Health Care Financing for Children and Adolescents in Foster Care

Health care financing for children and adolescents in foster care should support child welfare goals of health, safety, and permanency for children and adolescents. The goals of health care financing include

- Ensuring children receive health care according to standards outlined by the American Academy of Pediatrics (AAP), American Academy of Child and Adolescent Psychiatry (AACAP), and Child Welfare League of America (CWLA), so that all of their health conditions are addressed
- Reducing long-term adverse health effects of abuse and neglect
- Improving long-term physical, emotional, developmental, and dental health outcomes
- Improving communication and coordination among health care professionals, caregivers, and child welfare professionals by adequately funding health care management
- Ensuring that children and adolescents continue to receive necessary health care services even after they exit foster care, at least for some specified time period

Currently, health care for children and adolescents in foster care is financed out of existing funding streams through Medicaid and foster care. Unfortunately, the financing has not been developed with the above goals in mind and does not necessarily support the goals. This chapter addresses, in limited detail, the current funding situation as it is outlined in federal regulations. However, each state interprets federal regulations and develops its own funding strategies; refer to each state's or county's entity for a fuller understanding of

local practice. To facilitate the discussion of health care financing, useful vocabulary, barriers to timely insurance coverage, and Medicaid regulations and mandates are also covered in this chapter. Finally, recommendations are put forth for financing health care for children and adolescents in foster care to achieve the above goals.

Useful Vocabulary

A number of factors affect health care financing for children and adolescents in foster care, including the structure of foster care in a state, the type of agency caring for the child, the level of care in which the child is placed, and Medicaid eligibility at the time of placement or shortly thereafter.

Some states have state-mandated and state-administered foster care, while others have state-mandated and county-administered foster care. In the latter, more decentralized model, child welfare practices may differ more widely among counties in the same state.

The type of agency caring for the child is either direct or indirect. *Direct care* is foster care provided by public (ie, government) entities, which may be state or county. *Indirect care* is foster care provided by private agencies, which may be nonprofit or for-profit; these agencies operate under contract or a memorandum of understanding with the state or local government entity. Agencies providing indirect foster care services may pay for health care out of a medical per diem the agency receives from the state, by enrolling children in Medicaid, or some mixture of both. When agencies receive a medical per diem, they are expected to pay out of pocket for at least some health care services. Some agencies choose to offer certain health care services on-site to offset a portion of the costs. Money not expended on health care services is available to the agency for other purposes for the current fiscal year, but may result in a reduction in the future per diem rate.

The term *level of care* indicates the placement setting in which a child resides and includes group homes, residential treatment facilities, and foster family homes. In some states, residential treatment facilities or group homes may be required to provide some or all health care services on-site. Again, health care may be funded through Medicaid or a medical per diem rate paid to the agency.

Medicaid

Medicaid is a federally mandated entitlement program authorized by Title XIX of the Social Security Act; Medicaid expenditures accounted for 10% of all federal child welfare money in fiscal year 2000. While federally mandated, states have flexibility in setting eligibility requirements, benefits, and reimbursements paid to providers. The federal government has set minimum criteria for Medicaid eligibility. Children younger than 6 years are presumed eligible if their families have an income less than 133% of the federal poverty level ($19,977 for a family of 3 in 2002), while older children are eligible if their family income is less than 100% of the federal poverty level ($15,020 for a family of 3 in 2002). Most states have liberalized these eligibility criteria. At admission to foster care, about 57% of children are eligible for Medicaid because their families were receiving cash assistance or were eligible under their state's welfare laws as they applied in 1996. Birth parents' income is counted only for the first month in foster care, so almost all children become eligible after the first month in foster care. States also have the option under federal law to extend Medicaid eligibility to targeted populations (eg, children in foster care) and make them immediately eligible at the time of placement.

Medicaid can be billed retroactively for 90 days, so even if a child only becomes eligible after the first month of placement, any health care services rendered in that first month should be reimbursed. The federal-state match also varies from state to state, with the federal share ranging from 50% to 83%.

Children may not have health coverage immediately upon entry to foster care for a variety of reasons, including

- Precipitous entry to foster care
- Lack of presumptive Medicaid eligibility at entry to foster care
- Delays in disenrollment from a prior health insurance plan, which delays enrollment in Medicaid
- Delays in issuance of a Medicaid card

Other barriers to health care related to insurance issues include the lack of portability of Medicaid managed care (MMC) across different foster care placements, loss of Medicaid cards when children change placements, lack of health care professionals who accept Medicaid fee-for-service (FFS) reimbursement, and restrictions imposed on certain health care services, particularly mental health visits, by MMC.

Medicaid Fee-for-service Versus Medicaid Managed Care

No discussion of health care financing for children and adolescents in foster care would be complete without focusing on the relative benefits of Medicaid FFS and MMC. In general, children in direct care who are Medicaid eligible are issued a Medicaid number, although the card may not be issued for days or even months after placement. The federal government allows most Medicaid beneficiaries to be enrolled in MMC, although waivers still are required for children with special health care needs or those in foster care. By 1999, 18 states required that children in foster care be enrolled in MMC, and 30 others allowed, but did not require, enrollment in MMC.

The disadvantages of Medicaid FFS are those of Medicaid in general. Because Medicaid reimbursement often is lower than that of other insurance plans and insufficient to cover the costs health care professionals incur in seeing children with special health care needs, access to health care services often is more limited. Medicaid FFS allows for

liberal access to mental health care services, which is considered an advantage for this population, although reimbursement limitations again may create access issues. Generally, reimbursement for dental services is well below parity, meaning access to dental care is extremely limited. Access issues are even more significant in rural areas where the numbers and types of health care professionals accepting Medicaid FFS are restricted.

The advantages of MMC are felt to be the improved access to primary health care, emphasis on preventive health care services, and improved data collection. Health care professionals generally are more appropriately reimbursed for their services under MMC, which should ameliorate some access barriers. However, there are ongoing concerns that access to some types of health care, especially mental health care services, is more restricted and may further increase the morbidity of this medically complex and needy population. The attractiveness of MMC for states resides in the potential for cost savings and access to more accurate aggregate health data about children and adolescents in foster care. Currently, most states consider children with special health care needs to be "averaged into" the overall MMC population when rates are set. This may work well for an MMC organization covering a broad spectrum of the pediatric population, of which foster care and other children with special needs constitute only a small part. Medicaid managed care rates are incompatible with costs when such an organization serves a larger proportion of children in foster care or with special health care needs.

Neither Medicaid FFS nor MMC allow agencies the freedom to fund more creative and possibly more effective methods of health care service delivery. This is of particular concern in the arena of mental health because even very young children may have significant emotional and behavioral issues that are not easily treated using traditional mental health models. Innovative approaches such as mentoring for foster or birth parents, peer support groups for children

and adolescents in foster care, therapeutic or mentored visitation, and contextual mental health assessment and services currently are only fundable through grant support. Therapy for substance addiction also is poorly funded, especially if children or adolescents require extended inpatient therapy services. Child psychiatry services are extremely difficult to access for this population. While this is partly attributed to the shortage of child psychiatrists in general, inadequate reimbursement poses another major barrier. Thus, many children in foster care are on psychotropic medication without benefit of psychiatric expertise.

Early and Periodic Screening, Diagnosis, and Treatment and Foster Care

States, local government, and MMC organizations are required to fulfill federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements for all children covered by Medicaid or MMC and all Medicaid-eligible children. Early and Periodic Screening, Diagnosis, and Treatment is a federally mandated comprehensive package of preventive services, tests, regular checkups, and mandated follow-ups for children younger than 21 years. This means that Medicaid has to cover the treatment and follow-up of any health care condition (eg, physical, emotional, developmental, behavioral) identified by a health care professional during a health visit. This is true even if the services are not routinely covered by an individual state's Medicaid benefit package. Compelling a state entity to cover such identified health conditions when they are not part of the benefit package may require diligent advocacy by foster parents, birth parents, health professionals, caseworkers, attorneys, health care managers, or other interested parties.

Studies in California and Washington have indicated that while children in foster care expend more health care dollars than other children, they still have multiple unmet health care needs. Data show that children in foster care use inpatient and outpatient

mental health care services at about 20 times the rate of other children who are poor in these states, although this higher rate of use still may underestimate the actual need. Children undergoing thorough evaluations at entry to care routinely have been found to have higher rates of chronic medical illness, developmental issues, and mental health conditions than are reported by caregivers or caseworkers prior to the evaluation. Such evaluations uncovered unrecognized and unmet physical, emotional, and developmental conditions up to 3 times more often than suspected prior to evaluation. Ideally, under federal EPSDT guidelines, there should be no unmet health care needs because all identified health conditions are eligible for services.

Financing Health Care Management

Health care management is fundamental to achieving good health outcomes for children and adolescents in foster care. Unfortunately, except for agencies that receive a medical per diem to coordinate and manage the health of children and adolescents in their care and custody, there currently is no mechanism for funding health care management. Health care management financing has to allow for flexibility in the delivery of health care services, provide incentives for enhanced communication among multidisciplinary professionals, and support the integration of health information and permanency planning. A number of different health care management models already exist, although all share the commonalities of using health care professionals responsible to foster care agencies to manage health care. Some models combine the health care delivery and management functions in a specialized primary care office or multidisciplinary health team devoted to the care of children and adolescents in foster care. Others use public health nurses working closely with foster care caseworkers. Another approach involves the use of health passports with centralized data collection to monitor health care at a population level. Financing has to allow for different strategies and models,

while promoting the goals of health care management as described in Chapter 5.

Principles of Health Care Financing

Health care financing for children and adolescents in foster care has to address the broad spectrum of health conditions, including unmet health needs, of this population in a planned, comprehensive manner. Federal EPSDT regulations mandate that any identified health condition must be treated. Funding for mental health and developmental assessments and services is particularly crucial in a population in which so many social and environmental factors may erode a child's emotional well-being or developmental competencies. The following principles are considered fundamental:

- Health insurance for children and adolescents in foster care has to have an extensive benefits package (*see* "Comprehensive Benefits Package" on page 122) to cover the wide array of services needed to ensure optimal physical, emotional, developmental, and dental health, as outlined in this manual and recommended by the AAP, AACAP, and CWLA.
- Adequate financing is essential to ensuring timely access to appropriate health care services. Children and adolescents in foster care should receive health care through a medical home (*see* Chapter 2), with health care professionals familiar with foster care, its mandates, and regulations and their effect on children and families. Health care professionals must be reimbursed for the more complex and lengthy visits that are typical of the foster care population. Mechanisms to recruit, train, and reimburse "preferred" health care professionals for children and adolescents in foster care should be part of financing considerations. Reimbursement rates should correlate with the expertise and experience of individual health care professionals in caring for this group of children. Foster care agencies should maintain a list of health care professionals within a reasonable distance of most foster care residences in their counties.

- Financing must cover the cost of the health care management necessary to ensure that this medically complex population receives appropriate and timely health care services. Health care management is not the same as case management by insurance providers; the latter is a separate function. Health care management is a responsibility of the foster care agency, but the functions have to be performed by health care professionals, regardless of the type or level of foster care placement. Funding streams in addition to Medicaid or medical per diem need to be established to pay for this function. Money must cover the complete array of health care management functions outlined in Chapter 5 of this manual.
- While health care management is focused on individual children, financing should provide a structure within which accountability across the foster care population occurs, including
  - Tracking compliance with health care standards
  - Ensuring the quality of health care services through rigorous monitoring and assessment
  - Ensuring frequent communication among health, child welfare, and health management systems about health care issues, changes in health benefits, health care access, quality of care, confidentiality, and continuity
  - Promoting fiscal management and cost-efficient care delivery
  - Ensuring confidentiality issues are addressed appropriately
- Financing should include funds for developing family-based approaches to mental health and developmental services. Such services could include, among others,
  - Therapeutic or mentored visitation models for children and birth parents
  - Contextual assessments that occur in the child's environments rather than at a mental health agency
  - Foster or birth parent mentoring to improve the skills of parents in managing the behaviors of distressed children

  - Wraparound services that address the complex educational, developmental, and emotional needs of families and children
- Insurance portability is extremely important for this mobile population. Insurance coverage has to begin immediately with placement and continue for the duration of a child's stay in foster care, regardless of changes in placement, level of placement, type of agency, or moves across county lines.
- There needs to be universal presumptive eligibility at entry to foster care. Children in kinship care need to be treated the same as children in traditional foster care with respect to health care financing. Exceptions may be made for children in kinship care with relatives whose income is more than 200% of the federal poverty level and who have another source of health insurance for children in their care and custody.
- Insurance coverage should extend automatically beyond foster care for 12 months. Adolescents leaving foster care should retain presumptive Medicaid eligibility for at least 12 months or until age 21 years, whichever is longer. All states should come into compliance with the Chafee Foster Care Independence Act concerning Medicaid eligibility for adolescents leaving foster care.

Comprehensive Benefits Package

Health care insurance for children and adolescents in foster care has to cover

- Comprehensive admission series as outlined in Chapter 2
- Enhanced well-child care schedule as described in Chapter 2
- Extra visits that occur related to foster care issues
- Discharge health planning
- Child abuse and neglect issues
- A wide array of mental health care services including comprehensive mental health evaluations at admission, ongoing indicated services or periodic reassessments of needs, and drug and alcohol evaluation and rehabilitation services

- Funding for other mental health strategies as outlined on pages 117 and 118
- A full developmental or educational evaluation, unless such an evaluation is available through other systems already in place (eg, early intervention programs), with ongoing indicated developmental services or periodic reassessments
- Emergency health services
- Respite services
- Indicated home health care services
- Medical equipment and supplies, including orthotics and prosthetics
- Inpatient hospital and mental health care services
- Medical transportation costs
- Laboratory costs
- Medications
- Optometry and corrective lenses
- Care for acute and chronic illnesses
- Dental evaluation with periodic reassessments and all indicated treatment, including orthodontia

Summary

Health care financing for children and adolescents in foster care should be designed to improve the overall physical, emotional, developmental, and behavioral health of children in foster care. In doing so, it should support the child welfare goals of health, safety, and permanency for children and adolescents. Because health care management is fundamental to integrating health care and child welfare planning, funding for this function is vital. In addition, health insurance for children and adolescents entering foster care should be immediate, universal, portable, and ongoing during the stay in foster care. It should support the principles outlined in this chapter, including providing a comprehensive benefits package, promoting the identification of a medical home for each and every child

and adolescent, and supporting the development of mental health strategies that address the special needs of this population. Lastly, health insurance should remain intact for at least 12 months after leaving care, to ensure that health conditions continue to be addressed beyond foster care.

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Internet Resources

Centers for Medicare and Medicaid Services: www.cms.hhs.gov