

# Medicaid Spending on Foster Children



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**E**ach year more than 800,000 children in the United States spend time in foster care as a result of abuse and neglect. States disburse about \$10 billion a year in federal and state funds to meet the needs of children placed in foster care. Foster children are at particularly high risk for physical and mental health problems stemming from not only the maltreatment they have experienced but also the separation from their homes and families, and the continuing disruptions to their daily lives.

Prior research has documented that foster children have more health problems, especially mental health problems, than the general population or the population of poor children. Previous studies suggest that as many as 80 percent of youth involved with child welfare agencies have emotional or behavioral disorders, developmental delays, or other issues requiring mental health intervention (Farmer et al. 2001; Landsverk, Garland, and Leslie 2002; Taussig 2002). In contrast, mental health disorders are diagnosed in approximately 20 percent of youth in the general population (Costello et al. 1996; HHS 1999).

Child welfare agencies are responsible for meeting the health and mental health needs of all children they take into custody. This includes completing timely, comprehensive health and mental health screenings and ensuring foster children receive preventive health and dental services as well as any necessary therapeutic health and mental health services. All foster children for whom states receive federal reimbursement for foster care expenses (under title IV-E of the Social Security Act) are categorically eligible for Medicaid. States have the option to extend Medicaid benefits to non-IV-E eligible foster children, and all states do. In addition, children receiving federally reimbursed adoption subsidies are categorically eligible for Medicaid. All states but one have also chosen to cover adopted children supported by state-funded subsidies in their Medicaid programs. Thus, virtually all children in foster care and in adoptive placements are eligible for Medicaid.

While child welfare agencies are expected to meet the health care needs of the children they supervise, and foster and adopted children are generally eligible to receive Medicaid-funded health services, each state establishes eligibility standards, determines services, sets payment rates, and administers its own foster care and Medicaid program in accordance with general federal guidelines. In addition, some

children in foster care or receiving adoption subsidies may be covered through private coverage available to their foster and adoptive parents. The resulting diversity produces variation in which services are available to children in foster care and when they receive them.

Data suggest that many foster children do not receive needed health care services. In recent assessments of state child welfare agency performance, the U.S. Department of Health and Human Services (HHS) found that only one state met federal standards for provision of health and mental health services to children involved with the child welfare system (HHS 2005). Overall, HHS found that child welfare agencies failed to provide adequate services in more than 30 percent of the cases reviewed. The HHS Office of Inspector General analyzed Medicaid claims for foster children in eight states and identified issues in each state about meeting the health care needs of children in foster care. Combined, these HHS reports identified common challenges faced by states, including an insufficient number of doctors and dentists willing to accept Medicaid, a lack of consistency in conducting adequate and timely health and mental health assessments, and a lack of consistency in providing children with preventive health and dental services. A sheer lack of mental health services for children was also cited as a major challenge. These access issues are not unique to the child welfare population.

Previous studies, including several that relied on Medicaid claims data, have examined health care use by foster youth. These studies consistently find that children in foster care account for a disproportionate share of Medicaid expenditures, relative to their share of Medicaid enrollment. Much of this disparity results from foster children's disproportionate receipt of mental health services. For example, youth in foster care use Medicaid-reimbursed mental health services at a rate 8 to 15 times higher than other eligible youth (dosReis et al. 2001; Halfon, Mendonca, and Berkowitz 1995; Harman, Childs, and Kelleher 2000). At the same time, the rate of foster children's receipt of services, especially mental health and substance abuse treatment, appears to vary significantly across states. Average per child Medicaid expenditures vary widely as well, consistent with patterns of variation in service use (Rosenbach, Lewis, and Quinn 2000).

The present study is the first to examine the health care services received by foster children based on Medicaid expen-



diture data from all 50 states and the District of Columbia. This brief provides some key statistics on the medical and mental health services provided to foster children based on federal fiscal year (FFY) 2001 data from the Medicaid Statistical Information System (MSIS) Annual Summary File. The quality and completeness of MSIS data have improved significantly in recent years, making such an analysis of health care expenditures on foster children possible.

Study results reinforce and expand the findings of prior research by documenting significant variation in state Medicaid expenditures on foster children, and variation in spending among foster children of different ages, genders, and races/ethnicities. In addition, the study examines states' use of targeted case management for foster children, a practice that has been debated by the current administration, the Centers for Medicare and Medicaid Services (CMS), and Congress. However, given the limitations of the MSIS data, this brief does not answer research questions itself, but rather identifies and refines the questions that future studies should examine.

## Data and Methods

Data from the MSIS Annual Summary File are compiled by CMS and consist of person-level Medicaid eligibility and expenditure data. For each individual, data are available on basic demographics, eligibility information, and aggregated expenditures for medical services divided by service type. Our analysis is based on enrolled Medicaid children with an eligibility code of "foster children" using an annual eligibility flag.<sup>1</sup> This includes both children in federal- and state-subsidized foster care, and children who were adopted from foster care and supported with federal- or state-subsidized adoption assistance.<sup>2</sup>

While MSIS contains detailed information on Medicaid expenditures in all states, its data also have limitations. First, our sample is limited to foster children who were enrolled in Medicaid and identified by the annual file last/best basis-of-eligibility flag in MSIS. This variable contains the last basis of eligibility reported for the child during the year. The sample thus excludes foster children who were never enrolled in Medicaid and were either covered through private health insurance or remained uninsured. Further, this sample cannot identify, and may or may not include, children involved with child protective services but not in foster care.

Second, while the MSIS Annual Summary File includes monthly eligibility data for all Medicaid enrollees, expenditures are reported annually, and so cannot be linked to a specific period of eligibility. Thus, expenditures reported in this analysis for foster children include spending on some children before they were enrolled in Medicaid as foster children, and do not include enrollment or spending on foster children who left foster care and were subsequently reclassified based on other Medicaid eligibility criteria.

Third, although foster children receiving health care services under a capitated health care delivery system are included in the data, specific information about the services they receive is limited. An unknown number of children with capitated expenditures but zero expenditures in another service category in MSIS may have received such a service through capitated arrangements with providers. Thus, our reporting of the percent of children receiving any specific service likely underestimates the true share.

Finally, despite significant improvements in the quality of the MSIS data since 1999, the data quality for this sample and analysis has not been established. State submission of MSIS data is guided by federal instructions on how to classify Medicaid expenditures by specific service types, and the expenditure data are subject to validity checks and minimum quality thresholds established by CMS. However, some quality and consistency issues may remain in how states report Medicaid spending or how services are coded, and the effect on estimates reported is unknown. Moreover, expenditures reported in MSIS do not include Medicaid spending by child welfare agencies that is not associated with a specific child, including administrative service claims.

## Medicaid Enrollment and Spending on Foster Children

Based on MSIS annual eligibility, we identified 869,087 children as enrolled in Medicaid on the basis of being a foster child in fiscal year 2001. Further analysis using monthly eligibility data indicates that 961,555 children were ever enrolled in Medicaid on the basis of being a foster child during fiscal year 2001.<sup>3</sup> This means 92,468 children enrolled in Medicaid were in foster care at some point during the year, left foster care, and were later reclassified to another basis of eligibility. These children represent only about a third of the

more than 269,000 children who left foster care in 2001.<sup>4</sup> Using the monthly eligibility data, we also determined that 509,914 of the 869,087 children identified through the annual eligibility variable were enrolled in Medicaid all year. The remaining 359,173 children were enrolled in Medicaid for part of the year, either enrolling late in the year or disenrolling before the year's end.

While we do not know the exact number of children in foster care and in adoptive placement eligible to receive Medicaid in FFY 2001, we estimate the number is approximately 1,158,000.<sup>5</sup> Based on this estimate, 83 percent of eligible foster children were ever enrolled in Medicaid in FFY 2001. However, 96,336, or 10 percent of foster children ever enrolled in Medicaid in FFY 2001, had no reported expenditures, including capitated expenditures (11 percent of the 869,087 children based on annual eligibility had no reported expenditures).<sup>6</sup> Thus, approximately 75 percent of eligible foster children were ever enrolled in Medicaid in FFY 2001 and had any expenditures. Further estimates on expenditures here are based on the sample of 869,087 foster children identified by MSIS annual eligibility.

States expended approximately \$3.8 billion of Medicaid on foster children in FFY 2001. On average, states expended considerably more on foster children—\$4,336 per child—than on all non-disabled children enrolled in Medicaid (\$1,315).<sup>7</sup> Although foster children represent only 3.7 percent of the non-disabled children enrolled in Medicaid, they account for 12.3 percent of expenditures for the same group.<sup>8</sup> This difference should not be surprising given that foster children tend to have significant health problems.

Using MSIS data, we can categorize Medicaid expenditures into 29 service types (table 1). Almost three-quarters of all Medicaid spending on foster children was for seven service types:

- Services coded as “other” (\$628 million, 16.7 percent of all spending on foster children): Services not listed in the other categories, including, but not limited to, prosthetic devices, eyeglasses, and some home- and community-based waiver services.
- Rehabilitative services (\$493 million, 13.1 percent of spending): Medical or remedial services to reduce physical or mental disability and to restore recipients to their best possible functional level.
- Inpatient psychiatric services (\$376 million, 11.0 percent of spending): Services provided

under the direction of a physician in a psychiatric facility or accredited inpatient program.

- Inpatient hospital services (\$354 million, 9.4 percent of spending): Services furnished by physicians in an institution maintained primarily for the care and treatment of inpatients with disorders other than mental diseases.
- Clinic services (\$327 million, 8.7 percent of spending): Preventive, diagnostic, therapeutic, rehabilitative, or palliative items or outpatient services delivered in a non-hospital clinic setting.
- Prescribed drugs (\$290 million, 7.7 percent of spending): Drugs prescribed by physicians or other licensed practitioners.
- Targeted case management, or TCM (\$266 million, 7.1 percent of spending): Services furnished to help recipients access needed medical, social, educational, and other services.

Foster children account for a particularly large portion of Medicaid expenditures on a few key services. Foster children account for 28 percent of all Medicaid expenditures on inpatient psychiatric services (46 percent of such expenditures on non-disabled children), 15 percent of TCM (40 percent), 13 percent of rehabilitative services (35 percent), and 10 percent of therapy services (21 percent).

Several services have extremely high per child expenditures among foster children using the service, including institutional services for the mentally retarded (\$54,916 per child), nursing facility services (\$51,262), and private-duty nursing (\$42,023). However, only a very small number of children (less than 0.1 percent) receive each of these services, so together these services account for less than 1.5 percent of all spending. Four services are received by a relatively small proportion of foster care enrollees but account for a significant share of total Medicaid expenditures. Slightly more than 40 percent of Medicaid spending on foster children was for rehabilitative, inpatient psychiatric, inpatient hospital, and TCM services. Less than 17 percent of children received each of these services, but 28 percent received at least one of the four.

### Variation in Medicaid Average Spending among Foster Children

Significant variations in Medicaid average spending among foster children are evident across foster child subgroups (table 2). States expended rela-

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TABLE 1. Medicaid Expenditures and Enrollment for Foster Children by Service Category

	Total spending (millions)	Percent of total spending	Enrollment	Percent of enrollees with spending	Spending per enrollee for children receiving
Other	\$ 628	16.7%	241,178	27.8%	\$ 2,605
Rehabilitative	493	13.1	102,166	11.8	4,823
Inpatient psychiatric	376	11.0	14,154	1.6	26,581
Inpatient hospital	354	9.4	37,342	4.3	9,473
Clinic	327	8.7	201,246	23.2	1,626
Prescription drug	290	7.7	437,104	50.3	664
Targeted case management	266	7.1	144,508	16.6	1,840
Health maintenance org.	193	5.1	198,369	22.8	975
Physician	170	4.5	416,360	47.9	409
Prepaid health plan	159	4.2	251,902	29.0	632
Outpatient hospital	129	3.4	269,065	31.0	479
Home health	68	1.8	10,435	1.2	6,506
Other practitioners	57	1.5	142,148	16.4	400
Dental	55	1.5	238,715	27.5	229
Therapy	49	1.3	32,401	3.7	1,525
Home- and community-based <sup>a</sup>	38	1.0	2,898	0.3	13,267
Private-duty nurse	22	0.6	521	0.1	42,023
Laboratory and x-ray	21	0.6	233,051	26.8	89
ICF mental retardation	19	0.5	350	0.04	54,916
Transportation	19	0.5	34,144	3.9	559
Nursing facility	16	0.4	308	0.04	51,262
Personal care	14	0.4	2,019	0.2	6,723
Nurse practitioner	2	0.04	14,844	1.7	109
Primary care case mgt.	2	0.04	52,689	6.1	31
Midwife	0.1	0.00	817	0.1	149
Hospice	0.1	0.00	17	0.00	7,024
Abortion	0.06	0.00	127	0.01	443
Sterilization	0.05	0.00	504	0.1	106
Other mental health (for elderly)	0.04	0.00	22	0.00	1,656
<b>Total</b>	<b>\$3,768</b>	<b>100.0%</b>	<b>869,087</b>	<b>89.2%</b>	<b>\$4,336</b>

Source: FFY 2001 MSIS Summary File.

Note: Includes children adopted from foster care.

<sup>a</sup> Expenditures for home- and community-based services (HCBS) are reported separately in the MSIS and on the CMS-64, but are not designated by an MSIS service category. To create an HCBS service category variable, we use a state-by-state protocol to back out HCBS dollars from service categories, primarily "other," personal care, and home health, to prevent double counting of these dollars.

tively more on infants (\$5,149 per child), adolescents 11 to 15 (\$5,309), and older adolescents 16 to 18 (\$5,712) than other foster children. States also spent more on boys (\$4,792 per child) than on girls (\$3,827). States expended relatively more on Caucasian children (\$4,715 per child) than they did on African American (\$3,872) and Hispanic (\$3,921) foster children.

Receipt of TCM and capitated enrollment in an HMO or prepaid health plan (PHP) could explain some differences in service use by age, gen-

der, and race/ethnicity. Capitated enrollment also would affect how service expenditures are reported in the MSIS, as described earlier. Acute care services such as physician, outpatient, clinic, lab and x-ray, and inpatient services are most likely to be capitated, so we can expect them to be under-reported in the data. Below we stratify expenditures by receipt of TCM and capitated expenditures, to better compare service use across age, gender, and racial/ethnic groups. In the next section, we report variation across states.



TABLE 2. Demographic Characteristics of Foster Children Receiving Medicaid

	Percent of enrollees	Percent of spending	Percent receiving TCM	Percent with capitated health care spending	Expenditures per Enrollee		
					Total	With capitated health care spending	Without capitated health care spending
<b>Sex</b>							
Female	47%	42%	16%	45%	\$3,827	\$4,083	\$3,621
Male	53	58	17	44	4,792	4,950	4,667
<b>Age</b>							
Less than 1	2	3	19	28	5,149	6,932	4,455
1 to 5	20	14	19	45	3,087	3,000	3,158
6 to 10	26	20	16	46	3,349	3,622	3,117
11 to 15	30	36	17	46	5,309	5,526	5,127
16 to 18	18	24	15	44	5,712	6,043	5,454
19+	4	3	8	34	3,099	3,034	3,132
<b>Race</b>							
Caucasian	44	48	17	52	4,715	4,956	4,457
African American	35	31	20	39	3,872	3,964	3,813
Hispanic	8	7	18	62	3,921	3,671	4,324
Other	3	3	17	55	4,544	4,207	4,956
<b>All foster children</b>	<b>100%</b>	<b>100%</b>	<b>17%</b>	<b>44%</b>	<b>\$4,336</b>	<b>\$4,539</b>	<b>\$4,174</b>

Source: FFY 2001 MSIS Summary File.

Note: Includes children adopted from foster care.

### Medicaid Expenditures by Receipt of TCM

The Social Security Act that authorizes Medicaid defines case management as services that can help an individual eligible under the state plan gain access to needed medical, social, educational, and other services, but do not include the direct delivery of the underlying service. Case management services are “targeted” when states are permitted under a Medicaid-approved option to limit such services to specific classes of individuals and/or to individuals who reside in specified areas. States may define target populations based on eligibility for, or participation in, a state social welfare program or other programs; many states have designated foster children as a targeted population for case management services. While not defined by CMS, case management services are understood to include assessment of service needs, development of a specific service plan, referral and related activities to help the individual obtain needed services, and monitoring and follow-up.

Overall, approximately 17 percent of all foster children received TCM services. However, only 38 states funded TCM services for foster children

under Medicaid. In these states, 19 percent (144,508) of foster children received TCM services. In 11 of the 38 states, at least 40 percent of Medicaid-enrolled foster children received TCM services. In 18 states, less than 9 percent of foster children received TCM services.<sup>9</sup> There was relatively little variation in the receipt of TCM services by age, race/ethnicity, or gender. Overall, children under 5 years old were slightly more likely to receive TCM (19 percent). Caucasian children were slightly less likely to receive TCM (17 percent) than African American (20 percent) or Hispanic (18 percent) children. There were no differences in TCM receipt between boys and girls.

Because TCM services are intended to link recipients to other services, we compared the Medicaid expenditures of TCM and non-TCM recipients in states that funded TCM for foster children under Medicaid (table 3). TCM recipients were more likely than non-TCM recipients to receive several services, including physician (68 percent of TCM recipients compared with 44 percent of non-TCM recipients), prescription drug (70 versus 47 percent), dental (44 versus 24 percent), rehabilitative (23 versus 11 percent), inpatient (8 versus 4 percent), clinic (34 versus



TABLE 3. Spending for TCM and Non-TCM Foster Care Recipients

Service	TCM Enrollees (n = 144,508)		Non-TCM Enrollees (n = 626,760)		Difference	
	Percent receiving	Spending per child receiving	Percent receiving	Spending per child receiving	Percent receiving	Spending per child receiving
All		\$9,462		\$2,956		\$6,506
TCM	100%	1,841	0%	0	100%	1,841
Physician	68	399	44	246	25	153
Prescription drug	70	848	47	600	24	248
Dental	44	238	24	222	21	15
Other practitioner	31	621	14	297	17	323
Laboratory and x-ray	42	119	25	80	17	39
Outpatient	43	437	29	437	15	-1
Clinic	34	2,647	20	1,158	13	1,489
Rehabilitative	23	6,637	11	3,689	12	2,948
Therapy	11	1,767	2	1,309	9	458
Transportation	8	530	3	439	5	91
Inpatient hospital	8	11,629	4	8,105	5	3,525
Primary care case mgt.	9	35	6	30	4	5
Nurse practitioner	3	118	1	94	2	24
Home health	3	9,399	1	4,653	2	4,745
Inpatient psychiatric	3	22,686	1	25,394	2	-2,708
Personal care	1	6,672	0	7,095	1	-423
Home- and community-based	1	14,944	0	12,117	1	2,826
Other	30	3,586	29	1,920	0	1,666
Private duty nurse	0	43,105	0	36,076	0	7,029
Nursing facility	0	30,500	0	67,048	0	-36,548
ICF mental retardation	0	40,972	0	60,033	0	-19,061
Hospice	0	6,606	0	6,402	0	204
Other mental health (for elderly)	0	17,219	0	99	0	17,120
Abortion	0	336	0	518	0	-183
Midwife	0	156	0	142	0	14
Sterilization	0	91	0	101	0	-11
Prepaid health plan	23	516	28	464	-5	52
Health maintenance org.	17	1,183	23	943	-5	240

Source: FFY 2001 MSIS Summary File.

Notes: Includes children adopted from foster care. Includes only data from the 38 states with targeted case management expenditures for foster children.

20 percent), inpatient psychiatric (3 versus 1 percent), and home health care services (3 versus 1 percent). Moreover, states spent on average \$6,506 more on TCM recipients (\$4,665 more if you remove the TCM services received) than on non-recipients. Among recipients of a service, states expended \$2,948 more on rehabilitative services, \$3,525 more on inpatient services, \$1,489 more on clinic services, \$4,745 more on home health care services, and \$1,666 more on other services for TCM recipients than for non-TCM recipients.

### Capitated Health Care Enrollment and Spending in Fee-for-Service

Enrollment in capitated health care plans varies significantly among children and among states and may greatly affect the per enrollee spending reported in MSIS. Overall, states had capitated health care spending for approximately 44 percent of foster children (table 4). However, the difference among states is striking. In 19 states, at least 75 percent of foster children had capitated health care spending, while in 19 others, less than 15 percent of foster children did.

TABLE 4. State Medicaid Spending and Enrollment for Foster Children

State	Expenditures	Percent of total expenditures	Enrollees	Percent of total foster care enrollment	Spending per enrollee	Percent of enrollees with capitated health care spending
CA	\$401,936,035	10.67%	143,169	16.47%	\$2,807	85%
NY	394,120,419	10.46	79,418	9.14	4,963	11
IL	292,352,214	7.76	82,248	9.46	3,555	1
TX	184,882,555	4.91	31,185	3.59	5,929	16
PA	183,839,821	4.88	46,886	5.39	3,921	58
CO	144,300,926	3.83	16,878	1.94	8,550	95
NJ	142,733,135	3.79	19,828	2.28	7,199	6
MO	142,094,860	3.77	23,805	2.74	5,969	63
FL	135,779,718	3.60	40,545	4.67	3,349	72
OR	98,596,613	2.62	14,525	1.67	6,788	90
OH	91,687,967	2.43	40,533	4.66	2,262	1
MD	86,726,340	2.30	16,367	1.88	5,299	91
NC	73,275,317	1.94	15,680	1.80	4,673	26
TN	72,278,008	1.92	12,767	1.47	5,661	97
VA	71,981,745	1.91	14,334	1.65	5,022	0
KY	71,165,325	1.89	8,761	1.01	8,123	96
ME	65,307,764	1.73	3,365	0.39	19,408	19
MI	64,114,279	1.70	40,564	4.67	1,581	60
SC	61,706,085	1.64	7,692	0.89	8,022	7
AL	59,641,790	1.58	5,676	0.65	10,508	87
RI	57,542,250	1.53	5,537	0.64	10,392	47
NE	56,762,855	1.51	10,120	1.16	5,609	80
MN	56,441,343	1.50	9,065	1.04	6,226	11
WV	51,156,357	1.36	6,484	0.75	7,890	11
UT	49,403,486	1.31	6,581	0.76	7,507	92
KS	48,099,804	1.28	12,016	1.38	4,003	15
GA	47,381,816	1.26	18,877	2.17	2,510	14
WI	46,774,071	1.24	18,505	2.13	2,528	13
IN	45,849,829	1.22	12,056	1.39	3,803	21
DC	44,718,246	1.19	4,632	0.53	9,654	13
OK	39,669,933	1.05	6,387	0.73	6,211	16
IA	39,088,614	1.04	9,640	1.11	4,055	92
AR	38,663,242	1.03	5,913	0.68	6,539	94
NV	35,875,203	0.95	4,834	0.56	7,421	4
NM	35,111,947	0.93	3,587	0.41	9,789	79
VT	30,999,287	0.82	2,358	0.27	13,146	79
NH	30,134,052	0.80	2,605	0.30	11,568	6
MT	27,721,972	0.74	3,947	0.45	7,024	56
LA	22,958,250	0.61	9,540	1.10	2,407	2
WA	22,839,012	0.61	15,905	1.83	1,436	12
DE	16,580,621	0.44	1,934	0.22	8,573	77
AK	14,288,202	0.38	1,596	0.18	8,953	0
CT	13,114,767	0.35	8,858	1.02	1,481	77
ND	11,795,376	0.31	1,735	0.20	6,798	11
AZ	10,053,221	0.27	7,682	0.88	1,309	100
HI	7,817,237	0.21	5,045	0.58	1,550	95
MS	7,694,830	0.20	3,224	0.37	2,387	19
SD	7,141,826	0.19	1,776	0.20	4,021	100
WY	6,831,874	0.18	1,839	0.21	3,715	0
ID	5,924,151	0.16	1,973	0.23	3,003	28
<b>USA</b>	<b>\$3,768,414,806</b>	<b>100.00%</b>	<b>869,087</b>	<b>100.00%</b>	<b>\$4,336</b>	<b>44%</b>

Source: FFY 2001 MSIS Summary File.

Notes: Includes children adopted from foster care. Massachusetts data are not included in the table because the state significantly underreports Medicaid spending on foster children.



Children younger than age 1 were significantly less likely to have capitated health care spending (28 percent) than other age groups. In addition, Caucasian children were much more likely than African American children to have capitated health care spending (52 versus 39 percent), though Hispanic children were the most likely to have capitated health care spending (62 percent).

Medicaid expenditures were 9 percent higher on average for children with capitated health care spending than for children without capitated health care spending. This difference in expenditures is actually less than the 15 percent difference between all non-disabled children with capitated health care spending and those without. To reiterate, an important limitation of the MSIS data is that we do not know what services are provided under capitated health care and thus we do not know whether children with capitated health care expenditures in fact received more services.<sup>10</sup>

The difference in spending on children with and without capitated health care varies greatly by sex, age, and race. Medicaid expenditures were 6 percent higher per child on boys with capitated spending than boys without capitated spending, while the difference among girls was 13 percent. Medicaid expenditures were 56 percent higher on infants younger than age 1 with capitated spending than infants without. In contrast, states spent less per child on children age 1 to 5 and children 19 and older with capitated health care spending than those without (5 and 3 percent less, respectively). Finally, Medicaid expenditures were 11 percent higher per child on Caucasian children with capitated health spending than those without. In comparison, Medicaid expenditures were 4 percent higher on African American children with capitated health spending than those without, but 15 percent lower on Hispanic children with capitated health spending than those without.

### **State Variation in Medicaid Expenditures**

Per foster child Medicaid spending varies among states from \$1,309 in Arizona to \$19,408 in Maine. Twelve states expended more than \$8,000 and 11 states expended less than \$3,000 per enrolled foster child (table 4). This variation is much greater than the variation in per enrollee spending on other Medicaid eligibility groups.<sup>11</sup> The expenditures of eight states (CA, CO, IL,

MO, NJ, NY, PA, and TX) account for more than half of Medicaid spending nationally on foster children. Meanwhile, six states account for half of foster care enrollees nationally (CA, FL, IL, MI, NY, and PA).

We also see enormous variation in states' reliance on different health care delivery options. For example, while inpatient psychiatric services accounted for 10 percent of Medicaid expenditures for foster children nationally, these services were not reported in several states but accounted for more than a third of all Medicaid expenditures on foster children in New Jersey (data not shown). Similarly, rehabilitative services accounted for 13 percent of expenditures nationally but ranged at the state level from 0 to 45 percent (in Ohio) of expenditures. TCM accounted for 7 percent of expenditures nationally but for more than half the Medicaid expenditures on foster children in Oregon. Clinic services, 9 percent of expenditures nationally, were 65 percent of the expenditures in Alabama. Inpatient services, 9 percent of expenditures nationally, were 22 percent of expenditures in Washington. Home health services, less than 2 percent of expenditures nationally, were 14 percent of expenditures in Connecticut. Some of these differences may be due to differences in the penetration of capitated enrollment, which could affect both reported levels of capitated services and service patterns.


### **Discussion**

By documenting the significant variation in state Medicaid spending both across states and among enrollees with different demographic characteristics, this brief raises more questions than it answers. For example, do boys have greater mental health needs than girls, or are they simply more likely to be placed in residential settings? To what extent can racial differences in Medicaid spending be explained by differences in need, or differences in the state health care delivery systems in which greater numbers of minority foster children reside? To what extent can state variation in Medicaid spending be explained by differences in the population of foster children served, differences in optional services states provided (e.g., TCM and rehabilitative services), or the use of capitated health care plans? The dataset used for this analysis does not include information on enrollees' assessments or diagnoses. So we are unable to assess the underlying need for care in this population.

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*Per foster child Medicaid spending varies among states from \$1,309 in Arizona to \$19,408 in Maine.*





The MSIS data also raise the question of why a substantial minority of foster children apparently are not enrolled or do not receive Medicaid services. States may not enroll many of the large numbers of children who are in foster care for relatively short periods. States may also encourage foster and adoptive parents to place children on private insurance policies instead of relying on Medicaid. This may be particularly true for foster children placed with relatives; prior research has found that children in kinship care are less likely to receive Medicaid (Leslie et al. 2000; GAO 1995).

This analysis also raises the question of why so many children who leave foster care apparently do not retain their Medicaid eligibility. Analysis using monthly eligibility files could assist in determining the association between duration of enrollment and the likelihood of no reported expenditures, and receipt of specific services, such as capitation.

Our analysis using MSIS data does not examine Medicaid spending on the more than 700,000 children who were substantiated as victims of abuse or neglect by child welfare agencies but were not removed from their parents' homes. Many of these children were enrolled in Medicaid but cannot be identified in MSIS as involved with child welfare authorities. When a population like abused and neglected children is provided more formal oversight through mandated initial health screening and regular monitoring, the prevalence of health conditions may appear higher. Prior research has found that youth in contact with social service agencies are more likely to receive mental health services, even if they are not placed in foster care (Farmer et al. 2001). At the same time, research has found that foster children are more likely to receive mental health services than children involved with child welfare agencies who remain in their parents' home, even after controlling for need (Burns et al. 2004). Thus, the health care expenditures on children involved with child welfare agencies but not removed from their parents' homes are likely higher than the expenditures on the general population but lower than those on foster children.

Future research on Medicaid spending on children involved with child welfare agencies should be conducted with more detailed Medicaid claims data and/or links with child welfare administrative data. Such data would allow researchers to examine not only Medicaid enrollment and services receipt, but also assessments, diagnoses, and patterns of health care usage. Such data could also help examine the

timing of Medicaid service receipt and whether children involved with child welfare agencies have continuity of care as they are returned home, placed with relatives, or adopted. Linked data would also allow researchers to examine differences in Medicaid receipt between title IV-E and non-IV-E eligible children, children in foster care and those adopted, children in family foster care and congregate care placements, and foster children and children involved with child welfare agencies who remain in their parents' homes.

Our analysis of MSIS data found that TCM recipients received considerably more Medicaid services than non-recipients. States' use of TCM for foster children has been a topic of significant debate. While CMS has approved many state Medicaid plan amendments to add TCM as an optional service, several states that recently applied for similar amendments had their proposals denied. Moreover, President Bush's FFY 2006 budget proposes to clarify which services may be claimed under TCM and to lower the reimbursement rate for TCM services to the Medicaid administrative matching rate of 50 percent, with a projected savings to the federal government of \$129 million for FFY 2006 and \$3.1 billion over five years. The budget expresses the administration's concern that states are shifting costs that are the obligation of other programs to Medicaid. It is uncertain what impact such a change to TCM may have on children involved with the child welfare system. Without additional information on children's needs, it is hard to determine if TCM is helping foster children access additional services or if foster children who have significant needs and are receiving more services are also more likely to receive TCM.

The topic of federal child welfare financing has been hotly debated in the last two congresses, with various proposals for wide-scale reforms. However, the debate has almost exclusively focused on title IV-E spending, the federal open-ended entitlement that reimburses states for a portion of certain foster care and adoption expenses. Title IV-E does represent the largest federal funding source for child welfare—about \$5.3 billion in FFY 2001. However, Medicaid spending on children involved with child welfare agencies may not lag far behind. MSIS data show that states expended \$3.7 billion on foster children, at least \$2.1 billion of which was federal spending.<sup>12</sup>

While foster children are a small group compared to other categorically eligible Medicaid



recipients, their significant health and mental health needs make them disproportionately high users of Medicaid. At the same time, because foster children are a small eligible group, foster care advocates have expressed concern that the needs of these children may not be considered in debates about the future of Medicaid. This brief highlights the significant variation in state Medicaid spending on foster children. Understanding the state and federal policies that affect health care delivery choices for foster children is essential to foreseeing the potential effects of Medicaid reforms.

## Notes

1. Prior research found that identifying children using Medicaid eligibility files instead of linking Medicaid directly to state foster care administrative data leads to a sampling bias that overrepresents children in foster care who use more services (Rubin et al. 2005).
2. Except for children receiving adoption assistance in New Mexico who are not automatically eligible for Medicaid.
3. This enrollment estimate is based on all children who had an eligibility code of foster care in any month during the year and may overstate the actual number of children who received Medicaid while in foster care. A number of children who had an eligibility code of foster care in the early months of the year likely had left foster care late in the previous year and states had failed to change their eligibility code.
4. The number of children that exited foster care is based on data from the Adoption and Foster Care Analysis and Reporting System (AFCARS), <http://www.acf.hhs.gov/programs/cb/dis/tables/entryexit2002.htm>.
5. Data from AFCARS indicate that more than 817,000 children were served in foster care during FFY 2001 and that about 253,000 children received federally funded adoption subsidies. Given HHS estimates that approximately 74 percent of adoption subsidies are federally funded, we estimate the adoption population eligible for Medicaid as about 341,000. This estimate does not include children who have exited foster care to guardianship arrangements and may be eligible for Medicaid, and thus likely overestimates the percent of eligible children enrolled.
6. We define capitated spending to include any spending reported through health maintenance organizations, prepaid health plan, and primary care case management service categories.
7. These comparative estimates are based on all children under age 21 in child basis of eligibility categories and exclude children classified as disabled.
8. Even compared to all other Medicaid recipients, states expend a disproportionate share of Medicaid on foster children. Overall, foster children represent 1.8 percent of total Medicaid enrollees but account for 2.1 percent of total spending.
9. This variation in state enrollment is greater than the variation for other Medicaid services overall, but not much different than the variation in other optional services. For example, in 35 states, at least some foster children received rehabilitative services. In 8 of these states, at least 25 percent of all foster children received rehabilitative services while in foster care, less than 1 percent did so.
10. In addition, the share of children with spending is affected by the length of time they are enrolled in Medicaid. A likely pathway to enrollment in managed care is for the child to be initially enrolled through fee-for-service. This could happen through presumptive eligibility, or through retrospective fee-for-service payments to providers for services rendered before enrollment in Medicaid, and through the delays in the assignment process to a managed care plan for foster children relocating. It is possible that the non-capitated population is overrepresented by children newly enrolled in Medicaid. This might explain why children with capitated claims have somewhat higher total spending.
11. For example, per enrollee spending on all children varies from \$854 to \$3,138 with only two states below \$1,000 and four states above \$2,000 per enrollee. Per enrollee spending for all Medicaid enrollees varies from \$2,273 to \$7,749; only three states spend more than \$6,000 per enrollee.
12. This estimate is calculated based on each state's FMAP rate, but does not account for expenditures for which states received an enhanced federal match.

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