children and Families with Current or Past Child Welfare Involvement

Below is a discussion of the major Medicaid eligibility pathways available to current and former foster children and youth. (These pathways are summarized in greater detail in **Appendix B**.) Notably, four pathways are specifically available for this population—a mandatory pathway for children if they qualify for the Title IV-E program (whether in foster care or after leaving foster care for adoption or legal guardianship); an optional pathway for certain children who are adopted (primarily from foster care) and who receive adoption assistance funded wholly by the state; an optional pathway for young adults up to the age of 21 who were in foster care at age 18; and a

⁵⁷ Kerry DeVooght with Megan Fletcher, Brigitte Vaughn & Hope Cooper, *Federal, State and Local Spending to Address Child Abuse and Neglect in SFYs 2008 and 2010*, Child Trends with support from Annie E. Casey Foundation and Casey Family Programs (June 2012), pp. 28-30, 36. As part of this survey, states were asked to report only on Medicaid spending for which the state child welfare agency provided the non-federal matching dollars (this excludes funding for basic health care services such as those covered by EPSDT). States reported spending child welfare dollars to match Medicaid expenditures most frequently under the rehabilitative services option, TCM, and for Medicaid-funded therapeutic foster care. "Other" Medicaid spending by child welfare agencies included, for example, Medicaid administration and transportation.

⁵⁸ Ibid. All dollars were adjusted for inflation and represent 2010 dollars.

⁵⁹ Section 1916A(b)(3) of the Social Security Act provides that states may not impose premiums or cost sharing on children who receive federal assistance (whether foster care, adoption assistance, or guardianship) under Title IV-E of the Social Security Act (regardless of their age) and further that they may not impose such cost on any child under age 18 who is in foster care and for whom aid or assistance is made available under Title IV-B of the Social Security Act. Because any child in foster care is eligible for services under Title IV-B this provision would appear to effectively apply to any child in foster care.

⁶⁰ Section 1937(a)(2)(viii) of the Social Security Act. The statute provides that states may not require enrollment in a benchmark plan for any individual who is in foster care and for whom aid or assistance is made available under Title IV-B of the Social Security Act and for any individual who is receiving assistance (whether foster care, adoption assistance, or guardianship) under Title IV-E of the Social Security Act (regardless of age). Because any child in foster care is eligible for services under Title IV-B this provision would appear to effectively apply to any child in foster care.

new mandatory pathway, available beginning on January 1, 2014, for young adults up to the age of 26 who were in foster care at age 18. Current and former foster children and youth may also qualify for Medicaid through other mandatory and optional pathways that are available to categories of eligible individuals.⁶¹ This section also addresses possible Medicaid coverage for the families who come into contact with child welfare services.

Children in Foster Care

Mandatory Pathways

Under Title IV-E of the Social Security Act, the federal government reimburses states for a part of the cost of administering a foster care program and providing foster care maintenance payments (covering costs of room, board, and incidentals) and related child placement services on behalf of eligible children in foster care. The primary mandatory Medicaid pathway for children in foster care applies only to those children who qualify for assistance under the Title IV-E program.⁶² Specifically, Title IV-E requires that a child in foster care (1) meet income/assets tests and family structure rules in the home he/she was removed from; (2) be subject to specific judicial determinations related to reasons for the removal and other aspects of his/her removal and placement in foster care; (3) be placed in an eligible licensed setting with an eligible provider(s); and (4) be under the age of 18, or, if the state the youth resides in has elected this option, age 19, 20, or 21 (provided a youth of this age meets certain education, work, or other specified requirements).⁶³

Other mandatory pathways available to children in foster care who are not eligible for Medicaid under the Title IV-E category include poverty-related pathways for children under age six in families with incomes at or below 133% FPL, and children ages six through 18 in families with incomes below 100% FPL.⁶⁴ Young adults ages 18 through 20 who are in foster care may also be eligible under mandatory pathways that are available to adults generally, including pregnant women with income at or below 133% FPL.

⁶¹ The Centers for Medicare & Medicaid Services (CMS) will consolidate certain existing mandatory and optional eligibility groups into two categories: (1) parents and other caretaker relatives; and (2) pregnant women; and children effective January 1, 2014. Beginning in 2014, these consolidated eligibility groups will rely on the modified adjusted gross income (MAGI) income counting rule when determining eligibility. (See U.S. Department of Health and Human Services, “Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010; Final Rule,” *77 Federal Register* 57, March 23, 2012.)

⁶² Section 1902(a)(10)(A)(i)(I) of the Social Security Act. See also Section 473(b) of the Social Security Act.

⁶³ Nearly all states may provide federal Title IV-E assistance to youth who remain in foster care up to their 19th birthday if the youth is completing high school or an equivalent education or training credential. As of FY2011, states may seek reimbursement for the cost of providing foster care to eligible youth until age 19, 20, or 21, at the state’s option. States must amend their Title IV-E state plan to indicate their intention to provide such assistance and may seek reimbursement for a youth age 18 or older who is completing high school or a program leading to an equivalent credential; enrolled in an institution that provides post-secondary or vocational education; participating in a program or activity designed to promote, or remove barriers to, employment; or employed at least 80 hours per month (i.e., part-time). States may also seek reimbursement for an older youth’s foster care if the youth has a medical condition that makes him or her incapable of participating in the activity, and this incapacity is supported by regularly updated information in the youth’s case plan. For further information, see CRS Report RL34499, *Youth Transitioning from Foster Care: Background and Federal Programs*, by Adrienne L. Fernandes-Alcantara.

⁶⁴ Beginning January 1, 2014, ACA requires states to increase the mandatory Medicaid income eligibility level for poverty-related children ages 6 to 19 from 100% FPL to 133% FPL (as applied under prior law to children under age 6).

Both children and older youth in care may also be eligible under other mandatory pathways, including the Supplemental Security Income (SSI) eligibility pathway for certain individuals with severe disabilities,⁶⁵ and the Section 1931 pathway available to members of low-income families that meet the financial requirements (based on family size) of the former Aid to Families with Dependent Children (AFDC) program, as in effect on July 16, 1996.⁶⁶ Under Section 1931 of the Social Security Act, states may cover higher-income families by increasing the 1996 financial threshold to account for inflation or by using additional disregards that reduce income countable toward the threshold. States can also scale back on eligibility by using a lower threshold in effect as of 1988.

Optional Pathways

A child in foster care who is not eligible for a mandatory pathway may be covered under several optional Medicaid eligibility groups. The major coverage option is known as the Ribicoff pathway, named for the late Senator Abraham Ribicoff. Ribicoff children are under the age of 21 (or under the age of 20, 19, or 18 as the state chooses) and meet the income and resource requirements for the former AFDC program but do not meet other “dependent child” eligibility requirements for that program. (For example, they may be living alone, or they may be older than age 17, or older than 18 if in high school). The Ribicoff pathway allows the state to extend Medicaid eligibility to youth in foster care under the age of 21, or at state option under the age of 20, 19, or 18 as the state may choose.⁶⁷ Through this pathway, states can opt to cover all eligible children or “reasonable categories” of children, including children residing in institutions or children or youth in foster care placements or adoptive homes who are not eligible to receive Title IV-E assistance but receive support funded solely by the state. Under this option, parental income does not apply to children who do not reside with their parents.

States may also use other optional pathways that are available to children and adults generally to provide Medicaid coverage to children in foster care. One such pathway is available to infants (and pregnant women) in families with incomes between 133% and 185% FPL. States can also take up what are known as Medicaid expansions under the State Children’s Health Insurance Program (CHIP) that provide coverage to infants and children through age 18 in families with higher incomes. Another optional pathway is for children with high medical expenses that can be deducted from income. Such deductions allow them to meet applicable Medicaid financial requirements. This is referred to as the “medically needy” pathway. Any state that opts to provide

⁶⁵ The SSI eligibility pathway described above is not limited to children with disabilities; it may include individuals of any age who are blind or disabled and are receiving SSI.

⁶⁶ States are required to continue providing Medicaid coverage to families who lose Medicaid eligibility under Section 1931 due to increased child or spousal support collections or due to an increase in earned income or hours of employment. This continuation is available for a limited time period and is known as transitional medical assistance (TMA).

⁶⁷ Based on a 2005 review of state Medicaid plans and amendments, 26 states provided Medicaid coverage to children and young adults through this pathway: 22 states provided coverage through age 20, one provided coverage through age 19, two states provided coverage through age 18, and one state provided coverage through age 17. For further information, see Abigail English, Amy J. Stinnett, and Elisha Dunn-Georgiou, *Health Care for Adolescents and Young Adults Leaving Foster Care: Policy Options for Improving Access*, Center for Adolescent Health & the Law, February 2006, p. 5, <http://www.cahl.org/PDFs/FCIssueBrief.pdf>. A 2006 review of state Medicaid plans and amendments (and other documents) found that 15 states used the Ribicoff option to cover children and young adults through age 20. For further information, see Harriette B. Fox, Stephanie J. Limb, and Margaret A. McManus, *The Public Health Insurance Cliff for Older Adolescents*, The National Alliance to Advance Adolescent Health, Fact Sheet No. 4, April 2007, <http://www.thenationalalliance.org/jan07/factsheet4.pdf>.

medically needy coverage is required to extend that coverage to children under age 18, pregnant women, certain newborns, and certain other specified, protected persons. Other groups can be included as well, such as children ages 18 through 20.⁶⁸ Finally, states that want to provide coverage to adult groups beyond what the law allows may seek approval from the Centers for Medicare & Medicaid Services (CMS) for Section 1115 waivers.⁶⁹ This coverage may provide access to a more limited set of benefits than what would be available under Medicaid state plan services. Section 1115 waivers could be available to former foster care youth ages 18 through 20 who do not otherwise qualify for Medicaid.

Medicaid Eligibility in Practice

According to a nationally representative study of children in foster care that examined Medicaid eligibility, approximately 76% of children were determined eligible for the program based on mandatory eligibility pathways, another 23% were determined eligible based on optional eligibility pathways adopted by the state (or county), and less than 1% were ineligible for coverage.⁷⁰ Of those children eligible under the mandatory federal pathways, three-quarters were eligible because they qualified for Title IV-E foster care (i.e., roughly 57% of all children in foster care). Another 11% of those children in foster care who were eligible on a mandatory basis qualified through a pathway linked to SSI; and approximately 14% qualified because their families had very low income.

In this same study, nearly all respondents (state and county health and child welfare officials) reported that there were mechanisms in place to ensure that children received health care coverage immediately upon entering foster care. Most (93%) reported that Medicaid eligibility could be established through presumptive eligibility.⁷¹ Other mechanisms for minimizing delays in Medicaid enrollment included minimizing the time required to initiate the Medicaid application by child welfare staff (80%); a computer link between the child welfare and Medicaid agencies (70%); trained child welfare staff to certify for eligibility (57%);⁷² and uniform intake applications for child welfare and Medicaid (50%).

This study also examined timing of application for coverage and recertification of eligibility. Officials reported that applications for Medicaid were made immediately for 36% of children entering foster care (even though nearly all of these respondents also reported that mechanisms

⁶⁸ A 2006 review of state Medicaid plans and amendments (and other documents) found that 16 states covered 19- and 20-year olds in their medically needy programs. See Harriette B. Fox, Stephanie J. Limb, and Margaret A. McManus, *The Public Health Insurance Cliff for Older Adolescents*, The National Alliance to Advance Adolescent Health, April 2007, p. 3, <http://thenationalalliance.org/jan07/factsheet4.pdf>.

⁶⁹ Section 1115 of the SSA authorized the Secretary of Health and Human Services (HHS) to waive certain statutory requirements for conducting research and demonstration projects that further the goals of Medicaid and/or CHIP.

⁷⁰ Anne M. Libby et al., "Child Welfare Systems Policies and Practices Affecting Medicaid Health Insurance for Children: A National Study," *Journal of Social Science Research*, vol. 33, no. 2 (2006), p. 33.

⁷¹ Under presumptive eligibility states may enroll individuals for a limited period of time before completed Medicaid applications are filed and processed.

⁷² However, actual Medicaid eligibility determinations must be made by the state Medicaid agency except in cases of states that have CMS approval to rely on a finding from specified "Express Lane" agencies (e.g., those that administer programs such as Temporary Assistance for Needy Families (TANF), CHIP, and the Supplemental Nutrition Assistance program (SNAP)) to determine whether a child under age 19 (or an age specified by the state not to exceed 21 years of age) has met one or more of the eligibility requirements necessary to determine an individual's eligibility for medical assistance under Medicaid or CHIP.

were in place to ensure immediate coverage upon entering care). Applications were made for 33% of children within seven days of entering foster care; and applications were made for the remaining 31% of children seven days or more after entering care. With regard to the frequency of redetermination for Medicaid eligibility, 64% of respondents reported that recertification happens annually without regard to the child's foster care placement setting; approximately one-fifth reported recertification every six months.

Young Adults Who Were Formerly in Foster Care

Mandatory Pathways

Like children in foster care, youth age 18 and older who were formerly in care may be Medicaid eligible under mandatory pathways. These young adults can gain coverage through one of the mandatory eligibility pathways described above that are available to *adults* generally. For example, if former foster youth meet certain income and other criteria, they may qualify under the pathways available to low-income pregnant women and adults with disabilities who are eligible for SSI.

Mandatory Pathway Effective in 2014

Effective January 1, 2014, ACA⁷³ adds a new mandatory Medicaid eligibility group that will include individuals

- under 26 years of age;
- not eligible or enrolled under existing Medicaid mandatory eligibility groups, or who are described in any of the existing Medicaid mandatory eligibility groups but have income that exceeds the upper income eligibility limit established under such group;
- were in foster care under the responsibility of the state on the date of attaining 18 years of age (or a higher age at the state's option); and
- were enrolled in the Medicaid state plan or under a waiver while in foster care.

This language appears to enable former foster youth to qualify for this pathway if they are *not* eligible for the other mandatory pathways.⁷⁴

ACA also allows states to make “presumptive eligibility” determinations for individuals eligible for the new mandatory foster care pathway to Medicaid. That is, states may enroll such individuals for a limited period of time before completed Medicaid applications are filed and processed. (Such individuals must then formally apply for coverage within a certain timeframe to continue receiving Medicaid.) This new group of former foster care youth will also be exempt from mandatory enrollment in Medicaid benchmark plans and will instead receive traditional

⁷³ Section 2001 of ACA contains requirements related to the Medicaid expansion group.

⁷⁴ Section 2004 (as amended by Section 10201) of ACA contains requirements related to Medicaid coverage for youth who age out of foster care. This provision excludes and does not refer to the new mandatory eligibility pathway up to 133% FPL created under Section 2001 of ACA (P.L. 111-148).

Medicaid benefits.⁷⁵ Finally, ACA requires state plan services rendered to individuals in this new mandatory eligibility group for former foster care youth to be matched at the state's regular Federal Medical Assistance Percentage (FMAP) rate.⁷⁶

This new mandatory coverage category for youth aging out of foster care is distinct from the Medicaid expansion requirements and related to coverage for the ACA expansion group up to 133% FPL.⁷⁷ The U.S. Supreme Court targeted the ACA expansion group in *National Federation of Independent Business (NFIB) v. Sebelius*.⁷⁸ In that decision, the Court held that the federal government cannot terminate current Medicaid federal matching funds if a state refuses to expand its Medicaid program to include the ACA expansion group. If a state accepts the new ACA Medicaid expansion funds, it must abide by the new expansion coverage rules, but, based on the Court's opinion, it appears that a state can refuse to participate in the expansion without losing any of its current federal Medicaid matching funds. In other words, states must have a "genuine choice" to accept or reject the new ACA expansion funds and requirements that come with those funds. The Supreme Court's decision did not specifically affect, change, or limit any other Medicaid or ACA provisions; it merely limited the Secretary of Health and Human Service's enforcement mechanism for states that do not participate in the ACA expansion. The Supreme Court's decision leaves enforcement of other provisions of ACA intact, including the new coverage group created by ACA for youth aging out of foster care.⁷⁹ Accordingly, all states are expected to comply with new mandatory coverage category for youth who have aged out of foster care as of January 1, 2014.

Optional Pathway

In states that utilize the "Chafee option"—named for the late Senator John. H. Chafee—youth who meet the definition of "independent foster care adolescent" may be eligible for Medicaid. The law defines an "independent foster care adolescent" as someone who is under the age of 21, was in foster care under the responsibility of the state on his or her 18th birthday, and meets the income or resource criteria established by a state (if any).⁸⁰ States that elect to provide Medicaid through the Chafee option may further restrict such eligibility based on any "reasonable" criteria,

⁷⁵ Beginning in 2006, as an alternative to traditional benefits, states were given the option to provide what are called "benchmark" benefit packages to certain Medicaid subpopulations. In general, benchmark benefit packages may cover fewer benefits than traditional Medicaid, but there are some requirements, such as coverage of EPSDT services and transportation to and from medical providers, that make them more generous than the benefits that would be available to children through a typical private health insurance plan.

⁷⁶ For more information on Medicaid FMAP, see CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by Alison Mitchell and Evelyne P. Baumrucker.

⁷⁷ Section 2001 of ACA (P.L. 111-148) contains requirements related to the Medicaid expansion group. Requirements related to Medicaid coverage for youth who age out of foster care are included in Section 2004 (as amended by Section 10201) of ACA.

⁷⁸ 567 U.S. ___ (2012), available at <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>. See also CRS Legal Sidebar, Health and Medicine, "Conditioning Federal Grants after *NFIB v. Sebelius*," posted July 3, 2012 and "To Be or Not to Be a 'New Program?' What Does *NFIB v. Sebelius* Mean for Implementation of the Medicaid Expansion Provision?," posted July 7, 2010, by Kathleen S. Swendiman.

⁷⁹ For more information, see CRS Congressional Distribution Memo, *Selected Issues Related to the Effect of NFIB v. Sebelius on the Medicaid Expansion Requirements in Section 2001 of the Affordable Care Act* by Kathleen S. Swendiman and Evelyne P. Baumrucker.

⁸⁰ Section 1905(w) of the Social Security Act. States are not required to establish income or resources limits for these youth but if they do they may not set those tests lower than the test provided in Section 1931(b) of the Social Security Act.

including whether or not the youth had received Title IV-E funding.⁸¹ However, this optional pathway for youth who age out will be supplanted starting in 2014, when states are required to provide Medicaid coverage to young people under age 26 who age out of foster care.

Medicaid Eligibility in Practice

Based on a 2008 survey of state child welfare staff in 45 states, 29 states (64.4%) had extended the Chafee option to eligible youth. Of the 28 states that responded to a follow-up question about eligibility requirements, 25 reported that youth must have been in foster care on their 18th birthday to be eligible; 15 reported that youth must complete an application to be eligible; one state said that youth are automatically eligible; and nine states reported other (unspecified) eligibility criteria (e.g., enrollment in an education program).

Of the 45 states surveyed, the 15 states that had not taken up the Chafee option reported that former foster youth could be eligible for CHIP (six of the states) or Medicaid through other pathways (13 of the states). States reported that youth were eligible for Medicaid through meeting the “medically needy” criteria (seven states), through a 100% state funded program (three states), and through other unspecified pathways (three states). One state reported that former foster youth are not categorically eligible for Medicaid.⁸²

Children Who Leave Foster Care for Adoption or Guardianship

Mandatory Pathway

Under the Title IV-E program, eligible children who leave foster care for placement in a new permanent home—via adoption or legal guardianship with a relative—are eligible for Medicaid under the mandatory Title IV-E pathway.⁸³ The income and resources of the adoptive parents or relative guardians must not be considered under this pathway. Further, children moving from receipt of a Title IV-E foster care maintenance payment to coverage under a Title IV-E adoption assistance agreement or receipt of Title IV-E kinship guardianship assistance payments must not be required to submit a new application for Medicaid eligibility, and they remain eligible for Medicaid (without redetermination) for as long as a Title IV-E adoption assistance agreement on their behalf remains in effect or for as long as they are receiving Title IV-E kinship guardianship assistance payments.⁸⁴ In general, once it is established a state must maintain a Title IV-E

⁸¹ Section 1902(a)(10)(A)(ii)(XVII) of the Social Security Act.

⁸² Amy Dworsky and Judy Havlicek, *Review of State Policies and Programs to Support Young People Transitioning Out of Foster Care*, University of Chicago, Chapin Hall Center for Children, 2009, p. 11, <http://www.wsipp.wa.gov/pub.asp?docid=08-12-3903>. A 2006 survey of state human service officials by the American Public Human Services Association (APHSA) found that 17 states reported extending Medicaid coverage to eligible youth through the Chafee option. For further information, see Sonali Patel and Martha A. Roherty, *Medicaid Access for Youth Aging Out of Foster Care*, American Public Human Services Association, 2007, <http://www.aphsa.org/Home/Doc/Medicaid-Access-for-Youth-Aging-Out-of-Foster-Care-Rpt.pdf>. Puerto Rico was not included in this analysis.

⁸³ Section 1902(a)(10)(A)(i)(I) of the Social Security Act. See also Section 473(b) of the Social Security Act.

⁸⁴ See Association for Administrators of the Interstate Compact on Adoption and Medical Assistance (AAICAMA) FAQ at http://aaicama.org/cms/medicaid-docs/Medicaid_4E_Med_Application.pdf. See also HHS, CMS, Family and Children’s Health Programs Group, Letter to Associate Regional Administrators [regarding Medicaid eligibility impacts of the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351)], April 15, 2009 available at http://aaicama.org/cms/medicaid-docs/Medicaid_4E_Med_Application.pdf.

adoption assistance agreement until a child’s 18th birthday or (at state option, or on a case-by case basis) up to age 19, 20, or 21—assuming, in either case, that the adoptive parent(s) remain legally responsible for the child and are providing support to the child. The same age provisions apply with regard to Title IV-E kinship guardianship payments (again, providing that a relative guardian continues to have legal responsibility for the child and is providing support to the child).⁸⁵

Adoption Assistance

States that operate a Title IV-E program are required to enter into an adoption assistance agreement with the adoptive parent of each child who is determined by the state to have “special needs.” All children who are eligible for Title IV-E adoption assistance must be determined to have special needs. Additional eligibility rules for Title IV-E adoption assistance (related primarily to the income and resources of the home from which the adopted child was previously removed to foster care) are being phased out (based primarily on the age of the child at the time of adoption). However, those income and resource rules will continue to apply to some children until FY2018.⁸⁶

A “special needs” determination by the state child welfare agency must include findings that the child cannot be returned to his/her parents and that there is a factor or condition specific to the child—such as the child’s age; membership in a sibling group; race and ethnicity, medical condition; or a physical, emotional, or mental disability—that makes it “reasonable to conclude” that the child will not be adopted without provision of adoption assistance and/or medical assistance. Finally, unless it is not in the child’s best interest (for instance, because of significant bonding with foster parents), the state must also determine that reasonable but unsuccessful efforts to place the child for adoption without such assistance have been made.⁸⁷

Kinship Guardianship Assistance

States that operate a Title IV-E program are not required to provide kinship guardianship assistance but may choose to do so. To be eligible for Title IV-E kinship guardianship assistance, a child must have been eligible to receive Title IV-E foster care maintenance payments while in foster care and been living (for at least six consecutive months) with the prospective relative guardian. Further, the state child welfare agency must have determined that neither returning home (to biological parents) nor placement for adoption are appropriate permanency plans for the

⁸⁵ States that want to provide Title IV-E assistance (of any kind) to eligible youth beyond their 18th birthday (or 19th if youth is completing high school) must generally, amend their Title IV-E plan to permit these claims. See Section 475(8) of the Social Security Act and related guidance in HHS, ACF, ACYF-CB-PI-10-11. However, on a case-by-case basis (*and without amending its Title IV-E plan*), a state may maintain a Title IV-E adoption assistance agreement, or continue to provide Title IV-E kinship guardianship assistance payments, for a youth (up to age 21) if the state determines that the youth has a mental or physical disability that warrants this continued assistance. See Section 473(a)(4)(A) of the Social Security Act.

⁸⁶ For information on phase in of broader adoption assistance eligibility see CRS Report RL34704, *Child Welfare: The Fostering Connections to Success and Increasing Adoptions Act of 2008*, by Emilie Stoltzfus. The statute also provides Title IV-E adoption assistance eligibility for any child with “special needs” (described above) who is 1) eligible for SSI; or 2) the child of a youth in foster care (provided that youth is eligible for Title IV-E assistance).

⁸⁷ States determine specific “special needs” factors that are not explicitly required in federal law. For state-by-state information on determination of special needs see http://www.childwelfare.gov/adoption/adopt_assistance/questions.cfm?quest_id=1.

child; the child has a strong attachment to the relative guardian; and the relative guardian has a strong commitment to providing permanent care for the child.⁸⁸

Optional Pathways

Federal child welfare policy requires states to provide health insurance coverage (either Medicaid or another program with comparable benefits) to any child on whose behalf they have in place a (state-funded) adoption assistance agreement.⁸⁹ These are adopted children who meet the state definition of “special needs” but do not meet other Title IV-E eligibility criteria (e.g., income or asset rules tied to their *biological* family). States may use a variety of the optional pathways similar to those available for children in foster care to provide Medicaid or CHIP coverage to these adopted children. However, under these pathways the income and resources of the adoptive parents or guardian would generally be counted in determining eligibility.

One notable exception is available to a child (1) for whom the state child welfare agency has entered into an adoption assistance agreement with his/her adoptive parent or parents; (2) for whom the state child welfare agency has determined there is a pre-existing need for special or medical rehabilitative care that would preclude the child’s adoption *absent* medical assistance; and (3) who at the time the adoption assistance agreement was executed met certain “needy” criteria (i.e., Medicaid eligible or Title IV-E income eligible).⁹⁰ In states that elect to provide this optional coverage, children who receive wholly state-funded adoption assistance are Medicaid eligible without regard to the income or resources of their adoptive parents.⁹¹ Only one state (New Mexico) has not taken the specific Medicaid optional pathway offered for state-funded adoptions. It appears this optional eligibility pathway may largely be supplanted by the mandatory Title IV-E pathway as of FY2018. That is the year in which new Title IV-E adoption assistance eligibility criteria included in the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) will be fully phased in. Those new eligibility criteria provide that Title IV-E assistance is available to any adopted child for whom the state determines there are “special needs.”

⁸⁸ Section 471(a)(28) and 473(d) of the Social Security Act. A child who is at least age 14 must be consulted before placement in a kinship guardianship. Siblings of a child eligible for Title IV-E kinship guardianship may also be eligible if they are placed, appropriately, in the same kinship guardianship arrangement. Further any child who was receiving guardianship assistance under a Title IV-E waiver as of September 30, 2008 remains eligible for kinship guardianship assistance. As implemented by HHS, state may define eligibility for kinship guardianship assistance (in their state Title IV-E plan) in a more restrictive manner than the broadest federal eligibility criteria. See HHS, ACF, ACYF-CB-PI-10-11, issued July 9, 2010 http://www.acf.hhs.gov/programs/cb/laws_policies/pi/2010/pi1011.htm.

⁸⁹ Section 471(a)(21) of the Social Security Act.

⁹⁰ Section 1902(a)(10)(A)(ii)(VIII) of the Social Security Act. See also AAICAMA FAQs on Medicaid and state-funded adoption assistance at <http://aaicama.org/cms/index.php/frequently-asked-questions-faqs/medicaid-and-state-funded-aa>.

⁹¹ All states but New Mexico are believed to have taken this Medicaid option. See “AAICAMA, COBRA Option/Reciprocity as of October 2011.” A state child welfare agency may elect to limit state-funded adoption assistance based on the income or resources of a parent. However, the Medicaid agency may not base eligibility on income and resources of adoptive parents if the state child welfare agency has entered into a (state-funded) adoption assistance agreement with the family and provided the state has elected to take this optional Medicaid category.

Interstate Application

A Title IV-E adoption assistance or kinship guardianship assistance agreement remains in effect between a state child welfare agency and the adoptive parents (or relative guardian) even if the adoptive family (or relative guardian) moves out of state and the Title IV-E (child welfare) agency in the state that originally entered into the agreement continues to be responsible for providing any adoption or guardianship assistance promised in that agreement. By contrast, a child for whom a Title IV-E adoption assistance agreement is in effect is eligible for Medicaid coverage in the state where the child is residing.⁹² For example, if a child is placed out-of-state in a residential facility, the state where that facility is located becomes responsible for Medicaid coverage of the child, while the state where the child's adoptive parents live continues to be responsible for any payments under the Title IV-E adoption assistance agreement.⁹³ The Interstate Compact on Adoption and Medicaid Assistance, which has been adopted by 49 states and the District of Columbia, governs procedures by which Medicaid coverage of adopted children may be transferred between states.⁹⁴

While continued Medicaid coverage of Title IV-E eligible children who move across state lines is required under federal law, children who are Medicaid eligible under a state-funded adoption assistance agreement are not automatically assured Medicaid coverage if they move to another state. However, some states do offer this coverage to some or all children with state-funded adoption assistance agreements who move to a different state.⁹⁵

Possible Coverage for Child Welfare-Involved Families

ACA's attention to health insurance coverage and enrollment could affect other populations served by the child welfare agency. States will likely vary in how they implement the required and optional changes to Medicaid law. Therefore, it is not entirely clear how states will address health insurance coverage for children who come in contact with child welfare services—even if they are not removed from their homes—and their families. The following brief discussion highlights some areas that may provide new opportunities for serving child welfare-involved children and their families.

Children and Families Served in the Home

Child welfare agencies—principally through investigations or other assessments related to alleged child abuse or neglect—come into contact with many more children beyond those who enter foster care. Research indicates that this larger group of children—including children who remain in their homes after an investigation—have greater health care needs than the general

⁹² Section 9529 of the Consolidated Budget and Reconciliation Act (COBRA) of 1985 (P.L. 99-272) made this residency stipulation applicable to any child receiving Title IV-E assistance (whether foster care or adoption assistance). See also 42 CFR 435.403(g).

⁹³ For more information, see related AAICAMA FAQs at <http://aaicama.org/cms/index.php/frequently-asked-questions-faqs>.

⁹⁴ Wyoming is the only state not a part of the ICAMA. AAICAMA, "COBRA Option/Reciprocity as of October 2011." For more information on ICAMA see <http://aaicama.org/cms/index.php/the-icama>.

⁹⁵ AAICAMA FAQ, "What is meant by the term COBRA reciprocity in reference to state-funded adoption assistance and Medical assistance?" http://aaicama.org/cms/medicaid-docs/Medicaid_SF_COBRA_rec.pdf

population.⁹⁶ In a nationally representative study of children who came into contact with child welfare services and remained in the home, with or without services, caregivers reported that 78% of children were in excellent or very good health, compared to 84% of children generally.⁹⁷ Further, these children tended to live in homes with little income. Close to 60% were in homes with income below the poverty level.⁹⁸ The parents or caregivers of children who remain in the home following a child welfare investigation also had significant health and mental health needs. In fact, such caregivers were less likely to report having excellent or very good health (45% versus 68%) than adults generally, including caregivers of children who were removed from the home. Although these caregivers mostly had mental health outcomes similar to adults in the general population, they were more likely to have major depression within the past 12 months (25% versus 7%).⁹⁹

At the same time, children in families who come into contact with child welfare services but are not placed in foster care are less likely to be enrolled in Medicaid than those children who are placed in foster care. Using supplemental data from the same study referenced above, researchers found that of the children who remained in their own homes following an investigation of abuse or neglect, about 66% were covered under mandatory Medicaid eligibility pathways and another 18% were covered through optional Medicaid pathways. Approximately 16% were ineligible for Medicaid. The study also found that less than 1% of children in foster care were ineligible for Medicaid.¹⁰⁰

The emphasis in health care reform on enrollment of all individuals, including low-income families who do not qualify for Medicaid or CHIP, may provide new opportunities for child welfare agencies to ensure access to health insurance coverage for a greater share of the children and adults they serve. For example, families could gain access to counseling through Medicaid, which may in turn strengthen these families and reduce the risk of abuse and neglect.

Families of Children Entering Foster Care

ACA may also provide greater opportunities for a child welfare agency to provide mental health or other Medicaid-supported services to the *parents* of children entering foster care. These services may be required so that the child and parents can be reunited. However, under existing

⁹⁶ Post-investigative services are provided in the home or community and are intended to strengthen the family, among other purposes. These services can include respite care for parents and other caregivers; caseworker visits and other casework provided or arranged supports for the family; early developmental screening of children to assess needs and to provide assistance in obtaining relevant services; mentoring, tutoring, and health education for youth; a range of center-based activities (informal interactions in drop-in centers, parent support groups); services designed to increase parenting skills; and counseling and home visiting activities. Federal funding for these services is provided primarily through programs under Title IV-B of the Social Security Act.

⁹⁷ U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation, *National Survey of Child and Adolescent Well-Being (NSCAW) II Baseline Report: Child Well-Being*, pp. 3-4, 17, August 1, 2011.

⁹⁸ U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation, *National Survey of Child and Adolescent Well-Being (NSCAW) Baseline Report: Introduction to NSCAW II*, p. 10, August 1, 2011.

⁹⁹ U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation, *National Survey of Child and Adolescent Well-Being (NSCAW) II, Baseline Report: Caregiver Health and Services*, pp. 4-5, 19-22, August 1, 2011.

¹⁰⁰ Anne M. Libby, "Child Welfare Systems Policies and Practices Affecting Medicaid Health Insurance for Children: A National Study," p. 44.

Medicaid rules (until 2014), parents whose children are placed out-of-home may be vulnerable to losing eligibility for Medicaid because of the change in their household composition. The mandatory eligibility rules for Medicaid generally provide that in addition to being low income, applicants must be living with their children (or be pregnant, disabled, or elderly). Thus, a child's placement in foster care could mean a potential loss of Medicaid for the parent and a loss of access to services that may be needed to allow the child(ren) to return to living with the parent.

Prior to ACA, states could opt to cover childless adults under Section 1115 demonstration waivers. Otherwise, childless adults were ineligible for the Medicaid program. States that implement the new ACA expansion pathway for certain low-income adults under age 65 should ensure an eligibility pathway remains open for any low-income adult—regardless of whether that adult's child is placed in foster care.

Private Health Insurance Reforms Affecting the Child Welfare Population

According to a nationally representative survey of children in families who come into contact with the child welfare system, approximately 63% of those who were insured had Medicaid coverage and another 26% had private insurance. The remaining children (10%) were uninsured. At the three-year follow-up, those with private insurance remained at 26%, those with Medicaid coverage increased slightly to 67%, and those without insurance declined to 6%.¹⁰¹

Private health insurance also plays a significant role for children who are adopted or who age out of foster care. With respect to adopted children who were previously in foster care, a survey of adoptive parents found that 94% were continuously insured for the prior 12 months, with 37% through private health insurance.¹⁰² A separate study of former foster youth in three states showed that by age 26, nearly six out of 10 had health insurance. Of those who had coverage, just over 20% had private insurance from an employer or through the individual health insurance market (see **Table A-1** in **Appendix A**).¹⁰³

Furthermore, the research literature has found that individuals with a child welfare history may struggle to maintain health insurance or have medical conditions that limit their ability to obtain insurance. For example, a study of such youth ages 18 through 20 in eight Midwestern counties found that 67% lost health insurance coverage within an average of three months of leaving foster

¹⁰¹ Each set of numbers totals 99% because of rounding. Ramesh Raghaven et al., “Longitudinal Patterns of Health Insurance Coverage Among a National Sample of Children in the Child Welfare System,” *American Journal of Public Health*, March 2008, vol. 98, no. 3.

¹⁰² This same 2007 survey found that 75% of children adopted from foster care had an adoption assistance agreement with the state child welfare agency that included Medicaid. This means that some of the 37% of children adopted from foster care who were covered by private insurance were also covered by Medicaid. In these instances, Medicaid may provide wrap around for services not covered by the private health insurance plan. Sharon Vandivere, Karin Malm, and Laura Radel, *Adoption USA: A Chartbook Based on the 2007 National Survey of Adoptive Parents*, Washington, D.C., U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary of Planning and Evaluation (ASPE), 2009, pp 23-24; and Karin Malm, Sharon Vandivere, Amy McKlindon and Laura Radel, “Children Adopted from Foster Care: Adoption Agreements, Adoption Subsidies, and Other Post-Adoption Supports,” HHS, ASPE Research Brief, May 2011, p. 8.

¹⁰³ Courtney et al., *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 26*.

care and only about one-fourth of those regained coverage after an average period of eight months.¹⁰⁴ The prevalence of chronic conditions in persons that have been in foster care has been estimated to be between 44% and 82%.¹⁰⁵

Given the role private insurance plays in the lives of many individuals with experience in the child welfare system, the rules governing that market for health insurance are relevant to this population, especially those with physical and/or mental health care needs. Prior to ACA, the ability of many individuals to gain and maintain coverage in the private market was limited to some degree by the health status of the individual. For example, prior to health care reform, some insurance applicants with a preexisting condition could be denied coverage altogether; be issued coverage that excluded benefits that would treat the preexisting condition; or be charged more in premiums because of that condition, then allowed under state and federal law at the time.

Selected Private Health Insurance Reforms under ACA

ACA includes reforms that are designed to provide additional private coverage options to individuals and families generally, while prohibiting certain insurance practices such as excluding coverage for preexisting health conditions.¹⁰⁶ The ACA insurance reforms discussed below may be particularly relevant for young adults who were formerly in foster care, children who leave care and are reunited with their families, parents of children who are or were in foster care, and parents of children who are adopted from foster care. These reforms are grouped according to effective date—“immediate”¹⁰⁷ or 2014.

“Immediate” Health Insurance Reforms and Programs

With the high prevalence of health conditions (chronic and acute) in individuals with experience in the child welfare system, ACA’s temporary high risk pools (HRPs) are one potential insurance option.¹⁰⁸ The temporary HRP program is intended to provide transitional coverage for uninsured individuals with preexisting conditions until January 1, 2014, when ACA’s insurance reforms, including the prohibition against preexisting condition exclusions, become fully effective.¹⁰⁹ The temporary federal HRP program can be administered by either the state or the U.S. Department of Health and Human Services (HHS). The HHS-administered temporary HRPs are collectively

¹⁰⁴ Ramesh Raghavan, Peichang Shi, Gregory A. Aarons, Scott C. Roesch, and J. Curtis McMillen, “Health Insurance Discontinuities Among Adolescents Leaving Foster Care,” *Journal of Adolescent Health*, Volume 44, Issue 1, pp. 41-47 (January 2009).

¹⁰⁵ Sandra Jee, Richard Barth, Moira Szilagyi, Peter Szilagyi, Masahiko Aida, and Matthew Davis, “Factors Associated with Chronic Conditions among Children in Foster Care,” *Journal of Health Care for the Poor and Underserved*, 2006, vol. 17, no. 2, pp.328-341.

¹⁰⁶ Prior to ACA’s new insurance reforms, many states had already taken related steps in reforming their own insurance markets. Post-ACA enactment, states retain the role of primary regulator of the business of insurance. Therefore, each state decides the extent to which it will actively monitor and enforce ACA’s market reforms, in addition to other applicable federal and state requirements.

¹⁰⁷ ACA was enacted on March 23, 2010. Immediate is generally applicable to plan or policy years beginning on or six months after ACA enactment, i.e., as of September 23, 2010. Many plan or policy years follow the calendar year, but there is no requirement regarding which month a plan or policy year must begin or end.

¹⁰⁸ For additional information about the temporary high-risk pool program, see CRS Report R41235, *Temporary Federal High Risk Health Insurance Pool Program*, by Bernadette Fernandez.

¹⁰⁹ Section 1201 of the Patient Protection and Affordable Care Act (ACA); Section 2704 of the Public Health Services Act (PHSA).

known as the Pre-Existing Condition Insurance Plan (PCIP) and are operated by the Government Employees Health Association, Inc. (GEHA), a nonprofit insurance carrier.¹¹⁰ States that operate their own temporary HRPs may use a different name and insurance carrier.¹¹¹ To be eligible for the temporary HRPs, an individual must have a preexisting condition, as determined by HHS, and be a citizen or national of the United States or be lawfully present in the United States. Eligible individuals must also have been without “credible coverage” for a six-month period prior to the date on which he or she is applying for coverage through the federal HRP program.¹¹²

ACA includes several other “immediate” insurance reforms that are particularly relevant to the child welfare population. For example, ACA prohibits (1) lifetime limits¹¹³ on the dollar value of essential health benefits,¹¹⁴ and (2) annual limits on those same benefits, but allows limits defined by HHS as “restricted.”¹¹⁵ ACA also generally prohibits the retroactive cancellation of coverage, except in cases where the covered individual committed fraud or made an intentional misrepresentation.¹¹⁶ In addition, ACA currently prohibits coverage exclusions for preexisting health conditions¹¹⁷ in children under age 19 (as of January 1, 2014, ACA will prohibit coverage exclusions for preexisting health conditions for all individuals regardless of age).

Children age 18 and older who were formerly in foster care, including those who are adopted, may also have expanded private insurance coverage opportunities through extension of coverage from an insured parent. Health plans that provide dependent coverage must extend that existing coverage to children under age 26. However, certain health plans are exempt from this requirement if the adult child has an offer of coverage from his/her employer.

¹¹⁰ Government Employees Health Association, Inc., “Pre-Existing Condition Insurance Plan administered by GEHA: Benefits Summary,” July 2010, available at <http://www.pciplan.com/forms/pdfs/BenefitsSummary.pdf>.

¹¹¹ For a listing of the state-administered temporary HRPs, see <http://www.healthcare.gov/law/features/choices/pre-existing-condition-insurance-plan/index.html>.

¹¹² Creditable coverage is defined by Section 2701(c) of the PHSA as a group health plan, health insurance coverage, Medicare Part A or Part B, Medicaid, coverage from the Department of Defense, a medical care program of the Indian Health Service (IHS), a state health benefits risk pool, the Federal Employee Health Benefits Program (FEHBP), a public health plan (as defined in regulations), or a health benefit plan under the Peace Corps Act.

¹¹³ Limits essentially cap the amount that a plan will pay out for medical claims, either over the course of an individual’s life or on an annual basis. Once a covered individual reaches the dollar value limit, s/he is fully responsible for all additional medical expenses.

¹¹⁴ ACA requires certain health plans to provide “essential health benefits.” Such benefits were not explicitly listed in the law. Instead, ACA listed ten broad benefit categories, meant to establish a federal floor with respect to minimum level of benefits covered by a plan.

¹¹⁵ ACA allows health plans to impose annual dollar limits, prior to 2014, but they are restricted according to amounts specified in regulation. The interim final rule on annual limits adopts a three-stage approach for the restricted annual limits. Under these regulations, annual limits may not be less than the following amounts: (1) for plan years beginning on or after September 23, 2010, but before September 23, 2011: \$750,000; (2) for plan years beginning on or after September 23, 2011, but before September 23, 2012: \$1.25 million; and (3) for plan years beginning on or after September 23, 2012, but before January 1, 2014: \$2 million.

¹¹⁶ This insurance practice is known as “rescission.” It is not a common practice, but if a policy is rescinded, it generally occurs after a policyholder has generated large medical claims. Usually the insurer attributes those claims to a medical condition that existed prior to the policyholder obtaining health coverage. In such instances, an insurer will generally justify the rescission by claiming that if it knew about the policyholder’s preexisting condition during the insurance application process, it would not have issued the insurance policy in the first place.

¹¹⁷ A “preexisting health condition” is a medical condition that was present before the date of enrollment for health coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

With respect to other circumstances and characteristics of the child seeking coverage through a parent's insurance, the interim final rule on ACA's dependent coverage provisions clarified that a health plan may not deny or restrict coverage for a child who has not attained age 26 "based on the presence or absence of the child's financial dependency (upon the participant or any other person), residency with the participant or with any other person, student status, employment, or any combination of those factors."¹¹⁸ Moreover, health plans "may not limit dependent coverage based on whether a child is married."¹¹⁹ Still, young adults who leave foster care (and are otherwise ineligible under the new mandatory Medicaid pathway beginning in 2014) may not necessarily gain coverage under this reform measure, given that some of these young people may not have relationships (or may have strained relationships) with their parents or their parents may not have access to employer sponsored health insurance.

Health Insurance Reforms and Programs Effective in 2014

ACA establishes the American Health Benefits Exchanges ("exchanges") that will be operational beginning in 2014. Exchanges will not be insurers, but will provide individuals and small businesses with access to private health insurance plans. In general, exchange plans will provide comprehensive coverage and meet all applicable market reforms specified in ACA. Nearly all individuals will be allowed to purchase insurance in the exchanges. These exchanges could benefit parents of children who return home from foster care and of children adopted from care, as well as individuals that have aged out (as long as they meet the eligibility criteria).¹²⁰

Also beginning in 2014, federal tax credits will be made available to certain low-to-middle income individuals and families to make exchange coverage more affordable. In addition, some of those tax credit recipients will receive subsidies to reduce their out-of-pocket spending on medical expenses. Such financial assistance may be particularly relevant to youth who age out and the parents of children who return home from foster care or are adopted from care.

A number of ACA's insurance reforms are designed to provide protection to potentially vulnerable groups with a high prevalence of preexisting conditions, such as youth previously in foster care. Among ACA's reforms are provisions that will subject most health plans to the following requirements:

- Exclusion of coverage for preexisting health conditions is prohibited, regardless of the age of the covered individual. (Excluding coverage for preexisting conditions refers to the practice in which an applicant is offered a health insurance policy but that policy does not provide benefits for certain medical conditions.)
- Basing eligibility for coverage on health status-related factors is prohibited. (Such factors include health status; medical condition, including both physical and mental illness; claims experience; receipt of health care; medical history;

¹¹⁸ "Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under ACA," *Federal Register*, Vol. 75, No. 92, May 13, 2010, p. 27136, available at <http://www.regulations.gov/contentStreamer?objectId=0900006480aecb7d&disposition=attachment&contentType=html>.

¹¹⁹ *Ibid.*, p. 27124.

¹²⁰ Individuals may enroll in an exchange plan if they are (1) residing in a state in which an exchange was established; (2) not incarcerated, except individuals in custody pending the disposition of charges; and (3) lawful residents.

genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; disability; and any other health status-related factor determined appropriate by HHS).

- Waiting periods greater than 90 days are prohibited. (A “waiting period” refers to the time period that must pass before an individual is eligible to obtain health benefits.)
- Coverage is required to be offered on a guaranteed issue and guaranteed renewal basis. (“Guaranteed issue” in health insurance is the requirement that a health plan accept every applicant for health coverage as long as the applicant accepts the terms of the coverage, such as the premium. “Guaranteed renewal” in health insurance is the requirement that a plan renew group coverage at the option of the plan sponsor (e.g., employer) or individual coverage at the option of the policyholder. Guaranteed issue and renewal alone would not guarantee that the insurance offered is affordable.)
- The use of adjusted community rating rules is required.¹²¹ (“Adjusted, or modified, community rating” prohibits health plans from pricing insurance based on health factors, but allows pricing to be based on other key characteristics such as age or sex.) Under the law, premiums will be allowed to vary based on the following factors: self-only or family enrollment; geographic area; age (within limits); and tobacco use (within limits).
- Imposing annual cost-sharing requirements that exceed specified dollar values is prohibited beginning in 2014. These cost-sharing limits would be annually adjusted thereafter by the rate of growth in health insurance premiums.¹²²

Issues and Challenges

While federal policies regarding child welfare, Medicaid, and private health insurance seek to address the unique health-related issues facing individuals in the child welfare system, challenges to ensuring the health care needs of these children are met remain.

Cross-Agency Collaboration

A multi-state study of health care services by children in foster care (carried out by the Department of Health and Human Services (HHS), Office of the Inspector General (OIG) from 2003-2005) suggested a role for both state child welfare and Medicaid agencies in improving health care services.¹²³ The OIG found that access to health care services for children in foster care who are Medicaid beneficiaries may be hampered by lack of Medicaid providers (or

¹²¹ Section 1201 of ACA (new PHSA Section 2701).

¹²² Section 1302(c) of ACA.

¹²³ The HHS/OIG conducted these studies in eight states and made findings and recommendations specific to issues identified in each of those states. (The reports are available on the reports publications website of the HHS OIG website <http://oig.hhs.gov>.) For overall recommendations see HHS, OIG “Children’s Use of Health Care Services While in Foster Care: Common Themes,” Memorandum to Susan Orr, Associate Commissioner for the Children’s Bureau, ACF and Dennis G. Smith, Director of CMS, from Brian Ritchie, Acting Deputy Inspector General for Evaluation and Inspections, July 2005 (OEI-07-00-00645).

providers of a specific service) in a given area; failure of child welfare caseworkers and foster care providers to know about Medicaid services as well as the state time tables for provision of those services; failure of state Medicaid and child welfare agencies to fully document services provided; and failure of state child welfare agencies to provide complete health care information to foster care providers. Additionally, a more recent study finding that not all child Medicaid beneficiaries received the preventive screenings covered by EPSDT and suggested a lack of knowledge on part of Medicaid providers about what those screenings are to include may be a part of the reason.¹²⁴

With the 2008 enactment of the Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351), federal law requires each state to ensure that the child welfare agency and the agency that administers Medicaid work together to develop a health oversight and coordination plan applicable to each child in foster care. Given the distinct roles played by the state child welfare agency (which acts as a de facto parent to children in foster care) and the state Medicaid agency (which provides health insurance coverage to foster children, along with many other vulnerable populations) the exact nature of the collaboration is uncertain.

Federal guidance on how to accomplish cross-agency cooperation in the implementation of the health care oversight plan has been limited. However, a November 2011 joint letter from the administrators of ACF, CMS and SAMHSA to their state-level counterparts provides some concrete examples primarily in the context of better overseeing the use of psychotropic medication for youth in foster care.¹²⁵ Awareness raising, training, and technical assistance – including opportunities for agency leaders to meet – are highlighted for all three agencies (and their state level counterparts). For example, ACF plans to provide more resources related to recommended guidelines for medication oversight and to instruct state child welfare agencies on preparing and including protocols for use of psychotropic medication in state planning documents; SAMHSA is committed to finalizing guidelines for use of psychotropic medication for children and youth for community service providers; and CMS intends to continue efforts to refine and develop children’s health care quality measures (including measures related to behavioral health) as well as working with states to use Drug Utilization Review to help monitor drug prescriptions, including psychotropic medications.

The November 2011 letter also suggests ways that additional health oversight plan items might be acted on – including efforts to adopt use of the medical home concept by state Medicaid agencies (as permitted by Section 2703 of ACA); further development of electronic health records use by these agencies; and development of additional resources by SAMHSA for health and mental health providers related to both addressing trauma and engaging youth in their treatment.

While this letter is suggestive of ways that collaboration might happen, guidance on collaboration related to many items of the health oversight plan is not available¹²⁶ and agencies may be

¹²⁴ HHS, OIG, “Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services,” May 2010 (OEI-05-08-00520).

¹²⁵ Joint HHS Letter from George Sheldon, Acting Assistant Secretary, ACF; Donald Berwick, Administrator, CMS; and Pamela Hyde, Administrator, SAMHSA to “State Director,” November 23, 2011. <http://www.childwelfare.gov/systemwide/mentalhealth/effectiveness/jointlettermeds.pdf>

¹²⁶ For example, the oversight plan refers to communicating with youth leaving foster care about issues involving serious illness and death and helping them execute legal documents. Child welfare agencies may lack expertise to do this work (especially for youth with cognitive disabilities) and in developing educational resources for the youth, child welfare agencies might look to the state Medicaid agency and/or the Attorney General’s office (or other legal (continued...))

challenged to find the resources, including time, for establishing and maintaining collaboration around improving the quality of health care for children in foster care.

Communicating Across Programs

Both Medicaid and the child welfare program authorized under Title IV-B and Title IV-E of the Social Security Act are federal-state programs with complex federal policy and data reporting requirements. Currently even the most basic language used in one program (both in the statute and/or for purposes of data reporting) does not translate to the other.

For example, for the state child welfare agency a child in foster care generally means a child for whom a court has given the agency 24-hour care and placement responsibility. Once the court relieves the state child welfare agency of that responsibility (either because the child with court sanction leaves care to a permanent home via adoption, guardianship, or reunification, or because the child reaches the state age of majority and is “emancipated” by the court) the child is no longer considered a child in foster care. By contrast for purpose of reporting Medicaid data to the federal government, “foster care children” appear primarily determined by Medicaid’s mandatory Title IV-E eligibility pathway.¹²⁷ This group of beneficiaries includes some children in foster care (only the part of a state’s foster care caseload that is eligible for Title IV-E foster care assistance), as well as children who leave foster care for adoption or legal guardianship (provided those children meet a different set of Title IV-E eligibility criteria).

In FY2010 about 70% of the children receiving Title IV-E assistance were, in fact, children who had left foster care for adoption. Therefore the major mandatory eligibility category – referred to in the Medicaid program as serving “foster care children” may well include more adopted enrollees than foster care enrollees.¹²⁸ Further many other children who are in foster care (as understood by the child welfare agency) but who do not meet the Title IV-E eligibility criteria and who therefore are enrolled in Medicaid via other eligibility pathways (e.g., low income or SSI)

(...continued)

department) for assistance. (This issue was raised by state officials at a July 20, 2010 meeting convened by the HHS/ACF regarding older youth in foster care and those who age out of foster care.)

¹²⁷ For purposes of reporting state Medicaid data to the federal government (via MSIS) children who are classified as “foster care children” include 1) children eligible under the mandatory pathway tied to Title IV-E eligibility (including those eligible for Title IV-E adoption, foster care, and kinship guardianship assistance); 2) children covered under the optional pathway related to state-funded adoption assistance agreements; and 3) youth who age out of care (“independence adolescents”) and are covered by the Chafee option. While there is also reference in the MSIS codebook (release 3.1, August 2010) to including “children with special needs covered by State foster care payments” in the foster care children eligibility category, in the absence of any specific statutory or regulatory citation that indicates who is included in that group (and given that federal child welfare policy does not seem to include a concept of “special needs children in foster care”), it is unclear how it might be interpreted at the state level. The statutory and regulatory cites referred to in the MSIS codebook for “foster care children” are 1) Section 1902(a)(10)(A)(i)(I) of the Social Security Act and Section 42 CFR 435.145 (for the mandatory Title IV-E pathway); 2) Section 1902(a)(10)(A)(ii)(VIII), as added by Section 9529 of P.L. 99-272 (for the state-funded adoption assistance pathway); and 3) [Section 1902(a)(10)(A)(ii)(VXII), as added by Section 121 of the] Foster Care Independence Act of 1999 (for Chafee option youth).

¹²⁸ At the same time data reported in MSIS is primarily concerned with Medicaid *beneficiaries*, rather than *enrollees*. There is some reason to believe that Title IV-E children in foster care may be more frequent beneficiaries than those who are Title IV-E children receiving adoption assistance. That’s because the latter group appears more likely than the former to be covered by both private insurance and under Medicaid’s third party liability rules, the private insurer would be required to pay any covered benefit before Medicaid may be held liable. For more information see **Appendix B**.

may not be understood by Medicaid administrators as children in foster care. This could affect the ability to understand research on services provided to children in foster care (across both agencies) as well as ability of Medicaid to administer requirements applicable to children in foster care without regard to their Title IV-E eligibility (e.g., restrictions on TCM claiming related to any child in foster care, or prohibition on mandatory enrollment in benchmark programs also eligible to any child in foster care).

Additionally, changes to federal child welfare policy made by the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) broadened Title IV-E eligibility and consequently expanded the pool of children eligible for mandatory Medicaid enrollment. In some instances the broadened eligibility is applicable across all states (but on a phased in basis) and in other instances it is tied to state child welfare agency options (i.e., the agency may amend its Title IV-E plan to include certain additional groups of children as eligible). To ensure access to and continuity of Medicaid enrollment for these new groups of eligible children, state child welfare agencies may need to communicate the changes made in their Title IV-E plan to the state Medicaid agency.¹²⁹

Disruptions in Medicaid Coverage for Children in Foster Care and Leaving Care

While nearly all children in foster care are eligible for Medicaid, some may receive this coverage immediately upon placement but, coverage may lapse when they change placements, including when they return home to their families. Children who enter care may not gain Medicaid coverage if they are in care for a shorter period than the amount of time it takes to establish Medicaid eligibility. As discussed above, researchers found that nearly all states had mechanisms to minimize enrollment delays (including immediate or presumptive eligibility), but in nearly a third of child welfare cases, applications for Medicaid were submitted at least seven days after the child entered foster care.¹³⁰

Children may also lose Medicaid coverage when they return home to their parents. In a nationally representative study of children in families who come into contact with the child welfare system, researchers found that the child's placement in foster care—and not characteristics of the child or a caregiver (a parent or foster care caregiver)—was most influential in whether a child retained Medicaid coverage. Children in foster care placements were more likely to gain coverage, because eligibility while they are in care is frequently based on their eligibility status for federal foster care under Title IV-E of the Social Security Act. At the same time, those who transitioned back to their own homes were more likely to lose Medicaid coverage.¹³¹ Discharge from foster care would prompt a Medicaid eligibility review that might result in a loss of coverage if an alternative eligibility pathway (i.e., other than the child's eligibility for the Title IV-E foster care program) could not be established.

¹²⁹ This issue is raised in HHS, CMS, Family and Children's Health Programs Group, Letter to Associate Regional Administrators [regarding impacts on Medicaid eligibility from the Fostering Connections to Success and Increasing Adoptions Act of 2008] (P.L. 110-351), April 15, 2009. Available at http://aaiacama.org/cms/federal-docs/CMS_MA_Elig_FostConnect_0409.pdf.

¹³⁰ Anne M. Libby et al., "Child Welfare Systems Policies and Practices Affecting Medicaid Health Insurance for Children: A National Study," pp. 44-45.

¹³¹ Ramesh Raghaven et al., "Effects of Placement Changes on Health Insurance Stability Among a National Sample of Children in the Child Welfare System," *Journal of Social Service Research*, vol. 35, no. 4, pp. 352-363.

A 2003 report from the Kaiser Commission on Medicaid and the Uninsured identified procedural barriers to maintaining Medicaid that can produce gaps in health care coverage for children who return home after being reunified with their parent(s).¹³² Among the challenges cited were frequent eligibility reviews and paperwork, complex forms for renewing coverage, cumbersome renewal procedures, and lack of coordination upon renewal for children whose eligibility shifts between Medicaid and separate CHIP programs. In addressing loss of Medicaid eligibility for children in care, the report suggests that states should monitor the loss of coverage at foster care discharge through the state's existing process for reviewing cases of children whose Medicaid coverage has been terminated, denied, or suspended. As part of this process, states could also monitor changes in Medicaid coverage for specific subpopulations through what are known as alternative case action reviews. Such reviews could be targeted to children in care to learn more about the extent to which children leaving care lose Medicaid coverage and the reasons for losing such coverage.

Implementation of the New Pathway for Young Adults Formerly in Foster Care

The requirement that states provide Medicaid coverage to youth who have aged out of foster care up to their 26th birthday parallels a requirement made by ACA that applies to the private health insurance sector. Specifically, the law requires health insurance carriers to allow (but not require) most children under age 26 to enroll in their parent's health plan. The effective dates for these provisions vary, however. This requirement became effective in 2010 for some plans. In contrast, the Medicaid pathway for former foster youth becomes effective on January 1, 2014. In short, some of these young adults may not have coverage for at least a few years (and in fact may age out during that time), while others without coverage may be more likely to gain coverage via their biological parents' insurance plans, if their parents have access to such a plan. In a study of former foster youth in Midwest states who were age 23 or 24 in 2008 and 2009 (before ACA was enacted), about 2% had coverage under their parents' plan compared to about 13% of their same-age peers.¹³³ By age 26 (in 2010 and 2011, as the private health insurance requirement was going into effect), about 1% to 2% of former foster youth and their same-age peers were covered through their parents' insurance.¹³⁴ This could be due to the fact that at the time of the study, nearly all of the young people would not have been eligible to be covered under their parents' plan by virtue of reaching age 26.

Although the intent of the law may be to extend a new Medicaid eligibility pathway to any young person who was in foster care on their 18th birthday (or a higher age at the state's option), the provision raises questions. For example, would a youth be eligible if she/he lives in a state that allows young people to remain in foster care beyond age 18 but that youth decides to leave care upon reaching age 18? Age 18 is the legal age of majority in most states. If a state extends care until age 21, it is unclear whether former foster youth who exited at age 18 or 19 would be

¹³² Pat Redmond, Center on Budget and Policies Priorities for the Kaiser Commission on Medicaid and the Uninsured, *Children Discharged from Foster Care: Strategies to Prevent the Loss of Health Coverage at a Critical Transition*, January 2003, pp. 11-16, <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14317>.

¹³³ Courtney et al., *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Ages 23 and 24*.

¹³⁴ Courtney et al., *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 26*.

eligible under the new pathway. Also, would a young person be eligible through this pathway if they aged out prior to 2014 and are under the age of 26 when this provision takes effect?

Varying Income Counting Rules Across Medicaid Eligibility Pathways

Unlike nearly every other mandatory Medicaid eligibility pathway, income rules do not always apply for certain child welfare populations. Specifically, the Medicaid provision (effective on January 1, 2014) for young adults who age out of foster care does not require those youth to meet any income rules. Further, under current law, the adoptive parents or legal relative guardians of children who have left care but remain eligible for Title IV-E kinship guardianship assistance payments or adoption assistance agreements also do not need to meet any income rules in order for those children to be eligible for Medicaid. However, for children receiving Title IV-E foster care maintenance payments or Title IV-E kinship guardianship assistance payments there are income eligibility rules that are tied to the home from which the child was removed to foster care. Income eligibility rules tied to a child's "home of removal" currently apply, as well, to a declining share of those children covered by Title IV-E adoption assistance agreements. (This means the income of the child's biological—rather than their adoptive family—is relevant to his/her Medicaid eligibility pathway.) However, changes made in federal child welfare policy will effectively remove (as of FY2018) all income rules associated with Medicaid eligibility of a child on whose behalf a Title IV-E adoption assistance agreement is in place. (Those rules however are to be retained for children in foster care as well as those who leave foster care for guardianship.)

Further, beginning in 2014, income eligibility for most Medicaid eligibility groups will be based on Modified Adjusted Gross Income (MAGI).^{135,136} The transition to MAGI income counting rules for most Medicaid-eligible populations (e.g., most nondisabled children, parents, pregnant women, and other caretaker relatives) was intended, in part, to reduce the variability and complexity of the definition of income under the current Medicaid program.¹³⁷ The new MAGI income counting rules will make the Medicaid program's categorical eligibility requirements moot for most individuals. However, Congress chose to retain (or create new) categorical eligibility criteria for certain Medicaid-eligible populations. Specifically, and among others groups, categorical eligibility requirements were retained for some children in foster care, most children who leave foster care for adoption, some children who leave foster care for kinship guardianship, and (as of January 1, 2014) all youth who age out of foster care. The categorical eligibility criteria tied to some of these populations include income and resource rules that do not conform to MAGI. Going forward, it remains to be seen how Medicaid agencies will balance the move toward administrative simplicity promoted by the use of MAGI, while continuing to capture the detailed information necessary to make the categorical and financial distinctions that

¹³⁵ MAGI is defined as the Internal Revenue Code's (IRC's) adjusted gross income (AGI) plus certain foreign earned income and tax-exempt interest. AGI reflects a number of deductions, including trade and business deductions, losses from sale of property, and alimony payments, increased by tax-exempt interest and income earned by U.S. citizens or residents living abroad.

¹³⁶ For information on modifications to the MAGI income counting rule that were enacted subsequent to ACA's enactment see CRS Report R41997, *Definition of Income in ACA for Certain Medicaid Provisions and Premium Credits*, coordinated by Janemarie Mulvey.

¹³⁷ See U.S. Department of Health and Human Services, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," 76 *Federal Register* 51142, August 17, 2011.

will be required in determining Medicaid eligibility for groups that are exempt from the MAGI income counting criteria.¹³⁸

Balancing State Fiscal Constraints

Beginning in 2014, states will have a choice as to whether they will accept or reject the new ACA expansion funds and requirements that come with those funds to extend Medicaid coverage to certain individuals under the age of 65 with income up to 133% FPL. States that choose to extend coverage to the ACA expansion group may enable more families with children in foster care to qualify for Medicaid. Medicaid (and CHIP) program rules provide states with numerous tools to promote enrollment, retain coverage, and facilitate eligibility renewal (e.g., state use of electronic data matches to obtain or verify information at the time of enrollment and/or renewal; reliance on presumptive eligibility determinations to enable certain Medicaid-eligible populations to receive care until a formal eligibility determination has been completed; use of 12 months of continuous eligibility regardless of fluctuations in family income, assets, or other circumstances; etc.).¹³⁹ In general, states also use these same tools to reduce program enrollment and control program costs during times of fiscal constraint.¹⁴⁰ While ACA includes enhanced federal matching funds to assist states with some of the costs associated with anticipated program growth, states will likely face an increase in their Medicaid spending. Thus, state fiscal challenges will continue to be a primary focus as states attempt to balance the costs associated with Medicaid's future expanded role in providing insurance coverage for low-income populations and ongoing state fiscal pressures during economic downturns.

Accessing Private Health Insurance

ACA includes several “immediate” private health insurance reforms that are particularly relevant to this population. For example, ACA prohibits (1) lifetime limits on the dollar value of essential health benefits and (2) annual limits on those same benefits, except for limits defined by HHS as “restricted.” Prior to ACA, the ability of many individuals to gain and maintain coverage in the private market was limited to some degree by their health status. However, youth aging out of foster care may continue to struggle to obtain private health insurance until full implementation of ACA’s insurance reforms and programs in 2014, including the establishment of American Health Benefits Exchanges. These exchanges will provide new opportunities for individuals to access private health insurance, and provide access to premium tax credits and cost-sharing subsidies offered through the exchanges to make coverage in the private insurance market more affordable for former foster youth who are no longer eligible for Medicaid.

¹³⁸ See U.S. Department of Health and Human Services, “Medicaid Program: Eligibility Changes Under the Affordable Care Act of 2010; Final Rule,” *77 Federal Register* 57, March 23, 2012.

¹³⁹ For more information on state use of these and other eligibility and enrollment simplification strategies, see Kaiser Commission on Medicaid and the Uninsured, *Holding Steady, Looking Ahead: Annual Finding of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and CHIP, 2010-2011*, January 2011, <http://www.kff.org/medicaid/upload/8130.pdf>.

¹⁴⁰ Because states are prohibited from curbing the cost of Medicaid through restricting eligibility standards, methodologies, or procedures due to the Maintenance of Effort Requirements (MOE) requirements included in the American Recovery and Reinvestment Act (ARRA, P.L. 111-5) and ACA, states have focused cost containment strategies on reducing provider rates, making changes to their benefit packages, or implementing limitations on the use of benefits. However, states want greater flexibility to restrain their Medicaid expenditures through eligibility restrictions.

Once the exchanges are operational, this population may struggle to assess all the insurance options potentially available to them, and to find their way through government and corporate bureaucracies to obtain the most appropriate coverage. ACA provides consumer assistance for prospective enrollees in exchanges. Specifically, ACA requires exchanges to establish a grant program for “Navigators,” which would receive funding from exchanges (not the federal government) to conduct public education activities. Those activities will include information about the availability of exchange plans, based on fair and impartial information on enrollment in plans and subsidies. However, it is not clear which organizations could best serve as Navigators for this special population, nor what the costs would be. Finally, staff in child welfare and Medicaid agencies and those who run the state exchanges must be trained to understand the new law and its implementation in their state to enable them to assist applicants in obtaining insurance.

Appendix A. Research on the Health Needs of Current and Former Foster Children and Youth

Children in Foster Care

As discussed above, children who are placed in foster care are at a higher risk of having a medical, social, or behavioral disability than children in the general population. Select research further highlights these health care issues.

In a CRS analysis of 2008 total fee-for-service spending in Medicaid,¹⁴¹ expenditures for nondisabled children coded as “foster care children”¹⁴² in the Medicaid Statistical Information System (MSIS)¹⁴³ outpaced expenditures for all other groups of nondisabled children served by the program. Although these foster care children represented only 3% of the nondisabled Medicaid child recipients in FY2008, they accounted for 10% of expenditures for all children.¹⁴⁴

¹⁴¹ There are two major types of service delivery systems under Medicaid: fee-for-service (FFS) and managed care (MC). Under a FFS model, states pay providers directly for each covered service received by the Medicaid beneficiary. Under MC, states typically pay a monthly fee to a managed care plan for each person enrolled in the plan. The managed care plan then pays providers for the Medicaid services an enrollee receives that are covered in the plan’s contract. In many cases, these two delivery systems are not entirely independent approaches to providing medical care under Medicaid. In a number of states, there are hybrid models (such as primary care case management (PCCM)) that combine various features of fee-for-service and managed care for a given population or set of interrelated services. Under a PCCM model, providers receive a per-person monthly fee for coordinating each enrollee’s care, but services are provided through the fee-for-service delivery system. In the PCCM model, the provider acts as a care coordinator and/or gatekeeper to the services specified under the PCCM contract. In FY2010, comprehensive managed care plans accounted for nearly 21% of total Medicaid spending on benefits while limited benefit plans and PCCM programs accounted for less than 3%. (See MACPAC, *Report to the Congress on Medicaid and CHIP*, March 2011)

¹⁴² In the Medicaid Statistical Information System (MSIS), which was used to generate this analysis, the “foster child” population is both more and less inclusive than how that population is understood for child welfare purposes. Specifically, the MSIS “foster care child” category *includes* (1) children for whom the state makes adoption assistance foster care maintenance payments (and beginning in FY2009) kinship guardianship assistance payments under Title IV-E of the Social Security Act, (2) children with special needs covered by state foster care payments or under a state adoption assistance agreement that does not involve Title IV-E, and (3) children who leave foster care due to age. This definition is less inclusive than a child welfare understanding of the population because it appears to *excludes* children who are ineligible for federal foster care maintenance payments under Title IV-E of the Social Security Act (nationally, this is estimated to be more than half of all children in foster care on a given day). At the same time, it is more inclusive than a child welfare definition because it *includes* some children and youth who have left foster care—including children who leave for adoption (whether they receive Title IV-E assistance or state-only assistance) and those who age out, presumably under the Chafee option, which is available in some states for children who aged out of foster care through the age of 21. It is unclear what “children with special needs covered by state foster care payments” means in MSIS.

¹⁴³ The Medicaid Statistical Information System (MSIS) is one of the primary federal data sources for the Medicaid program. MSIS is a national Medicaid enrollment and claims repository and includes information on demographic characteristics of beneficiaries, service utilization by enrollment group, and payments for benefits. The MSIS consists of standardized, quarterly submissions of eligibility and claims files from each state to the federal government. These submissions contain data extracted from states’ claims processing systems, called the Medicaid Management Information Systems (MMIS). Since 1999, all states have been required to participate in MSIS but not all do.

¹⁴⁴ Congressional Research Service (CRS) analysis of MSIS data for FY2008. Non-disabled children were identified as those Medicaid recipients whose basis of eligibility was reported as “foster care child,” “child,” and “child (unemployed parent).” There are two ways these data may not capture all expenditures for a given category of service provided to non-disabled children. First, these variables represent the last basis of eligibility reported for the child during the year and thus may not capture expenditures associated with an individual who was previously classified under another Medicaid eligibility category. Second, Medicaid recipients include both those individuals for whom fee-(continued...)

CRS analysis of Medicaid program data for that same year found that annual per capita Medicaid spending for children in foster care (including those adopted from foster care) was \$5,694, compared to \$1,891 per nondisabled child recipient and \$13,509 per disabled child recipient.¹⁴⁵ In FY2008, just over 46% of all Medicaid fee-for-service spending for children in foster care (including those adopted from care) was for prescription drugs (\$743 million), rehabilitative services (\$660 million),¹⁴⁶ inpatient psychiatric care services (\$509 million), inpatient hospital care services (\$501 million), and targeted case management (\$302 million).¹⁴⁷

Given the significant physical and mental health issues faced by children in foster care, this per capita spending level is not necessarily surprising. Children who are placed in foster care are more likely to receive mental health care services than similarly situated children who are not placed in out-of-home care.¹⁴⁸ At the same time, some research suggests that per capita spending for children in foster care may be overstated. One large study that matched foster care administrative data with Medicaid administrative data found that as many as one-third of all children who were in foster care after one year were not classified as such in the Medicaid data system. Further, these incorrectly coded children represented the majority (78%) of children in foster care who did not use any Medicaid services after entering foster care. Thus, the researchers concluded that failure to include these incorrectly coded children in the Medicaid spending for children in foster care “modestly” understated total Medicaid spending for children in foster care, but it “significantly overrepresented the per-capita health care utilization by individual children.”¹⁴⁹

Still, researchers have identified concerns about access to health care services for children in foster care. Most Medicaid-eligible individuals under the age of 21 are entitled to early and periodic screening, diagnostic, and treatment (EPSDT) services, but it appears that not all foster care children receive these services. The purpose of EPSDT is to ensure screening for physical

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for-service claims were paid during the year and those for whom capitation payments were made during the year in the 50 states and the District of Columbia. However, information about service use under capitated service delivery systems is limited and does not allow for analysis of specific services. (Since 1995, capitated payments have become more prevalent under Medicaid, primarily enrolling non-disabled adults and children.) Because this analysis necessarily includes only those services provided under the fee-for-service delivery system, the percent of children receiving a given service likely underestimates the true share.

¹⁴⁵ The MSIS data files generally available do not permit analysis to identify which individuals among those coded as foster care children also have a disability.

¹⁴⁶ Medicaid rehabilitative services include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law for maximum reduction of physical or mental disability and restoration of a recipient to his/her best possible functional level.

¹⁴⁷ Medicaid targeted case management services are defined as services that are furnished to individuals eligible under the plan to gain access to needed medical, social, educational, and other services.

¹⁴⁸ Ramesh Raghaven, et al, “A Preliminary Analysis of the Receipt of Mental Health Services Consistent with National Standards Among Children in the Child Welfare System,” *American Journal of Public Health*, April 2010, pp. 742-749.

¹⁴⁹ David M. Rubin, et al, “A Sampling Bias in Identifying Children in Foster Care Using Medicaid Data,” *Ambulatory Pediatrics*, May-June 2005, pp. 185-190. An additional data concern arises from the fact that Medicaid administrative data (MSIS) categorizes both children adopted from foster care and those in foster care as “foster children.” At least one study based on nationally representative data found that children adopted from foster care had somewhat greater special health care needs than children in foster care. See U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning Research and Evaluation, National Survey of Child and Adolescent Well-Being (NSCAW), “Special Health Care Needs Among Children in Child Welfare,” Research Brief No. 7, no date.

and mental conditions or developmental delays and to pay for that screening, diagnosis, and any treatment needed to correct or ameliorate any defects or chronic conditions discovered. This may include payment for services that may not otherwise be covered under a given state's Medicaid plan (i.e., optional benefits). However, while a large majority of public child welfare agencies reported having policies to ensure screening of physical health needs of children entering foster care (94%), less than half (43%) had policies calling for comprehensive assessments that screened for any physical health, mental health, and developmental needs of children entering foster care.¹⁵⁰ A series of studies conducted in eight states (during the first half of the 2000s) by the Office of Inspector General (OIG) at the Department of Health and Human Services concluded that some children in foster care did not receive the basic services mandated by EPSDT.¹⁵¹

In addition to these reviews by HHS, the Government Accountability Office (GAO) examined how 10 states addressed challenges in identifying and responding to the health care needs of children in foster care.¹⁵² According to GAO, these states reported that they had policies that specified the timing and scope of health assessments for children in care, which were intended to identify their health needs and related follow-up. Further, states took steps to deliver appropriate health care services to children in foster care, including facilitating access to Medicaid coverage. This review, however, did not assess the extent to which states are adequately meeting health care needs of children or whether states are providing adequate services.

Separate from this federal oversight, researchers have raised concerns about findings that children in foster care are receiving one specific kind of treatment—psychotropic medication—at roughly three times the rate of all other children served by Medicaid. Although evidence of their clinical safety and effectiveness for children is often lacking, psychotropic medications are typically prescribed to address mental, emotional, or behavioral issues ascribed to children in foster care.¹⁵³ A national study found that as many as 18% of Medicaid-enrolled children in foster care received psychotropic medication at a given point in time while the comparable percentage for all children in Medicaid (based on several statewide studies) was 5% to 6%.¹⁵⁴ Studies that estimated use of psychotropic medication for some part of a child's stay in foster care showed that the medicines were being prescribed to much higher percentages of these children compared to other Medicaid-enrolled children or other children who have had contact with child welfare but were not in an out-of-home placement.¹⁵⁵ Some research also shows interstate variation in the prescription of

¹⁵⁰ Laurel K. Leslie, et al, "Comprehensive Assessments for Children Entering Foster Care: A National Perspective," *Pediatrics*, July 2003, pp. 134-142.

¹⁵¹ U.S. Department of Health and Human Services, Office of the Inspector General, "Children's Use of Health Care Services While in Foster Care: Common Themes," Memorandum to Susan Orr, Associate Commissioner for the Children's Bureau, Administration for Children and Families and Dennis G. Smith, Director of Centers for Medicare and Medicaid Services, from Brian Ritchie, Acting Deputy Inspector General for Evaluation and Inspections, July 2005 (OEI-07-00-00645).

¹⁵² U.S. Government Accountability Office, *Foster Care: State Practices for Assessing Health Needs, Facilitating Service Delivery, and Monitoring Children's Care*, GAO-09-26, February 2009.

¹⁵³ Michael Naylor, M.D., Director, Division of Child and Adolescent Psychiatry, "Improving the Quality of Care for State Wards: The Illinois Department of Children and Family Services Centralized Psychotropic Medication Consent Unit," testimony before Subcommittee on Income Security and Family Support, House Committee on Ways and Means, July 19, 2007.

¹⁵⁴ Ramesh Raghavan, et al, "Psychotropic Medication Use in a National Probability Sample of Children in the Child Welfare System," *Journal of Child and Adolescent Psychopharmacology*, Vol. 15, No. 1, 2005, pp. 97-106.

¹⁵⁵ Mollie Zito, et al, "Psychotropic Medication Patterns Among Youth In Foster Care," *Pediatrics*, July 2008, pp e157-e163 and U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research, and Evaluation, National Survey of Child and Adolescent Well-Being, "Psychotropic Medication (continued...)"

psychotropic medication that is based on a child's characteristics rather the child's mental health needs.¹⁵⁶ Additional research indicates that foster children in one state who qualify for Medicaid were more likely to receive two or more psychotropic medications simultaneously and for longer periods of time than children who participate in Medicaid under other pathways. Nearly half of these foster children used two or more psychotropic medications at the same time. The share of other medically enrolled children who used two or more of these medications ranged from 13% to 40%.¹⁵⁷ Nearly one-fifth of foster children took the medications for 180 days or more; no more than 14% of children who qualified for Medicaid under other pathways used the medications for this same amount of time.¹⁵⁸

Young Adults Who Were Formerly in Foster Care

The research literature regarding children who age out of foster care shows that physical and mental health problems persist into adulthood.¹⁵⁹ Two studies—the Northwest Foster Care Alumni Study and the Midwest Evaluation of the Adult Functioning of Former Foster Youth—have tracked outcomes for a sample of youth across several domains, either prospectively (following youth in care and as they age out) or retrospectively (examining current outcomes for young adults who were previously in care and comparing these outcomes to those of young people in the general population).

Researchers with the Northwest Foster Care Alumni Study interviewed and reviewed the case files of 479 foster care youth who were in public or private foster care any time from 1988 to 1998 in Oregon or Washington.¹⁶⁰ The study compared the mental health status and education and employment outcomes for the foster care alumni to those of the general population. Over 54% of foster care alumni had at least one mental health problem—depression, social phobia, panic disorder, and post-traumatic stress disorder, among others—compared to 22.1% of the general population.¹⁶¹ About one-quarter of the alumni experienced post-traumatic stress disorder (PTSD). This figure is greater than the occurrence of PTSD among Vietnam or Iraq War veterans,

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Use by Children in Child Welfare,” Research Brief No. 17, 2012, http://www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/reports/psychotropic-meds/NSCAW-Psychotropic-Meds-Brief-No-17.pdf.

¹⁵⁶ Ramesh Raghavan, et al., “Interstate Variations in Psychotropic Medication Use Among a National Sample of Children in the Child Welfare System,” *Child Maltreatment*, vol. 15, no. 1 (May 2010), pp 121-131.

¹⁵⁷ This includes foster children who also qualified for Medicaid during the year under another pathway.

¹⁵⁸ Researchers examined the use of psychotropic drugs for a period of 30 or more days. This timeframe was intended to omit children who were tapering off of one drug and introducing another. Susan dosReis et al., “Antipsychotic Treatment Among Youth in Foster Care,” *Pediatrics*, vol. 128, no. 6 (December 2011).

¹⁵⁹ The studies do not posit that foster care, *per se*, is associated with the challenges former foster youth face in adulthood. In fact, children tend to have a range of challenges upon entering care. Wulczyn et al. *Beyond Common Sense*, p. 116.

¹⁶⁰ Peter J. Pecora et al., *Improving Foster Family Care: Findings from the Northwest Foster Care Alumni Study*, Casey Family Programs, 2005, at http://www.casey.org/Resources/Publications/pdf/ImprovingFamilyFosterCare_FR.pdf. On average, they interviewed youth who were 24.2 years old, with a range of 20 to 33 years old. The youth tended to have entered care as adolescents and exited care between the ages of 15 and older. These youth were placed in care prior to the enactment of the Foster Care Independence Act of 1999 (P.L. 106-169) and most entered care because of sexual abuse and other type of maltreatment.

¹⁶¹ In a nationally representative study of children ages 11 to 14 entering foster care, 56.1% had a clinical/borderline score based on the Child Behavior Checklist (CBCL) “total problems” score. Researchers often use the CBCL as a proxy for measuring mental health concerns. Wulczyn et al., *Beyond Common Sense*, p. 108.

which is about 15%. Foster care alumni tended to have recovery rates similar to their counterparts in the general population for major depression, panic syndrome, and alcohol dependency, but lower rates of recovery for other disorders such as generalized anxiety disorder, PTSD, social phobia, and bulimia.

Few foster care alumni studies are prospective, meaning that they follow youth while in care through the time they leave care and beyond. The Midwest Evaluation is an ongoing study that tracks approximately 600 former foster youth in three states—Illinois, Iowa, and Wisconsin.¹⁶² **Table A-1** displays the physical health and mental health outcomes for alumni at ages 25 and 26 compared to their same-age peers in the general population. Overall, youth formerly in foster care reported having more negative health outcomes than their general population peers and participating in counseling and substance abuse treatment more often. They were also less likely than their peers to be covered by employers' health care plans, and more likely to have public health insurance.

Table A-1. Comparisons of Select Outcomes Between Young Adults in the Midwest Study and Young Adults in the Add Health Study

Outcome	Midwest Evaluation (Wave 4)—Former Foster Youth at Ages 25 and 26	Add Health—Peers Surveyed at Ages 25 and 26
Description of General Health^a		
Excellent	25.8%	18.5%
Very good	29.4%	40.1%
Good	27.0%	32.7%
Fair	15.6%	7.5%
Poor	2.2%	1.1%
Health Condition or Disability Limits Daily Activities^{a,b}	14.8%	8.1%
Mental Health and Behavioral Care Services^a (from survey of youth at age 23 and 24)^c		
Received psychological or emotional counseling	11.3%	6.5%
Attended substance abuse treatment program	5.1%	2.4%
Has Medical Insurance^a	58.7%	78.0%
Source of Medical Insurance^a		
Parents' insurance	1.2%	2.0%
Spouse's insurance	6.3%	10.7%
Employer provided insurance ^a	20.2%	56.3%
School provided insurance	0.9%	3.7%

¹⁶² Courtney et al., *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 26*. All of the surveyed youth entered care prior to their 16th birthday. Surveyed youth responded to researcher questions about outcomes in five data collection waves, most recently when the youth were age 25 or 26. For each of the data collection waves, wherever possible, researchers asked the same questions that were taken directly from the National Longitudinal Survey of Adolescent Health ("Add Health"), a nationally representative survey that tracks a cohort of youth over time.

Outcome	Midwest Evaluation (Wave 4)—Former Foster Youth at Ages 25 and 26	Add Health—Peers Surveyed at Ages 25 and 26
Purchase own private insurance	1.2%	3.9%
Medicaid or medical assistance ^a	47.6%	9.4%
State Children's Health Insurance Program (S-CHIP)	19.6%	n/a ^d
Other	3.2%	2.3%
Don't know type of insurance	0%	1.7%
Last Physical Exam^a		
Less than a year ago	66.9%	59.3%
1 to 2 years ago	15.8%	17.1%
More than 2 years ago	16.4%	22.0%
Missing or don't known	0.8%	1.5%
Did Not Receive Needed Medical Care^a	13.0%	22.6%

Source: Congressional Research Service presentation of data in Mark E. Courtney et al., *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Ages 23 and 24*, Chapin Hall Center for Children, University of Chicago, 2010.

Note: The Midwest Evaluation has tracked the outcomes of foster youth across five waves when these youth were age 17, age 19, age 21, age 23 and 24, and age 26 (a small number of youth were age 25 or 27). For each of the data collection waves, wherever possible, researchers asked the same questions that were taken directly from the National Longitudinal Survey of Adolescent Health (“Add Health”), a nationally representative survey that tracks a cohort of youth over time.

- a. Indicates that the difference between the youth in the Midwest Evaluation and youth in the Adolescent Health Survey is statistically significant.
- b. The Add Health Study questions asked whether any health conditions limited their ability to engage in moderate activities.
- c. The Add Health survey instrument for youth surveyed at ages 25 and 26 did not have comparable data.
- d. The Add Health Study did not report this figure.

Children Adopted from Foster Care

Children adopted from foster care are those children who were removed from their biological parents – typically because of abuse or neglect – and for whom reuniting with those biological parents was determined not possible or not in the child’s best interest. Roughly 50,000 to 55,000 children leave foster care for a permanent adoptive family each year.¹⁶³ The large majority of these children (88% in FY2010)¹⁶⁴ were determined by the state to have “special needs” that made it “reasonable” for the state to conclude the child would not be adopted without provision of an adoption subsidy and/or medical assistance.¹⁶⁵

¹⁶³ HHS, ACF, ACYF, Children’s Bureau, “Trends in Foster Care and Adoption, FY2002-FY2010,” based on data submitted by states as of June 2011.

¹⁶⁴ National percentage calculated by CRS based on HHS, ACF, ACYF, Children’s Bureau, “Child is Identified as Special Needs Adoption: October 1, 2009 to September 30, 2010 (FY2010),” June 2011.

¹⁶⁵ States determine which children have “special needs” within certain federal parameters (included at Section 473(c) (continued...))

Greater Health and Mental Health Needs

A nationally representative survey conducted in 2007 found children who were adopted – whether from foster care, domestically by private arrangement, or from another country – tended to have greater health and mental health needs than children in the general population.¹⁶⁶ Further among all adopted children those who were adopted from foster care had the greatest needs. For example, 19% of all children in the nation were reported by their parents as having special health care needs in 2007, compared to 39% of all children who were adopted and 54% of children adopted from foster care. Additionally, among children ages 6 through 17, about 1 in 10 (10%) in the general population had been formally diagnosed with attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) at some point and, at the time of the 2007 survey, the parents of about 1 in 25 children (4%) considered their child's diagnosed ADD/ADHD condition to be moderate or severe. The comparable rates among all adopted children in this age range was more than 1 in 4 ever diagnosed (26%) and roughly 1 in 8 with a current moderate or severe condition (14%); for those in this age range who were adopted from foster care more than 1 in 3 had ever received an ADD/ADHD diagnosis (37%) and fully 1 in 5 (20%) had a current moderate or severe condition as reported by their adoptive parents.

The 2007 survey also found that 2% of all adopted children (ages 8 through 17) had spent some time in a residential psychiatric facility or hospital following their adoption; the comparable share reported for children adopted from foster care was 7%.¹⁶⁷ (Because this question is linked specifically to services provided *after* a child was adopted there is no comparable percentage for children in the general population.) **Table A-2** shows these and additional data on the health and mental health needs of children adopted from foster care compared to all adopted children and children generally.

More Likely to Have Insurance Coverage

At the same time, children who are adopted are more likely to have had continuous (over past 12 months) health insurance coverage than children in general. The 2007 survey of adopted parents found that 85% all children had this continuous coverage, compared to 91% among all adopted children and 94% of children adopted from foster care.¹⁶⁸ Federal law provides that the children adopted from foster care who have “special needs” (which may be but are not necessarily related to health or mental health needs) are eligible for Medicaid (or a comparable state benefit plan).¹⁶⁹

(...continued)

of the Social Security Act). As part of this determination, states must find that a factor or condition specific to the child would make it reasonable to conclude that a child can not be placed in an adoptive family without adoption assistance and/or medical assistance. Such factors include the child’s age, membership in a sibling group, race and ethnicity, or physical, social, or emotional disability.

¹⁶⁶ 2007 National Children’s Health Survey and related 2007 National Adoptive Parents Survey. For more information see Sharon Vandivere, Karin Malm, and Laura Radel, *AdoptionUSA: A Chartbook Based on the 2007 National Survey of Adoptive Parents*, HHS, Office of the Assistant Secretary of Planning and Evaluation, 2009, p. 1.

¹⁶⁷ Ibid, pp. 21-27, 47-49. See also Tables 7, 8, and 19.

¹⁶⁸ Ibid, pp. 22-24. See also Table 7.

¹⁶⁹ According to the 2007 National Survey of Adoptive Parents, 92% of children adopted from foster care were the subject of an adoption assistance agreement between a state and the adoptive parent. Under federal law all of these children would be expected to be *eligible* for Medicaid coverage or a comparable public benefit plan. States are required to enter into an adoption assistance agreement on behalf of any child who meets “special needs” criteria (Section 473(a)(1)(A) of the Social Security Act), including those who meet all the Title IV-E eligibility criteria and (continued...)

Not surprisingly then, public health insurance is the most common form of coverage among children adopted from foster care. Nearly 6 in 10 (59%) were reported by their adoptive parent as covered by Medicaid or CHIP – roughly double the 3 in 10 (29%) children generally who were covered by those public programs.

Although 37% of children adopted from foster care were covered by private insurance coverage, some of these privately insured children were also enrolled in Medicaid.¹⁷⁰ In fact, parents of children adopted from foster care reported that 65% had ever received a Medicaid benefit, over half (55%) used Medicaid for dental care, and nearly one out of three (32%) used Medicaid to pay for mental health services. In those instances where a child is covered by both Medicaid and private insurance, the law provides that Medicaid is the payer of last resort. This means that the private insurer must pay any covered benefits first. However, Medicaid coverage could supplement those benefits (if the private insurance benefits are exhausted) and it might wholly fund services not covered by private the adopted children's private insurance carriers (e.g., many private insurers do not cover residential psychiatric treatment).¹⁷¹

Table A-2. Presence of Certain Health and Mental Health Conditions Among All Children, All Adopted Children, and Children Adopted from Foster Care

CONDITION (Children are ages 0 through 17 years of age unless otherwise noted)	All Children	All Adopted Children ^a	Children Adopted From Foster Care
Special health care need: Parent reported that the child currently experiences at least one of five consequences attributable to a medical, behavioral, or other health condition that has lasted or is expected to last for at least 12 months. The consequences include: 1) ongoing limitations in ability to perform activities that other children of the same age can perform, 2) ongoing need for prescription medications, 3) ongoing need for specialized therapies, 4) ongoing need for more medical, mental health, or educational services than are usual for most children of the same age, and 5) the presence of ongoing behavioral, emotional, or developmental conditions requiring treatment or counseling.	19%	39%	54%

(...continued)

those with special needs who do not meet all of the Title IV-E eligibility criteria. For adoptive children with state-determined special needs who meet all the federal Title IV-E eligibility criteria federal law provides mandatory Medicaid eligibility (Section 1902(a)(10)(A)(i)(I) and Section 473(b)(3)(A) of the Social Security Act). For adoptive children with state-determined special needs who do not meet all the Title IV-E eligibility criteria, federal law requires states to provide those children with health insurance coverage via Medicaid or another comparable state plan (Section 471(a)(21) of the Social Security Act). States may use a number of optional pathways to provide Medicaid to these children, including one specifically for such children (Section 1902(a)(10)(A)(ii)(VIII) of the Social Security Act).

¹⁷⁰ Seventy-five percent of children adopted from foster care were reported to be covered by an adoption assistance agreement that included Medicaid coverage. See Karin Malm, Sharon Vandivere, Amy McKlindon and Laura Radel, *Children Adopted from Foster Care: Adoption Agreements, Adoption Subsidies, and Other Post-Adoption Supports*, HHS, ASPE, May 2011, pp. 8-9.

¹⁷¹ Section 1902(a)(25) of the Social Security Act. This is referred to as Medicaid's "third party liability" rule. In general, this rule provides that *any other program or insurer* (e.g., Medicare, employer-sponsored health insurance, other private insurance, workers compensation, or other federal and state programs) must pay any covered benefit or service before Medicaid can be made liable for the cost.

CONDITION <i>(Children are ages 0 through 17 years of age unless otherwise noted)</i>	All Children	All Adopted Children^a	Children Adopted From Foster Care
Diagnosis of Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD): Parent of child (ages 6 through 17) was at some point told by a doctor or other health care provider that the child has ADD/ADHD and at time of the survey the parent reported the child's condition was moderate or severe.	4%	14%	20%
Diagnosed with Attachment Disorder: Parent of child was at some point told by a doctor or other health care provider that the child has attachment disorder (or reactive attachment disorder). This disorder, which is associated with severe neglect of a young (under age 5) child's basic emotional needs, may make a child be excessively inhibited or indiscriminately sociable.	Not included in general survey.	12%	21%
Diagnosis of conduct or behavior problems: Parent of child (ages 2 through 17) was at some point told by a doctor or other health care provider that the child has conduct or behavior problems, and at the time of the survey the parent reported the condition was moderate or severe.	4%	17%	24%
Child received mental health service(s) since adoption (ages 5 through 17)	Not applicable.	39%	46%
Child received psychiatric residential treatment/hospitalization since adoption (ages 8 through 17)	Not applicable.	4%	7% ^b

Source: Data are as reported by parents in the 2007 National Children's Health Survey and the related 2007 National Adoptive Parents Survey as included in Sharon Vandivere, Karin Malm, and Laura Radel, *Adoption USA: A Chartbook Based on the 2007 National Survey of Adoptive Parents*, HHS, Office of the Assistant Secretary of Planning and Evaluation, 2009.

Note: The difference in percentage shown between all children and all adopted children is statistically significant for each of these outcome measures. Also, the differences between all adopted children and by private domestic arrangement and children adopted from another country are statistically significant unless otherwise noted.

- a. Includes children adopted from foster care, those adopted domestically by private arrangement, as well as those adopted from other countries. However, children adopted by stepparents were excluded from this analysis.
- b. This percentage is significantly different from the share reported for child adopted from another country but not for domestic, privately arranged adoptions.

Appendix B. Medicaid Pathways for Current and Former Foster Children and Youth

Table B-1. Major Mandatory and Optional Medicaid Pathways for Current and Former Foster Children and Youth

Pathway (Statutory Citation in Title XIX of the Social Security Act)	Key Eligibility Criteria		
	Income (and Assets for Selected Pathways) ^a	Age	Selected Other
<i>Major Mandatory Groups</i>			
Title IV-E Foster Care (§1902(a)(10)(A)(i)(I)) [States that receive Title IV-E funding (all states do) must provide foster care maintenance assistance.]	<p>Must have been removed from a family whose income met the state's need standard as it existed on July 16, 1996 for purposes of determining eligibility under the prior law cash welfare program, Aid to Families with Dependent Children (AFDC). Income standards may not be adjusted for inflation.</p> <p>Child must have assets under \$10,000.</p>	<p>Under age 18, or, if still completing high school or equivalent education or training, under age 19; OR Up to age 19, 20, or 21 in states that elect to extend foster care to such older age. (Older youth must meet certain employment, education, or medical criteria.)</p>	<ul style="list-style-type: none"> - Child is removed from home of a parent, or other relative specified in prior law cash welfare program (AFDC). - At removal child is "deprived" of parental care or support (i.e., single parent household) or principal earner in two-parent household meets unemployment criteria. - A judge determined that removal was necessary because the home was "contrary to the welfare" of the child and that state made reasonable efforts (when required) to prevent the removal of the child from his or her home.^b - Judge gives care and placement responsibility to the state child welfare agency. - Child is placed with an eligible caregiver in a licensed setting (e.g., foster family home, group home, or other residential institution). - No less often than every 12 months a judge determines that the state is making reasonable efforts to achieve a permanent home for the child.

Pathway <i>(Statutory Citation in Title XIX of the Social Security Act)</i>	Income (and Assets for Selected Pathways)^a	Key Eligibility Criteria	
		Age	Selected Other
Title IV-E Guardianship Assistance <i>(§1902(a)(10)(A)(i)(I))</i> (States that receive Title IV-E funding (all states do) may choose to provide kinship guardianship assistance but are not required to do so.)	<p>Child must have been removed from a family whose income met the state's need standard as it existed on July 16, 1996 for purposes of determining eligibility under the prior law cash welfare program, Aid to Families with Dependent Children (AFDC). Income standards may not be adjusted for inflation.</p> <p>No income or resource rules are applicable to the guardian.</p>	<p>Under age 18, or, if still completing high school or equivalent education or training, under age 19; OR</p> <p>If a state elects this definition of "child" in its Title IV-E plan, up to age 19, 20, or 21 (Older youth must meet certain employment, education, or medical criteria.).</p> <p>In addition, the state may provide coverage up to age 21 (on a case-by-case basis), if the child welfare agency determines the youth has a physical or mental condition warranting continued kinship guardianship assistance to that age.</p>	<p>Child met all of the Title IV-E foster care eligibility criteria prior to being placed in legal guardianship with a relative. and</p> <p>—Child resided with the relative guardian for no less than 6 consecutive months prior to the guardianship placement and the child welfare agency has determined that 1) return home (to biological parents) or adoption are not appropriate permanency options; 2) the child demonstrates a strong attachment to the prospective relative guardian; and 3) the relative guardian has a strong commitment to caring permanently for the child;^c and</p> <p>—Relative guardian with whom child is placed meets applicable requirements;^d and</p> <p>—If the child is 14 years or older regarding the kinship guardianship arrangement.</p> <p>Any child who was receiving Title IV-E guardianship assistance on September 30, 2008 (under Section 1130 child welfare waiver authority) remains eligible for Medicaid.</p>

Pathway (Statutory Citation in Title XIX of the Social Security Act)	Key Eligibility Criteria		
	Income (and Assets for Selected Pathways) ^a	Age	Selected Other
Title IV-E Adoption Assistance (§1902(a)(10)(A)(i)(I)) [States that receive Title IV-E funding (all states do) must provide adoption assistance.]	<p>Title IV-E foster care income/asset rules (tied to biological family from which a child was removed to foster care) are being phased out between FY2010-FY2018. As of FY2012 any child adopted from foster care at age 12 or older does not need to meet any of those prior family income or resource criteria. The phase out of income rules will apply to progressively younger adoptees in subsequent years and, as of FY2018 will apply to an adoptee of any age.</p> <p>Any youth who has been in foster care for 60 consecutive months does not need to meet the Title IV-E foster care income/asset test.</p> <p>Siblings of a child to whom the income and resource rules (related to prior family) may also be eligible as long as they are placed in same adoptive family.</p> <p>No income or resources rules are applicable to adoptive families.</p>	<p>Under age 18, or, if still completing high school or equivalent education or training, under age 19; OR</p> <p>If a state elects this definition of "child" in its Title IV-E plan, up to age 19, 20, or 21 (Older youth must meet certain employment, education, or medical criteria.).</p> <p>In addition, the state may provide coverage up to age 21 (on a case-by-case basis) if the child welfare agency determines the youth has a physical or mental condition warranting continued kinship guardianship assistance to that age.</p>	<p>Child must be determined by the Title IV-E child welfare agency to have "special needs." This means that that agency has determined that:</p> <ul style="list-style-type: none"> —child cannot or should not return home (to biological parents); —because of a specific factor or condition, the child is unlikely to be adopted without provision of adoption assistance and/or medical assistance. Specific factors are established by each state but may include factors related to child's age, race/ethnicity, membership in a sibling group, race or ethnicity, medical condition, or physical, emotional, or mental disabilities; and —reasonable but unsuccessful efforts have been made to place the child for adoption without assistance (either adoption or medical) but only if this is in child's best interest. <p>Also eligible: Child who has special needs and who is eligible for SSI. (Until FY2018 some of these children will need to continue to meet income and resources rules of the SSI program, but beginning with FY2018 those rules no longer apply).</p>
Eligible for aid under prior law cash welfare rules (§1902(a)(10)(A)(i)(I) and §1931)	Meets state income and asset criteria for receipt of assistance under the prior law AFDC program as it existed on July 16, 1996. Income and asset standards may be adjusted for inflation and special income counting rules may apply.	Under age 18, or under age 19 if enrolled in high school or equivalent program, or an adult who is responsible for a child.	Must be a child in a single parent household or in a two-parent household if principal wage-earner meets certain unemployment criteria, or an adult in such a household.

Pathway <i>(Statutory Citation in Title XIX of the Social Security Act)</i>	Key Eligibility Criteria		
	Income (and Assets for Selected Pathways)^a	Age	Selected Other
Low-Income Infants and Young Children (§1902(a)(10)(A)(i)(IV); § 1902(l)(1)(A); § 1902(a)(10)(A)(i)(VI); and §1902(l)(1)(C))	Annual income of less than 133% federal poverty level (FPL). Special income counting rules may apply. ^a	Under age 6.	
Low-Income Children (§1902(a)(10)(A)(i)(VII); §1902(l)(1)(D))	Annual income of less than 100% of FPL (<i>133% FPL beginning on January 1, 2014</i>). Special income counting rules may apply. ^a	At least age 6 through age 18.	
Pregnant Women (§1902(a)(10)(A)(i)(IV); §1902(l)(1)(A))	Annual income less than 133% FPL. Special income counting rules may apply. ^a	Any.	Eligible during pregnancy, labor, and delivery, and for 60 days post-partum.
Supplemental Security Income (SSI) (§1902(a)(10)(A)(i)(II))	Meet federal SSI income (up to about 75% FPL), and asset eligibility standards. (Assets may not exceed \$2,000 for an individual and \$3,000 for a couple. Certain assets, such as a person's home, are exempt.)	Any.	Must also meet SSI disability criteria.
Youth in Foster Care on 18th Birthday (§1902(a)(10)(A)(i)(IX))	None.	At least age 18 through age 25.	Must have been in foster care on 18 th birthday and covered under Medicaid while in care. Must not be eligible or enrolled under other Medicaid mandatory eligibility groups (except the pathway for non-disabled adults with income less than 133% FPL). Effective January 1, 2014.

Pathway (Statutory Citation in Title XIX of the Social Security Act)	Key Eligibility Criteria		
	Income (and Assets for Selected Pathways) ^a	Age	Selected Other
<i>Major Optional Groups</i>			
Chafee Youth (Independent Foster Care Adolescent) (§1902(a)(10)(A)(ii)(XVII); §1905(w)(1))	No federal criteria but states are permitted to establish income and asset criteria lower than criteria under the prior law AFDC program.	Under age 21.	Must have been in foster care on 18 th birthday. States can limit coverage to any “reasonable” category of independent foster care adolescents. States may also restrict coverage to those who received federal foster care maintenance payments (before age 18) or those who received independent living services under Title IV-E of the Social Security Act.
State-funded Adoption Assistance (§1902(a)(10)(A)(ii)(VIII))	Child –based on his or her own income and resources—meets (or met) eligibility criteria for a mandatory or optional categorically needy pathway at time when adoption assistance agreement is executed (or before that time). No federal income/asset criteria for adoptive families need apply. However, state may choose to apply such criteria to their state-funded adoption assistance program (which would effectively limit the coverage under this category by income/resources of adoptive family).	Under age 21 (or under age 20, 19, or 18 as the state may elect).	State child welfare agency must have entered into an adoption assistance agreement with the parent of the child (other than agreement under Title IV-E); and State child welfare agency must have determined that child cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care; and Before the state-funded adoption assistance agreement was executed, child must have been receiving Medicaid (under either a mandatory or optional categorically needy category) OR child would have been eligible for Medicaid given his/her own income and resources (and based on Title IV-E income and resource levels).
“Reasonable categories” of low- income children (“Ribicoff option”) (§1902(a)(10)(A)(ii)(I); §1905(a)(i))	Meets state income and asset criteria for receipt of assistance under the prior law AFDC program without regard to whether state granted this aid. Standards may be adjusted for inflation.	Under the age of 21, or at state option under the age of 20, 19 or 18 as the state may choose.	State defines “reasonable categories.” Reasonable category can include children residing in state based institutions or foster care.
Infants and Pregnant Women (§1902(a)(10)(A)(ii)(IX))	Annual income more than 133% but less than 185% FPL. Special income counting rules may apply. ^a	Under age 1, or for pregnant women, any age.	Pregnant women eligible during pregnancy, labor and delivery, for 60 days of post-partum care.

Pathway (Statutory Citation in Title XIX of the Social Security Act)	Key Eligibility Criteria		
	Income (and Assets for Selected Pathways) ^a	Age	Selected Other
Medicaid Expansion Under State Children's Health Insurance Program (SCHIP) (§1902(a)(10)(A)(ii)(XIV); (§1905(u)(2)(B); §2110(b))	Annual income under 200% FPL, or 50 percentage points above applicable Medicaid level that is equal to or greater than 200% FPL.	Through age 18, or for pregnant women, any age.	Targeted low-income uninsured children, and certain pregnant women.
Medically Needy Children and Adults^e (§1902(a)(10)(C)(ii), (iii))	Annual income up to 133½% of the maximum payment amount applicable under a state's former AFDC programs. For families of one (i.e., child in foster care), the statute gives certain states some flexibility to set these limits to amounts that are reasonably related to the AFDC payment amounts for two or more persons.	Under age 18 and for certain other individuals, any age.	States may extend Medicaid coverage to persons who are members of one of the broad categories of Medicaid covered groups (e.g., over 64, disabled, families with dependent children), but do not meet the applicable income requirements and, in some instances, assets requirements for other eligibility pathways.
Section 1115 Waiver (§ 1115)	Upper income eligibility thresholds and income counting rules as specified in CMS approved Special Terms and Conditions.	Any age.	Eligibility groups and income counting rules as specified in CMS approved Special Terms and Conditions. Time limited demonstrations.

Source: CRS analysis of Title XIX of the Social Security Act.

Notes: Section 1902(10)(A)(i)(I) authorizes a mandatory Medicaid pathway for individuals who are receiving aid or assistance under any plan of the state approved under Titles I, X, XIV, or XVI. These pathways provide aid to individuals who are old, disabled, and blind, and reside in the territories.

- a. As per Section 1902(r)(2), for many Medicaid eligibility groups, states may use more liberal standards for counting income and assets than are specified within each of the groups' specific definitions. Because of the 50-state variability in terms of how these income counting rules are applied, only reported rules regarding asset tests that apply universally across the 50 states are included in this table.
- b. Alternatively a child may enter foster care via a voluntary placement agreement between the state child welfare agency and the parent(s)/guardian(s) of the child. That child may be Title IV-E eligible for up to six months. However, for eligibility to continue beyond that period, a judge must determine that the placement continues to be in the child's best interest.
- c. If the agency places a sibling of the child in the same kinship guardianship arrangement that child may be eligible even if he/she does not meet all of the Title IV-E foster care related requirements.

- d. As interpreted by HHS, ACF, ACYF, Children's Bureau, states have some flexibility to provide somewhat more restrictive eligibility criteria for this assistance than the broadest eligibility permitted by federal law. For example, a state may limit assistance to youth age 12 or older, or may require that youth have lived with prospective guardian for longer than 6 months. See HHS, ACF, ACYF-CB-PI-10-
- e. If states elect to provide medically needy coverage, they must include children under age 18 (as well as certain adults) whose income and resources are too high to qualify under former AFDC-related rules. If a child has a disability that meets the SSI disability standard, then SSI-related financial standards will apply to medically needy coverage. States may also provide medically needy coverage to individuals under age 21 (or 20, 19, or 18 years) if such persons do not fall into reasonable classifications such as individuals in foster care, in publicly subsidized adoptions, in nursing homes and intermediate care facilities for the mentally retarded, and persons receiving active treatment as inpatients in psychiatric facilities.

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