How Health Care Reform Can Help Children and Families in the Child Welfare System
Options for Action

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HOW HEALTH CARE REFORM CAN HELP CHILDREN AND FAMILIES IN THE CHILD WELFARE SYSTEM

The Affordable Care Act (ACA), enacted in March 2010 and taking full effect in January 2014, increases the number of people who have access to health insurance, simplifies insurance enrollment, requires that benefits include substance abuse and mental health coverage as well as medical services, and promotes innovations to help coordinate the fragmented delivery of care. All these changes, if implemented fully and carefully, would be particularly valuable for the highly vulnerable children and families in contact with the child welfare system. These families frequently have substantial health and mental health needs, lack insurance coverage completely (parents) or experience gaps in coverage when their circumstances change (children), and find the complex world of health insurance and health care difficult to navigate. For these vulnerable families, health care reform is truly, in the words of one expert we interviewed, “the biggest social service change in decades.”

The ACA also includes a specific provision to help one group of youth in the child welfare system: those who age out of foster care. The provision, effective in January 2014, requires states to extend Medicaid coverage to age 26 for all youth who are enrolled in Medicaid and in foster care on their 18th birthday or when they age out of foster care. A foster youth who was enrolled in Medicaid when he or she either turned 18 or aged out of foster care and who is younger than 26 on January 1, 2014, will be eligible for Medicaid under the ACA. This provision is intended to ensure these young people—just like others who can enroll in their parents’ plan—can have health insurance without interruption until they are 26 even though they are not living with their families.

Yet, none of the effects will come about automatically. For children, youth, and families involved with child welfare to get the health care help they are entitled to, child welfare leaders, policy experts, and
advocates, need to actively participate in ACA implementation. Effective participation means both informing those who make broader state policy choices and taking action within the child welfare system to revamp service delivery, involve staff and partner agencies, and reach out to youth and families.

This paper is meant to jump-start that process, drawing on interviews with 17 child welfare and health policy experts inside and outside government,3 as well as reviewing papers and web-based materials currently available. Its goals are as follows:

1. To provide an overview of the key opportunities and issues the ACA has engendered relevant to children and families enrolled in child welfare, targeted primarily to the child welfare community but also useful to Medicaid and other health experts.

2. To motivate child welfare leaders to get involved in ACA implementation and suggest particular topics around which their engagement is likely to be especially helpful.

3. To offer potential strategies for action by state and federal child welfare and health officials, philanthropic funders, and outside experts.

We focus on three groups specifically affected by the ACA: youth aging out of foster care, parents or guardians of children in (or at risk of entering) the child welfare system, and children already involved with the system. For each group, the second section of this paper analyzes the implications of the ACA for coverage (that is, whether and how they can get health insurance), and the third section analyzes the ACA’s implications for care (that is, the content of the benefits they can receive and special provisions affecting the quality and nature of service delivery). We summarize in boxes throughout the text potential actions for state, federal, and philanthropic stakeholders that could improve coverage and care for each of the three groups. The final section provides a brief conclusion.

Opportunities to Enhance Coverage

Table 1 summarizes the major ACA provisions that could enhance coverage for children and families involved with the child welfare system. One provision specific to child welfare extends coverage to youth who age out of foster care. The other provisions apply more broadly to low-income adults and to everyone enrolled in health care, but we describe below their potential importance to children and parents involved with child welfare.

Coverage for Youth Aging Out of Foster Care

Effective January 1, 2014, the ACA provides that youth in foster care on their 18th birthday are eligible for Medicaid until they turn 26. The provision gives these youth access to health coverage that their parents are unable to extend to them, just as other parts of the ACA furnish coverage to other young people by giving them the right, until their 26th birthday, to enroll in their parents’ health plans. As table 1 indicates, this provision is separate from the ACA provisions that add newly income-eligible adults to the Medicaid program; it is a mandatory expansion, not affected by the Supreme Court decision that gives states the option to implement the act’s expansion to cover adults with an income up to 133 percent of the federal poverty level (FPL). In addition, as explained more fully in the discussion of care below, young people eligible for Medicaid under this provision are to receive full Medicaid benefits, not the “alternative benefit plan”4 that states may define for newly eligible adults.
TABLE 1. ACA Provisions That Affect Health Coverage for Youth, Children, and Parents Involved in the Child Welfare System

Youth Aging Out of Foster Care
- The ACA requires all states, starting on January 1, 2014, to extend Medicaid eligibility to former foster care children who were (1) in “foster care under the responsibility of the State” and receiving Medicaid when they turned 18 (or the applicable higher age in a state that provides foster care assistance to a later age) and (2) have not turned 26. Income is irrelevant to eligibility for this category of Medicaid.
- The Center for Medicaid Services’ (CMS) proposed rule provides that states (1) are only required to extend Medicaid coverage to age 26 for those eligible youth who aged out of foster care in their state or (2) may choose an option to include youth currently residing in the state but who aged out in another state. CMS specifically asked for comment on their interpretation of this statute.
- Former foster care children must be treated as such, not as newly eligible adults, even if they seem to qualify as newly eligible adults; that is, their income is at or below 133 percent of FPL and they would not have qualified for Medicaid before the ACA. Accordingly, states receive standard federal matching payments for all former foster care children, not the greatly enhanced match that ACA provides to newly eligible adults.
- The U.S. Supreme Court decision about the ACA does not affect this requirement to cover former foster children.

Parents of Children in the Child Welfare System
- The ACA includes an expansion of Medicaid coverage to all adults with incomes up to 133 percent of FPL. However, the U.S. Supreme Court concluded that states that fail to implement this expansion may not be sanctioned with the loss of all federal matching funds for their entire Medicaid program. This finding has been described as a “state option” to implement the expansion.
- States that decide to implement the ACA expansion of Medicaid to all adults with incomes up to 133 percent of FPL receive a highly enhanced match for all newly eligible adults. This match covers 100 percent of health care costs during calendar years 2014 through 2016. Starting in 2017, this percentage gradually declines to 90 percent in 2020 and later years.
- For two groups of parents who receive Medicaid because of their state’s decision to extend adult eligibility beyond the minimum requirements of federal law—namely, parents covered through either (1) a Medicaid expansion adopted after the ACA’s passage and in effect before 2014 or (2) a Medicaid expansion for adults with income over 133 percent of FPL in 2014 or later—these parents may not receive Medicaid unless their children have health coverage, through either Medicaid or another source.
- Parents with incomes above 133 percent but not more than 400 percent of FPL will be eligible for subsidized health insurance through the exchange in all states.

Everyone—Youth Aging Out, Parents, and Children
- The ACA requires highly streamlined methods for eligibility determination, enrollment, and retention. For example, a single, simple application is used for all health coverage programs. Regardless of where the application is filed (e.g., with the insurance exchange or with the Medicaid agency), agencies cooperate behind the scenes to sort the applicant into the right program, eliminating any need for the family to go from program to program. Eligibility is determined by matches with third-party data, whenever possible, rather than documentation provided by the consumer, and applications and renewals can take place in person, by phone, online, or by mail.

a. This reflects CMS’s interpretation in the Notice of Proposed Rulemaking of Social Security Act Section 1902(a)(10)(A)(i)(IX), added by ACA Section 2004 and amended by ACA Section 10201. The statute is less specific than the proposed regulation about whether the requirement of Medicaid coverage during foster care is tied to a youth’s 18th birthday.
c. Social Security Act Section 1902(a)(10), clause (XVI) in the matter following subparagraph (G), as enacted by ACA Section 10201(a)(2).
e. Social Security Act Section 1902(k)(5), added by ACA Section 2001(a)(4).
g. ACA Section 1413.
The number of youth newly eligible for coverage under this provision is hard to estimate, and the share of those eligible who will actually enroll is even harder to estimate. A high-end estimate can be derived from the Adoption and Foster Care Analysis and Reporting System (AFCARS) 2006–2011 data (U.S. Department of Health and Human Services [HHS], Children’s Bureau 2009a, 2009b, 2010a, 2011a, 2012), which indicate that approximately 26,000–29,000 youth age out of foster care per year. If all were 18 when they aged out, then eight cohorts of youth (those who turned 18 from 2006 to 2013) would mean anywhere from 208,000 to 232,000 youth would be younger than age 26 and thus eligible for coverage on January 1, 2014. However, this range is clearly too high because some states maintain youth in foster care until age 19, 20, or 21; youth who aged out in these states in the earlier years—say, those who were 20 rather than 18 in 2006—will be past the age limit by 2014. This estimate is also too high because some youth who age out are already eligible for Medicaid through Supplemental Security Income as a result of a disability, so they do not represent new eligibles, and potentially because (as indicated below) CMS’s proposed regulation limits eligibility for youth who move across state lines after they leave foster care. On the lower end, CMS’s Notice of Proposed Rulemaking estimates that 55,000 former foster youth will actually take advantage of their new Medicaid eligibility in 2014, increasing to 74,000 by 2017.5

While the total number of youth affected may seem small, they represent a vulnerable, high-need, and potentially high-cost population. Youth who have aged out of foster care are more likely than their general peers to have a health condition that limits their daily activities, are more likely to take part in psychological and substance abuse counseling, and are less likely to be insured (Baumrucker et al. 2012). The Congressional Research Service reports that between 35 and 60 percent of youth who enter foster care have at least one chronic or acute health condition that needs treatment, and 50 to 75 percent of foster youth exhibit behavioral or social competency issues that may require mental health treatment. Further, nearly half of children in foster care suffer from chronic conditions such as asthma, cognitive abnormalities, visual and auditory problems, dental decay, and malnutrition, and they are also more likely to experience developmental delays or emotional and behavioral problems (Kruszka et al. 2012). More than half of foster children require ongoing medical treatment, and an even larger proportion have moderate to severe mental health problems, with Medicaid claims data suggesting that as many as 57 percent of youth in foster care meet criteria for a mental disorder (dosReis et al. 2001). Young adults who were involved in out-of-home care during adolescence are more than twice as likely as their peers to have a current mental health problem, have higher rates of drug dependence than their peers, and experience higher rates of housing instability and homelessness, with 22.2 percent of youth who aged out of foster care finding themselves homeless at least once within a year of leaving foster care (Pecora et al. 2006). Youth who have aged out of foster care also have higher rates of childbirth, with a study finding that this population is twice as likely to have a child in the household by age 21 (Courtney et al. 2007).

What will it take to get these youth health insurance coverage under Medicaid and make sure they keep it until they turn 26? Recent research offers useful evidence, drawn from the experience of states that have implemented Chafee programs, which allow the extension of Medicaid from age 18 to age 21 for youth aging out of foster care. Important lessons from a study of 30 states (Pergamit et al. 2012) include the following:

- States varied greatly in their approach to enrolling youth in Medicaid and redetermining their eligibility, from those that required youth to go to a Medicaid office and enroll (with or without help from a social worker) to those that handled the whole transaction automatically, with no involvement required from the youth or social worker.
Based on the available data, those states with the most automatic forms of enrollment and redetermination appeared to keep the largest number of youth on Medicaid. In states that required youth involvement in enrollment, youth were less likely to be enrolled in the month before their 19th birthday.

Child welfare staff often understood very little about Medicaid enrollment for youth aging out of foster care.

States where child welfare agencies were more involved in designing the enrollment process were more likely to have automated enrollment and integrated data systems. In states where the child welfare agency was minimally involved, the Medicaid agency was more likely to try to fit former foster youth into their existing system.

States have a perfect opportunity to apply these lessons to the new provision. Because of the ACA’s emphasis on easy and automatic enrollment and the federal resources currently available for states to redo their Medicaid and human services eligibility system, many states are now designing and performing major systems overhauls. Medicaid regulations driving these ACA changes require eligibility to be granted, without asking for documentation, whenever data matches and applicant attestations are reasonably consistent; this would include instances when former foster care children identify themselves as such and state records establish that they were in the foster care system at age 18. Similarly, Medicaid regulations require eligibility to be continued automatically whenever the information in state hands is sufficient to demonstrate continued eligibility, which is very likely to be the case for former foster care children younger than age 26. Improvements to ensure easy, automatic, and continuous eligibility as young people age out of foster care should thus be included. Necessary upgrades to information technology systems serving foster care programs can be funded with all-Medicaid dollars, including 90 percent of funding from federal matching funds, so long as those upgrades take place by December 31, 2015. If states miss this opportunity and use a process that requires considerable intervention from the child welfare agency or the youth, they raise the risk of causing these youth to remain without health insurance.

More difficult than enrolling young people as they age out of foster care will be finding and enrolling those who have already aged out, as in those who turned 18 in foster care several years ago and are no longer in the system. Some state child welfare agencies and their nonprofit partners may have gained experience finding youth when they adopted the Chafee option or in some other way expanded Medicaid eligibility to age 21. However, given the high rates of these youth’s housing instability and homelessness as described above, finding them could be difficult. Among the strategies mentioned by those we interviewed who are tracing youth through nonprofit service-delivery organizations, was (1) convening focus groups of foster youth to talk about strategies they think would work, (2) using broad public information messages, and (3) ensuring that people involved and required by Medicaid to help the public enroll in health insurance, also known as “navigators,” understand they should ask about former foster care status.

CMS’s proposed regulations require a state to cover only those former foster youth who aged out of foster care in that same state. According to the proposed regulations, states will have the option to cover youth in their state who aged out of foster care in other states, but doing so is not mandated. CMS specifically sought comments about this provision, and a number of organizations have replied that it poses major challenges to reaching these youth and keeping them enrolled in health insurance, given the limited data available about their frequent moves (Houshyar 2013). To our knowledge, no data exist about these youth indicating the frequency of moves across state lines.
To achieve the goals of the provision and ensure that as many youth as possible have continued (and, ideally, seamless) coverage through age 26, even when they move across state lines, the federal government may be able to help states transfer information about these youth, whether the final regulation either requires or leaves as an option to provide coverage for youth from other states. It may be able to offer technical assistance to help states resolve how this continued coverage could occur and what roles the sending and receiving states should play. (See boxes for potential actions for state officials, federal officials, and philanthropic organizations.)

**Potential Actions for State Child Welfare Leaders**

**Population Focus: Youth Aging Out of Foster Care**

**Key questions child welfare state leaders need to answer in partnership with their Medicaid colleagues:**
- What will the enrollment and redetermination processes for Medicaid look like for youth currently in foster care and aging out in 2014 and beyond? What steps can be taken to ensure automatic enrollment?
- What will be the process for finding and enrolling youth who aged out before 2014 but who are still younger than 26? The child welfare agency and its networks of nonprofit partners will likely need to take the lead, but the Medicaid agency will need to ensure its public enrollment web site, and those at exchange call centers and community-based organizations that are contracted with Medicaid programs to provide application and enrollment assistance will be able to flag former foster youth.
- What benefits will be available to youth? What will be the approach to inform them about their health care coverage? How can we design plans with the right mix of benefits, including care coordination and case management to help them get to the right services, and to sign them up for the plan best tailored to their needs?

**Key actions:**
Reach out to state Medicaid and health colleagues who may be making relevant decisions about enrollment and benefits right now.
- Gather data about the foster youth aging out in your state (e.g., numbers affected by the provision, health and mental health needs). Gather any information you have about youth moving out-of-state and their destinations (e.g., in college, staying with out-of-state relatives, moving around a multistate metropolitan area).
- If a Chafee state, or a state that provided Medicaid coverage to youth aging out of foster care, review relevant data on past experiences with Chafee implementation and reflect on the lessons learned.
- Ensure your state’s plans for automated enrollment, eligibility determination, and redetermination for Medicaid include, at a minimum, (1) a smooth and automated approach for enrolling youth currently in the foster care system into Medicaid at the point where they age out of foster care; and (2) a strategy for keeping them in Medicaid with minimum intervention required until they turn 26 (or, depending on the final regulation, move out of state).
- Develop a strategy for reaching out to youth who have already aged out of foster care, especially those who may have lost touch with the system, and work with the Medicaid agency to make enrollment as smooth as possible for this group as well.
  - Consider focus groups with youth and/or youth-serving organizations.
- Develop and roll out a plan for how child welfare staff and partners will help enroll, educate, and support youth in both groups (those now in foster care and those who have already aged out of it) so they can best use the new health insurance benefit.
  - Engage and train child welfare agency staff so they are fully comfortable with their role in enrolling both groups of youth into Medicaid and supporting them through the process.
  - Engage outreach and public education networks that can help reach and support youth.
- If the final CMS regulations continue to provide an option, but not a mandate, for covering youth who aged out of foster care in other states, inform the discussion regarding the option in your state and consider reaching out (in partnership with your Medicaid colleagues) to states that are frequent destinations for youth from your state.
- Develop a method (as seamless and automated as possible) to confirm a youth’s status as having aged out of foster care in your state when you receive requests from another state that the youth may have moved to.
As states move to implement this provision, the child welfare and health policy experts we interviewed raised a number of policy questions for clarification at the state and federal levels. These questions should not hold up the urgent implementation actions, but the answers may lead to fine-tuning actions along the way.

First, based on the Chafee experience, states and the federal government may need to examine definitions of foster care to ensure youth do not lose health insurance eligibility because of state choices about how to define care arrangements. Some states may place youth with kin in arrangements that are less formal than foster care but do involve state oversight, for example, through systematic use of Temporary Assistance for Needy Families (TANF) child-only grants in situations that other states would treat as foster care. According to one interview, one such arrangement was not treated as foster care for the purpose of the Chafee Medicaid expansion. We have not explored this issue enough to identify specific solutions but would urge attention at both state and federal levels to protect youth’s health insurance eligibility.

Second, some interview participants expressed concern regarding the health insurance options available to teenagers in the child welfare system who do not age out, but instead achieve a permanent home through guardianship before they turn 18. From the child welfare perspective, subsidized guardianship is a better outcome for a young person than aging out of foster care because it provides a permanent family. However, child welfare experts and stakeholders are concerned that potential guardians might face a disincentive because youth would not be eligible for Medicaid upon turning 18 and because they also may not be covered under a guardian’s insurance plan. Those we interviewed said that it is unclear whether insurance companies are required to cover young adults under a guardian’s plan. But, at a minimum, if an employer plan offers dependent coverage to the children of guardians, it must extend such coverage until such children’s 26th birthdays, based on the ACA’s statutory language.

Potential Actions for Federal Child Welfare and Health Leaders

**Population Focus: Youth Aging Out of Foster Care**

- The key federal agency that serves youth aging out of foster care, the Administration for Children and Families (ACF), and the two key federal agencies overseeing the ACA’s health and mental health services provisions, the Center for Medicaid and Medicare Services (CMS), and the Substance Abuse and Mental Health Administration (SAMHSA), should promptly begin technical assistance activities to support state officials in the activities laid out in this report. As part of this technical assistance effort, the agencies should consider performing the following actions:
  - Immediately develop and disseminate technical assistance materials that will provide crucial information to all states and partners, such as a short information piece, list of frequently asked questions, or webinar.
  - Plan and carry out a series of more intensive technical assistance activities, such as telephone or in-person consultations with state officials and peer learning meetings.
  - As they emerge, identify and disseminate best practices from states.
  - Promote state and cross-state data collection to track health coverage for these youth, and help states develop measures and measurement strategies that draw on both child welfare and health expertise.
  - Address specific challenging issues, including those raised earlier. For example, help states develop a model approach to providing health insurance for youth in subsidized guardianships after they turn 18.
  - Provide overall guidance and technical assistance for a cross-state framework that will ensure youth aging out of foster care will be covered by Medicaid and receive needed benefits, whether they stay in the state where they were in care, or move across state lines. Such a technical assistance role would be valuable whether the final regulations require states to cover these youth or to leave cross-state coverage as an option, as in the proposed rules.
Addressing this issue is urgent because kin and foster caregivers are making decisions now about whether to agree to become permanent guardians for teens currently in foster care. Therefore, we would encourage both state and federal policymakers to address this concern promptly to encourage kin and caregivers to provide permanent arrangements for children. In addition, this question seems important to consider given the greatly increased role of guardianships: 12,15,707 youth went from foster care to guardianship in 2011. 13

Coverage for Parents in the Child Welfare System

The opportunities the ACA offers for uninsured adults to gain coverage (see table 1) are especially important for parents involved with the child welfare system because they often experience a high level of medical and mental health problems themselves. Research based on a national sample of children reported to child welfare hotlines for maltreatment shows that these children’s parents have very high mental health and substance abuse service needs and generally are not in good health. Only 39.8 percent of parents reported for maltreatment of their children report themselves in very good or excellent health. About one-fifth (19.6 percent) of parents in the sample scored in the clinical range for major depression within the past 12 months before their interview, compared with 7 percent among the general population (Dolan et al. 2011). Almost half (46 percent) of caregivers reported having experienced major depression in their lifetime, almost three times the national estimate of adult lifetime prevalence for depression, 17 percent (Dolan et al. 2011).

In addition, because untreated substance abuse and mental health problems can be underlying reasons for children’s maltreatment, providing parents with health care coverage can give them access to services that have the potential to help prevent abuse and neglect, enable parents to keep children safely at home after an incident, and help parents address their own problems so children can more quickly and safely reunite with them from foster care. When parents with mental health problems receive coverage and care, the incidence of maltreatment among their children can decline (Golden and Fortuny 2011;
Golden et al. 2011). The scale of these benefits could be very large, potentially affecting millions of families: more than 3 million reports of abuse and neglect were documented in 2010 (HHS, Children’s Bureau 2011b).

Today, the typical state sets the Medicaid eligibility ceiling for parents extremely low, with coverage in the median state capped at 63 and 37 percent of FPL for working and nonworking parents, respectively, meaning that many poor and low-income parents are not eligible for health or mental health coverage at all (Heberlein et al. 2012). In addition, even if states were to provide coverage for parents while their children live at home, they generally do not cover childless adults at any income level. Our interviewees reported that this policy means a parent will lose Medicaid eligibility if children are taken out of the home and placed in foster care. With no funding stream for treatment, the child welfare agency (or other largely state-funded source, such as the mental health agency) may support services for parents, but these services may be limited in intensity and quality or have long waiting lists.

As table 1 indicates, under the ACA, states will receive highly enhanced federal reimbursement if they take the option to provide Medicaid coverage to previously ineligible adults with incomes up to 133 percent of FPL, ensuring that parents at risk of maltreating a child as well as parents who have already entered the child welfare system can receive health insurance. Taking this option will also allow states to substitute federal Medicaid dollars for current state spending on mental health services furnished to uninsured, poor, and limited income adults. In all states, parents whose incomes are above 133 percent of FPL will be eligible for subsidized health care coverage through the insurance exchange.

Several major policy and implementation steps affect these important opportunities to expand parents’ general health and mental health coverage. First is the policy choice available to states as a result of the Supreme Court’s decision regarding the ACA (see table 1): whether to implement the expansion of Medicaid to all adults with incomes up to 133 percent of FPL. As indicated in the previous box detailing action steps, those child welfare and health leaders we interviewed thought that child welfare agencies in some states might be able to guide this decision—for example, by ensuring decisionmakers understand the extent of state-funded mental health care and parenting programs that could instead be federally funded through Medicaid if the state chooses that option, or by providing evidence about the potential opportunity to prevent or shorten foster care stays if parents get treatment.

To bring about change, state child welfare officials can play an important role in enrolling qualified parents in Medicaid coverage, whatever the state’s choice. For states that do adopt the Medicaid expansion, a key issue is how best to ensure that parents in these vulnerable families get and keep the coverage they are eligible for as easily and smoothly as possible. Part of the answer is the same as for other low-income families: the more customer-friendly the enrollment and redetermination systems, the better for everyone. In addition, we heard ideas from those we interviewed about how the child welfare system in particular could help: for example, the suggestion that as soon as children are known to the system in any way—through a report of maltreatment, for example—parents should immediately be enrolled. One interviewee suggested that a push to enroll all children in contact with the system in 2013 could pay off for parents in 2014, particularly if states use that enrollment effort to identify uninsured parents and lay the groundwork for enrolling them into Medicaid starting in 2014.

Another important issue for states that adopt the Medicaid expansion is how to handle the potential financial windfall the state will receive when it gets federal reimbursement for services that are now state funded—for example, mental health services provided through general fund revenues in the child welfare...
Potential Actions for State Child Welfare Leaders

Population Focus: Parents
In states that are undecided about the Medicaid expansion, child welfare leaders may have a role in guiding the decision. State leaders are in the best position to decide whether this role would be useful in their state.
- If your state is reviewing information about state-funded spending for mental health and substance abuse services for adults covered by the expansion, child welfare officials can ensure child welfare agency spending is included in that review.
- In states looking to estimate cost savings from early treatment of health and mental health problems, child welfare officials can provide data about the number of children who enter foster care, or who cannot be reunified with their families because of their parents’ unmet health and mental health needs.

For states that will not be expanding Medicaid coverage for low-income adults, include this action step:
- Coordinate with Medicaid and health officials to ensure child welfare parents benefit from improvements in enrollment for those currently eligible for Medicaid.

For states that will be expanding Medicaid coverage for low-income adults, include these action steps:
- Inform the Medicaid agency about the needs and circumstances of the extremely isolated and vulnerable parents involved with child welfare and the best opportunities to reach them.
- Redesign child welfare processes and systems to ensure that parents are enrolled as soon as they have contact with the child welfare agency.
- Train staff and community partners and educate parents and their networks promptly so everyone is well informed in advance.
- Work closely with Medicaid and health agencies that are considering “health homes,” an optional service that can be tailored to specific groups of Medicaid participants such as those with chronic health and mental health needs, or are considering other integrated benefit strategies for this population as a possible target group.
- Influence state Medicaid agency decisions about whether to use some new federal Medicaid dollars to strengthen behavioral health and social services systems.

Potential Actions for Federal Child Welfare and Health Leaders

Population Focus: Parents
- Consider ongoing technical assistance activities supported jointly by ACF, CMS, and SAMHSA to help state officials from Medicaid, health agencies, behavioral health agencies, and child welfare agencies get and stay connected on issues affecting child welfare families (both parents and children).
- Consider building on the strong relationships already developed between children’s well-being and psychotropic medication.a
  - Begin with relatively brief activities such as a joint webinar or letter to state directors.
  - Consider a jointly funded technical assistance center for child welfare and the ACA.
- Consider joint ACF-CMS-SAMHSA guidance on several specific issues.
  - Joint guidance for developing health home applications targeting families with high needs for both parents and children (two-generational) (Howell, Golden, and Beardslee 2013).
  - Joint guidance for those at exchange call centers and community-based organizations contracted with Medicaid programs who will be helping vulnerable people through the enrollment process.
  - Joint materials about enrollment issues for special populations.

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a. Because of concerns that children in foster care may be overmedicated or inappropriately medicated, the Children’s Bureau has worked to promote links between child welfare and health on this topic. See http://www.nrcyd.ou.edu/publication-db/documents/psychmedyouthguide.pdf.
Potential Actions for Philanthropic Leaders

Population Focus: Parents

• Amplify the reach of federal technical assistance by supporting outreach to more audiences and more thoroughly publicizing best practices and disseminating information to other states.
• Support broad public outreach to vulnerable populations and their support networks.
• Partner with health funders to identify and support intensive demonstrations in a few key areas — for example, health home design, integrated service delivery, care coordination for families with complex needs, or preventive services for parents.
• Support child welfare advocacy organizations, child welfare experts, and other external stakeholders to gather information and analyze data about parents and their needs, provide input to states, and make recommendations for policy choices and implementation strategies.
• Track implementation of health care reform from the perspective of child welfare families.
• Assess successes and gaps during the transition and implementation period and issue regular information about where these fragile populations are and the next steps to take.
• Develop joint materials on enrollment issues for special populations.

In states that do not choose to implement the Medicaid expansion, a key implementation step will be to ensure that all parents currently eligible for Medicaid coverage get enrolled. Depending on the state, there may be hundreds of thousands who are eligible but not yet enrolled (Kenney et al. 2012). As a result of the ACA’s requirement that the eligibility and redetermination process be streamlined, the publicity surrounding health care reform, the improvements in automated systems that states are now undertaking with federal support, the requirement that most Americans must obtain health coverage, and the availability of new subsidies in health insurance exchanges, currently eligible adults will be more likely to sign up for Medicaid, even in states that fail to enact the Medicaid expansion (Holahan et al. 2012). Child welfare agencies have the opportunity to provide hands-on assistance that helps parents who have children in the system take advantage of these improvements, despite their often chaotic lives.

Coverage for Children Involved with the Child Welfare System

The implications of the ACA for children currently involved with the child welfare system are less dramatic than the implications for those young people who have aged out of foster care or for parents. The reason is because most children currently involved in the system are eligible for Medicaid today, before ACA implementation, because of either their families’ low income or their current foster care status. However, there are still big opportunities for improvement in these children’s health coverage, particularly improved continuity as they move from one setting to another. These improvements may matter a great deal given their high level of medical and mental health problems.

Children involved with the system but not in foster care

At the front end of the child welfare system, millions of children have their initial contact with the system represented by a referral to states’ child abuse and neglect hotlines. In 2010 alone there were...
3.3 million referrals to the child welfare system that included 5.9 million children (HHS, Administration on Children and Families 2010). Recent research has demonstrated the major health and developmental challenges facing these children whether or not the maltreatment is substantiated. For example, infants and toddlers in this group have high rates of developmental delay compared with those in the general population, even when the maltreatment is not substantiated. A study has found that nearly 60 percent of foster children between the ages of 6 months and 2 years were at high risk for developmental delays or neurological impairment (Vandivere, Chalk, and Moore 2003). Children who come into contact with child welfare are less likely to be reported as being in “very good” or “excellent” health than their general peers (78 percent for children reported to child welfare versus 84 percent for children overall) (Baumrucker et al. 2012).

For these children, one key opportunity offered by the ACA is simpler enrollment into Medicaid for them and their parents (see table 1). Child welfare agencies have the opportunity to use this initial contact to ensure that all these children and their families have health insurance coverage.

However, those we interviewed also noted that the complexity and instability of these children’s family situations could continue to place their health care coverage at risk under the ACA. Children in these particularly vulnerable families may move frequently among different relatives and in and out of formal care, with parents sometimes present and sometimes not, which can create difficulties in maintaining continuity of coverage. As one interviewee noted, the issue of complex families like these is “something that we are constantly worried about” in implementing the ACA. Because the children involved in the child welfare system are likely to be consistently eligible for Medicaid until age 18, determining ways that child welfare and Medicaid can collaborate to ensure health care continuity is essential to making sure they do not get lost in the cracks, once reform is enacted. An important step toward achieving that goal is likely to be assigning to a social worker or other qualified person the ongoing responsibility for tracking changes in these children’s circumstances while making sure they retain an ongoing, continuous source of health care coverage, no matter what else changes. However, although continuous coverage is key, ensuring coverage alone does not guarantee continuity of care.

**Children in foster care**

Even though almost all children in foster care have health insurance coverage through Medicaid, observers have identified a number of problems. Some, such as overprescription of psychotropic medications, have to do with the quality of care, which is addressed in the next section. On the coverage side, the biggest issue identified by child welfare experts we interviewed is continuity and in particular, ensuring that coverage will continue uninterrupted when children return from out-of-home care and are reunified with their parents. Seizing opportunities to ensure continued enrollment when children are reunified with their families and looking for opportunities to make this enrollment automatic, along with ongoing, hands-on responsibility for maintaining coverage and access to care, need to be priorities for policymakers.

**Children who spend time in the juvenile justice system**

Those we interviewed also highlighted the need to understand health insurance eligibility under the ACA for children and youth who spend time in the juvenile justice system. We mention this issue here because there is considerable movement back and forth for young people from troubled families. For these young people, continuity of coverage while they are in foster care, in the juvenile justice system, home with parents, or on their own is particularly important. We were not able to delve extensively into
Potential Actions for State Child Welfare Leaders

Population Focus: Children

- Work closely with state Medicaid, health partners, and health experts to promote full enrollment in health insurance for the vulnerable children in the child welfare system, as well as continuity when their family circumstances change.
- Serve as a resource to the health experts on the circumstances of children involved with child welfare, at risk of involvement, or reunified afterward.
- Identify improvements to child welfare processes, systems, and staffing that can ensure initial and continuing enrollment for children at any point of contact with the system.
- Work closely with health experts to maximize the state’s ability to draw on federal Medicaid dollars to provide high-quality health and mental health benefits in a coordinated manner to these very vulnerable children. In some states, this may mean working to ensure that current approaches to care for foster children are adapted appropriately to the ACA; in other states, the ACA may open up new opportunities.
- Work closely with state Medicaid and health partners to take advantage of health homes and other new opportunities under the ACA to provide enriched service delivery for children at risk of involvement or in the system who have high levels of health and mental health needs.

Potential Actions for Federal Child Welfare and Health Leaders

Population Focus: Children

- Provide ongoing technical assistance activities supported jointly by ACF, CMS, and SAMHSA to help state officials from Medicaid, health agencies, behavioral health agencies, and child welfare agencies get and stay connected on issues affecting child welfare families (both parents and children).
- Consider joint ACF-CMS-SAMHSA guidance on several specific issues:
  - Direction about how to develop health home applications targeting families with high needs for both parents and children (two-generational) (Howell et al. 2013).
  - Peer-to-peer technical assistance to help states that want to continue or create enriched service delivery systems under the ACA for children with major behavioral health needs, including benefits for children in foster care or at risk of foster care, that could keep them at home or in the community instead of in institutions.
  - Clarification by CMS that interventions under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions of Medicaid to address a child’s developmental challenges can include treatments for the dyad (parent and child) or family, whether or not the parent is eligible for Medicaid.
  - Develop avenues to promote continuity for children in the child welfare and juvenile justice systems.

Potential Actions for Philanthropic Leaders

Population Focus: Children

- Partner with health funders to identify and support intensive demonstrations in a few key areas—that is, health home design, integrated service delivery, care coordination for complex families, or preventive services for parents.
- Commission papers and share peer expertise to fill in knowledge gaps that federal and state officials may not have time to address.
- Track the implications of health care reform for children in the child welfare system and for subgroups, including racial and ethnic minorities, children with major health and mental health problems, and children who have been reunified.
- Support child welfare advocacy organizations, child welfare experts, and other external stakeholders in gathering information and analyzing data about parents and their needs, providing input to states, and making recommendations for policy choices and implementation strategies.
- Leverage the commitment of health funders by supporting additional tracking that specifically focuses on children in the child welfare system.
the Medicaid and ACA issues for this population within the scope of this paper. Nevertheless, work before the enactment of the ACA suggested the importance of several specific strategies to achieve the following goals:

- Simplify enrollment into Medicaid and the Children’s Health Insurance Program;
- Retain health coverage through transitions that young people experience; and
- Integrate and coordinate services with partners of juvenile justice agencies (Schwartz and Glascock 2008).

Further developing these strategies in light of the ACA will require exploration in future work.

**Opportunities to Improve Care**

Getting and keeping health insurance coverage through Medicaid is a critical first step for children, youth, and parents involved with the child welfare system. But the end goal is not just staying insured but also getting effective and high-quality health care, leading to better physical and emotional health. Therefore, child welfare agencies also need to understand the key state decisions that affect the benefit packages for these vulnerable children and adults, as well as the opportunities for case management and other approaches to better-coordinated care. Table 2 summarizes the ACA’s key provisions.

**Care for Youth Aging Out of Foster Care**

As we have seen, youth aging out of foster care experience high levels of health problems and need high-quality medical and mental health treatment as well as help navigating the complex world of health care. It is not surprising that with the combination of complex needs, limited personal support, and highly stressful and unstable lives, they find negotiating the health care world a daunting task. One researcher we interviewed notes that youth he has studied may understand little or nothing about the meaning of Medicaid enrollment, and youth will need several kinds of help to get good care:

> [We need to] make sure they are aware they are enrolled, understanding the benefits of being enrolled . . . helping them learn how to find a provider, value of seeking health care, their options, what they are, those kinds of things.

The ACA offers opportunities to provide these youth with all these kinds of help, including a strong benefit package and better-coordinated care. As indicated in table 2, the ACA requires that states provide youth aging out of foster care with the full Medicaid benefit, not the alternative benefit that the state is allowed to choose for adults newly eligible for the ACA based on their low income. Until the youth turn 21, they will be covered by Medicaid’s benefit package for children, called EPSDT (for Early and Periodic Screening, Diagnostic, and Treatment); after that, they will be covered by their state’s benefit package for adults (Kenney and Pelletier 2010). EPSDT includes regular screenings for health and developmental problems and all treatment that is medically necessary to prevent or heal these problems.¹⁵

The ACA also emphasizes integrated care as a way of delivering benefits. Integrated approaches may be especially useful to guide these youth because they emphasize care coordination; or there may be other approaches to helping individuals navigate the system, giving continuity over time and strong links
between physical and behavioral health services. For example, states may apply for health homes that can be targeted to address the chronic health and mental health needs of specific groups of Medicaid patients. The idea is that more intense and well-coordinated services for these high-need and high-cost groups can pay off in better health and potential health care and social service savings down the road. States implementing this option receive short-term access to 90 percent federal matching rates. Currently, seven states’ health home applications have been approved for specific high-need and high-cost populations (Howell et al. 2013; Órmond and Bovbjerg 2011).

### TABLE 2. Selected ACA Provisions That Affect Care for Youth, Children, and Parents Involved with the Child Welfare System

**Youth Aging Out of Foster Care**
- Young people receiving Medicaid as former foster care children receive, until age 26, full Medicaid benefits, as opposed to the alternative benefit plan that potentially applies to newly eligible adults under the ACA.a
- Youth aging out of foster care are eligible for the benefits from the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions of Medicaid until age 21. EPSDT benefits include preventive, dental, mental health, and developmental services for youth, and states are required to provide all Medicaid-coverable, appropriate, and medically necessary services needed to these youth to improve their health conditions.

**Parents of Children in the Child Welfare System**
- Parents who are added as “newly eligible adults” as a result of a state’s decision to expand Medicaid may receive a benefit different from the full Medicaid benefits available to current eligibles. Specifically, many newly eligible adults can be limited to so-called “alternative benefits,” which are based on coverage offered by health plans for federal employees, state employees, health maintenance organizations (HMOs) with high enrollment, and other coverage approved by the Secretary of the U.S. Department of Health and Human Services.
- The alternative benefit plan for adults still requires services for mental health and substance abuse, prescription drugs, rehabilitation, laboratory, preventive and wellness care, chronic disease management, as well as others.

**Everyone—Youth, Parents, and Children**
- Medicaid programs are undertaking new initiatives to integrate physical and mental health services to improve patient access to appropriate and comprehensive care. Two examples follow:
  - Two multipayer primary care medical home demonstrations funded by the Centers for Medicare and Medicaid Services (CMS 2010)
  - The Medicaid Pediatric Accountable Care Organization Demonstrations also authorized by the ACA and administered by CMS
- **Section 2703 of the Affordable Care Act** provides states with the opportunity to build health homes. Health homes are very closely related to patient-centered medical homes in terms of care coordination and have an increased emphasis on linkages between physical and behavioral health care.b
- **Section 2402 of the Affordable Care Act** allows states to develop a state plan amendment to create an eligibility category to provide full Medicaid benefits to individuals eligible for home- and community-based services under a waiver.c
- **Section 2951 of the Affordable Care Act** allows states to apply for Maternal Infant Early Childhood Home Visiting Program grants. One category of eligible family states that MIECHV programs can focus on are those involved in the child welfare system, or with a history of child abuse and neglect.d

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a. Newly eligible adults have incomes no higher than 133 percent of FPL and would have been ineligible for their state’s pre-ACA Medicaid program. Social Security Act Section 1937 (a)(2)(B)(viii), as amended by ACA Section 2004(c)(2). For the benefits they receive, See Social Security Act Sections 1902(k)(1), providing an alternative benefit plan to newly eligible adults, and 1937(b), describing the alternative benefits offered. Alternative benefit plans provided to newly eligible adults must include all essential health benefits. ACA Section 2001(a)(2).

b. To qualify, beneficiaries must have two chronic conditions, one chronic condition and at risk for a second, or one serious and persistent mental health condition. States have some leeway in which conditions they choose to target. Thus the demonstrations could be serving mothers with depression or children with behavioral problems and who also have co-occurring physical problems such as diabetes, hypertension, or asthma (Howell et al. 2013).

c. See [http://www.hhs.gov/od/topics/community/iathcbssmd8-6-102.pdf](http://www.hhs.gov/od/topics/community/iathcbssmd8-6-102.pdf).

d. See [https://www.cfda.gov/?s=program&cmode=form&tab=step1&id=65733ca5e5902beb890e19e5fbb36be8](https://www.cfda.gov/?s=program&cmode=form&tab=step1&id=65733ca5e5902beb890e19e5fbb36be8).
Other integrated care models that may offer opportunities for case management and integrated health and mental health services that would help youth aging out of foster care include primary care medical homes, demonstration projects for integration of mental health and primary care, and accountable care organizations (Hanlon 2010; Howell et al. 2013). In addition, Medicaid has long allowed states to cover targeted case management services, which provide for coordination of both health care and non–health care services (Shirk 2008).

State child welfare agencies will want to consider how to coordinate their own roles in helping youth navigate the health care system given this potential for ongoing support from Medicaid-funded programs. Currently, the Fostering Connections Act\textsuperscript{16} requires child welfare agencies to inform youth about health care as part of a transition plan at least 90 days before they age out of foster care. In addition, some youth may receive guidance in connecting with health care providers through Chafee-funded transition providers (generally nonprofit organizations), while other youth may not have any help.\textsuperscript{17} To take advantage of the far greater opportunities under the ACA, key child welfare staff who work with youth will need to understand the Medicaid benefits and approach to care and, ideally, would introduce youth before they age out of foster care to their key health caregivers. The child welfare agency might also provide back-up support for youth as their lives change, offering them guidance in connecting back to the health care system should they lose touch for some reason. In addition, the ACA requires child welfare agencies to discuss the idea of a health care power of attorney with youth as they transition out of care, potentially providing an opportunity for a broader discussion about the use of health care (Baumrucker et al. 2012).

In addition to these key choices that allow states to design a benefit package to best meet the needs of youth aging out of foster care, child welfare agencies and their Medicaid colleagues may encounter other policy and implementation issues. For example, if states serve youth aging out of foster care through managed care plans, they will need to consider how to match youth with plans that offer the right services for their needs (such as strong mental health as well as medical services and strong care coordination). In some states, when Medicaid beneficiaries do not select a managed care plan within specified periods, the state selects the plan in which they will be enrolled. If such auto-assignment happens with former foster care children, the state will need to consider whether these young people will be better served by some plans than by others and, if so, how to ensure auto-assignment to the appropriate plan.

Finally, states will need to plan for continuity of services, not only coverage, for these young people—which may not be easy given the instability of their lives. Particularly for youth with serious and continuing problems, continuity between providers who cared for youth before they turned 18 and those who see them as young adults may be important. For youth who are parents, states will want to consider how to meet the needs of highly vulnerable infants and toddlers, as well as young adults. And, as noted earlier, these youth move frequently, leading to continuity issues not only when they cross state lines, but also when managed care plans are limited to counties or other substate regions.

**Care for Parents**

As indicated earlier, parents involved with the child welfare system have high rates of health, substance abuse, and mental health problems—in particular, depression—that can damage parenting when left untreated. Successful treatment of these parental problems could prevent child welfare involvement for at-risk parents, speed reunification with children in foster care, prevent future spells of foster care, and
enhance children’s development. While no comprehensive studies yet exist, successful treatment also has the potential to save money for states, by preventing children’s health and developmental problems associated with maltreatment, lowering foster care costs, and enhancing parents’ ability to manage children’s health problems, such as asthma (Howell et al. 2013). Despite these opportunities, many parents involved in child welfare today receive no treatment for these problems. Recent data from the 2012 NSCAW II show that, of parents involved with child welfare who need mental health services, only 56.2 percent received treatment through inpatient care, outpatient care, or prescription medication (HHS, Office of Planning, Research, and Evaluation 2012).

As indicated earlier, providing health insurance coverage through Medicaid is a critical first step. However, linking parents to successful treatment requires steps beyond coverage. These include helping parents choose benefit packages that are targeted to their needs, designing service delivery approaches that address stigma and fit the stressed lives of struggling families, and effectively implementing those decisions. Recent research gives a sense of the scale of the challenge. While low-income mothers of young children were considerably more likely to receive treatment for a major depressive episode if they had Medicaid coverage than if they were uninsured, around a third of Medicaid-covered mothers still received no treatment at all (McDaniel and Lowenstein 2013).

The ACA offers several important opportunities to link parents to effective treatment, including mental health and substance abuse services.

- Overall benefit package and inclusion of mental health services. Once a state chooses to provide Medicaid coverage to low-income adults with incomes up to 133 percent of FPL, it may either provide them with the full package of benefits available to current Medicaid recipients or provide the alternative benefit package, determined based on other comparable plans (see table 2). The alternative benefit plan is required to include behavioral health (mental health and substance abuse) as well as medical services. In making the choice of what benefit package to provide, states will want to consider evidence about the high levels of mental health problems and chronic medical issues among these vulnerable parents. They may also want to consider the potential cost savings from effective treatment, as well as the potential for savings in state dollars now spent on mental health and family services without federal reimbursement.

Many states will also make decisions about how to organize services and, in particular, how to use managed care. Whether a state’s model includes mental health within broader managed care plans (“carve in”) or provides separate plans for mental health (“carve out”), it will want to ensure that at least some plans are well-designed to address the needs of parents with chronic medical problems and behavioral health problems such as depression and who have young children at great risk for developmental delay.18

- Opportunities to target vulnerable populations for integrated and coordinated care. In separate research on maternal depression, Dr. Golden and her coauthors concluded that the best chance for making inroads in linking depressed mothers to treatment may arise from the demonstration and innovation opportunities offered by the ACA in support of integrated and coordinated care, such as medical homes, health homes, and accountable care organizations. (Howell et al. 2013). The authors call on the Department of Health and Human Services and the states to consider adapting these existing demonstrations for this purpose—for example, by exploring the possibility of “two-generational” health homes that could serve parents with major mental health problems such as depression, along with their young children.
Maternal and early childhood home visiting. Home visiting has the potential to link vulnerable parents to mental health and health services. A strong and trusting relationship with a home visitor can make parents comfortable with disclosing depression or other sensitive issues despite concerns about stigma. (Golden et al. 2011). Thus, child welfare agencies should consider how the expansion of home visiting, funded in the ACA, can support the overall goal of high-quality treatment for parents at risk of entering or already in the system.

Additional mental health and social services investments to supplement Medicaid coverage. States may identify savings in child welfare, mental health, and social services line items if they shift services and treatment previously supported through state resources to federally funded Medicaid coverage for newly eligible adults.

Care for Children Involved with the Child Welfare System

As noted above, children already involved or at risk of involvement in the child welfare system are not affected as dramatically by the ACA as aging-out youth or parents, because almost all of them are already eligible for Medicaid and its EPSDT benefit package. Nonetheless, these children face major health, developmental, and mental health problems and substantial concerns about the quality of their care. Because of the children’s high levels of health problems, these concerns about low-quality or inadequate treatment raise the possibility of additional costs for Medicaid.

Therefore, states may want to take advantage of the ACA’s opportunities for integrated care or delivery system improvements for this group, both to improve results and reduce Medicaid expenditures. A recent study found that children using behavioral health care represented less than 10 percent of the child population on Medicaid, but accounted for approximately 38 percent of total Medicaid child expenditures (Pires et al. forthcoming). A child welfare advocate we interviewed made this link: “Children in the child welfare system have a lot of costs in the Medicaid system and [redesign of health care systems under the ACA] is an opportunity for us to do a lot better for them.”

In addition, some states already have specially designed waivers or other approaches to care for these children. In those states, we heard in at least one interview that child welfare officials will need to be closely involved with Medicaid officials to maintain or enhance those approaches in the context of the ACA. According to an outside expert on the process in Maryland, child welfare agencies in this situation need to partner with their Medicaid agency, jointly analyze the data about services and costs, and determine how best to adapt existing Medicaid state plans through waivers or other mechanisms to the ACA environment. The goal is to identify and assess Medicaid finance and structure options that would best serve priority populations such as children within the child welfare system.

States may be particularly interested in seizing new opportunities to improve care for the large number of highly vulnerable children who are reported to the child welfare system at the front end but do not end up in out-of-home care. As noted earlier, these children have serious developmental, health, and mental health needs, but little is known about whether they receive health care to meet their needs. The Child Abuse Prevention and Treatment Act reauthorization in 2010 required that child welfare agencies ensure that infants and toddlers who are the subject of reports connect to the state’s early intervention agency for a developmental assessment, but doing so has been uneven.19

For children in foster care, researchers and practitioners have expressed concern both about the considerable share who do not receive needed treatment and about the quality of care for those who do.
The GAO and the Children’s Bureau have highlighted concerns about the quality of treatment when children do receive it, particularly the high rate of prescriptions of psychotropic medication for children and youth in foster care (Kutz 2011).  

Finally, for both groups of children, those in their own homes and those in foster care, a major problem for the quality of care is discontinuity of services and lack of knowledge of their past health history. According to one expert familiar with services in many states:

> When children are served in home, there’s very little ability of agencies to understand what current health care status is, and they have to rely on what is already available. When kids are in care, there are all kinds of complications when they move back and forth, have placements, in terms of accessing past health history, making sure that when they go back home, care is linked back to their family.

The ACA offers many opportunities to address these concerns: for example, integrated care models such as health homes, home- and community-based services, home visits, and greater opportunities for treatment for the parent-child dyad. At the same time, in states that have already developed optional Medicaid benefits specially targeted to this group, agencies may need to focus on how to preserve or modify the benefits to ensure continued effectiveness under the state’s ACA structure.

- **Integrated care including health homes.** As noted earlier, the ACA emphasizes care that is coordinated and that integrates medical and mental health care for high-need individuals. Some states have already identified the health home option as particularly useful for children with behavioral problems. Howell and colleagues (2013) offer a list of other integrated care options in the ACA.

- **Home and community-based services.** The ACA makes it easier for states to cover a package of home- and community-based services intended to prevent more intensive care for certain populations. States should consider whether a stronger benefit package for some children and youth in foster care could prevent their placement in a more intensive residential setting.

- **Maternal and early childhood home visiting.** The ACA includes $1.5 billion over the next five years for states to operate evidence-based home visiting programs for pregnant women and mothers with young children. In 2010, HHS provided $88 million in funding to state home visiting programs, and in 2011, HHS allocated $224 million in formula and competitive grants to home visiting programs nationwide. Child welfare agencies in the states should seriously consider participating in the design and targeting of these programs, which could play a very important role in linking families at risk of child welfare involvement.

- **Treatment of the parent-child dyad.** Parents’ emotional and physical well-being and family stress have major impacts on young children’s development and well-being. Yet treating the parent and child together (the parent-child “dyad”) has traditionally been difficult under the old framework for Medicaid eligibility, which often covered the child but not the parent (Golden and Fortuny 2011). States that choose the Medicaid option for coverage of low-income parents have the opportunity to build treatments for the dyad or the family when those are recommended to address young children’s mental health and development. For states that do not choose the option, CMS may want to consider clarifying the circumstances under which Medicaid can cover treatments for the parent-child dyad that are intended to help the child’s developmental conditions, even when only the child is eligible.
Conclusion

ACA implementation offers crucial opportunities to help vulnerable children and families involved with the child welfare system, including preventing child abuse and neglect. Yet, strengthening connections between child welfare and health care reform to achieve these goals will be dauntingly difficult. Both health and child welfare leaders in the states are “overwhelmed,” a word used repeatedly in the interviews—on the health side, by health care reform demands and deadlines, and on the child welfare side, by the high-stress nature of the job, in which workers and agencies respond to life-or-death situations in a never-ending stream. Those we interviewed also pointed out how intricate both systems are, how substantially each varies by state, and how rare it is for any individual to understand both. Medicaid and health officials may also think that linking to the broader human services programs—in particular, income support programs that are more similar in structure to Medicaid—takes care of their linkages to child welfare. However, services to abused and neglected children and their families differ considerably from income support in both structure and target population.

The two worlds of health and child welfare also, in the words of one interviewee, “speak different languages.” Particularly at this time of urgent deadlines to implement the ACA, Medicaid agencies typically organize their work around functions and specific requirements of the law—for example, the functions of enrollment and design of a benefit package. Child welfare agencies typically organize their work around populations, often defined by their stage in the child welfare process—for example, children reported to the hotline for maltreatment; children receiving services in their homes; children in foster care; or children who have left foster care for guardianship, adoption, or reunification.

The purpose of this paper is to provide early and tentative ideas about how to bridge these gaps, as well as suggestions for how state, federal, and philanthropic officials can continue and deepen the collaborative work. Some of these suggestions are for urgent matters, and we hope many state and federal officials will be able to move quickly on these most immediate priorities.

However, those we interviewed also reminded us that the benefits from health care reform for vulnerable children and families, and on the child welfare system as a whole, will not all happen at once. Our interviewees urged us to remind federal officials and, above all, philanthropic funders that reaping the full benefits of the new law for vulnerable and distressed families will be a multiyear task. For that reason, our suggestions include not only immediate steps but also longer-term strategies, such as federal funding of a joint technical assistance center and foundation, and commitment to research that tracks the implications of health care reform for child welfare families as findings emerge. The view of those we interviewed was that funders and leaders in child welfare need to achieve a balance: paying attention right away to urgent opportunities and needs while also “staying in it for the long haul.”
APPENDIX A.

METHODOLOGY

Our goal in writing this paper was to identify issues and opportunities at the intersection of child welfare and the Affordable Care Act, a topic that had received very limited attention from either health or child welfare experts at the time we began our research. Our goal is to provide a broad overview, rather than a detailed examination, of the populations the ACA would benefit, as well as the health care services they need, that also takes into account the changes in policy and law that influence the effectiveness of the ACA. For example, states were deciding whether to expand Medicaid to adults newly eligible under the ACA, and the federal government issued proposed regulations affecting certain statutory provisions during the time of our research.

We drew on two kinds of sources for this paper. First, we reviewed (1) the very limited web materials and reports containing information about the ACA and child welfare relevant to this paper’s core topic and (2) related literature that provided context about the characteristics and needs of the child welfare population and about previous efforts to link Medicaid and child welfare. Second, we developed and interviewed a list of experts drawn from both the health and the child welfare worlds, seeking those who (1) had already analyzed the intersection of health and child welfare or related human services programs, (2) had directly relevant expertise within one of these areas, even though they had not studied the other (for example, health experts who had thought about eligibility for children and families but not specifically about child welfare), or (3) had expertise regarding relevant aspects of state ACA implementation. We spoke with 17 experts, summer to winter in 2012. A list of all interviewees is available in appendix B.
The interviews lasted about an hour and addressed such key topic areas as the following:

1. The most important implications of the ACA for child welfare programs, including implications for youth aging out, for children, for parents, and for providers.
2. The status of state implementation, including collaborative efforts between states and child welfare officials regarding health care reform.
3. Opportunities and risks in the implementation of the ACA that could affect child welfare families.
4. Recommended actions for state and federal officials and for outside partners, particularly those in the philanthropic sector.

Notes from the key informant interviews were organized to identify similar themes and divergences that appeared across respondents and used to shape the structure of the report.
APPENDIX B.
INTERVIEW LIST

1. Joan Alker, Georgetown University Center for Children and Families
2. MaryLee Allen, Children’s Defense Fund
3. Richard Barth, University of Maryland School of Social Work
4. Shelby Gonzalez, Center for Budget and Policy Priorities
5. Melissa Harris, Centers for Medicare and Medicaid Services
6. Catherine Hess, National Academy for State Health Policy
7. Rutledge Hutson, Center for Law and Social Policy
8. Brooke Lehmann, Georgetown University Center for Children and Families
9. Gene Lewit, Packard Foundation
10. Judith Meltzer, Center for the Study of Social Policy
11. Michael Pergamit, The Urban Institute
12. Nadia Sexton, Casey Family Programs
13. Laura Radel, Office of the Assistant Secretary for Planning and Evaluation
14. Jennifer Ryan, Centers for Medicare and Medicaid Services
15. Nicole Tambouret, Community Catalyst
16. Tracy Wareing, American Public Human Services Association
17. Michelle Zabel, University of Maryland School of Social Work
APPENDIX C.
SELECTED RESOURCES

The following papers were particularly useful to us in developing this paper. Child welfare officials and others seeking further depth in the topics and issues discussed in this paper should refer to the reports listed below:


NOTES

1. In some states, youth are able to remain in foster care until the age of 21 through programs implemented under the Chafee Foster Care Independence Act of 1999. The act increases funds available to states to assist former foster youth in their transition to independence. One area that states have the option to assist these youth is by extending access to Medicaid for 18-, 19-, and 20-year-olds who aged out of foster care.


3. The interview methodology is attached as appendix A, and a complete list of interviewees is attached as appendix B.


5. “Medicaid, Children’s Health Insurance Programs, and Exchanges.”


7. See 42 CFR 435.916(a)(2) and (b).

8. “Navigators” is a broad term that includes all those that contract with Medicaid programs to provide enrollment and application assistance, including exchange call centers and community-based organizations.

9. “Medicaid, Children’s Health Insurance Programs, and Exchanges.”

10. We also heard concerns about whether there would be disincentives for potential adoptive parents of teens in the foster care system. On the one hand, these concerns are less than those for potential guardians. The reason is that youth age 18–26 must be included under an adoptive parent’s insurance just as they would be under a biological parent’s, although adding adult dependents to an insurance policy may increase the adoptive parents’ premiums. On the other hand, if adoptive parents are struggling economically themselves, and if they live in a state that does not take the
Medicaid expansion, then they would not be able to guarantee health coverage for their adopted adult child. This will likely be particularly salient when low-income kin or foster parents are considering adopting a foster youth with major health needs.

11. See Public Health Service Act Section 2714, added by ACA Sec 1001(5).

12. The Fostering Connections Act increased the use of kin guardianship programs.

13. An additional issue has been raised among interviewees regarding cross-over youth involved in the juvenile justice system, and we briefly discuss this group on page 12. Careful consideration needs to be given to youth formerly involved in foster care who turned 18 in the juvenile justice system, but this issue is beyond the scope of what we are able to address in this paper.

14. This count includes instances of duplication, in which a family may be reported multiple times, or in which multiple children are included in a single report on a family.


21. See Guyer, Lehmann, and Lewandowski (2012) for a more in-depth discussion of the provision itself and the ACA.


Courtney, Mark E., Amy Dworsky, Gretchen Ruth Cusick, Judy Havlicek, Alfred Perez, and Tom Keller. 2007. "Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 21." CS-146. Chicago, IL: Chapin Hall Center for Children at the University of Chicago.


