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

Emilie Stoltzfus
Specialist in Social Policy

Evelyne P. Baumrucker
Analyst in Health Care Financing

Adrienne L. Fernandes-Alcantara
Specialist in Social Policy

Bernadette Fernandez
Specialist in Health Care Financing

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Summary

Approximately 641,000 children spend some time in foster care each year. Most enter care because they have experienced neglect or abuse by their parents. Between 35% and 60% of children entering foster care have at least one chronic or acute physical health condition that needs treatment. As many as one-half to three-fourths show behavioral or social competency problems that may warrant mental health services. A national survey of children adopted from foster care found that 54% had special health care needs. Research on youth who aged out of foster care shows these young adults are more likely than their peers to report having a health condition that limits their daily activities and to participate in psychological and substance abuse counseling.

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

States are not permitted to use federal child welfare program funds to pay medical expenses of children in care or those who left foster care due to their age or placement in a new permanent family. However, states can (and do) receive federal support through Medicaid to pay a part of the medical expenses, including well-child visits, dental care, and other services for many of these children and youth. In FY2010, the most recent year for which these data were available from all states, Medicaid agencies reported spending $5.754 billion to provide services to foster care children. Most of this Medicaid services spending was provided on a fee-for-services basis (82%) with the remainder provided through managed care arrangements.

Most children in foster care are eligible for Medicaid under mandatory eligibility pathways, meaning that states must provide coverage because these children receive assistance under the Title IV-E program, or, because they meet other eligibility criteria such as low income, or receipt of Supplemental Security Income (SSI). Children in foster care who are not eligible under mandatory pathways generally qualify for Medicaid because the state has implemented one or more optional eligibility categories allowing coverage. Further, children who leave foster care for legal guardianship and nearly all children with state-defined "special needs" who leave foster care for adoption retain mandatory eligibility for Medicaid provided they receive Title IV-E assistance. Additionally, special needs adoptees who receive state-funded support may also be eligible under an optional Medicaid eligibility pathway specifically for them.

Separately, as of January 1, 2014, states are required to continue Medicaid coverage to youth who age out of foster care on their 18th (or later) birthday. This Medicaid coverage was added to the law by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), must be available until the youth reaches age 26, and unlike most Medicaid pathways must be provided without regard to the youth's income and assets. This new pathway for youth who age out of care without return to their parents or placement with a new permanent family parallels another ACA

requirement that directs health insurance companies to continue coverage of children up to age 26 who are enrolled in their parents' private health care plans. Additionally, under a separate eligibility pathway states continue to have the option of providing Medicaid to youth aging out of foster care (up to the age of 21). Under this optional pathway, and unlike the newer mandatory pathway, a youth does not need to have received Medicaid while in foster care to be eligible for the coverage.

Effective January 1, 2014, the ACA established the Modified Adjusted Gross Income (MAGI) income counting rule. MAGI draws on federal income tax rules (with certain revisions defined in Medicaid law and regulation) to establish uniform standards for what income to include or disregard in determining Medicaid eligibility for most non-elderly and non-disabled people. In transitioning to the new MAGI income counting rule, states were required to establish income eligibility thresholds no less than the effective income eligibility levels that were applicable in the state on the date of enactment of the ACA (i.e., March 23, 2010). In addition to this transition policy, several additional protections ensure that children in, or formerly in, foster care retain eligibility under the new counting rules.

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

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Introduction

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

Effective January 1, 2014, the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) created a new mandatory Medicaid pathway for young adults up to age 26 if they were in foster care at age 18 and were receiving Medicaid. This new mandatory coverage category for youth aging out of foster care is distinct from the ACA Medicaid expansion requirements in Section 2001 of the ACA that are related to coverage for most non-elderly adults with annual incomes below 133% of the federal poverty level.[2] For that group, the U.S. Supreme Court's 2012 decision in *National Federation of Independent Business (NFIB) v. Sebelius*[3] effectively made state participation in ACA Medicaid expansion voluntary.[4] However, the Supreme Court's decision leaves enforcement of other provisions of the ACA intact, including the new coverage group created by the ACA for youth aging out of foster care. Accordingly, all states were expected to comply with the new mandatory coverage category for youth who have aged out of foster care as of January 1, 2014. The ACA made additional changes outside of Medicaid to assist adults in obtaining private health insurance, which may benefit young adults who age out of foster care and families who are served by child welfare agencies.

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

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

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

[3] 567 U.S. ___ (2012), available at http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf.

[4] Under *NFIB v. Sebelius* decision, the federal government cannot terminate current federal Medicaid matching funds if a state refuses to implement the Medicaid expansion group as required by Section 2001 of ACA. The Court ruled in that case that states must have a genuine choice to accept or reject the new ACA expansion funds and requirements that come with those funds. Therefore, a state's choice whether or not to cover the Section 2001 ACA Medicaid expansion group cannot be tied to the loss of all Medicaid funding. See also CRS Legal Sidebars, Health and Medicine, "Conditioning Federal Grants after *NFIB v. Sebelius: Carrots, Sticks, and a New Program*," posted July 3, 2012, by Kathleen S. Swendiman and "To Be or Not to Be a 'New Program?' What Does *NFIB v. Sebelius* Mean for Implementation of the Medicaid Expansion Provision?," posted July 7, 2010, by Kathleen S. Swendiman.

foster care due to age or placement in a permanent adoptive family. **Appendix B** shows Medicaid services spending, in selected years, for "foster care" children (as that group is defined in Medicaid eligibility and claims data). **Appendix C** summarizes the major mandatory and optional Medicaid eligibility pathways for current and former foster children.

Children and Families Currently or Previously Involved With Child Welfare

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

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

Major Findings

- Approximately 35% to 60% of children placed in foster care have at least one chronic or acute physical health condition that needs treatment, including growth failure, asthma, obesity, vision impairment, hearing loss, neurological problems, sexually transmitted diseases, and complex chronic illnesses. As many as one-half to three-fourths show behavioral or social competency problems that may warrant mental health services. Studies indicate that many health and mental health care issues persist and that—relative to their peers in the general population—children who leave foster care for adoption and those who age out of care continue to have greater health care needs. (For more information, see "Health Care Needs of Children in Foster Care" and **Appendix A**.)
- Federal child welfare policy includes health-related provisions. For example, child welfare agencies must ensure that the health care records of children in foster care are periodically reviewed and updated. In addition, states must develop a strategy that addresses the health care needs of each child in foster care including, among other things, health care screenings and oversight of prescription medicines. States must also ensure that young people aging out of foster care are provided a copy of their health records, and information about health insurance options and designating other individuals to make health care decisions on their behalf in the event that they are unable to do so. (For more information, see "Child Welfare Policies Addressing the Health Care Needs of Children in Foster Care and Those Aging Out of Foster Care.")
- Federal child welfare law requires cooperation between state child welfare and Medicaid agencies to ensure that the health needs of children in foster care are

properly identified and treated. Given the distinct roles played by the child welfare and Medicaid agencies, understanding precisely what cooperation means and how it should occur remains a question. To date, federal guidance on this matter has primarily focused on monitoring psychotropic medication use and improving access to psychosocial mental or behavioral health screening and services. (For more information, see "Child Welfare Policies Addressing the Health Care Needs of Children in Foster Care and Those Aging Out of Foster Care.")

- State child welfare and state Medicaid agencies refer to different, albeit overlapping, populations when describing who is in foster care. For child welfare agencies, children in foster care include all those under the state agency's care and placement responsibility (on a round-the-clock basis) without regard to whether they are eligible for Title IV-E foster care assistance. By contrast, the state Medicaid agency principally counts as a "foster care" child any individual eligible for Title IV-E assistance (whether foster care maintenance payments, adoption assistance, or kinship guardianship assistance). For policymakers and researchers this difference in who is counted as being in foster care makes it difficult to understand the type and level of Medicaid services provided to children currently living in foster care versus those who have left foster care for new permanent homes. The difference in meaning of the same term may also introduce challenges for administrators seeking to work across agencies to ensure access to appropriate services for children in foster care. (For more information, see "Varying Definitions of Children in Foster Care.")
- Analysis of state-reported Medicaid claims shows that fee-for-service remains the most common form of payment arrangement for Medicaid services provided for "foster care" children. However, there has been strong growth in the use of managed care arrangements to provide Medicaid services to "foster care" children (as described by the Medicaid agency). The share of Medicaid services spending provided through managed care arrangements increased from a little more than 5% of total Medicaid services spending for "foster care" children in FY2001 to close to 18% in FY2010. Among Medicaid services provided on a fee-for service basis, spending on "prescribed drugs" generally grew from FY2001 through FY2008 but appears to have leveled off since that time. Several other fee-for-service categories have been consistently important for Medicaid "foster care" children across the FY2001-FY2010 time period. These are "other services" (which includes support for certain home and community based waiver services and other items), "clinic services," "inpatient mental health facilities," "inpatient hospital services," and "rehabilitative services." (For more information, see "CRS Analysis of Medicaid Spending For Foster Care Children.")
- As of January 1, 2014, the modified adjusted gross income (MAGI) rule is used in determining eligibility for most of Medicaid's non-elderly and non-disabled populations. In transitioning to MAGI, the ACA directed states to establish income eligibility thresholds for children that are not lower than the effective income eligibility levels that were applicable in the state on the date of enactment of the ACA. Several policies work to ensure that children who would have been eligible prior to the ACA, including those in foster care or those who left foster care for adoption, legal guardianship, or via aging out, do not lose access to Medicaid. (For more information, see "ACA Income Counting Rule, Protections for Children, and Exemptions.")

- The ACA created a new mandatory Medicaid pathway (beginning January 1, 2014) for young adults up to age 26 if they were in foster care at age 18 and were receiving Medicaid. Unlike most Medicaid eligibility pathways, eligibility for former foster youth who aged out of care must be provided without regard to the youths' income and assets. In addition, states may not require mandatory enrollment in Medicaid alternative benefit plans for these individuals, but former foster care youth may be subject to premiums and cost-sharing. Proposed regulations interpret the law to mean that a youth must be enrolled in Medicaid at the time he or she ages out of foster care (as opposed to at any time while the child was in foster care). In addition, proposed regulations and subsequent guidance do not *require* states to cover eligible foster youth who aged out of care in another state, but permit states to do so. Final regulations on these issues are pending. (For more information see, "Young Adults Who Were Formerly in Foster Care" and "Implementing the New Eligibility Pathway.")
- As of January 1, 2014, the ACA requires states to extend Medicaid coverage to certain non-elderly adults with annual income up to 133% of the federal poverty level (i.e., the ACA Medicaid expansion group). However, in June 2012 the U.S. Supreme Court held in *NFIB vs. Sebelius* that the federal government cannot terminate current Medicaid federal matching funds if a state refuses to expand its Medicaid program to include the ACA Medicaid expansion group. The Supreme Court's ruling effectively allows states to choose whether or not to provide Medicaid coverage to this new eligibility group. As of August 2014, a total of 27 states and the District of Columbia have chosen to do this. More states may choose to do so at any time. In states that elect to include the ACA Medicaid expansion group in their Medicaid state plans, the expansion may enable more family members with children in foster care—or otherwise involved with child welfare—to qualify for Medicaid. (For more information, see "Eligibility" and "Possible Coverage for Child Welfare-Involved Families.")
- The ACA made additional changes outside of Medicaid to assist childless adults and children and their families (e.g., children in foster care who are vulnerable to losing Medicaid upon returning home) in obtaining and maintaining Medicaid eligibility, and in obtaining private health insurance. The ACA includes private health insurance reforms that prohibit insurance industry practices such as denying health insurance based on health factors and excluding coverage for preexisting health conditions. These and other provisions are designed to provide protection to potentially vulnerable groups with a high prevalence of preexisting conditions, which could include youth previously in foster care. (For more information, see "Selected Private Health Insurance Reforms under the ACA.")
- The ACA also requires the establishment of health insurance exchanges, which are currently in operation in every state and the District of Columbia. Exchanges provide qualified individuals and small businesses access to private health insurance plans. In general, the exchange plans provide comprehensive coverage and meet all applicable market reforms specified in the ACA. To make exchange coverage more affordable, eligible individuals may receive financial assistance in the form of premium tax credits and cost-sharing subsidies. These ACA provisions may provide additional options to young adults who age out of foster care and/or families who are served by child welfare agencies to access private

health insurance. (For more information, see "Selected Private Health Insurance Reforms under the ACA.")

Children in, or Formerly in, Foster Care

Children in foster care are children that the state has removed from their homes and placed in another setting that provides round-the-clock care (e.g., foster family home, group home, child care institution).[5] Placement in foster care means that a judge has determined that the child's removal from his or her home was necessary because the home was "contrary to the welfare" of the child and, accordingly, the judge has given responsibility for the child's "care and placement" to the state child welfare agency.[6] The large majority of children enter foster care because of neglect or abuse at the hands of their parents. However, in some instances a child's behavior may also be a reason for entry into foster care; this is more often true for older children.[7]

During FY2013, some 641,000 children spent at least one day (24 hours) in foster care and 238,000 left the system, resulting in more than 402,000 of those children remaining in care on the last day of that fiscal year. Although there is variation at the state level, the national foster care caseload has generally been in decline for more than a decade. Across the nation, there were 122,000 fewer children in foster care on the last day of FY2013 as compared to the last day of FY2002 (when 524,000 were in care). [8]

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

Of the approximately 238,000 children who left foster care custody during FY2013, most—almost six out of every 10 (59%)—returned to their biological parents or went to live with another "fit and willing" relative while another 29% (131,000) left care for new permanent homes

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

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

[7] Based on "circumstances of removal" data reported by states via the Adoptions and Foster Care Analysis and Reporting System (AFCARS) as of July 21, 2014, and provided to the Congressional Research Service (CRS) by HHS, ACF, Administration on Children, Youth and Families (ACYF), Children's Bureau.

[8] HHS, ACF, ACYF, Children's Bureau, *Trends in Foster Care and Adoption: FFY 2002-FFY 2013*, based on foster care data reported by states via AFCARS as of July 21, *2014*.

via adoption or legal guardianship. However, another 10% (23,000) aged out of foster care custody without reunification or placement in a new permanent family.[9] The number of youth who age out of foster care each year initially increased over the past decade, rising from 19,000 in FY2002 to nearly 31,000 in FY2009, as the share of foster care exits attributable to aging out grew to 11%.[10] The number of children aging out of foster care may have stabilized in recent years due to an expected decrease in the number of children in foster care ages 10 through 17.[11]

Health Care Needs of Children in Foster Care

Among a national sample of children who were in families investigated for child abuse and neglect (during 2008-2009), between 31% and 49% were reported by their caregivers to have chronic health conditions.[12] This is more than one and a half times the prevalence of chronic health conditions among the general population of children and is roughly consistent with earlier, mostly smaller-scale studies that found between 35% and 60% of children and youth *entering* foster care had at least one chronic or acute physical health condition that needs treatment.[13] For example, chronic problems include growth failure, asthma, obesity, vision impairment, hearing loss, neurological problems, gastro-esophageal reflux, sexually transmitted diseases, and complex chronic illnesses.

Children in families investigated for abuse and neglect were more often found to have social competency and behavioral problems that may warrant mental health services than children in the population generally and this was especially true for children who, after the investigation, were placed in non-relative foster care or group/residential settings and for children who were living in foster care (or other out-of-home placement setting) three years after the initial child abuse and neglect investigation.[14]

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[9] Additionally, in FY2013 more than 1,100 youth (less than 1% of exits) ran away from their foster care placement and were discharged by courts from state foster care responsibility. Another 3,700 (2%) left care during FY2013 because they were transferred to another agency (i.e., juvenile justice, etc.). HHS, ACF, ACYF, CB, *AFCARS Report #21*.

[10] Based on "circumstances of removal" data reported by states via the AFCARS as of July 21, 2014 and provided to the Congressional Research Service (CRS) by HHS, ACF, ACYF, Children's Bureau.

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

[12] Ruth E.K. Stein, et al., "Chronic Conditions Among Children Investigated by Child Welfare: A National Sample," *Pediatrics*, March 2013, pp. 445-462. The range given represents alternative measures for determining whether a child had a reported chronic health care condition, described by the researchers as "conservative" or "liberal." This study found children with poorer health were more likely to be male, older, and receiving special educational services, but were not more likely to be in an out-of-home placement (e.g., foster care).

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

[14] Cecilia Casanuvea, et al., *NSCAW II: Baseline Report Child Well-Being*, HHS, ACF, Office of Planning and Research Evaluation (OPRE), August 2011, pp.7-9,29,35 and 51 and Cecilia Casanuvea, et. al., *NSCAW II: Wave Three Report: Wave 3 Tables*, June 2014. The NSCAW baseline data looked at national sample of children in families investigated for child abuse or neglect (n=5,872) between February 2008 and April 2009; the wave 3 data looked at this same sample of children roughly 36 months later with data collected June 2011-December 2012. See also Barbara Burns, et. al "Mental Health Need and Access to Mental Health Services by Youth Involved with Child Welfare: A National Survey," *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 43, no. 8 (August 2004), pp. 960-970.

Children who leave foster care often carry with them significant health and mental health needs. A national survey of children adopted from foster care found that 54% had special health care needs, which means they have one or more conditions (expected to last 12 months or more) that required ongoing need for more medical, mental health, or educational services than is usual for most children of the same age.[15] Other research has found that young adults who aged out of foster care at age 18 or soon thereafter were more likely than their peers generally to report having a health condition that limits their daily activities and to participate in psychological and substance abuse counseling. They were also less likely to have health insurance.[16] (Research on the health care needs of children who have aged out of foster care, and those who have left foster care for adoption is described further in **Appendix A**.)

Child Welfare Programs: Overview

The majority of federal child welfare policy and funding is provided via programs authorized in Title IV-B and Title IV-E of the Social Security Act.[17]

Under two formula grant programs included in Title IV-B—the Stephanie Tubbs Jones Child Welfare Services program and the Promoting Safe and Stable Families program—the federal government provides funds to state child welfare agencies for provision of a wide range of child welfare-related services to children and families. Overall, the focus of those services is to support and strengthen families (whether biological, adopted, or extended) in ways that ensure children's safety, permanence (with a stable family), and well-being. Funding is provided on a discretionary or capped entitlement basis and states may generally choose to serve any child or family they believe would benefit from these services.[18] The exact number of children and families served via these programs is not known. However, most are believed to access services following an investigation or other child protection agency response to an allegation of child abuse or neglect. In FY2012, state child protection agencies conducted some 2.1 million child abuse and neglect investigations or assessments, involving some 3.8 million children. Many states mandate that services be provided during the investigation as needed. In addition, roughly 1.2 million of these children received services after the conclusion of the investigation—either in the home (79% of those receiving post-investigation services) or via removal to foster care (21%).[19]

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

[16] Mark E. Courtney et al., *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 26*, Chapin Hall Center for Children, University of Chicago, 2011, http://www.chapinhall.org/research/report/midwest-evaluation-adult-functioning-former-foster-youth (Hereinafter, Courtney et al., *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 26.*). See also, HHS, ACF, ACYF, NYTD Data Brief #3, *Highlights from the National Youth in Transition Database (NYTD), Federal Fiscal Year 2013*, July 2014.The studies do not posit that foster care, per se, is associated with the challenges former foster youth face in adulthood. In fact, children tend to have a range of challenges upon entering care. Fred Wulczyn et al. *Beyond Common Sense: Child Welfare, Child Well-Being, and the Evidence for Policy Reform* (New Brunswick: Aldine Transaction, 2005), p. 116.

[17] CRS Report R43458, *Child Welfare: An Overview of Federal Programs and Their Current Funding*, by Emilie Stoltzfus.

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

[19] HHS, ACF, ACYF, Children's Bureau, *Child Maltreatment 2012* (December 2013). Children who were part of a family investigated more than once in the fiscal year were counted each time an investigation occurred. The (continued...)

The Title IV-E program has three main components: foster care, adoption assistance, and kinship guardianship assistance. States that choose to operate a Title IV-E program (all states do) must provide foster care maintenance payments to each eligible child in foster care and must enter into an adoption assistance agreement with parents of each eligible adopted child.[20] States are not required to provide kinship guardianship assistance to eligible children who leave foster care for placement with a legal (relative) guardian. However, states may elect to offer this assistance (in which case any child eligible for kinship guardianship, as defined in the state's Title IV-E plan, must be served). Not all children in foster care and not all those leaving care for guardianship or adoption are eligible for federal assistance under Title IV-E, and eligibility for Title IV-E varies by each of these components. (The various Title IV-E eligibility criteria are summarized in the context of Medicaid eligibility in a subsequent discussion.) Funding for the Title IV-E program is authorized as an open-ended entitlement; states are entitled to federal reimbursement for a part of each eligible cost incurred on behalf of an eligible child.[21] In FY2013, close to 608,000 children received Title IV-E assistance on an average monthly basis, and more than two-thirds of these children (71%) had exited foster care for adoption and were receiving adoption assistance.[22]

Finally, under the Chafee Foster Care Independence Program (Section 477, Title IV-E of the Social Security Act) state child welfare agencies receive funds to provide independent living services—such as mentoring, tutoring, substance abuse prevention, and preventive health services—to youth who are expected to age out of foster care (without placement in a new permanent family), those who have recently aged out, and those who left foster care for adoption or kinship guardianship at age 16 or older. Services are intended to improve these youths' ability to transition from foster care custody to successful adulthood. Funding is provided on a discretionary and capped entitlement basis.[23]

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

(...continued)

"unduplicated" number of children involved in investigations is 3.2 million. Any child who received a post-investigation service is also counted twice in this number and there is no estimated "unduplicated" number available.

[20] Throughout this report, the child welfare agency that administers the Title IV-E program is referred to as the "state" child welfare agency. "States" with an approved Title IV-E plan include all 50 states, the District of Columbia, and Puerto Rico. In addition, effective October 1, 2009, tribes are permitted to seek approval of a Title IV-E plan and to operate a Title IV-E program. As of fall 2014, five tribes have been granted this approval.

[21] For more information see CRS Report R42792, *Child Welfare: A Detailed Overview of Program Eligibility and Funding for Foster Care, Adoption Assistance and Kinship Guardianship Assistance under Title IV-E of the Social Security Act*, by Emilie Stoltzfus.

[22] Based on state FY2013 Title IV-E claims as compiled by HHS, ACF, Office of Legislative Affairs and Budget (OLAB). During FY2013, of the 607,916 children receiving Title IV-E assistance on an average monthly basis, 431,533 received adoption assistance, 158,994 received foster care maintenance payments, and 17,389 received kinship guardianship assistance.

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

Child Welfare Policies Addressing the Health Care Needs of Children in Foster Care and Those Aging Out of Foster Care

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

Health Care Records

Federal law requires that the state child welfare agency have a written plan for each child in foster care, including certain health-related records. These records must include the names and addresses of the child's health care providers, a record of the child's immunizations, information about the child's medication, and any other relevant health information concerning the child.[24] These records must be reviewed, updated, and supplied to a child's foster care parent or provider at the time of each foster care placement. Additionally, a copy of the record must be provided to a youth at the time he/she leaves care due to age.[25]

Health Care Oversight and Coordination Planning

As part of the requirements that demonstrate compliance with the Stephanie Tubbs Jones Child Welfare Services Program (Title IV-B, Subpart 1), states must develop and submit to HHS a plan for the ongoing oversight and coordination of health care services, including mental health and dental health services, for each child in foster care. This coordinated strategy and oversight plan must be developed via a collaborative effort between the state child welfare agency and the state agency that administers Medicaid, in consultation with pediatric and other health care experts, as well as experts in, or recipients of, child welfare services.[26]

[24] Section 475(1)(C) of the Social Security Act.

[25] Section 475(5)(D) of the Social Security Act and, effective September 29,2015, Section 475(5)(I), as amended by P.L. 113-183, of the Social Security Act.

[26] Section 422(a)(15) of the Social Security Act.

Health Care Oversight and Coordination Planning Requirements

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

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

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

The requirement for states to develop a coordinated strategy and health care oversight plan for children in foster care is relatively new. It was added to the law in 2008 and has been revised twice since then. (In 2010 to include planning related to youth aging out of foster care, and in 2011 to require protocols for use of psychotropic medication and to focus on screening and responding to emotional trauma experienced by children.)[27] Initial federal guidance on meeting this requirement offered states flexibility on how to administer the ongoing oversight while re-iterating the need to include a regular schedule of physical, mental, and dental health screenings, as well as standards of care, that follow existing professional guidelines. In 2014 state child welfare agencies were instructed to provide HHS with a new health care oversight and coordination plan that "reflect[s] lessons learned since development of the prior plan and continue[s] to strengthen activities to improve the health care and oversight of children and youth in foster care."[28]

Through early fall 2014 most federal guidance and activities related to meeting this requirement have focused on specific aspects of the plan—developing protocols on the use of psychotropic

[27] P.L. 110-351 (2008); P.L. 111-148 (2010) and P.L. 112-34 (2011).

[28] HHS, ACF, ACYF, Children's Bureau, *Title IV-B Child and Family Services Plan ...* , ACYF-CB-PI-14-03, March 5, 2014, pp. 30-31.

medication, as well as screening for and meeting the behavioral and mental health needs of children in foster care—and have sought to facilitate cross-agency collaboration on these issues.[29]

Although evidence of their clinical safety and effectiveness for children is often lacking, psychotropic medications are typically prescribed to address mental, emotional, or behavioral issues ascribed to children in foster care. A national study found that between 16% and 23% of children in foster care received psychotropic medication (depending on their length of time in care) while the comparable percentage for all children in Medicaid (based on several statewide studies) was 5% to 6%. Studies that estimated use of psychotropic medication for some part of a child's stay in foster care showed that the medicines were being prescribed to much higher percentages of these children compared to other Medicaid-enrolled children or other children who have had contact with child welfare but were not in an out-of-home placement.[30]

In keeping with these efforts, HHS, as part of its FY2015 budget request, proposes a joint agency endeavor (between ACF and CMS) to encourage use of evidence-based psychosocial interventions to address children's mental and behavioral needs and reduce over-prescription of psychotropics among children in foster care. More specifically, the Administration seeks legislative authority and funding to allow ACF to make competitive grants to improve and grow capacity to offer psychosocial interventions, including through multi-agency collaboration, and to allow CMS to provide incentive payments to states that demonstrate measured improvements.[31]

Health Care Power of Attorney

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

A health care power of attorney (or health care proxy) is a document that lays out the circumstances under which health care decisions can be made for a person if he or she is unable to make or communicate those decisions. The document designates an individual (sometimes

[29] See letter from HHS, ACF, CMS, and Substance Abuse Prevention and Treatment Administration (SAMHSA), to State directors (regarding safe and appropriate use of psychotropic medication for children in foster care), November 23, 2011, http://www.childwelfare.gov/systemwide/mentalhealth/effectiveness/jointlettermeds.pdf and (regarding trauma-focused screening, function assessments and use of evidence-based practices to improve child well-being), July 11, 2013, http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf. See also information from tri-agency summit (for state child welfare, Medicaid, and mental health directors), *Because Minds Matter: Collaborating to Strengthen Management of Psychotropic Medications for Children and Youth in Foster Care*, http://www.pal-tech.com/web/psychotropic. Additional information is at HHS, CMS, Center for Medicaid and CHIP Services (CMCS) Informational Bulletin, *Prevention and Early Identification of Mental Health and Substance Use Conditions*, March 27, 2013, http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf; and HHS, ACF, CMS, and SAMHSA, *Coverage of Behavioral Health Services for Children, Youth and Young Adults with Significant Mental Health Conditions*, http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf.

[30] For an overview of this issue and related research, see CRS Report R43466, *Child Welfare: Oversight of Psychotropic Medication for Children in Foster Care*, by Adrienne L. Fernandes-Alcantara, Sarah W. Caldwell, and Emilie Stoltzfus. See also Leyla F. Stambaugh et al., *Psychotropic Medication Use by Children in Child Welfare*, HHS, ACF, Office of Planning, Research, and Evaluation, National Survey of Child and Adolescent Well-Being Report. No. 17, 2012.

[31] HHS, *Budget in Brief, Fiscal Year 2015*, p. 115.

referred to as an "agent") who can make decisions on that person's behalf. The agent can be anyone that the individual chooses; the agent does not have to be a relative. The power of attorney form can be tailored to an individual's circumstances, although states have generic forms that can be used.[32]

The health care oversight provision on health care power of attorney references the transition planning requirement under Title IV-E of the foster care program. The transition plan requirement directs states to develop a plan for (and with) any youth in foster care for whom the state's responsibility is expected to end because the youth has reached the state's age of majority (i.e., age 18 or a later age, up to 21, at state option). The plan must be developed during the 90-day period immediately prior to the date on which the youth is expected to age out of foster care, and it must include specific options on housing, health insurance, education, local opportunities for mentors and continuing support services, and workforce supports and employment services.[33]

As of FY2011, the transition plan must include information about the importance of designating another individual to make health care treatment decisions on behalf of the youth if he or she becomes unable to participate in these decisions *and* does not have a relative who would be authorized to make these decisions under state law, or he or she does not want that relative to make those decisions. In addition, the transition plan must provide the youth with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under state law. States must meet related requirements under the Title IV-E Chafee Foster Care Independence Program (CFCIP).[34] As part of their application for these funds, states must certify that they meet requirements pertaining to health care power of attorney.

A health care power of attorney may be especially important for young people aging out of care when they do not have a relative upon whom they can rely to make decisions if they become incapacitated. Even if former foster youth maintain relationships with kin, these relationships may be tenuous. A prospective study that is tracking young people who emancipated from care in three Midwest states found that at ages 25 or 26, roughly one-third to one-half of the former foster youth surveyed reported being "very close" or "somewhat close" to their biological mother (52%), biological father (31%), grandparents (46%), or "other relatives" (39%).[35] (Comparable data were not reported for youth generally.) This suggests that a significant share of former foster youth in the study did not have strong relationships with at least some of their relatives after having been out of care for at least a few years.

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[32] A health care power of attorney is different from a living will, which allows an individual to express his or her wishes concerning life-sustaining procedures but does not specify who should make decisions on the individual's behalf if needed. Laws pertaining to health care power of attorney are specific to each state. Generally, if an adult becomes ill and incapacitated, and no health care power of attorney has been executed, then state law will determine how medical decisions will be made. For further information, see archived CRS Report R40235, *End-of-Life Care: Services, Costs, Ethics, and Quality of Care*, coordinated by Kirsten J. Colello.

[33] HHS, ACF, ACY, Children's Bureau (CB) encourages child welfare agencies to use transition planning to build on earlier efforts to assist young people in making the transition from foster care, including through the case planning process and permanency hearings. HHS, ACF, ACYF, CB, *Guidance on Fostering Connections to Success and Increasing Adoptions Act*, ACYF-CB-PI-10-11, July 9, 2010, http://www.acf.hhs.gov/programs/cb/resource/pi1011. According to this 2010 guidance, the component of the plan pertaining to health care power of attorney for youth aging out of foster care will be addressed in future guidance.

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

[35] Mark E. Courtney et al., *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 26.*

Medicaid Program: Overview of Benefits and Eligibility

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term care, covering more than 58 million people in FY2013.[36] The Medicaid program is jointly funded by states and the federal government and many program details are determined at the state level. The Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) is responsible for Medicaid program administration at the federal level, but individual state Medicaid agencies administer their own programs on a day-to-day basis.

Benefits

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

As an alternative to providing all of the mandatory and selected optional benefits under traditional Medicaid, states are permitted to offer Alternative Benefit plans (ABPs).[37] ABPs are a Medicaid benefit structure that has different requirements than the traditional Medicaid benefits. For example, under ABPs states may waive coverage requirements concerning "statewideness" and "comparability" that otherwise would apply under traditional Medicaid. This flexibility permits the state to define populations that will be served and the specific benefit packages that will be available. In general, ABPs allow states to offer less coverage (fewer benefits) than under traditional Medicaid. However, like traditional Medicaid, ABPs are required to cover EPSDT services, family planning services and supplies, and both emergency and non-emergency transportation to and from providers. This array of benefits might make them more generous than private insurance.

[36] FY2013 Medicaid enrollment estimates represent "person-year equivalents." See, HHS, CMS Office of the Actuary (OACT), "Health Insurance Enrollment and Enrollment Growth Rates, Calendar Years, 2007-2023," Table 17. For more information on the Medicaid program, see CRS Report R43357, *Medicaid: An Overview*, coordinated by Alison Mitchell.

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

Eligibility

Eligibility for Medicaid is determined by both federal and state law. While states set eligibility criteria for individuals they serve they must do this within federal minimum standards. Some eligibility groups defined in federal law are mandatory; others are optional. For most groups (mandatory or optional) to qualify for coverage, applicants' incomes, and sometimes their resources or assets, must meet Medicaid financial requirements. Historically, in addition to low-income criteria, Medicaid eligibility was generally limited to certain groups (or categories) of individuals, including those with disabilities, the elderly, children, adults in families with dependent children, and pregnant women. However, with enactment of the ACA, Congress moved away from eligibility restrictions based on these categories and moved toward broader Medicaid eligibility for low-income individuals (under age 65).[38]

Specifically, Section 2001 of the ACA added a new eligibility group to the Medicaid statute to include individuals under the age of 65 with income at or below 133% of the federal poverty level[39] provided, generally, that they were not already eligible for Medicaid. [40] Coverage for this new eligibility group—referred to as the ACA expansion group—was to be extended in all states[41] no later than January 1, 2014.[42] However, in its June 28, 2012 decision, *National Federation of Independent Business v. Sebelius*, the U.S. Supreme Court held that the federal government cannot terminate current Medicaid federal matching funds if a state refuses to expand its Medicaid program to include the ACA Medicaid expansion group.[43] This effectively makes state participation in the expansion voluntary because it limits the ability of the Secretary of HHS to enforce coverage of the expansion group through withholding of federal funds. At the same time, the Court's decision did not specifically affect, change, or limit any other Medicaid or ACA provisions. Further, if a state chooses to accept ACA Medicaid expansion funds (tied to providing coverage to the ACA Medicaid expansion group), it must abide by all the coverage rules related to this new eligibility group.[44] As of early fall 2014, 27 states and the District of Columbia have adopted the ACA Medicaid expansion.[45]

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[38] See CRS Report R43564, *The ACA Medicaid Expansion*, by Alison Mitchell.

[39] Section 1902(e)(14)(I) of the Social Security Act effectively raises this low-income threshold to 138% of the federal poverty line (FPL) by making a 5% income disregard applicable for individuals at the highest income limit for coverage (under the modified adjusted gross income (MAGI) counting rule).

[40] Federal poverty guidelines are based on family size and are recalculated periodically (usually on an annual basis) to keep pace with inflation. Under the FY2014 federal poverty guidelines, 133% of FPL for a family of one (living in one of the 48 contiguous states) was roughly $15,521and 138% of FPL for a family of one was roughly $16,105. See *Federal Register*, January 24, 2013, at https://www.federalregister.gov/articles/2014/01/22/2014-01303/annual-update-of-the-hhs-poverty-guidelines.

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

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

[43] 567 U.S. ___ (2012), available at http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf.

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

[45] For more information see CRS Report R43564, *The ACA Medicaid Expansion*, by Alison Mitchell.

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

States have the option to impose premiums or other cost sharing requirements for some Medicaid beneficiaries and to enroll some in Medicaid alternative benefit plans (ABPs), which typically cover fewer services than traditional Medicaid benefit packages. However, children who are in foster care (like most non-disabled children who are Medicaid eligible) and those who leave foster care for adoption or legal guardianship (provided they are Title IV-E eligible) must remain free of any beneficiary cost-sharing requirements. Additionally states are not permitted to require mandatory enrollment of these children in Medicaid ABPs.[46] Federal policy differs somewhat for youth who are eligible under the new mandatory Medicaid pathway for former foster youth who have aged out of care. While states may not require their mandatory enrollment in Medicaid ABPs, former foster youth who aged out of care may be subject to alternative premiums and cost-sharing.[47]

Early Periodic, Screening, Diagnostic, and Treatment (EPSDT) Services

The EPSDT program is a required benefit for nearly all children (under age 21) who are enrolled in Medicaid. This includes former foster youth under the new mandatory Medicaid eligibility pathway, but like other Medicaid enrollees, only until their 21st birthday.[48] It covers health screenings and services, including assessments of each child's physical and mental health development; laboratory tests (including lead blood level assessment); appropriate immunizations; health education; and vision, dental, and hearing services.[49] The screenings and services must be provided at regular intervals that meet "reasonable" medical or dental practice standards.[50] States are required to provide all federally allowed treatment to correct problems identified through screenings, even if the specific treatment needed is not otherwise covered under a given state's Medicaid plan.[51]

[46] Section 1916A(b)(3) of the Social Security Act (regarding limitations on premiums and cost sharing) and Section 1937(a)(2)(viii) of the Social Security Act (regarding limitation on enrollment in ABPs). In addition to children for whom Title IV-E assistance is available, these restrictions also apply to any child in foster care to whom "child welfare services are made available" under Title IV-B of the Social Security Act. Because any child in foster care is eligible for Title IV-B services, these provisions could effectively apply to any child in foster care (although the premium or cost-sharing exemption applies only to these IV-B children who are under age 18).

[47] Section 1937(a)(2)(viii) of the Social Security Act (regarding limitation on enrollment in ABPs and HHS, Centers for Medicaid and Medicare Services (CMS), "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Plans, Eligibility Notices, Fair Hearings and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment; Final Rule," 78 *Federal Register* 42160, July 15, 2013, see p. 42281. (Hereinafter, HHS, CMS, Final Rule, July 15, 2013.)

[48] HHS, CMS, "Medicaid and CHIP FAQs: Funding for the New Adult Group, Coverage of Former Foster Care Children and CHIP Financing," December 2013.

[49] Section 1905(r) of the Social Security Act Section 1902(a)(43) of the Social Security Act. EPSDT is not a mandatory benefit for the medically needy, although states that choose to extend EPSDT to their medically needy population must make the benefit available to all Medicaid-eligible individuals under age 21.

[50] Section 1905(r) of the Social Security Act.

[51] This means states may be required to cover some services for children that would be optional or not covered at all for adults.

Tracking receipt of EPDST covered services is complicated by the diverse range of licensed providers (e.g., medical doctor, nurse practitioner, dentists, and others) that may offer the services, as well as the wide range of locations in which the screenings or other services may be provided (ranging from well-child clinics to Head Start programs and many other locations).[52] Further, the primary data source on use of EPSDT services is separate from the overall Medicaid claims data reported to CMS and does not include information received by specific eligibility groups.[53]

At the same time, EPSDT is clearly a critical benefit for children covered by Medicaid and available information indicates receipt of EPSDT services by Medicaid children, including those in foster care, is not always complete. An early 2000s investigation by the HHS Office of Inspector General (OIG) found inconsistent receipt of basic health care services for children in foster care. [54] Further, the HHS OIG reported in 2010 that many Medicaid-eligible children did not receive all required EPSDT services.[55] In a follow up study conducted in 2013, the HHS OIG found that CMS had taken steps to encourage greater participation in EPSDT screenings and treatments. However, citing data that showed a national participation rate for EPSDT screenings of 63% in FY2013 (well below the HHS goal of 80% participation), it stated that the "underutilization of medical screenings is an ongoing concern."[56]

Despite this finding that children in foster care may not be receiving all screening or treatments for which they are eligible under EPSDT, researchers have repeatedly shown that per child Medicaid expenditures for beneficiaries counted as "foster care" children exceed the per child expenditures for other Medicaid beneficiaries[57] who, like "foster care" children, are categorized in the Medicaid data set as "non-disabled children." It is possible that the higher than average costs for foster care children are tied to a relatively small number of children in that population with very high (usually mental health-related) service needs.[58] Additionally, some research

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

[53] States use CMS Form 416 to report annual aggregate data on the number of children (by age group) who are eligible for EPSDT services and have received certain services. See FY2013 data available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html. Beginning, July 1, 2014 states must submit Medicaid program and financial data through the Transformed-Medicaid Statistical Information System (T-MSIS). T-MSIS will replace CMS Form 416 data and will eventually allow for more detailed analysis of EPSDT service use (e.g., by foster care children).

[54] See HHS, OIG *Children's Use of Health Care Services While in Foster Care: Common Themes*, Memorandum from Brian Ritchie, Acting Deputy Inspector General for Evaluation and Inspections, to Susan Orr, Associate Commissioner for the Children's Bureau, Administration for Children and Families, and Dennis G. Smith, Director of Centers for Medicare and Medicaid Services, July 8, 2005 (OEI-07-00-00645), https://oig.hhs.gov/oei/reports/oei-07-00-00645.pdf.

[55] HHS, Office of the Inspector General (OIG), *Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services*, May 2010 (OEI-05-08-00520), http://oig.hhs.gov/oei/reports/oei-05-08-00520.pdf. The report cited a need for improved documentation of certain screenings as well as better provider knowledge of what a screening entails (among other things) as ways to improve services. In December 2010, CMS convened a National EPSDT Improvement Workgroup to help identify areas to improve EPSDT and to work at the federal level and with states to improve children's access to EPSDT services and the quality of the data reporting on receipt of those services.

[56] HHS, OIG, "Recommendation Followup Memorandum Report: *CMS Needs to Do More to Improve Medicaid Children's Utilization of Preventive Screening Services* OEI-05-13-00690," November 12, 2014. Available at http://oig.hhs.gov/oei/reports/oei-05-13-00690.pdf

[57] See, for example, analyses in Rob Geen, Anna Sommers, and Mindy Cohen, *Medicaid Spending on Foster Children*, The Urban Institute, Child Welfare Research Program, Brief No. 2, August 2005 (using 2001 Medicaid data); and Sheila Pires, et. al., "Faces of Medicaid: Examining Children's Behavioral Health Service Use and Expenditures," Center for Health Care Strategies with support of the Annie E. Casey Foundation, 2013 (using 2005 Medicaid data).

[58] See *Addressing the Health Care Needs of Foster Care Children*, Issue Brief, First Focus, May 2008, pp. 1-2.

suggests that children in foster care with less high-end needs may not always be coded as "foster care" children while those with higher needs (and generally longer stays in foster care) are included in the foster care eligibility category.[59]

Limitations in Understanding Medicaid Spending for Foster Care Children

Data used by researchers to determine Medicaid spending per foster care child nationally are generally based on eligibility and expenditure claims data submitted to the federal government by state Medicaid agencies via the Medicaid Statistical Information System (MSIS).[60] CRS identified several limitations with regard to what the MSIS data can indicate about spending for children in foster care. These include differences in who is counted as a child in foster care for purposes of Medicaid data (as compared to child welfare data) and incomplete information on types of services provided.

Varying Definitions of Children in Foster Care

Both Medicaid and the child welfare programs authorized under Title IV-B and Title IV-E of the Social Security Act are federal-state programs with separate federal policy and data reporting requirements. Currently "foster care" children are described differently in these two reporting systems. Consequently the type and amount of Medicaid spending for "foster care" children, as reported in MSIS, may vary from the type and amount of Medicaid spending for children in foster care as understood (and counted) by the child welfare agency.

State child welfare agencies must report data on the demographics and other characteristics of each child in foster care via the Adoption and Foster Care Analysis Reporting System (AFCARS).[61] In this reporting system, a child in foster care generally means a child for whom a court has given the state child welfare agency 24-hour care and placement responsibility. Such a child must be counted in foster care with or without regard to whether the child is eligible for federal foster care assistance under the Title IV-E program. Once the court relieves the state child welfare agency of that responsibility—either because the child with court sanction leaves foster care for a permanent home via adoption, legal guardianship, or reunification; or because the child reaches the state age of majority and is "emancipated" by the court (ages out)—the child is no longer considered as a child in foster care.

By contrast, for purposes of Medicaid (MSIS) reporting children are counted as "foster care" children primarily based on whether or not they are eligible to receive Title IV-E foster care, adoption assistance, or kinship guardianship assistance. This IV-E eligible group includes (1) children counted by the child welfare agency as in foster care, but only if they are eligible for federal (Title IV-E) foster care maintenance payments; (2) the majority of children who have left foster care for adoption; and (3) some children who left foster care for legal guardianship.[62]

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[59] David M. Rubin, et al., "A Sampling Bias in Identifying Children in Foster Care Using Medicaid Data," *Ambulatory Pediatrics*, May-June 2005, pp. 185-190.

[60] As of July 2014, states are required to begin data reporting using T-MSIS, which stands for Transformed Medicaid Statistical Information System. T-MSIS is an expansion of the existing Centers for Medicare & Medicaid (CMS) MSIS extract process that will provide data about beneficiaries, providers, claims, and encounters.

[61] For the definition of foster care in child welfare policy see 45 C.F.R. §1355.20. Regarding "foster care" reporting population in AFCARS see HHS, ACF, ACYF, Children's Bureau, *Child Welfare Policy Manual*, Section 1.3, Q&A 1.

[62] In addition to the Title IV-E eligible children, state Medicaid agencies are instructed to report children eligible for (continued...)

Further, until July 1, 2014, state Medicaid agencies were instructed to code certain youth beneficiaries who aged out of foster care as "foster care" children as well.[63] As of that date states are required to submit Medicaid program data via a revised reporting system. In this new system (T-MSIS) former foster youth who aged out of care are counted separately from children who are in foster care. However, children who leave foster care for adoption or kinship guardianship are expected to continue to be included in the Medicaid "foster care" children population.

The mismatch in definition of "foster care" children makes it impossible for researchers and policymakers to know with certainty the type and level of Medicaid services children currently in foster care receive. In the first place, the Medicaid (MSIS) services data for "foster care" children do not clearly include children in foster care who are made eligible for Medicaid through a pathway other than the Title IV-E eligibility group (e.g., low-income or SSI children). Further, children receiving Title IV-E adoption assistance represent the large majority of all Title IV-E children (close to 71% of all children who received Title IV-E assistance in FY2013) and those adoptees are counted as "foster care" children for Medicaid purposes.[64] Title IV-E eligible adoptees must by definition have "special needs" and may, in general, have somewhat greater health care needs than children in foster care generally.[65] Apart from this concern for researchers and policymakers trying to understand Medicaid services to children in foster care, the mismatched definitions could affect the ability of state Medicaid agencies to administer requirements applicable to children in foster care or otherwise meet the unique needs of children in care. The inability of Medicaid data to accurately identify children served by the program and who were in foster care was a key concern identified in a demonstration project that sought to improve access to and services provided to children in foster care.[66]

Type of Service Provided Not Reported for All Spending

As mentioned, Medicaid data reporting does not allow the amount of spending on foster care children that is provided under the EPSDT benefit to be determined. (T-MSIS will eventually allow for more detailed analysis of EPSDT service use.) Additionally, as discussed in the next section of the report, "other services" represents the largest single category of Medicaid services spending on behalf of "foster care" children. Although this category includes some discreet items

(...continued)

Medicaid through the optional pathway available for "special needs" adoptees who receive state funded adoption assistance. (All states include this optional eligibility pathway in their Medicaid plan.) States are also instructed to include "special needs" foster care children in the "foster child" category. Unlike children who are adopted, there is no definition of "special needs" child in federal child welfare law that is specific to children in foster care, nor is there a specific Medicaid eligibility category exclusive to these children. Therefore the way state Medicaid agencies interpret this instruction is unclear. See *MSIS Data Dictionary*, February 2014, p. 157 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/MSIS/Downloads/msis-data-dictionary.pdf

[63] Ibid, p. 157 and (for T-MSIS, p. 175). Specifically, under MSIS these were youth who aged out and were Medicaid eligible under the "Chafee option." As of January 2011, 30 states included this option in their Medicaid state plan. Under T-MSIS, "Chafee option" youth are no longer included in the "foster care child" eligibility category.

[64] Based on state Title IV-E expenditure claims data for FY2013 (reported quarterly via CB-496) as compiled by HHS, ACF, Office of Legislative Affairs and Budget (OLAB).

[65] See U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning Research and Evaluation, National Survey of Child and Adolescent Well-Being (NSCAW), "Special Health Care Needs Among Children in Child Welfare," Research Brief No. 7, no date.

[66] Kamala D. Allen, et al., *Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit*, February 2014, Center for Health Care Strategies with funding from the Annie E. Casey Foundation, p.p. 8-9, 25, 45.

(i.e., eyeglasses, optician fees, and prosthetic devices), it is defined to include certain home and community-based waiver services that cannot be included in any other fee-for-service category. As a fee-for-service category then, it gives limited information about the types of services provided to foster care children with Medicaid dollars.

Finally, Medicaid (MSIS) data on specific types of services provided are only available if the service provider is paid under a fee-for-service arrangement. Under fee-for-service, state Medicaid agencies pay providers directly for each covered service received by the Medicaid beneficiary. Most Medicaid benefits for "foster care" children are paid through this arrangement. However, as discussed in the next section, an increasing share of Medicaid benefits—including those paid to foster care children—are paid under managed care arrangements. Under managed care, in general, state Medicaid agencies typically pay a monthly fee to a managed care plan for each person enrolled in the plan. The managed care plan then pays providers for the Medicaid services an enrollee receives that are covered in the plan's contract.[67] For purposes of reporting to MSIS, the state Medicaid agency simply notes total spending for beneficiaries under managed care plans (and most of this spending is referred to as "capitated" spending).

CRS Analysis of Medicaid Spending For Foster Care Children

Despite these limitations, analysis of MSIS data does provide an important picture of Medicaid spending for a broad range of children who were previously in foster care or who are currently in foster care. To determine Medicaid spending for these "foster care" children, CRS reviewed, for selected years, the amount of Medicaid spending by type of service (MSIS claims data) for children coded as "foster care" children (under MSIS eligibility categories).[68] Analysis of FY2010 total spending in Medicaid found that while children coded as "foster care" children represented only 3% of all nondisabled Medicaid child recipients in that year, they accounted for approximately 10% of expenditures for all non-disabled children. FY2010 per capita Medicaid service spending for a "foster care" child was $6,188, compared to $1,999 per nondisabled child recipient and $14,690 per disabled child recipient.

Overall Medicaid Service Spending for "Foster Care" Children

For FY2010, the most recent year for which data were available for this analysis from all states, state Medicaid agencies reported spending $5.754 billion on services for children in foster care. Of this amount $1.033 billion (18%) was spent under managed care arrangements (also referred to as capitated payments) and the remaining $4.721 billion (82%) was spent on fee-for-service benefits. State Medicaid agencies report service spending in multiple "types of service" categories, including at least three managed care categories and 26 fee-for-services categories.

[67] For more about use of managed care under Medicaid, see Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to the Congress on Medicaid and CHIP*, June 2014, Section 4.

[68] To do this analysis CRS used MSIS data as aggregated in the quarterly State Summary DataMart, which include data from the 50 states and the District of Columbia. These data capture eligibility status at a given point in time. Therefore not all Medicaid spending for foster care children may be captured if a child's basis of eligibility for Medicaid changes over the course of the year. For additional information on these data see HHS, CMS, "Medicaid Statistical Information System (MSIS) State Summary DataMarts" http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MSIS-Mart-Home.html

From FY2001 through FY2010, use of managed care to provide Medicaid services to "foster care" children increased from roughly 9% of Medicaid service spending for "foster care" children in FY2001 to close to 18% in FY2010. Although this represents significant growth, use of managed care for "foster care" children remains far less common than for other non-disabled children served by Medicaid. (In FY2010, 44% of Medicaid services spending for non-disabled children was paid under managed care arrangements.[69])

Across the same time period, combined spending on six Medicaid fee-for-service spending categories accounted for more than $6 of every $10 in Medicaid service spending for "foster care" children. These six categories are "other services" (which includes spending on some home and community-based waiver services, as well as spending for prosthetic devices, eyeglasses and optician fees), "clinic services," "prescribed drugs," "inpatient hospital services," "inpatient mental health facilities (for individuals under age 21)," and "rehabilitative service." (For more information on spending by each Medicaid services category see **Appendix B**.)

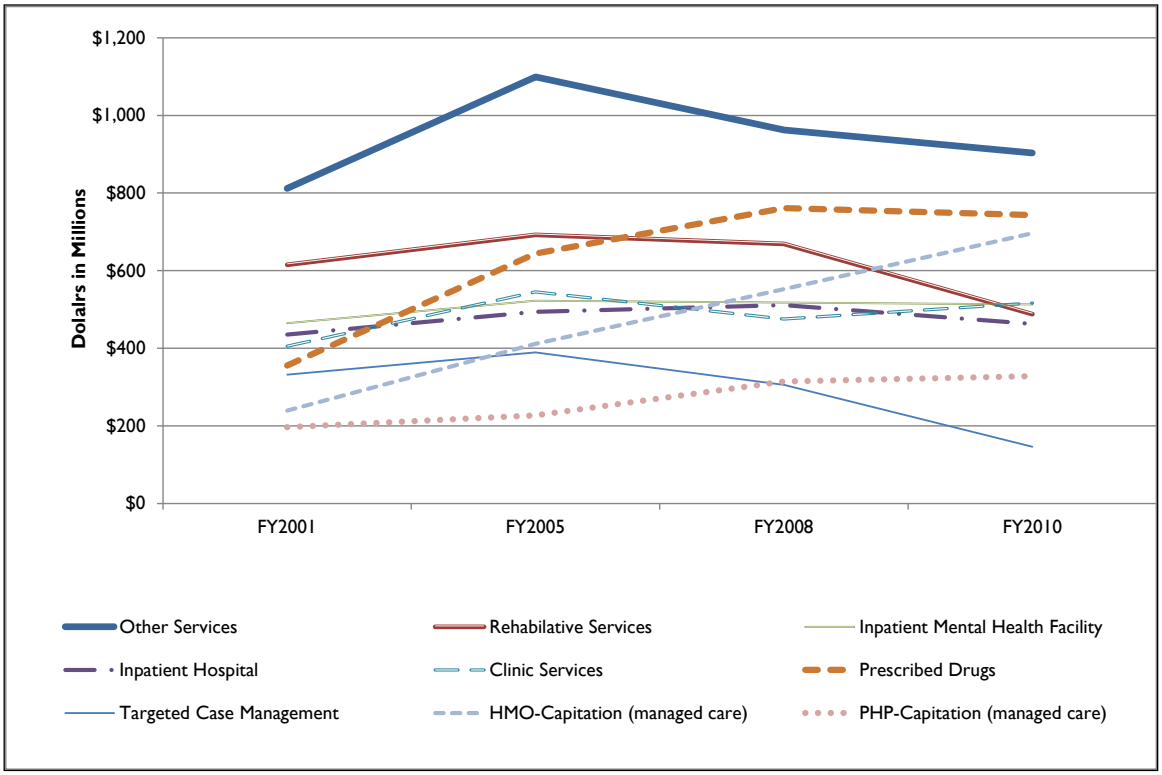
Figure 1 shows (in constant FY2010 dollars) trends in spending by each of the six fee-for-service spending categories, as well as for a seventh, "targeted case management" (which has historically been important for children in foster care). Further, it shows trends in spending for two major managed care categories: "HMO-capitated" and "PHP-capitated." (These trends, and each of these Medicaid service spending categories (managed care and fee-for-service) are described in the subsequent pages.)[70]

[69] MACPAC, *Report to the Congress on Medicaid and CHIP*, June 2013, p. 100, http://www.macpac.gov/reports.

[70] In addition to the specific limitations discussed in the text, readers should note that the trend analysis is not done on a per capita foster care child basis but instead relies on aggregate, national data as reported by state Medicaid agencies. Accordingly, changes in the size of the Medicaid "foster care" child population, which may affect overall spending, are not seen in these aggregate data. Further, the data are presented on a national basis and therefore mask expected variation by state.

Figure 1. Medicaid Spending for "Foster Care" Children by Selected Categories and Fiscal Years

Data are displayed in constant (inflation-adjusted) FY2010 dollars.



Source: Figure prepared by CRS based on analysis of MSIS data. Not all categories of reported service spending are shown in this figure. See **Appendix B** for table showing nominal dollar spending in these and other services categories, for which state Medicaid agencies reported spending on "foster care" children in FY2001, FY2005, FY2008, and FY2010.

Notes: For purposes of MSIS, "foster care" children reported during some or all of these years includes some children in foster care, the majority of children who have left foster care for adoption, some children who left foster for legal guardianship, and some who aged out of foster care.

Managed Care

As mentioned previously, managed care typically involves state Medicaid agencies paying a monthly fee to a managed care provider for each person enrolled in the managed care plan. Before 1997, use of managed care service delivery for Medicaid beneficiaries who were foster care children was not permitted outside of waiver authority. The Balanced Budget Act of 1997 loosened the Medicaid managed care requirements generally. However, children under age 19 with special needs (including children receiving foster care or adoption assistance under Title IV-E and foster care children in out-of-home placements) are protected groups in that such children are exempt from mandatory enrollment in managed care.[71] As of FY2010, 35 states enrolled at least some of their Medicaid foster care populations in managed care programs.[72]

[71] Sections 1932(a)(2)(A)(iv) - (v) of the Social Security Act.

[72] Kamala D. Allen and Taylor Hendricks, *Medicaid and Children in Foster Care*, Center for Health Care Strategies and the State Policy Advocacy and Reform Center (SPARC), March 2013.

There are two major types of managed care spending: HMO-capitation and prepaid health plans (or PHP-capitation). As shown in **Figure 1**, the largest growth in managed care spending for foster care children is in "HMO-capitation." In this managed care arrangement, the HMO (health maintenance organization), under a contract with the state Medicaid agency, receives a "capitated" (fixed) fee to provide a comprehensive set of services. Spending increased in this category from 5.3% of all Medicaid service spending for "foster care" children in FY2001 ($240 million in constant FY2010 dollars) to 17.9% in FY2010 ($696 million). Growth in "prepaid health plans" (shown as "PHP-Capitation" in **Figure 1**) has been less dramatic and, since FY2008, appears to have stalled or at least slowed. In the PHP-capitation model of managed care, state Medicaid agencies contract with physicians, physician groups, clinics, or other entities to provide a limited range of services (e.g., mental health, transportation) for a fixed fee. Spending under the PHP-capitation model represented 4.2% of Medicaid services spending for foster care children in FY2001 ($196 million in constant FY2010 dollars) and had risen to 5.7% of this spending in FY2010 ($326 million).

Some states also use a third model of managed care, referred to as primary care case management (or PCCM capitation in MSIS). Under the PCCM model, the managed care provider receives a monthly fee to act as a care coordinator and/or gatekeeper to the services specified under the managed care contract. However, services provided are generally paid by the state Medicaid agency through the fee-for-service delivery system. Use of this managed care model appears limited for Medicaid foster care children, with just $2 million in reported spending on this model in FY2001 (constant FY2010 dollars) and $8 million in FY2010. (These data are not shown in **Figure 1**.)

Traditionally some advocates have been concerned that use of managed care for such a high-need and high-risk population could restrict services provided to foster care children and some research found that children in counties with managed care for behavioral health care had lower odds of inpatient mental health service use.[73] However, other researchers and advocates argue that properly structured managed care can improve access to services and coordination of health care for children in foster care.[74]

Fee-for-Service

Under a fee-for-service model, states pay providers directly for each covered service received by the Medicaid beneficiary. MSIS includes some 26 fee-for-service service type categories. Across the decade (FY2001-FY2010), spending on six Medicaid fee-for-service categories represented between 67% (FY2005) and 63% (FY2010) of all Medicaid services spending for children in foster care (including managed care spending). These top fee-for-service categories (and spending for them in FY2010) are

- "other" services, which include prosthetic devices, eyeglasses, and certain Home and Community-Based waiver activities, provided those waiver activities could not

[73] See discussion of research in "Other Issues to Consider: Managed Care Models," *Addressing the Health Care Needs of Foster Care Children*, Issue Brief, First Focus, May 2008, p. 5.

[74] Kamala D. Allen, *Medicaid Managed Care for Children in Child Welfare*, Center for Health Care Strategies, Issue Brief, April 2008; and Kamala D. Allen and Taylor Hendricks, *Medicaid and Children in Foster Care*, Center for Health Care Strategies and the State Policy Advocacy and Reform Center (SPARC), March 2013. See also, Kamala D. Allen, Sheila A. Pires, Roopa Mahadevan, *Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit*, Center for Health Care Strategies, February 2012.

be reported in any other type of service category provided in MSIS ($903 million);[75]

- prescribed drugs ($743 million);
- clinic services, which include preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services provided in a facility for outpatients ($517 million);
- mental health facility (inpatient) for individuals under 21 ($513 million);
- inpatient hospital services ($462 million); and
- rehabilitative services, which include medical or remedial services recommended by a physician or other licensed practitioner of the healing arts for a maximum reduction of physical or mental disability and restoration for a recipient to his/her best possible functional level ($463 million).

As shown in **Figure 1,** across FY2001-FY2010 Medicaid fee-for-services spending for "foster care" children (on an aggregate basis) held constant or showed some decline for most categories with the largest spending. One notable exception is "prescribed drugs," which saw increases in spending that took it from the sixth largest Medicaid services spending category for "foster care" children in FY2001 to the second largest such category by FY2008. Between FY2008 and FY2010, Medicaid spending on prescribed drugs for "foster care" children appears to have stabilized. Separately, spending on "other services," which ranked as the largest services spending category across all the years studied, showed an initial spike before declining.

Finally, of the categories with declines in aggregate spending, among the most noticeable decreases were spending for "rehabilitative services," (which ranked second among all Medicaid services spending categories for "foster care" children in FY2001 and sixth in FY2010), and in "targeted case management" (TCM), (which ranked sevnth among all fee-for-services spending categories in FY2001 and eleventh in FY2010). Both TCM—which may be used to help individuals within specific populations or areas of a state gain access to needed medical, social, educational, and other services—and "rehabilitative services"—which are medical or remedial services used to reduce disability and restore an individual to his or her best possible level of functioning—are optional Medicaid benefits that have consistently been used to help meet needs of children in foster care. Additionally, both have been the subject of legislative and/or regulatory activity in the past decade. Although Congress (and the Obama Administration) generally acted to preserve access to these benefits for foster care children, the MSIS data suggests some decline in Medicaid services spending on "foster care" children in both of these categories.[76]

[75] According to the MSIS Data Dictionary, service spending may only be reported in this category if the service is not defined in any other fee-for-service spending category. With regard to home and community-based waiver services it notes that spending is to be reported in this category only if the service provided "cannot be associated" with other service categories and it provides two examples: community homes for the disabled and adult day care. See HHS, CMS, "MSIS Data Dictionary," Release 5, p. 167 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/MSIS/Downloads/msis-data-dictionary.pdf

[76] As part of the Deficit Reduction Act of 2005 (P.L. 109-171), Congress acted to both clarify what case management services include, and, with specific regard to children in foster care, the services that could not be supported via Medicaid's TCM benefit. Subsequently, CMS released an interim final rule on case management and TCM that was intended to implement these specific changes and, particularly, to clarify use of TCM for children in foster care and other Medicaid-eligible groups. Critics of the December 2007 interim rule, which included child welfare advocates and state administrators, argued that it was more restrictive than Congress intended, would result in cuts to necessary TCM services, and would increase state administrative costs. Congress enacted several temporary moratoria on its full (continued...)

A recent survey of state child welfare administrators found that *child welfare* agencies were spending fewer dollars to provide the non-federal share of Medicaid spending for rehabilitative services and TCM. However, some child welfare agency administrators suggested that these declines had more to do with changes in the entity responsible for providing these Medicaid benefits for children served by the child welfare agency, rather than a decline in access to the service for these children. They pointed to this explanation especially with regard to rehabilitative services, but suggested real declines in the use of TCM for the population.[77]

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

The major Medicaid eligibility pathways available to children and youth currently or formerly in foster care are the focus of this section. Notably, four pathways are specifically available for this population—a mandatory pathway for children if they qualify for the Title IV-E program (whether in foster care or after leaving foster care for adoption or legal guardianship); an optional pathway for certain children who are adopted (primarily from foster care) and who receive adoption assistance funded wholly by the state; as of January 1, 2014, a mandatory pathway for young adults up to the age of 26 who "aged out" of foster care at age 18 (or 19, 20, or 21 years of age if the state extends federal foster care to that older age); and an optional pathway for "independent foster care adolescents" up to the age of 21 who were in foster care at age 18. Current and former foster children and youth may also qualify for Medicaid through other mandatory and optional pathways that are available to eligible individuals based primarily, but not exclusively, on disability or income. A number of eligibility groups that existed in Medicaid statute and regulations prior to the enactment of the ACA were consolidated in 2014 as a result of the transition to the ACA income counting rule.

Implementation of the ACA income counting rules as they relate primarily to children in or formerly in foster care are discussed first in this section. This is followed by a look at each of the Medicaid eligibility pathways available for these children and youth, including those that were consolidated beginning in 2014 and the applicable income counting rules. (For additional

(...continued)

implementation. Ultimately, the Obama Administration expressed some of these same concerns about the interim final rule and responded by rescinding parts of it to address most or all of these concerns. As part of that same 2009 announcement, the Obama Administration rescinded, in whole, a proposed regulation that appeared to limit rehabilitative services for children in foster care, among other Medicaid enrollees. Similar to the TCM rule, Congress had acted on more than one occasion to temporarily prohibit CMS from implementing the proposed rehabilitative services rules and it further adopted a Sense of Congress (P.L. 111-5, Section 5003) indicating that CMS should never finalize the proposed rehabilitative services rule. See Conference Report to accompany S. 1932 (H.Rept. 109-362), Deficit Reduction of 2005, pp. 320-322; CRS Report RL33155, *Child Welfare: Foster Care and Adoption Assistance Provisions in the Deficit Reduction Act of 2005 (P.L. 109-171)*, by Emilie Stoltzfus. *Federal Register*, June 30, 2009, pp. 31183-31196; and CRS Report RL34764, *Select Bush Administration Medicaid Rulemakings: Congressional and Administrative Actions*, by Elicia J. Herz and Vanessa K. Burrows.

[77] Kerry DeVooght, Megan Fletcher, and Hope Cooper, "*Federal, State and Local Spending to Address Child Abuse and Neglect in SFY 2012*," Child Trends with support from Annie E. Casey Foundation and Casey Family Programs (September 2014), pp. 41-44. As part of this survey, state child welfare agencies were asked to report only on Medicaid spending for which the state child welfare agency provided the non-federal matching dollars (this *excludes* funding for basic health care services such as those covered by EPSDT).

information on those pathways see **Table C-1** of **Appendix C**.) Finally, this section addresses possible Medicaid coverage for the families who come into contact with child welfare services.

ACA Income Counting Rule, Protections for Children, and Exemptions

The ACA established the Modified Adjusted Gross Income (MAGI) income counting rule, which draws on federal income tax rules to establish uniform standards for what income to include or disregard in determining Medicaid eligibility for most non-elderly and non-disabled people.[78] Medicaid's MAGI income counting rule is set forth in law and regulation.[79] In addition to specifying the types of household income that must be considered during eligibility determinations, the policies also define "household." The income of any person defined as a part of an individual's household must be counted when determining that individual's income level for purposes of a Medicaid eligibility determination. [80]

The ACA required states to transition to the MAGI income counting rule no later than January 1, 2014. In transitioning to the new income counting rule, states were required to establish income eligibility thresholds no less than the effective income eligibility levels that were applicable in the state on the date of enactment of the ACA (i.e., March 23, 2010).[81] The ACA also included maintenance of effort (MOE) provisions, under which states were required to maintain their Medicaid programs for adults with no more restrictive eligibility standards, methodologies, and procedures through December 31, 2013 (i.e., until the exchanges were operational), and for Medicaid-eligible children up to age 19 until September 30, 2019.[82] (Failure to comply with the ACA MOE requirements means a state loses all of its federal Medicaid matching funds.) The purpose of these policies was to ensure that individuals who were eligible for Medicaid prior to 2014 could maintain coverage in 2014 under the MAGI-equivalent income standards. Additionally, through December 31, 2013, states were permitted to establish more expansive income eligibility policies (within federal parameters). As of January 1, 2014, states are no longer permitted to establish more expansive income eligibility standards, and they may not establish more restrictive income eligibility standards for children before October 1, 2019.[83]

As with other Medicaid eligible populations, these transition policies helped ensure child welfare-involved children and their families, including those in foster care or those formerly in foster care, did not lose Medicaid coverage. Several additional policies under the MAGI income

[78] MAGI is defined as the Internal Revenue Code's adjusted gross income (AGI), which reflects a number of deductions from income,(including trade and business deductions, losses from sale of property, and alimony payments), increased (if applicable) by tax-exempt interest and income earned by U.S. citizens or residents living abroad. For information on modifications to the MAGI income counting rule that were enacted subsequent to ACA's enactment see CRS Report R41997, *Definition of Income for Certain Medicaid Provisions and Premium Credits in ACA*, coordinated by Christine Scott.

[79] 42 C.F.R. §435.603(e) and Section 1902(e)(14)(E)) of the Social Security Act.

[80] See 42 C.F.R. §435.603.

[81] Section 1902(e)(14)(E)) of the Social Security Act.

[82] Section 1902(gg) of the Social Security Act

[83] Section 1902(gg)(4)(B) of the Social Security Act. This provision appears to permit states – with regard to children only – to continue to put in place more expansive eligibility policies through September 30, 2019. However, this conflicts with Section 1902(e)(14)(B) of the Social Security Act, which prohibits all income blocks or disregards as of January 1, 2014.

counting rule have special significance for children in foster care, and those who left for adoption, legal guardianship, or via "aging out." These include regulatory exceptions to how household is defined, which effectively ensure that the income of a child's foster parent or legal guardian (relative or non-relative) is not included in the determination of a child's income level; and specific statutory exemptions from the MAGI counting rules for certain eligibility groups (including those eligible for Medicaid because they are receiving Title IV-E assistance or Supplemental Security Income, SSI). Special relevance of these and the MAGI transition policies to certain children in foster care, as well as those leaving for adoption, legal guardianship, or via aging out, is briefly discussed next.

Transitioning to MAGI Income Counting Rule

States have long been allowed to establish "reasonable categories" of children who are eligible for Medicaid (e.g., children in foster care receiving state support only)[84] and under pre-ACA law states could choose to disregard any or all income of children in these groups when determining their eligibility for Medicaid.[85] In developing a plan to transition to MAGI counting rules, states—as described already—were required to maintain income eligibility standards that existed on the date of ACA enactment, March 23, 2010, or at state option (and provided the standards were not more restrictive), December 31, 2013. Accordingly, if as of either of those dates the state had chosen to apply no income test to state-funded foster care (i.e., it disregarded 100% of income for this "reasonable category" of children), then as of the date of implementation for the MAGI income counting rule (January 1, 2014) the state must continue to disregard all such income for this group of children.[86] However, any state that did not include a full income disregard for a given "reasonable category" of children (e.g., children in foster care receiving state support only) as of the date of the ACA's enactment (or as of December 31, 2013) may no longer adopt this policy.[87] Similarly, states opting to provide Medicaid for youth aging out under the "Chafee option" were permitted, but not required, to adopt an income test. States that did not apply an income test prior to ACA enactment (or as of December 31, 2013) must maintain this policy after implementation of the ACA's MAGI income counting rule.[88]

Determining Who to Include in a Child's Household

In general, the Medicaid MAGI counting rule provides that (for purposes of determining Medicaid eligibility based on income) a child's income level is determined by the household

[84] Section 1902(a)(10)(A)(ii)(I) and 1905(a)(i) of the Social Security Act.

[85] Section 1902(r)(2)(A) of the Social Security Act.

[86] Under the ACA child "maintenance of effort" rules, before October 1, 2019, no state may adopt more stringent Medicaid eligibility requirements for children than those that were in place as of the date of enactment of the ACA. Section 1902(gg)(1)and(2) of the Social Security Act.

[87] Section 1902(e)(14)(B) of the Social Security Act provides that (effective January 1, 2014, per Section 2002(a) of the ACA) "no type of expense, block, or other income disregard shall be applied by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose applicable under the plan or waiver for which a determination of income is required."

[88] In a proposed rule issued January 22, 2013, CMS describes this policy as applicable for many pathways. Although those provisions of the rule had not been finalized as of fall 2014, the principles appear to have been used in instructing states on how to transition to the MAGI counting rule. See HHS, CMS, Proposed Rules, *Federal Register*, v. 78, January 22, 2013, pp. 4688-4689.

income of the tax filer who claims the child as a dependent on his or her tax return.[89] However, the MAGI counting rules include some exceptions to this general rule. Specifically, for children living with someone who expects to claim them as a dependent on their tax return and who is not their parent (biological, adoptive, or step), as well as for individuals who do not need to file an income tax return and do not expect to be claimed as a dependent on any individual's tax form, "household income" is based on *the child's income alone*. (Or, if the child is living with a sibling(s) who is also under age 19, or, if elected by a state, a fulltime student under age 21, the child's income and income of any sibling(s) with whom he or she lives is countable income.)[90] Among other things, this rule is meant to ensure that the income of a child's foster parent, legal guardian (relative or non-relative), or other kinship caregiver is not included when counting a child's income for purposes of determining Medicaid eligibility.

Exemptions

Further, under the ACA certain groups are exempt from the MAGI income counting rule. For MAGI exempted groups, pre-ACA income determination rules under Medicaid will continue to apply. These include children who are categorically eligible for Medicaid based on their receipt of foster care, guardianship, or adoption assistance payments under the Title IV-E program, as well as certain disabled individuals, including those receiving SSI payments.[91] Also, as described previously, pre-ACA Medicaid income counting rules apply for children eligible under an optional eligibility group for children receiving state foster care payments or in state-funded foster care if the state covers such optional groups and does not apply an income test.[92] Finally, there are no income eligibility criteria for the new mandatory Medicaid eligibility pathway for certain youth who age out of foster care. Therefore, the MAGI income counting rule does not apply to this group.

Children in Foster Care

Mandatory Pathways

The primary mandatory Medicaid eligibility pathway for children in foster care applies only to those children who qualify for assistance under the Title IV-E program.[93] To qualify for Title IV-E foster care assistance, the state child welfare agency must determine that the child in foster care (1) met income/assets tests and family structure rules in the home he/she was removed from; (2) had specific judicial determinations made regarding the reasons for the child's removal from that home and placement in foster care; (3) is living in an eligible licensed setting with an eligible provider(s); and (4) is under the age of 18, or, if the state the youth resides in has elected this option, age 19, 20, or 21 (provided a youth of this age meets certain education, work, or other

[89] 42 C.F.R. §435.603(f)(2)

[90] 42 C.F.R. §435.603(f)(3). (The child must not be living with a spouse.) These rules are not exclusive to children or to children in foster care, guardianship or kinship care. However, for these populations they are expected to have the effect described in the text.

[91] Section 1902(e)(14)(D)(i)(I) of the Social Security Act; 42 C.F.R. §435.603(j)(1). See also HHS, CMS, "Medicaid Program Eligibility Changes Under the Affordable Care Act of 201," Final Rule, March 23, 2012, *Federal Register,* v. 77, p. 17158.

[92] Ibid.

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

specified requirements).[94] Individuals in this eligibility group are automatically eligible for Medicaid without a separate income test performed by the Medicaid program and this eligibility category is exempt from the MAGI income counting rules.

Other mandatory pathways available to children in foster care who are not eligible for Medicaid under the Title IV-E category primarily require a child to meet certain income eligibility criteria and as of January 1, 2014, all states must count income under these mandatory pathways using the MAGI rule. Under the Medicaid eligibility pathway described by CMS as the "consolidated group for children" any child (under age 19) who is considered to have countable income of 133% of federal poverty level is eligible, although in some instances (and with variation across states) a child with higher countable income would be eligible.[95] Under prior income counting rules, a child in state-funded foster care may have been considered a "family of one"—meaning only the child's income could be counted against an income eligibility test. Under MAGI counting rules this same policy is effectively continued.

For young adults ages 19 through 20 who are in foster care, but are not receiving Title IV-E assistance, the mandatory Medicaid eligibility pathways that are available to adults generally, including pregnant women with income at or below 133% federal poverty level, are available. These eligibility pathways are subject to MAGI income counting rules.

Finally, children in care, including those who are age 18, may also be eligible under the Supplemental Security Income (SSI) eligibility pathway for certain individuals (any age) with severe disabilities. These "disabled" children are not subject to MAGI rules.

Optional Pathways

A child in foster care who is not eligible for a mandatory pathway may be covered under several optional Medicaid eligibility groups. The major coverage option is known as the Ribicoff pathway, named for the late Senator Abraham Ribicoff. The Ribicoff pathway allows the state to extend Medicaid eligibility to children under the age of 21 (or under the age of 20, 19, or 18 as the state may choose) who meet a state-specific income test that (prior to January 1, 2014) was linked to the former cash assistance program known as Aid to Families with Dependent Children (AFDC).[96] Under this pathway, states are allowed to choose to cover all children who meet those income criteria, or they may choose to cover "reasonable categories" of eligible children, such as those residing in institutions or children or youth in foster care placements or adoptive homes who are not eligible to receive Title IV-E assistance.[97] As of January 1, 2014, eligibility under this

[94] For more information see CRS Report R42792, *Child Welfare: A Detailed Overview of Program Eligibility and Funding for Foster Care, Adoption Assistance and Kinship Guardianship Assistance under Title IV-E of the Social Security Act*, by Emilie Stoltzfus.

[95] This group, referred to as "consolidated" group for children includes (1) low-income families (i.e., Section 1902(a)(10)(A)(i)(I) and Section 1931); (2) qualified children less than age 19 (i.e., Section 1902(a)(10)(A)(i)(III)); (3) poverty-level related infants (i.e., Section 1902(a)(10)(A)(i)(IV)); (4) poverty-level related children age 1 through 5 (i.e., Section 1902(a)(10)(A)(i)(VI)); and (5) poverty-level related children age 6 through 18 (i.e., Section 1902(a)(10)(A)(i)(VII)).

[96] To be eligible under this pathway, children needed only to meet the applicable income and asset standards under the prior law AFDC program. They were not required to meet that program's additional "dependent child" requirements. For example, they could be living alone, or with someone other than a relative, and they may be older than age 17 (but not older than age 21).

[97] For more information on use of this pathway see *Health Care for Adolescents and Young Adults Leaving Foster* (continued...)

pathway must be determined via MAGI counting rules. However, any state that as of December 31, 2013, included a full (or partial) income disregard for this group must continue to do so under MAGI.

According to CMS, as of December 31, 2013, 20 states used this Medicaid eligibility pathway to cover non-Title IV-E foster care children as a "reasonable category" of children.[98] Of these 20 states, 10 states[99] covered these children with no income test (and thus will not have an income test for these groups under MAGI), and 10 states[100] covered them with an income test.[101]

States may also use other optional pathways that are available to children and adults generally to provide Medicaid coverage to children in foster care. One such pathway is available to infants (and pregnant women) in families with incomes between 133% and 185% of the federal poverty level. States can also take up what are known as Medicaid expansions under the State Children's Health Insurance Program (CHIP) that provide coverage to infants and children through age 18 in families with higher incomes. MAGI income counting rules apply for these groups. Another optional pathway is for children with high medical expenses that can be deducted from income. Such deductions allow them to meet applicable Medicaid financial requirements. This is referred to as the "medically needy" pathway—the MAGI-income counting rules do not apply for this group. Any state that opts to provide medically needy coverage is required to extend that coverage to children under age 18, pregnant women, certain newborns, and certain other specified, protected persons. Other groups can be included as well, such as children ages 18 through 20.[102] Finally, states that want to provide coverage to adult groups beyond what the law allows may seek approval from the Centers for Medicare & Medicaid Services (CMS) for Section 1115 waivers.[103] This coverage may provide access to a more limited set of benefits than what would be available under Medicaid state plan services. Section 1115 waivers could be available to former foster care youth ages 18 through 20 who do not otherwise qualify for Medicaid and are subject to the income counting rules specified in the waiver Special Terms and Conditions.

(...continued)

Care: Policy Options for Improving Access, Center for Adolescent Health & the Law, February 2006, p. 5, http://www.cahl.org/PDFs/FCIssueBrief.pdf. and Harriette B. Fox, Stephanie J. Limb, and Margaret A. McManus, *The Public Health Insurance Cliff for Older Adolescents*, The National Alliance to Advance Adolescent Health, Fact Sheet April 2007, http://www.thenationalalliance.org/pdfs/ FS4.%20The%20Public%20Health%20Insurance%20Cliff.pdf. (Hereinafter, Harriette B. Fox, Stephanie J. Limb, and Margaret A. McManus, *The Public Health Insurance Cliff for Older Adolescents*.)

[98] As permitted under Section 1902(a)(10)(A)(ii)(I) of the Social Security Act and 42 C.F.R. 435.222.

[99] States with no income test associated with this "reasonable" category of children are California, Illinois, Iowa, Louisiana, Missouri, Nevada, New York, Oregon, Texas, and Wyoming.

[100]States with an income test associated with this "reasonable" category of children (and the basis for that income test) are Alabama (Section 1931 income limit), Georgia (AFDC 1996 converted to a MAGI equivalent), Idaho (Section 1931 income limit), Kansas (Section 1931 income limit), Mississippi (Section 1931 income limit), Montana (Section 1931 income limit), Oklahoma (AFDC 1996 converted to a MAGI equivalent), South Carolina (Section 1931 income limit), South Dakota (AFDC 1996 converted to a MAGI equivalent), and Virginia (Section 1931 income limit). Each of the income tests is applied using MAGI counting rules.

[101] Information received in email correspondence from HHS, CMS' Office of Legislation, November 6, 2014.

[102] A 2006 review of state Medicaid plans and amendments (and other documents) found that 16 states covered 19- and 20-year-olds in their medically needy programs. See Harriette B. Fox, Stephanie J. Limb, and Margaret A. McManus, *The Public Health Insurance Cliff for Older Adolescents*.

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

Medicaid Eligibility for Foster Care Children in Practice

According to a national study conducted in the early 2000s, more than 99% of children in foster care were eligible for Medicaid. Most (76%) were believed to be eligible under a *mandatory* pathway and about 23% based on *optional* eligibility pathways selected by the state. Among those children eligible on a mandatory basis, the survey respondents estimated about three-fourths were eligible because they received Title IV-E assistance, close to 11% under the SSI eligibility pathway, and about 14% based on the very low income of their biological families from which they were removed.[104]

Nearly all respondents in this study (state and county health and child welfare officials) reported that there were mechanisms in place to ensure that children received health care coverage immediately upon entering foster care. Most (93%) reported that Medicaid eligibility could be established through presumptive eligibility.[105] Other mechanisms for minimizing delays in Medicaid enrollment included minimizing the time required to initiate the Medicaid application by child welfare staff (80%); a computer link between the child welfare and Medicaid agencies (70%); trained child welfare staff to certify for eligibility (57%);[106] and uniform intake applications for child welfare and Medicaid (50%).

This study also examined timing of application for coverage and recertification of eligibility. Officials reported that applications for Medicaid were made immediately for 36% of children entering foster care (even though nearly all of these respondents also reported that mechanisms were in place to ensure immediate coverage upon entering care). Applications were made for 33% of children within seven days of entering foster care; and applications were made for the remaining 31% of children seven days or more after entering care. With regard to the frequency of redetermination for Medicaid eligibility, 64% of respondents reported that recertification happens annually without regard to the child's foster care placement setting; approximately one-fifth reported recertification every six months.

Young Adults Who Were Formerly in Foster Care

Mandatory Pathways

As of January 1, 2014, certain former foster youth are eligible for Medicaid under a specific mandatory pathway created for this population in the ACA. Former foster youth are eligible if they meet the following requirements:

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

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

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

- are under 26 years of age;
- were not eligible or enrolled under existing Medicaid mandatory eligibility groups, or described in any of the existing Medicaid mandatory eligibility groups, but have income that exceeds the upper income eligibility limit established under any such group;
- were in foster care under the responsibility of the state on the date of attaining 18 years of age (or 19, 20, or 21 years of age if the state extends federal foster care to that older age); and
- were enrolled in the Medicaid state plan or under a waiver while in foster care. [107]

The ACA specifies that income and assets are not considered when determining eligibility for the new eligibility group of former foster care youth. Therefore, the MAGI income counting rules do not apply to this group. In addition, federal reimbursement (matching) for a part of the cost of providing services to individuals in this new mandatory eligibility group for former foster care youth is available at the state's regular Federal Medical Assistance Percentage (FMAP) rate.[108]

Youth age 18 and older who were formerly in care and do not qualify under the pathway for former foster youth may be eligible for Medicaid under other mandatory pathways available to *adults* generally. For example, if former foster youth meet certain income and other criteria, they may qualify under the pathways available to low-income pregnant women and adults with disabilities who are eligible for SSI. MAGI counting rules do not apply to youth eligible via SSI but may apply under other pathways.

Optional Pathway

In states that utilize the "Chafee option"—named for the late Senator John H. Chafee—youth who meet the definition of "independent foster care adolescent" may be eligible for Medicaid. The law defines an "independent foster care adolescent" as someone who is under the age of 21, was in foster care under the responsibility of the state on his or her 18th birthday, and meets the income or resource criteria established by a state (if any).[109] States that elect to provide Medicaid through the Chafee option may further restrict such eligibility based on any "reasonable" criteria, including whether or not the youth had received Title IV-E funding.[110]

As of 2012, most states that provided Medicaid eligibility under the Chafee option (25 out of 30) did not apply an income test. [111] Under the MAGI counting rule, states must maintain an income standard that is no lower than the standard in place in the state as of the date of ACA enactment

[107] Section 1902(10)(A)(i)(VII) of the Social Security Act.

[108] For more information on Medicaid FMAP, see CRS Report R42941, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2014*, by Alison Mitchell and Evelyne P. Baumrucker.

[109] Section 1905(w) of the Social Security Act. States were not required to establish income or resources limits for these youth but if they did so they were not permitted to set those tests lower than the state's criteria for prior law AFDC program as described in Section 1931(b) of the Social Security Act.

[110] Section 1902(a)(10)(A)(ii)(XVII) of the Social Security Act.

[111] Michael R. Pergamit et al., Urban Institute, *Providing Medicaid to Youth Formerly in Foster Care Under the Chafee Option: Informing Implementation of the Affordable Care Act*, for HHS, Office of the Assistant Secretary for Planning and Evaluation, November 2012. (Hereinafter, Michael R. Pergamit et al., Urban Institute, *Providing Medicaid to Youth Formerly in Foster Care Under the Chafee Option: Informing Implementation of the Affordable Care Act*.).

(March 23, 2010) or at state option, December 31, 2013. For states that applied no income test to the Chafee eligibility pathway as of that date, this effectively means they must disregard all income when determining a youth's Medicaid eligibility under this pathway.[112] In states that *did* apply an income test, the effective income test under the MAGI counting rules must be no lower than the test in place as of that date.[113]

The new mandatory Medicaid pathway for former foster youth who have aged out of care does not completely supersede the optional Chafee pathway. For example, states may continue to use the Chafee pathway to cover any youth who turned age 18 in foster care and was not enrolled in Medicaid at that time.[114] However, because more than 99% of children in foster care are estimated to be enrolled in Medicaid this circumstance may not occur often.[115]

Implementing the New Eligibility Pathway for Former Foster Youth

The mandatory Medicaid eligibility pathway for former foster youth who aged out of foster care is distinct from the eligibility pathway sometimes referred to as the "ACA expansion group." While the Supreme Court's decision in *National Federation of Independent Business (NFIB) v. Sebelius* effectively allows states to choose whether to provide Medicaid coverage to the ACA expansion group, it did not have this effect on the new eligibility category for former foster youth.[116] Accordingly, all states were expected to comply with new mandatory coverage category for youth who have aged out of foster care as of January 1, 2014.

As of early fall 2014, CMS had not issued a final rule with regard to the new Medicaid eligibility group for former foster youth who aged out of foster care.[117] However, in January 2013 it proposed rules for this group and in December 2013 it provided some clarifying guidance. This guidance notes that any youth who was in foster care—as that term is defined in federal child welfare regulations—may qualify for the new former foster youth Medicaid eligibility group. This includes youth who were in the care and placement responsibility of a state or tribal child welfare agency without regard to whether the youth received Title IV-E assistance or were placed in licensed or unlicensed foster care living arrangements. Additionally, the proposed rule

[112] For application of MAGI see HHS, CMS, Final Rule, March 23, 2012. Specific policy related to the Chafee pathway was proposed in HHS, CMS, Proposed Rule, January 23, 2013, p. 4689. Although the latter has not been finalized, the policy appears to have been in place as part of transition to MAGI.

[113] Ibid. In 2012, Michael R. Pergamit et al., Urban Institute, *Providing Medicaid to Youth Formerly in Foster Care Under the Chafee Option: Informing Implementation of the Affordable Care Act* found following: In Texas the income limit under the Chafee option was 400% of the federal poverty level, in Maryland 300 percent, in Indiana and Iowa 200 percent, and in Oklahoma 180 percent. Research and survey information suggest the income of former foster youth rarely exceed these limits. Texas also imposed a resource or asset limit. However, such limits are not permitted under MAGI counting rules.

[114] HHS, CMS, "Medicaid and CHIP FAQs," December 2013.

[115] Anne M. Libby et al., "Child Welfare Systems Policies and Practices Affecting Medicaid Health Insurance for Children: A National Study.

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

[117] HHS,CMS, "Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrolment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing; Proposed Rule," 78 *Federal Register* 4594, January 22, 2013. (Hereinafter, HHS, CMS, Proposed Rule, January 22, 2013.)

interpreted the law to mean that a youth must be enrolled in Medicaid at the time he or she ages out of foster care (as opposed to at any time while the child was in foster care). Subsequent guidance also explained that states have flexibility in determining the process for verifying that youth were in foster care receiving Medicaid at age 18 (or a later age if applicable), and may allow youth to attest to this themselves.[118] Separately, the subsequent guidance clarified that individuals who would qualify for Medicaid under both the new group for former foster and the new low-income adult category must be enrolled under the group for former foster youth.

As first described in the January 2013 proposed rule, CMS interprets the law to mean that a state is not *required* to cover former foster youth who would otherwise be eligible under this pathway if the youth aged out of care in a different state. At the same time, the proposed rule notes that states would be *permitted* to provide this coverage and, pending final regulations, the agency has instructed states that it will approve Medicaid state plan amendments from states opting to provide coverage to such former foster youth.[119] As of mid-October 2014, as many as 12 states extended this coverage (CA, GA, KY, LA, MA, MI, MT, NY, PA, SD, WI, and VA).[120]

CMS explicitly sought comment on its interpretation of the law, which could mean former foster youth who move across state lines between ages 18 and 26 lose access to this Medicaid coverage. In a letter to HHS, some members of Congress noted that young people who (under the ACA) receive health insurance coverage through their parents' plans until age 26 do not have a comparable residency requirement. The letter also asserted that former foster youth need access to quality health coverage, regardless of state of residency, because of their relatively negative outcomes across a number of health and other domains.[121] Some stakeholders have asserted that providing coverage to youth under the new pathway can help to reduce costs in the future because youth will presumably receive routine and preventative services.[122] Legislation introduced in the 113th Congress (S. 2461 and H.R. 5364) seeks to ensure that Medicaid coverage is available for former foster youth under this pathway regardless of where they reside.

A separate issue with regard to scope of coverage under this new eligibility pathway for former foster youth concerns the age at which youth may qualify for this pathway. Specifically, any youth who ages out of foster care prior to reaching age 18—such as the approximately 1,000 to 2,000 foster youth who emancipate at age 17 each year[123]—are not eligible for the new

[118] HHS, CMS, "Medicaid and CHIP FAQs: Funding for the New Adult Group, Coverage of Former Foster Care Children and CHIP Financing," December 2013. (Hereinafter, HHS, CMS, "Medicaid and CHIP FAQs," December 2013).

[119] HHS, CMS, Proposed Rule, January 22, 2013; and HHS, CMS, "Medicaid and CHIP FAQs," December 2013.

[120] Shadi Houshyar, *Medicaid to Age 26 for Former Foster Youth: An Update on the State Option and State Efforts to Ensure Coverage for All Young People Irrespective of Where They Aged Out of Care*, First Focus and State Policy Advocacy & Reform Center (SPARC), October 2014, http://childwelfaresparc.org/wp-content/uploads/2014/10/Medicaid-to-26-for-Former-Foster-Youth7.pdf. (Hereinafter, Shadi Houshyar, "Medicaid to Age 26 for Former Foster Youth: An Update on the State Option and State Efforts to Ensure Coverage for All Young People Irrespective of Where They Aged Out of Care.")

[121] Letter from Jim McDermott, Member of Congress and Karen Bass, Member of Congress to the Honorable Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services, February 20, 2013.

[122] Shadi Houshyar, "Medicaid to Age 26 for Former Foster Youth: An Update on the State Option and State Efforts to Ensure Coverage for All Young People Irrespective of Where They Aged Out of Care."

[123] Based on FY2004 through FY2013 data reported by states via AFCARS as of July 2014 and provided to CRS by HHS, ACF, ACYF, Children's Bureau. During this period, the number of youth discharged from foster care at age 17, via "emancipation" fell from more than 6% of all youth aging out in a given year to more than 4% and in absolute numbers ranged from a low of 932 (in FY2012) to a high of 1,928 (in FY2009).

mandatory pathway. The law requires that youth must have been in foster care under the responsibility of the state at age 18 (or a later age as elected by the state under its Title IV-E plan). These youth would also not be eligible for the Chafee pathway, which requires them to have been in foster care on their 18th birthday. States may consider taking steps to inform such youth that they would be ineligible for Medicaid coverage under these pathways if they are formally "emancipated" (age out) from care before age 18.

For those youth who are eligible for the new Medicaid eligibility pathway, another implementation question has to do with the extent to which youth can be enrolled and maintain enrollment under the mandatory Medicaid pathway when they age out of foster care. Current child welfare law provides that as part of a transition planning process for youth aging out of foster care, each youth must be made aware of specific health insurance options.[124] This planning process, which is to occur within 90 days of a youth's aging out of care, might be used to inform youth about Medicaid eligibility and enrollment. CMS has highlighted that at least one state, Idaho, is using the state child welfare independent living coordinator to reach out to former foster youth.[125]

A 2012 HHS-supported study on state implementation of the Chafee optional pathway for former foster youth suggests that Medicaid administrators, child welfare staff, and the youth themselves may need to be educated about the new eligibility pathway for former foster youth.[126] This is, in part, because youth aging out of foster care make up a very small share of Medicaid recipients, and few Medicaid staff may be knowledgeable about the new pathway. Further, Medicaid and child welfare agencies may lose contact with the youth when they are no longer involved in foster care and/or lack stable housing. Indeed some state Medicaid administrators have raised concerns about the costs of tracking, identifying, and confirming eligibility for this population.[127] Some stakeholders have suggested that the federal government could help facilitate data sharing to ensure that states are aware of other state policies for providing coverage, including how states verify that youth aged out in these other states.[128]

Medicaid Eligibility in Practice Under the Chafee Option

Under the optional Chafee pathway, Medicaid eligibility for youth formerly in foster care varies significantly by state. As of 2012 (the most recent year available), 30 states had extended the Chafee option to eligible youth. As required in the authorization legislation, youth covered under the Chafee pathway must have been in foster care on their 18th birthday. Some states reported having explicit definitions of what it means to be in care on a youth's 18th birthday. For example,

[124] Section 475(5)(H) of the Social Security act.

[125] HHS, CMS, *Medicaid and Foster Care – Idaho and Georgia Help Youth Stay Connected*, State Highlights, August 26, 2014.

[126] Michael R. Pergamit et al., Urban Institute, *Providing Medicaid to Youth Formerly in Foster Care Under the Chafee Option: Informing Implementation of the Affordable Care Act*. This study examined Medicaid data from 10 states that had taken up the Chafee option, and found that in states requiring more participation for youth to enroll, youth were almost 14 percentage points less likely to be enrolled in the month before their 19th birthday than youth in states that did not require their involvement.

[127] Ibid.

[128] Dina Emam and Olivia Golden, *The Affordable Care Act and Youth Aging Out of Foster Care: New Opportunities and Strategies for Action*, Urban Institute and Center for Law and Social Policy (CLASP) for the State Policy Advocacy and Reform Center (SPARC), April 2014. (Hereinafter, Dina Emam and Olivia Golden, *The Affordable Care Act and Youth Aging Out of Foster Care: New Opportunities and Strategies for Action*.)

some states required these youth to be in certain types of placements. The authorizing law allowed states to impose income and resource requirements; however, few states had opted to include these requirements. All states reported requiring youth to be residents of the state while covered under the Chafee option, and most states required youth to have been in foster care in that state on their 18th birthday to qualify under Chafee. Nearly all states automatically enrolled youth (27 states), sometimes with the youth's involvement (11 of these 27 states). Just over half of the states (17 states) reported that they do not require annual recertification of eligibility or require recertification that is "passive," whereby the state sends out notifications or letters to check for changes to the youth's eligibility status but the youth are not required to respond.[129]

Children Who Leave Foster Care for Adoption or Guardianship

Mandatory Pathway

Children who leave foster care for placement in a new permanent home—via adoption or legal guardianship with a relative—and who receive Title IV-E adoption or kinship guardianship assistance are eligible for Medicaid under the mandatory Title IV-E pathway.[130] MAGI income counting rules do not apply to these children. Instead, Title IV-E eligibility is determined by the state child welfare agency. The state Medicaid agency must enroll children found to be Title IV-E eligible by the state child welfare agency and it must not apply any income or resources test to the adoptive parents or relative guardians.[131]

Further, children moving from receipt of a Title IV-E foster care maintenance payment to coverage under a Title IV-E adoption assistance agreement or receipt of Title IV-E kinship guardianship assistance payments must not be required to submit a new application for Medicaid eligibility, and they remain eligible for Medicaid (without redetermination) for as long as a Title IV-E adoption assistance agreement on their behalf remains in effect or for as long as they are receiving Title IV-E kinship guardianship assistance payments.[132] In general, once it is established, a state child welfare agency must maintain a Title IV-E adoption assistance agreement until a child's 18th birthday or (at state option, or on a case-by case basis) up to age 19, 20, or 21—assuming, in either case, that the adoptive parent(s) remain legally responsible for the child and are providing support to the child. The same age provisions apply with regard to Title IV-E kinship guardianship payments (again, providing that a relative guardian continues to have legal responsibility for the child and is providing support to the child).[133]

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[129] See also, Amy Dworsky and Judy Havlicek, *Review of State Policies and Programs to Support Young People Transitioning Out of Foster Care*, University of Chicago, Chapin Hall Center for Children, 2009, p. 11, http://www.wsipp.wa.gov/pub.asp?docid=08-12-3903; and Michael R. Pergamit et al., Urban Institute, *Providing Medicaid to Youth Formerly in Foster Care Under the Chafee Option: Informing Implementation of the Affordable Care Act*.

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

[131] 42 C.F.R. §435.115(e) and §435.145.

[132] See Association for Administrators of the Interstate Compact on Adoption and Medical Assistance (AAICAMA), "Medicaid and Title IV-E Adoption Assistance," AAICAMA FAQ Series, at http://aaicama.org/cms/medicaid-docs/Medicaid_4E_Med_Application.pdf. See also HHS, CMS, Family and Children's Health Programs Group, "Dear Associate Regional Administrators" (regarding Medicaid eligibility impacts of the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351)), April 15, 2009, http://aaicama.org/cms/federal-docs/CMS_MA_Elig_FostConnect_0409.pdf.

[133] States that want to provide Title IV-E assistance (of any kind) to eligible youth beyond their 18th birthday (or 19th if (continued...)

Adoption Assistance

States that operate a Title IV-E program are required to enter into an adoption assistance agreement with the adoptive parent of each child who is determined by the state to have "special needs." No child may be eligible for Title IV-E adoption assistance unless the state determines the child to have special needs. Additional eligibility rules for Title IV-E adoption assistance (related primarily to the income and resources of the home from which the adopted child was previously removed to foster care) are being phased out (based primarily on the age of the child at the time of adoption). However, those income and resource rules, which are applied by the state child welfare agency to determine Title IV-E eligibility, will continue to apply to some children until the first day of FY2018 (October 1, 2017).[134] As noted previously, this group is exempt from the MAGI income counting rules.

A "special needs" determination by the state child welfare agency must include findings that the child cannot be returned to his/her parents and that there is a factor or condition specific to the child—such as the child's age; membership in a sibling group; race and ethnicity, medical condition; or a physical, emotional, or mental disability—that makes it "reasonable to conclude" that the child will not be adopted without provision of adoption assistance and/or medical assistance. Finally, unless it is not in the child's best interest (for instance, because of significant bonding with foster parents), the state must also determine that reasonable but unsuccessful efforts to place the child for adoption without such assistance have been made.[135]

Kinship Guardianship Assistance

States that operate a Title IV-E program are not required to provide kinship guardianship assistance but may choose to do so. To be eligible for Title IV-E kinship guardianship assistance, a child must have been eligible to receive Title IV-E foster care maintenance payments while in foster care and been living (for at least six consecutive months) with the prospective relative guardian. (The requirement that the child be eligible for Title IV-E foster care assistance effectively means the child must meet an income and asset test, which is generally tied to the biological home the child lived in before entering foster care.) Further, the state child welfare agency must have determined that neither returning home (to biological parents) nor placement for adoption are appropriate permanency plans for the child; the child has a strong attachment to the relative guardian; and the relative guardian has a strong commitment to providing permanent

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

[134] For information on phase in of broader adoption assistance eligibility, see CRS Report RL34704, *Child Welfare: The Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351)*, by Emilie Stoltzfus. The statute also provides Title IV-E adoption assistance eligibility for any child with "special needs" (described in text) who is (1) eligible for SSI; or (2) the child of a youth in foster care (provided that youth is eligible for Title IV-E assistance).

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

care for the child.[136] As noted previously, this group is exempt from the MAGI income counting rules.

Optional Pathways

Federal child welfare policy requires states to provide health insurance coverage (either Medicaid or another program with comparable benefits) to any child on whose behalf they have in place a (state-funded) adoption assistance agreement.[137] These are adopted children who meet the state definition of "special needs" but do not meet other Title IV-E eligibility criteria (e.g., income or asset rules tied to their *biological* family). States may use a variety of the optional pathways similar to those available for children in foster care to provide Medicaid or CHIP coverage to these adopted children. However, under these pathways the income and resources of the adoptive parents or guardian would generally be counted in determining eligibility and MAGI income counting rules apply.

One notable exception is available to a child (1) for whom the state child welfare agency has entered into an adoption assistance agreement with his/her adoptive parent or parents; (2) for whom the state child welfare agency has determined there is a pre-existing need for special or medical rehabilitative care that would preclude the child's adoption *absent* medical assistance; and (3) who at the time the adoption assistance agreement was made, was eligible for Medicaid.[138] In states that elect to provide this optional coverage, children who receive wholly state-funded adoption assistance are Medicaid eligible without regard to the income or resources of their adoptive parents.[139] Although the MAGI income counting rule applies to this group, no income test is required (beyond initial eligibility for Medicaid at the time of the adoption assistance agreement). Therefore application of MAGI would not appear to affect any child's eligibility under this pathway.[140]

Only one state (New Mexico) has not taken the specific Medicaid optional pathway offered for state-funded adoptions. It appears this optional eligibility pathway may largely be supplanted by the mandatory Title IV-E pathway as of FY2018. That is the year in which new Title IV-E adoption assistance eligibility criteria included in the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351) will be fully phased in. Those new eligibility

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

[137] Section 471(a)(21) of the Social Security Act.

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

[139] All states but New Mexico are believed to have taken this Medicaid option. See AAICAMA, "COBRA Option/Reciprocity as of May 2012." A state child welfare agency may elect to limit state-funded adoption assistance based on the income or resources of a parent. However, the Medicaid agency may not base eligibility on income and resources of adoptive parents *if* the state child welfare agency has entered into a (state-funded) adoption assistance agreement with the family and provided the state has elected to take this optional Medicaid category.

[140] See also HHS, CMS, Proposed Rule, January 22, 2013, p. 4609 and p. 4689.

criteria provide that Title IV-E assistance is available to any adopted child for whom the state determines there are "special needs."

Interstate Application

A Title IV-E adoption assistance or kinship guardianship assistance agreement remains in effect between a state child welfare agency and the adoptive parents (or relative guardian) even if the adoptive family (or relative guardian) moves out of state and the Title IV-E (child welfare) agency in the state that originally entered into the agreement continues to be responsible for providing any adoption or guardianship assistance promised in that agreement. By contrast, a child for whom a Title IV-E adoption assistance agreement is in effect is eligible for Medicaid coverage in the state where the child is residing.[141] For example, if a child is placed out-of-state in a residential facility, the state where that facility is located becomes responsible for Medicaid coverage of the child, while the state where the child's adoptive parents live continues to be responsible for any payments under the Title IV-E adoption assistance agreement.[142] The Interstate Compact on Adoption and Medicaid Assistance, which has been adopted by 49 states and the District of Columbia, governs procedures by which Medicaid coverage of adopted children may be transferred between states.[143]

While continued Medicaid coverage of Title IV-E eligible children who move across state lines is required under federal law, children who are Medicaid eligible under a state-funded adoption assistance agreement are not automatically assured Medicaid coverage if they move to another state. However, some states do offer this coverage to some or all children with state-funded adoption assistance agreements who move out of state.[144]

Possible Coverage for Child Welfare-Involved Families

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

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

[142] For more information, see related AAICAMA FAQs at http://aaicama.org/cms/index.php/frequently-asked-questions-faqs.

[143] Wyoming is the only state not a part of the ICAMA. AAICAMA, "COBRA Option/Reciprocity as of May 2012." For more information on ICAMA, see http://aaicama.org/cms/index.php/the-icama.

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

Children and Families Served in the Home

Child welfare agencies—principally through investigations or other assessments related to alleged child abuse or neglect—come into contact with many more children beyond those who enter foster care. The prevalence of chronic health care conditions among this larger child welfare-involved group is one and a half times greater than that of the general public and is not significantly different between children who remain living at homes after the investigation of child abuse and neglect and those who are placed out of the home (e.g., foster care).[145] These children also had "extensive" service needs related to identified developmental, cognitive, emotional/behavioral, and substance use concerns.[146]

Children who come into contact with the child welfare agency often live in homes with little income. Close to 60% were in homes with income below the poverty level.[147] The parents or caregivers of children who remain in the home following a child welfare investigation also had significant health and mental health needs. In fact, such caregivers were less likely to report having excellent or very good health (45% versus 68%) than adults generally, including caregivers of children who were removed from the home. Although these caregivers mostly had mental health outcomes similar to adults in the general population, they were more likely to have major depression within the past 12 months (25% versus 7%).[148]

At the same time, children in families who come into contact with child welfare services but are not placed in foster care are less likely to be enrolled in Medicaid than those children who are placed in foster care. In a related study, researchers found that of the children who remained in their own homes following an investigation of abuse or neglect, about 66% were covered under mandatory Medicaid eligibility pathways and another 18% were covered through optional Medicaid pathways. Approximately 16% were ineligible for Medicaid. The study also found that less than 1% of children in foster care were ineligible for Medicaid.[149]

The emphasis in health care reform on enrollment of all individuals, including low-income families who do not qualify for Medicaid or CHIP, may provide new opportunities for child welfare agencies to ensure access to health insurance coverage for a greater share of the children and adults they serve. For example, families could gain access to counseling through Medicaid, which may in turn strengthen these families, reduce the risk of abuse and neglect, and reduce other potential costs tied to that abuse. [150] The MAGI counting rule applies for children and their families who seek Medicaid coverage based on their income.

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[145] Ruth E.K. Stein, et al., "Chronic Conditions Among Children Investigated by Child Welfare: A National Sample," *Pediatrics*, March 2013, pp. 445-462.

[146] HHS, ACF, Office of Planning, Research and Evaluation, "National Survey of Child and Adolescent Well-Being (NSCAW) II: Children Placed Outside the Home and Children Who Remain in the Home Following a Maltreatment Investigation Have Similar and Extensive Service Needs, February 25, 2013. http://www.acf.hhs.gov/sites/default/files/opre/children_placed_outside_spotlight_2_final.pdf

[147] HHS, ACF, Office of Planning, Research and Evaluation, *National Survey of Child and Adolescent Well-Being (NSCAW) Baseline Report: Introduction to NSCAW II*, p. 10, August 1, 2011.

[148] HHS, ACF, Office of Planning, Research and Evaluation, *National Survey of Child and Adolescent Well-Being (NSCAW) II, Baseline Report: Caregiver Health and Services*, pp. 4-5, 19-22, August 1, 2011.

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

[150] Olivia Golden and Dina Emam, *How Health Care Reform Can Help Children and Families in the Child Welfare System: Options for Action*, June 2013, Low Income Working Families Paper 25, Urban Institute, pp. 16-17.

Families of Children Entering Foster Care

The ACA may also provide greater opportunities for a child welfare agency to provide mental health or other Medicaid-supported services to the *parents* of children entering foster care. These services may be required so that the child and parents can be reunited.[151] However, under Medicaid policy in place prior to implementation of the ACA Medicaid expansion group, parents whose children are placed out-of-home might be vulnerable to loss of Medicaid eligibility. As discussed in a previous section, this is because mandatory eligibility rules for Medicaid generally provided that *in addition* to having low income, applicants must have been living with their children (or be pregnant, disabled, or elderly). Thus, a child's placement in foster care could mean a potential loss of Medicaid for the parent and a loss of access to services that may be needed to allow the child(ren) to return to living with the parent. Prior to the ACA, states could opt to cover "childless" adults (i.e., adults with no children living with them) under Section 1115 demonstration waivers. Otherwise, "childless" adults were ineligible for Medicaid. States that implement the new ACA expansion pathway for certain low-income adults under age 65 can thus ensure an eligibility pathway remains open for any low-income adult—regardless of whether that adult's child lives with his or her parent or is placed in foster care. For children and their families who seek Medicaid coverage based on their income, the MAGI counting rule applies.

Private Health Insurance Reforms Affecting the Child Welfare Population

According to a national survey of children in families who come into contact with the child welfare system, approximately 63% of those who were insured had Medicaid coverage and another 26% had private insurance. The remaining children (10%) were uninsured. At the three-year follow-up, those with private insurance remained at 26%, those with Medicaid coverage increased slightly to 67%, and those without insurance declined to 6%.[152]

Private health insurance also plays a significant role for children who are adopted or who age out of foster care. With respect to adopted children who were previously in foster care, a survey of adoptive parents found that 94% were continuously insured for the prior 12 months, with 37% through private health insurance.[153] A separate study of former foster youth in three states showed that by age 26, nearly six out of 10 had health insurance. Of those who had coverage, just over

[151] Ibid., pp. 8-9.

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

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

20% had private insurance from an employer or through the individual health insurance market (see **Table A-1** in **Appendix A**).[154]

Furthermore, the research literature has found that individuals with a child welfare history may struggle to maintain health insurance or have medical conditions that limit their ability to obtain insurance. The prevalence of chronic conditions in persons that have been in foster care has been estimated to be between 44% and 82%.[155] A study of such youth ages 18 through 20 in eight Midwestern counties found that 67% lost health insurance coverage within an average of three months of leaving foster care and only about one-fourth of those regained coverage after an average period of eight months.[156] Separately, HHS is tracking health and other outcomes of youth who were in foster care at age 17. In FY2013, when the first cohort of surveyed youth had reached age 19, nearly nine out of ten had health insurance (primarily through Medicaid); however, youth who were no longer in foster care were less likely than youth who remained in care at age 19 to have coverage (80% versus 99%).[157]

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

Selected Private Health Insurance Reforms under the ACA

The ACA establishes federal requirements that apply to private health insurance, among other provisions.[158] The reforms affect insurance offered to groups and individuals, impose requirements on sponsors of coverage, and, collectively, establish a federal floor with respect to access to coverage, premiums, benefits, cost-sharing, and consumer protections.[159] The ACA insurance reforms discussed in this section may be particularly relevant for young adults who were formerly in foster care, children who leave care and are reunited with their families, parents of children who are or were in foster care, and parents of children who are adopted from foster care.

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

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

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

[157] For further information, see CRS Report R43752, *Child Welfare: Profiles of Current and Former Older Foster Youth Based on the National Youth in Transition Database (NYTD)*, by Adrienne L. Fernandes-Alcantara.

[158] See CRS Report R42069, *Private Health Insurance Market Reforms in the Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez.

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

Children age 18 and older who were formerly in foster care, including those who are adopted, may have expanded private insurance coverage opportunities through the health plan of an insured parent. The ACA requires health plans that provide dependent coverage to extend that existing coverage to children under age 26. ACA regulations further clarified that a health plan may not deny or restrict coverage for a child who has not attained age 26 "based on the presence or absence of the child's financial dependency (upon the participant or any other person), residency with the participant or with any other person, student status, employment, or any combination of those factors."[160] Moreover, health plans "may not limit dependent coverage based on whether a child is married."[161] Still, young adults who leave foster care (and are otherwise ineligible under Medicaid) may not necessarily gain coverage under this reform measure, given that some of these young people may not have relationships (or may have strained relationships) with their parents or their parents may not have access to health insurance.

Health insurance exchanges ("marketplaces") operate in every state and the District of Columbia (DC), per the ACA statute.[162] Essentially, exchanges are designed to sell health plans to individuals (and small businesses) interested in obtaining private health insurance.[163] In general, exchange plans provide comprehensive coverage and meet all applicable market reforms specified in the ACA. Given that nearly all individuals are allowed to purchase insurance in the exchanges, parents of children who return home from foster care and of children adopted from care, as well as individuals that have aged out, may possibly access coverage this way (as long as they meet the eligibility criteria).[164]

In tandem with these exchanges, the ACA established new federal tax credits. Currently, certain low-to-middle income individuals and families may qualify for these credits to make exchange coverage more affordable. In addition, some of those tax credit recipients will receive subsidies to reduce their out-of-pocket spending on medical expenses.[165] Such financial assistance may be particularly relevant to youth who age out and the parents of children who return home from foster care or are adopted from care.

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

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

[161] Ibid., p. 27124.

[162] Kaiser Family Foundation, *State Health Insurance Marketplace Decisions*, January 27, 2014, at http://kff.org/health-reform/slide/state-decisions-for-creating-health-insurance-exchanges/.

[163] The private health insurance market offers insurance products to individuals and families, as well as employers and other employment-based groups. Given these different types of customers, private health insurance is generally referred to as either nongroup insurance or group insurance. Small groups are businesses and other employment-based entities that meet size requirements specified at the federal and state level.

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

[165] See CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez.

- The ACA requires certain types of coverage to be offered on a guaranteed issue basis. In general, "guaranteed issue" in health insurance is the requirement that a plan accept every applicant for health coverage as long as the applicant agrees to the terms and conditions of the insurance offer (such as the premium).
- The ACA prohibits plans from basing eligibility or coverage on health status-related factors. Such factors include health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability, and any other health status-related factors determined appropriate by the Secretary of HHS.
- The ACA prohibits plans from excluding coverage for preexisting health conditions.[166] In other words, plans may not exclude benefits based on health conditions for any individuals. A preexisting health condition is a medical condition that was present before the date of enrollment for health coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.
- The ACA imposes adjusted (or modified) community rating rules on the determination of premiums.[167] Adjusted community rating rules prohibit plans from pricing health insurance products based on health factors but allow it for other key characteristics such as age. The ACA's rating rules restrict premium variation to the following factors: coverage for individual or family, geography, and limited premium variation allowed for age and tobacco use.

Accessing Private Health Insurance

The vast majority of the ACA's reforms to the private health insurance market are currently in effect. At the same time, individuals who were formerly in foster care or who have otherwise been in contact with the child welfare system may still face barriers to obtaining private health insurance. While individuals may no longer be denied insurance due to health factors or be offered coverage that excludes treatments for preexisting health conditions, the cost of purchasing and using private insurance may still be high for some, even if such individuals qualify for the premium tax credits and cost-sharing subsidies established under the ACA. On the other hand, the exchanges and insurance market reforms provide options for private health insurance that may not have existed for some individuals prior to ACA enactment. Moreover, former foster youth who are no longer eligible for Medicaid may possibly avail themselves of the financial assistance provided through the exchanges, thus giving them another source of subsidized coverage.

The complexity of the private insurance market may lead to difficulties for this population to assess all the insurance options potentially available to them. The ACA provides consumer assistance for prospective enrollees in exchanges. Specifically, the ACA requires exchanges to perform outreach to help individuals (and small businesses) make informed decisions about their insurance options, including the operation of "navigator" programs.[168] Navigators carry out public

[166] 42 U.S.C. §300gg-3.

[167] 42 U.S.C. §300gg.

[168] See CRS Report R43243, *Health Insurance Exchanges: Health Insurance "Navigators" and In-Person Assistance*, by Suzanne M. Kirchhoff.

education activities; provide information to prospective enrollees about insurance options and federal assistance; and examine enrollees' eligibility for other federal or state health care programs, such as Medicaid. A variety of organizations may become navigators, including labor unions, trade associations, chambers of commerce, and other entities; however, it is not immediately clear which entities are best suited to assist this population. Finally, staff in child welfare and Medicaid agencies and those who run the exchanges must be trained to understand the ACA and its implementation in their state to enable them to best assist applicants in obtaining insurance.

Appendix A. Research on the Health Needs of Certain Children and Youth Formerly in Foster Care

As discussed in the body of this report, health care needs of children in foster care are considerable. Research on health care needs of children who age out of foster care and those who leave foster care for adoption are discussed in greater detail in the following section. Many of these former foster care children and youth are counted as "foster care" children under the Medicaid data reporting system. Thus, the type and prevalence of their health care needs affects our understanding of Medicaid use by "foster care" children. As of July 1, 2014 states are required to submit Medicaid program data via a revised reporting system. In this new system (T-MSIS) former foster youth who aged out of care are counted separately from children who are in foster care. However, many children who leave foster care for adoption are expected to continue to be included in the Medicaid "foster care" children population.

Young Adults Who Were Formerly in Foster Care

The research literature regarding children who age out of foster care shows that physical and mental health problems persist into adulthood.[169] Two studies—the Northwest Foster Care Alumni Study and the Midwest Evaluation of the Adult Functioning of Former Foster Youth—have tracked outcomes for a sample of youth across several domains, either prospectively (following youth in care and as they age out) or retrospectively (examining current outcomes for young adults who were previously in care and comparing these outcomes to those of young people in the general population).

Researchers with the Northwest Foster Care Alumni Study interviewed and reviewed the case files of 479 foster care youth who were in public or private foster care any time from 1988 to 1998 in Oregon or Washington.[170] The study compared the mental health status and education and employment outcomes for the foster care alumni to those of the general population. Over 54% of foster care alumni had at least one mental health problem—depression, social phobia, panic disorder, and post-traumatic stress disorder, among others—compared to 22.1% of the general population.[171] About one-quarter of the alumni experienced post-traumatic stress disorder (PTSD). This figure is greater than the occurrence of PTSD among Vietnam or Iraq War veterans, which is about 15%. Foster care alumni tended to have recovery rates similar to their counterparts in the general population for major depression, panic syndrome, and alcohol dependency, but

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

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

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

lower rates of recovery for other disorders such as generalized anxiety disorder, PTSD, social phobia, and bulimia.

Few foster care alumni studies are prospective, meaning that they follow youth while in care through the time they leave care and beyond. The Midwest Evaluation is an ongoing study that tracks approximately 600 former foster youth in three states—Illinois, Iowa, and Wisconsin.[172] **Table A-1** displays the physical health and mental health outcomes for alumni at ages 25 and 26 compared to their same-age peers in the general population. Overall, youth formerly in foster care reported having more negative health outcomes than their general population peers and participating in counseling and substance abuse treatment more often. They were also less likely than their peers to be covered by employers' health care plans, and more likely to have public health insurance.

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

Outcome	Midwest Evaluation (Wave 4)—Former Foster Youth at Ages 25 and 26	Add Health—Peers Surveyed at Ages 25 and 26
Description of General Health[a]		
Excellent	25.8%	18.5%
Very good	29.4%	40.1%
Good	27.0%	32.7%
Fair	15.6%	7.5%
Poor	2.2%	1.1%
Health Condition or Disability Limits Daily Activities[a,b]	14.8%	8.1%
Mental Health and Behavioral Care Services[a] *(from survey of youth at age 23 and 24)*[c]		
Received psychological or emotional counseling	11.3%	6.5%
Attended substance abuse treatment program	5.1%	2.4%
Has Medical Insurance[a]	58.7%	78.0%
Source of Medical Insurance[a]		
Parents' insurance	1.2%	2.0%
Spouse's insurance	6.3%	10.7%
Employer provided insurance[a]	20.2%	56.3%
School provided insurance	0.9%	3.7%
Purchase own private insurance	1.2%	3.9%
Medicaid or medical assistance[a]	47.6%	9.4%

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

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

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

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

a. Indicates that the difference between the youth in the Midwest Evaluation and youth in the Adolescent Heath Survey is statistically significant.

b. The Add Health Study questions asked whether any health conditions limited their ability to engage in moderate activities.

c. The Add Health survey instrument for youth surveyed at ages 25 and 26 did not have comparable data.

d. The Add Health Study did not report this figure.

Separately, HHS data of current and former foster youth at age 19 show differences in health insurance coverage depending on whether the youth was still in foster care. Among 19-year-olds who were still in care in FY2013, 99% had Medicaid coverage. This is compared to 80% of youth who were no longer in foster care.[173]

Children Adopted from Foster Care

Children adopted from foster care are those children who were removed from their biological parents – typically because of abuse or neglect – and for whom reuniting with those biological parents was determined not possible or not in the child's best interest. Roughly 50,000 to 55,000 children leave foster care for a permanent adoptive family each year.[174] The large majority of these children (84% in FY2013)[175] were determined by the state to have "special needs" that

[173] For further information see, CRS Report R43752, *Child Welfare: Profiles of Current and Former Older Foster Youth Based on the National Youth in Transition Database (NYTD)*, by Adrienne L. Fernandes-Alcantara.

[174] HHS, ACF, ACYF, Children's Bureau, "Trends in Foster Care and Adoption, FY2002-FY2013," based on data submitted by states as of July 2014. http://www.acf.hhs.gov/sites/default/files/cb/trends_fostercare_adoption2013.pdf

[175] Based on adoption data reported by states (via AFCARS) as of July 2014 as provided to CRS by HHS, ACF, ACYF, (continued...)

made it "reasonable" for the state to conclude the child would not be adopted without provision of an adoption subsidy and/or medical assistance.[176]

Greater Health and Mental Health Needs

A nationally representative survey conducted in 2007 found children who were adopted – whether from foster care, domestically by private arrangement, or from another country – tended to have greater health and mental health needs than children in the general population.[177] Further, among all adopted children, those who were adopted from foster care had the greatest needs. For example, 19% of all children in the nation were reported by their parents as having special health care needs in 2007, compared to 39% of all children who were adopted and 54% of children adopted from foster care. Additionally, among children ages 6 through 17, about 1 in 10 (10%) in the general population had been formally diagnosed with attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) at some point and, at the time of the 2007 survey, the parents of about 1 in 25 children (4%) considered their child's diagnosed ADD/ADHD condition to be moderate or severe. The comparable rates among all adopted children in this age range was more than 1 in 4 ever diagnosed (26%) and roughly 1 in 8 with a current moderate or severe condition (14%); for those in this age range who were adopted from foster care, more than 1 in 3 had ever received an ADD/ADHD diagnosis (37%) and fully 1 in 5 (20%) had a current moderate or severe condition as reported by their adoptive parents.

The 2007 survey also found that 2% of all adopted children (ages 8 through 17) had spent some time in a residential psychiatric facility or hospital following their adoption; the comparable share reported for children adopted from foster care was 7%.[178] (Because this question is linked specifically to services provided *after* a child was adopted there is no comparable percentage for children in the general population.) **Table A-2** shows these and additional data on the health and mental health needs of children adopted from foster care compared to all adopted children and children generally.

More Likely to Have Insurance Coverage

At the same time, children who are adopted are more likely to have had continuous (over past 12 months) health insurance coverage than children in general. The 2007 survey of adopted parents found that 85% of all children had this continuous coverage, compared to 91% among all adopted children and 94% of children adopted from foster care.[179] Federal law provides that the children adopted from foster care who have "special needs" (which may be but are not necessarily related

(...continued)

Children's Bureau.

[176] States determine which children have "special needs" within certain federal parameters (included at Section 473(c) of the Social Security Act). As part of this determination, states must find that a factor or condition specific to the child would make it reasonable to conclude that a child cannot be placed in an adoptive family without adoption assistance and/or medical assistance. Such factors include the child's age, membership in a sibling group, race and ethnicity, or physical, social, or emotional disability.

[177] 2007 National Children's Health Survey and related 2007 National Adoptive Parents Survey. For more information see Sharon Vandivere, Karin Malm, and Laura Radel, *AdoptionUSA: A Chartbook Based on the 2007 National Survey of Adoptive Parents*, HHS, Office of the Assistance Secretary of Planning and Evaluation, 2009, p. 1.

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

[179] Ibid, pp. 22-24. See also Table 7.

to health or mental health needs) are eligible for Medicaid (or a comparable state benefit plan).[180] Not surprisingly then, public health insurance is the most common form of coverage among children adopted from foster care. Nearly 6 in 10 (59%) were reported by their adoptive parent as covered by Medicaid or CHIP – roughly double the 3 in 10 (29%) children generally who were covered by those public programs.

Although 37% of children adopted from foster care were covered by private insurance coverage, some of these privately insured children were also enrolled in Medicaid.[181] Parents of children adopted from foster care reported that 65% had ever received a Medicaid benefit, over half (55%) used Medicaid for dental care, and nearly one out of three (32%) used Medicaid to pay for mental health services. In those instances where a child is covered by both Medicaid and private insurance, the law provides that Medicaid is the payer of last resort. This means that the private insurer must pay any covered benefits first. However, Medicaid coverage could supplement those benefits (if the private insurance benefits are exhausted) and it might wholly fund services not covered by the adopted children's private insurance carriers (e.g., many private insurers do not cover residential psychiatric treatment).[182]

[180] According to the 2007 National Survey of Adoptive Parents, 92% of children adopted from foster care were the subject of an adoption assistance agreement between a state and the adoptive parent. Under federal law all of these children would be expected to be *eligible* for Medicaid coverage or a comparable public benefit plan. States are required to enter into an adoption assistance agreement on behalf of any child who meets "special needs" criteria (Section 473(a)(1)(A) of the Social Security Act), including those who meet all the Title IV-E eligibility criteria and those with special needs who do not meet all of the Title IV-E eligibility criteria. For adoptive children with state-determined special needs who meet all the federal Title IV-E eligibility criteria, federal law provides mandatory Medicaid eligibility (Section 1902(a)(10)(A)(i)(I) and Section 473(b)(3)(A) of the Social Security Act). For adoptive children with state-determined special needs who do not meet all the Title IV-E eligibility criteria, federal law requires states to provide those children with health insurance coverage via Medicaid or another comparable state plan (Section 471(a)(21 of the Social Security Act). States may use a number of optional pathways to provide Medicaid to these children, including one specifically for such children (Section 1902(a)(10)(A)(ii)(VIII) of the Social Security Act).

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

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

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

CONDITION *(Children are ages 0 through 17 years of age unless otherwise noted)*	**All Children**	**All Adopted Children[a]**	**Children Adopted From Foster Care**
Special health care need: Parent reported that the child currently experiences at least one of five consequences attributable to a medical, behavioral, or other health condition that has lasted or is expected to last for at least 12 months. The consequences include: 1) ongoing limitations in ability to perform activities that other children of the same age can perform, 2) ongoing need for prescription medications, 3) ongoing need for specialized therapies, 4) ongoing need for more medical, mental health, or educational services than are usual for most children of the same age, and 5) the presence of ongoing behavioral, emotional, or developmental conditions requiring treatment or counseling.	19%	39%	54%
Diagnosis of Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD): Parent of child (ages 6 through 17) was at some point told by a doctor or other health care provider that the child has ADD/ADHD and at time of the survey the parent reported the child's condition was moderate or severe.	4%	14%	20%
Diagnosed with Attachment Disorder: Parent of child was at some point told by a doctor or other health care provider that the child has attachment disorder (or reactive attachment disorder). This disorder, which is associated with severe neglect of a young (under age 5) child's basic emotional needs, may make a child be excessively inhibited or indiscriminately sociable.	Not included in general survey.	12%	21%
Diagnosis of conduct or behavior problems: Parent of child (ages 2 through 17) was at some point told by a doctor or other health care provider that the child has conduct or behavior problems, and at the time of the survey the parent reported the condition was moderate or severe.	4%	17%	24%
Child received mental health service(s) since adoption (ages 5 through 17)	Not applicable.	39%	46%
Child received psychiatric residential treatment/hospitalization since adoption (ages 8 through 17)	Not applicable.	4%	7%[b]

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

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

a. Includes children adopted from foster care, those adopted domestically by private arrangement, as well as those adopted from other countries. However, children adopted by stepparents were excluded from this analysis.

b. This percentage is significantly different from the share reported for children adopted from another country but not for domestic, privately arranged adoptions.

Appendix B. Medicaid Services Spending for "Foster Care" Children

Children for whom these spending data are reported in the Medicaid Statistical Information System (MSIS) include those determined to be a "foster care" child under MSIS based on their Medicaid eligibility pathway. These children principally include those who are eligible for federal Title IV-E assistance whether they are in foster care or have left that care for adoption or legal guardianship. They may also include children who are receiving state-funded adoption assistance as well as some children who have aged out of foster care. Children who are in foster care but who are not eligible for Title IV-E assistance do not appear to be included in this category.

Table B-1. Medicaid Services Spending for "Foster Care" Children by Types of Service, Selected Fiscal Years

Nominal dollar amounts shown in millions. Service categories listed in alphabetical order.

Service Category	FY2001		FY2005		FY2008		FY2010	
	Spending	*Share of Spending*	*Spending*	*Share of Spending*	*Spending*	*Share of Spending*	*Spending*	*Share of Spending*
Clinic Services	$328.6	8.7%	$485.2	9.2%	$468.9	7.9%	516.7	9.0%
Dental Services	$54.0	1.4%	$83.9	1.6%	$109.0	1.8%	120.2	2.1%
Health Maintenance Organization (HMO) and Health Insuring Organization (HIO)	$194.3	5.1%	$366.1	6.9%	$545.1	9.2%	696.1	12.1%
Home Health Services	$68.5	1.8%	$106.8	2.0%	$121.9	2.1%	113.3	2.0%
Hospice Services	$0.1	0.0%	$0.5	0.0%	$1.8	0.0%	$0.9	0.0%
Intermediate Care Facility Services for Individuals with Intellectual Disability	$19.2	0.5%	$32.3	0.6%	$50.6	0.9%	48.2	0.8%
Inpatient Psychiatric Facility Services for Individuals Age 21 and Under	$376.7	10.0%	$464.9	8.8%	$510.9	8.6%	512.7	8.9%
Inpatient Hospital Services	$353.3	9.4%	$439.4	8.3%	$504.2	8.5%	462.7	8.0%
Laboratory and X-Ray Services	$20.7	0.5%	$33.5	0.6%	$43.3	0.7%	46.2	0.8%
Nurse Practitioner	$1.6	0.0%	$3.3	0.1%	$4.3	0.1%	4.6	0.1%
Nursing Facilities	$16.2	0.4%	$15.1	0.3%	$15.6	0.3%	16.3	0.3%
Other Licensed Practitioners' Services	$56.9	1.5%	$88.3	1.7%	$67.9	1.1%	58.8	1.0%
Other Services	$658.4	17.4%	$978.2	18.5%	$949.7	16.0%	903.0	15.7%
Outpatient Hospital Services	$127.6	3.4%	$149.9	2.8%	$159.1	2.7%	174.5	3.0%
Primary Care Case Management	$1.6	0.0%	$2.1	0.0%	$3.3	0.1%	8.4	0.1%
Personal Care Services	$18.1	0.5%	$28.3	0.5%	$43.9	0.7%	45.7	0.8%
Prepaid Health Plans	$159.3	4.2%	$202.1	3.8%	$310.2	5.2%	328.4	5.7%

Service Category	FY2001		FY2005		FY2008		FY2010	
	Spending	*Share of Spending*	*Spending*	*Share of Spending*	*Spending*	*Share of Spending*	*Spending*	*Share of Spending*
Physicians' Services	$169.1	4.5%	$181.3	3.4%	$201.5	3.4%	203.7	3.5%
Prescribed Drugs	$288.1	7.6%	$573.2	10.8%	$751.4	12.7%	743.1	12.9%
Private Duty Nursing	$23.1	0.6%	$33.1	0.6%	$34.3	0.6%	41.8	0.7%
Rehabilitative Services	$498.9	13.2%	$616.2	11.7%	$660.3	11.1%	487.7	8.5%
Targeted Case Management Services	$269.2	7.1%	$346.4	6.6%	$301.6	5.1%	146.0	2.5%
Physical Therapy, Occupational Therapy, and Services For Individuals With Speech, Hearing, and Language Disorders	$49.5	1.3%	$34.6	0.7%	$41.7	0.7%	38.7	0.7%
Transportation	$19.2	0.5%	$21.0	0.4%	$22.8	0.4%	22.1	0.4%
Unknown	$0.9	0.0%	$0.1	0.0%	$12.4	0.2%	13.9	0.2%
All Categories	**$3,773**	**100%**	**$5,286**	**100%**	**$5,936**	**100%**	**$5,754**	**100%**

Source: Table prepared by the Congressional Research Service (CRS) based on analysis of Medicaid Statistical Information System (MSIS) data as aggregated in the quarterly State Summary DataMart. This file includes data from each of the 50 states and the District of Columbia. The file captures a child's eligibility status at a given point in time. Therefore, not all Medicaid spending for a "foster care" child may be captured if a child's basis of eligibility changes over the course of the year.

Notes: MSIS service categories are shown in this table only if states reported spending for this type of service for "foster care" children *and* if that spending totaled at least $1 million in any one of the given years. However, spending in any service category for which amounts smaller than this were reported are included in the "All Categories" services spending amount shown for "foster care" children. For information on the kinds of services included in each of the MSIS services categories and regarding who is counted as a "foster care" child, see the MSIS Data Dictionary available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/MSIS/Downloads/msisdata-dictionary.pdf.

a. "Other Services" includes some home and community-based waiver services (provided they cannot be reported in another fee-for-service (type of service) category), prosthetic devices, eyeglasses, and optician fees.

Appendix C. Medicaid Eligibility for Current and Former Foster Children and Youth

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

Pathway *(Statutory Citation in Title XIX of the Social Security Act; Regulatory Citation in Code of Federal Regulations (C.F.R.))*	**Key Eligibility Criteria**		
	Income (and Assets for Selected Pathways)[a]	**Age**	**Selected Other**
		Major Mandatory Groups	
Title IV-E Foster Care (§1902(a)(10)(A)(i)(I) and 42 C.F.R. §435.115(e) and §435.145)[b]	Modified adjusted gross income (MAGI) income counting rule does not apply. Eligibility is categorical and the income test is applied by child welfare agency. Child must have been removed from a family whose income met the state's need standard as it existed on July 16, 1996 for purposes of determining eligibility under the prior law cash welfare program, Aid to Families with Dependent Children (AFDC). Income standards may not be adjusted for inflation. Child must have assets under $10,000.	Under age 18, or, if still completing high school or equivalent education or training, under age 19; OR Up to age 19, 20, or 21 in states that elect to extend foster care to such older age. (Older youth must meet certain employment, education, or medical criteria.)[c]	- Child is removed from home of a parent, or other relative specified in prior law cash welfare program (AFDC); - At removal child is "deprived" of parental care or support (i.e., single-parent household) or is in two-parent household where the principal wage-earner meets unemployment criteria; - A judge determined that removal was necessary because the home was "contrary to the welfare" of the child and that state made reasonable efforts (when required) to prevent the removal of the child from his or her home;[d] - Judge gives care and placement responsibility to the state child welfare agency; -Child is placed with an eligible caregiver in a licensed setting (e.g., foster family home, group home, or residential institution); and - No less often than every 12 months a judge finds that the state is making reasonable efforts to find a permanent home for the child.

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

Pathway *(Statutory Citation in Title XIX of the Social Security Act; Regulatory Citation in Code of Federal Regulations (C.F.R.))*	Key Eligibility Criteria		
	Income (and Assets for Selected Pathways)[a]	**Age**	**Selected Other**
Title IV-E Adoption Assistance (§1902(a)(10)(A)(i)(I); 42 C.F.R. §435.115(e) and §435.145)[b]	MAGI income counting rule does not apply. Eligibility is categorical and the income test is applied by child welfare agency. Title IV-E foster care income/asset rules (tied to biological family from which a child was removed to foster care) are being phased out between FY2010-FY2018. As of FY2012 any child adopted from foster care at age 12 or older does not need to meet any of those prior family income or resource criteria. The phase out of income rules will apply to progressively younger adoptees in subsequent years and, as of FY2018 will apply to an adoptee of any age. Any youth who has been in foster care for 60 consecutive months does not need to meet the Title IV-E foster care income/asset test. Siblings of a child to whom the income and resource rules (related to prior family) may also be eligible as long as they are placed in same adoptive family. No income or resources rules are applicable to adoptive families.	Under age 18, or, if still completing high school or equivalent education or training, under age 19; OR If a state elects this definition of "child" in its Title IV-E plan, up to age 19, 20, or 21 (Older youth must meet certain employment, education, or medical criteria.). In addition, the state may provide coverage up to age 21 (on a case-by-case basis) if the child welfare agency determines the youth has a physical or mental condition warranting continued kinship guardianship assistance to that age.	Child must be determined by the Title IV-E child welfare agency to have "special needs." This means that that agency has determined that: —Child cannot or should not return home (to biological parents); —Because of a specific factor or condition, the child is unlikely to be adopted without provision of adoption assistance and/or medical assistance. Specific factors are established by each state but may include factors related to child's age, race/ethnicity, membership in a sibling group, race or ethnicity, medical condition, or physical, emotional, or mental disabilities; and —Reasonable but unsuccessful efforts have been made to place the child for adoption without assistance (either adoption or medical) but only if this is in child's best interest. Also eligible: Child who has special needs and who is eligible for SSI. (Until FY2018 some of these children will need to continue to meet income and resources rules of the SSI program, but beginning with FY2018 those rules no longer apply).

Pathway *(Statutory Citation in Title XIX of the Social Security Act; Regulatory Citation in Code of Federal Regulations (C.F.R.))*	Key Eligibility Criteria		
	Income (and Assets for Selected Pathways)[a]	**Age**	**Selected Other**
Consolidated Group for Children (§1902(a)(10)(A)(i)(I) and §1931, §1902(a)(10)(A)(i)(III), §1902(a)(10)(A)(i)(IV), §1902(a)(10)(A)(i)(VI), and §1902(a)(10)(A)(i)(VII); 42 C.F.R. §435.118)	Annual income of less than133% federal poverty level (FPL) based on MAGI income counting rule.[g]	Under age 19.	Group includes low-income families, qualified children less than age 19, poverty-level related infants, poverty-related children age 1 through 5, and poverty-level related children ages 6 through 18.
Consolidated Group for Pregnant Women (§1902(a)(10)(A)(i)(I) and §1931, §1902(a)(10)(A)(i)(III), and §1902(a)(10)(A)(i)(IV); 42 C.F.R. §435.116)	Annual income of less than133% federal poverty level (FPL) based on MAGI income counting rule.[g]	Any.	Group includes low-income families, qualified pregnant women, and poverty-level related pregnant women. Eligible during pregnancy, labor, and delivery, and for 60 days post-partum.
Supplemental Security Income (SSI) (§1902(a)(10)(A)(i)(II); 42 C.F.R. §435.120)	MAGI income counting rule does not apply. Eligibility is categorical. Meet federal SSI income (up to about 74% FPL in 2014), and asset eligibility standards. (Assets may not exceed $2,000 for an individual and $3,000 for a couple. Certain assets, such as a person's home, are exempt.)	Any.	Must also meet SSI disability criteria.
SSI Criteria States (§1902(f); 42 C.F.R. §435.121)	MAGI income counting rule does not apply. Eligibility is categorical. Individuals meeting more restrictive criteria than SSI in §209(b) states.	Any.	

Pathway *(Statutory Citation in Title XIX of the Social Security Act; Regulatory Citation in Code of Federal Regulations (C.F.R.))*	Key Eligibility Criteria		
	Income (and Assets for Selected Pathways)[a]	**Age**	**Selected Other**
Youth Who Aged Out of Foster Care (§1902(a)(10)(A)(i)(IX))	MAGI income counting rule does not apply. Eligibility is categorical.[h] Income and assets must not be considered when determining eligibility for this Medicaid coverage group.	At least age 18 through age 25.	Must have been in foster care on 18th birthday and covered under Medicaid while in care (or age 19, 20, or 21 if state provides federal foster care to this older age, and the youth elects to stay in care). Must not be eligible or enrolled under other Medicaid mandatory eligibility groups (except the pathway for non-disabled adults with income less than 133% FPL). Youth eligible for both the low-income adult pathway and the pathway for youth who aged out are to be enrolled in the latter pathway. Effective January 1, 2014.
	Major Optional Groups		
Chafee Youth (Independent Foster Care Adolescent) (§1902(a)(10)(A)(ii)(XVII)	No federal requirement for an income test but states were permitted to establish an income (and asset) test that was no more restrictive than those used by the state under the prior law AFDC program (with, at state option, adjustment for inflation.) MAGI income counting rule now applies. No asset test permitted and any income test that state had in place as of December 31, 2013, must have been converted to a MAGI equivalent income threshold. If a state, as of December 31, 2013, did not opt to include an income test for this eligibility pathway then the Medicaid agency may disregard 100% of the youth's income when determining eligibility for the youth under the MAGI counting rule.[g] [i]	Under age 21.	Must have been in foster care on 18th birthday. States can limit coverage to any "reasonable" category of independent foster care adolescents. States may also restrict coverage to those who received federal foster care maintenance payments (before age 18) or those who received independent living services under Title IV-E of the Social Security Act.

Pathway *(Statutory Citation in Title XIX of the Social Security Act; Regulatory Citation in Code of Federal Regulations (C.F.R.))*	Key Eligibility Criteria		
	Income (and Assets for Selected Pathways)[a]	**Age**	**Selected Other**
State-funded Adoption Assistance (§1902(a)(10)(A)(ii)(VIII); 42 C.F.R. §435.227)	Child must be under a state-funded adoption assistance agreement and before the state-funded adoption assistance agreement was executed, must have been receiving Medicaid (under either a mandatory or optional categorically needy category) OR would have been eligible for Medicaid given his/her own income and resources. MAGI income counting rule now applies. However, because no new income test was associated with this category, this is not expected to affect eligibility.[g i]	Under age 21 (or under age 20, 19, or 18 as the state may elect).	State child welfare agency must have entered into an adoption assistance agreement with the parent of the child (other than agreement under Title IV-E); and must have determined that child cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care; and
"Reasonable categories" of low-income children ("Ribicoff option") (§1902(a)(10)(A)(ii)(I), and §1902(a)(10)(A)(ii)(IV); 42 C.F.R. §435.222)	States were required to establish an income (and asset) test that was no more restrictive than those used by the state under the prior law AFDC program (with, at state option, adjustment for inflation.) MAGI income counting rule now applies. No asset test permitted and whatever income test that state had in place as of December 31, 2013, must have been converted to a MAGI equivalent income threshold. If a state, as of December 31, 2013, chose to disregard all income of a child when determining eligibility under this pathway, it may continue this policy under the MAGI counting rule.[g,i]	Under the age of 21, or at state option under the age of 20, 19 or 18 as the state may choose.	State defines "reasonable categories." Reasonable category can include children residing in state based institutions or foster care.

Pathway (*Statutory Citation in Title XIX of the Social Security Act; Regulatory Citation in Code of Federal Regulations (C.F.R.)*)	Key Eligibility Criteria		
	Income (and Assets for Selected Pathways)[a]	**Age**	**Selected Other**
Consolidated Group for Children (§1902(a)(10)(A)(ii)(IV), and §1902(a)(10)(A)(ii)(IX); 42 C.F.R. §435.118)	Annual income more than 133% but less than 185% FPL based on MAGI income counting rule.[g]	Under age 1.	Group includes children who would be eligible for AFDC if not institutionalized, and poverty-related infants.
Consolidated Group for Pregnant Women (§1902(a)(10)(A)(ii)(IV) and §1902(a)(10)(A)(ii)(IX); 42 C.F.R. §435.116)	Annual income more than 133% but less than 185% FPL based on MAGI income counting rule.[g]	Any age.	Group includes pregnant women who would be eligible for AFDC if not institutionalized, and poverty-related infants. Pregnant women eligible during pregnancy, labor and delivery, for 60 days of post-partum care.
Medicaid Expansion Under State Children's Health Insurance Program (SCHIP) (§1902(a)(10)(A)(ii)(XIV), and §2110(b); 42 C.F.R. §435.229)	Annual income under 200% FPL based on MAGI income counting rule, or 50 percentage points above applicable Medicaid level that is equal to or greater than 200% FPL based on MAGI income counting rule.[g]	Through age 18, or for pregnant women, any age.	Targeted low-income uninsured children, and certain pregnant women.
Medically Needy Children and Adults[i] (§1902(a)(10)(C); 42 C.F.R. §435.301 and §435.308)	MAGI income counting rule does not apply.[i] Annual income up to 133⅓% of the maximum payment amount applicable under a state's former AFDC programs. For families of one (i.e., child in foster care), the statute gives certain states some flexibility to set these limits to amounts that are reasonably related to the AFDC payment amounts for two or more persons.	Under age 18 and for certain other individuals, any age.	States may extend Medicaid coverage to persons who are members of one of the broad categories of Medicaid covered groups (e.g., over 64, disabled, families with dependent children), but do not meet the applicable income requirements and, in some instances, assets requirements for other eligibility pathways.
Section 1115 Waiver (§ 1115)	Upper income eligibility thresholds and income counting rules as specified in CMS approved Special Terms and Conditions.	Any age.	Eligibility groups and income counting rules as specified in CMS approved Special Terms and Conditions. Time limited demonstrations.

Source: CRS analysis of Title XIX of the Social Security Act, and Centers for Medicare and Medicaid Services, *Medicaid and Children's Health Insurance Program (CHIP) Eligibility Groups in 2014,* September 2012.

a. This table provides federal minimum or maximum income and asset rules that apply to all 50 states.

b. In a notice of proposed rulemaking (NPRM) issued January 22, 2013 (78 *Federal Register* 4593) CMS announced its intention to place relevant rules from 42 C.F.R. §435.115(e) (regarding Title IV-E eligible children) into the separate rule language concerning this same group that is included in 42 C.F.R. § 435.145. As part of the change it also proposed to reference the new Title IV-E eligibility group related to kinship guardianship assistance in the same regulation. CMS noted that these proposed changes were intended to be clarifying only and did not change current requirements. However, this change has not been finalized as of early fall 2014.

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

d. Alternatively a child may enter foster care via a voluntary placement agreement between the state child welfare agency and the parent(s)/guardian(s) of the child. That child may be Title IV-E eligible for up to six months. However, for eligibility to continue beyond that period, a judge must determine that the placement continues to be in the child's best interest.

e. If the agency places a sibling of the child in the same kinship guardianship arrangement, that child may be eligible even if he/she does not meet all of the Title IV-E foster care related requirements.

f. As interpreted by HHS, ACF, ACYF, Children's Bureau, states have some flexibility to provide somewhat more restrictive eligibility criteria for this assistance than the broadest eligibility permitted by federal law. For example, a state may limit assistance to youth age 12 or older, or may require that youth have lived with prospective guardian for longer than 6 months. See HHS, ACF, ACYF-CB-PI-10-11, issued July 9, 2010.

g. Under the MAGI rules, a state looks at each individual's MAGI, deducts 5% (which the law provides as a standard disregard), and compares that income to the new income standards set by each state in coordination with the Centers for Medicare and Medicaid Services (CMS).

h. Medicaid eligibility for this group is categorical and based, in part, on state child welfare agency record of child aging out of foster care at age 18 or later. CMS has directed states to allow youth to self-attest they were in foster care.

i. In converting the state's Pre-ACA income counting rules to the new MAGI threshold for this eligibility pathway, the proposed rule says that if the state provided Medicaid coverage under this optional pathway without an income test (prior to March 23, 2010 or December 31, 2013), then this policy (i.e., no income test) may remain in effect. See HHS, CMS, Proposed Rules, *Federal Register*, v. 78, January 22, 2013.

j. If states elect to provide medically needy coverage, they must include children under age 18 (as well as certain adults) whose income and resources are too high to qualify under former AFDC-related rules. If a child has a disability that meets the SSI disability standard, then SSI-related financial standards will apply to medically needy coverage. States may also provide medically needy coverage to individuals under age 21 (or 20, 19, or 18 years) if such persons do not fall into reasonable classifications such as individuals in foster care, in publically subsidized adoptions, in nursing homes and intermediate care facilities for the mentally retarded, and persons receiving active treatment as inpatients in psychiatric facilities.