



Health-Care Coverage for Youth in Foster Care—and After

Health care is a basic necessity for all children and youth. Children and youth who enter foster care because of abuse or neglect often have significant health-care needs. Changes in the nation’s health-care laws have increased access to and affordability of health care for some of our most vulnerable children and youth—those involved with child welfare. This issue brief reviews the eligibility pathways for children and youth in foster care to receive Medicaid or other health-care coverage and looks at some of the newer benefits now mandated through the Patient Protection and Affordable Care Act (ACA), especially those for older youth in or formerly in foster care.

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Acknowledgment and disclaimer

This brief provides a general overview; States differ with regard to health-care benefits and how they administer many of the benefits. For specifics in your State, visit <https://www.healthcare.gov/medicaid-chip/eligibility>. In addition to State examples of what works for Medicaid and non-Medicaid coverage for children and youth in foster care, this brief also provides resources to help youth and young adults understand their health-care options and resources for agencies on health-care access for children, youth, and families involved with child welfare.

Health-Care Needs of Children and Youth in Foster Care

Children and youth placed in foster care because of abuse or neglect often enter care with significant health challenges. Health issues may be related to poverty and other at-risk conditions such as parental substance abuse or mental illness. The actual abuse or neglect (including medical neglect) can also be a contributing factor to poor health, as can the disruption caused by removal from the home and placement in foster care. A government study that compared children receiving Medicaid who were in foster care with those not in care found that the children in foster care had much higher rates of developmental disorders, certain medical disorders (e.g., vision disorders, teeth and jaw disorders), and a number of behavioral disorders, including attention deficit and adjustment disorders (Center for Mental Health Services and Center for Substance Abuse Treatment, 2013). This same study showed that youth aged 12 through 17 in foster care had three times as many behavioral/mental health diagnoses and were more than twice as likely to require inpatient care of any kind compared to youth not in foster care.

The risk factors associated with poor health in children in foster care can also contribute to long-term and even lifetime problems. Studies such as the Adverse Childhood Experiences (ACEs) study from the U.S. Centers on Disease Control and Prevention show that, as the number of ACEs (e.g., abuse, neglect, parental substance abuse, witnessing domestic violence) increases, the risk increases for adulthood heart disease, suicide, HIV, and other conditions that can lead to early death (Anda, 2007).

ACEs are also associated with such factors as relationship stability and job performance in adulthood. Thus, quality health care for children and youth in foster care addresses many childhood conditions and also may set the stage for a healthier, happier, and more successful adulthood.

Medicaid Coverage—Who Is Eligible and How?

Medicaid, as authorized by title XIX of the Social Security Act, is a program funded jointly by Federal and State governments to provide health-care coverage to low-income citizens who meet certain additional criteria. States determine their own eligibility criteria within broad Federal guidelines. While States are not permitted to use Federal child welfare funds to pay for Medicaid, they do receive some reimbursement from Medicaid to help defray the costs of covering children in foster care (Baumrucker, Fernandes-Alcantara, Stoltzfus, & Fernandez, 2012).

The majority of children and youth in foster care are eligible for Medicaid, and this section outlines how children and youth in foster care meet those eligibility requirements.

Title IV-E and Foster Care

The most common eligibility pathway to Medicaid for children and youth in foster care is through title IV-E eligibility. Title IV-E of the Social Security Act provides funding to support safe and stable out-of-home care for children who are removed from their homes. Title IV-E does not provide Medicaid, but children and youth in foster care who receive title IV-E payments are categorically eligible for Medicaid in every State. This group includes the following:

Children and youth who receive title IV-E foster care maintenance payments. This is the category that covers most children and youth in foster care. If title IV-E payments are being received, the children or youth are eligible for Medicaid in their State of residence. A youth on whose behalf title IV-E foster

care maintenance payments are made is categorically eligible for Medicaid in the State of residence, including a youth up to age 21. A youth aged 18 through 20 is eligible for Medicaid (if IV-E payments are received for such a youth) whether or not the title IV-E agency in the State of residence has taken the option to provide extended IV-E assistance (ACF, 2010).

Children and youth who receive title IV-E guardianship assistance program (GAP) payments.

Children and youth who receive title IV-E guardianship assistance payments are eligible for Medicaid in their State of residence. A youth on whose behalf title IV-E guardianship assistance payments are made is categorically eligible for Medicaid in the State of residence, including a youth up to age 21. Such a youth is eligible for Medicaid (if IV-E GAP payments are received for such a youth) whether or not the title IV-E agency in the State of residence has taken the option to provide extended IV-E assistance (ACF, 2010).

Children and youth subject to a title IV-E adoption assistance agreement. Children and youth covered by title IV-E adoption assistance agreements are eligible for Medicaid. Generally, title IV-E adoption assistance agreements are available for children or youth who are deemed to have “special needs” as defined by the title IV-E agency, and they are children for whom adoption might not be feasible without the adoption assistance agreement. (See Child Welfare Information Gateway’s “Special Needs” Adoption: What Does It Mean? at <https://www.childwelfare.gov/pubs/factsheets/specialneeds/>.) A youth who is subject to a title IV-E adoption assistance agreement is categorically eligible for Medicaid in the State of residence, including a youth up to age 21. Such a youth is eligible for Medicaid (if the IV-E assistance agreement is in effect for such a youth) whether or not the title IV-E agency in the State of residence has taken the option to provide extended IV-E assistance (ACF, 2010).

Children of a minor parent or youth over age 18 in foster care. If a youth in foster care whose costs are covered by title IV-E foster care maintenance payments is or becomes a parent, that youth’s child is categorically eligible for Medicaid as a title IV-E child in the State where they live. This continues to hold true regardless of whether or not the title IV-E agency in that State has elected to extend foster care assistance to youth age 18 and older. If the State has placement and care responsibility for both the parent and the child, title IV-E eligibility must be determined individually for each, and title IV-E payments determine Medicaid eligibility (Children’s Bureau, n.d.).

The above information on title IV-E categorical eligibility for Medicaid is detailed in a Program Instruction published in 2010 by the Children’s Bureau, Administration for Children and Families, U.S. Department of Health and Human Services, which can be found at <http://www.acf.hhs.gov/sites/default/files/cb/pi1011.pdf>.

Other Ways Children in Foster Care May Qualify for Medicaid

For children and youth in foster care who are not eligible under title IV-E, there are other ways that they may be eligible to receive Medicaid.

Mandatory Medicaid eligibility for children under age 19. States are required to provide Medicaid coverage for children under age 19 whose household income is no more than 133 percent of the Federal poverty line (FPL) or a higher income limit established by the State for the child’s age group (under age 1, aged 1 through 5, or aged 6 through 18). Often, for a child placed out of home in foster care (especially if the parents do not intend to claim the child as a tax dependent for the current tax year), only the child’s income is considered for Medicaid eligibility. Therefore, most children under age 19 in foster care who do not qualify for the Medicaid IV-E eligibility do qualify for this other mandatory eligibility group. Many States cover children under age 19 to a higher income limit under the Children’s Health Insurance Program (CHIP; see below for more information).

Medicaid eligibility for the adult group. States have the option to cover the “adult group” added by the ACA for nonpregnant individuals aged 19 through 64 whose household income is no more than 133 percent of the FPL. Currently, 28 States cover this eligibility group. Because youth in foster care aged 19 or older often are considered for Medicaid eligibility as a household of one person, their income is usually within the limit for this group, if covered by their State of residence (see <http://www.medicaid.gov/medicaid-chip-program-information/by-population/adults/non-disabled-adults.html>).

Youth formerly in foster care and under age 26. The ACA provides a new mandated eligibility pathway for Medicaid, effective in 2014, for the “former foster care” group, which covers older youth no longer in foster care so they may continue to receive Medicaid until their 26th birthday. This coverage is similar to that of other young adults with no foster care connection who are able to remain on their parents’ health-care plans until age 26. Youth formerly in foster care are eligible for their State’s full Medicaid coverage, regardless of their income and regardless of whether the State where they live opted or declined to expand Medicaid coverage under the “adult group.” This provision applies to individuals under age 26 who were both enrolled in Medicaid and in foster care under the responsibility of the State or Tribe where they currently live upon attaining either age 18 or such higher age as the State or Tribe has elected for termination of Federal foster care assistance under title IV-E. States have the option to cover youth who were in foster care and/or enrolled in Medicaid in another State than where they currently live, but they are not required to do so. To date, 12 States have opted to cover eligible youth from other States (Houshyar, 2014). For more information, see the Medicaid website at <http://www.medicaid.gov/State-Resource-Center/Downloads/Medicaid-and-CHIP-FAQs-Coverage-of-Former-Foster-Care-Children.pdf>.

Youth who age out of foster care in States that offer the Chafee option. The Chafee Foster Care Independence Act of 1999 provides services and supports to help youth aging out of foster care make a successful

transition to adulthood and independence. Chafee funds may also cover youth who are adopted or enter a guardianship after their 16th birthday. The Chafee Act authorizes States to provide Medicaid to certain youth who age out of foster care. States receive grants to fund Chafee services, and States also have the option to determine eligibility under Medicaid for this group of “independent foster care adolescents” up to age 19, 20, or 21. Currently, 30 States have elected to cover this Medicaid group for older youth who were in foster care at age 18 and are not eligible for the mandatory Medicaid groups such as the former foster care group. Twenty-six of these States do not apply an income limit for this group.

The ACA's Coverage for Mandatory Former Foster Care Group Versus the Chafee Option—What's the Difference?

There is some overlap between the coverage mandated by the ACA for the former foster care group of older youth and young adults and the Medicaid coverage that some States provide through the Chafee option for older youth who have left foster care. A Medicaid factsheet that includes frequently asked questions on this topic makes the following points about differences in these Medicaid eligibility groups (Centers for Medicare and Medicaid Services [CMS], 2013; see <http://www.medicaid.gov/State-Resource-Center/Downloads/Medicaid-and-CHIP-FAQs-Coverage-of-Former-Foster-Care-Children.pdf>):

Chafee Optional Medicaid Group for Independent Foster Care Adolescents

- Youth receiving IV-E foster care or, at the State's option (as elected by all 30 of the States), were in State- or Tribal-funded care, are eligible.
- Youth must have been in foster care at age 18.
- Young adults with an income above a certain level are not eligible, if the State has an income test for this group (as only 4 out of 30 States do).
- Young adults are not required to have been in foster care in the same State where they are seeking coverage, unless the State imposes such a requirement (which 2 of the 30 States have).
- Chafee coverage goes up to age 19, 20, or 21 at State option.

ACA Mandatory Medicaid Coverage for Former Foster Care Group

- Young adults who were receiving IV-E foster care or State- or Tribal-funded foster care and were enrolled in Medicaid at age 18 or when they aged out of care are eligible.
- There is no income requirement.
- Young adults are eligible only in the State in which they aged out of foster care, although some States (currently, 12 States) are opting to cover young adults who were in foster care and/or Medicaid in other States.
- Coverage is provided until the young adult's 26th birthday.

For young adults who meet eligibility requirements under both Chafee and the ACA groups, the ACA requirements supersede Chafee option.

Other pathways to Medicaid eligibility. Within a broad range of Federal guidelines, States may offer other ways for children and youth in foster care to be eligible for Medicaid if they do not meet the criteria outlined above. These pathways are not specifically targeted for children in child welfare, and some are “optional pathways” (in contrast to the federally mandated pathways) available only in some States. The other pathways to eligibility include the following (Baumrucker et al., 2012):

- As noted above, the Federal Government requires all States to provide Medicaid coverage to children in families with incomes at or below 133 percent of the FPL or a higher income limit established by the State. Pregnant women are covered with this same income requirement. States are also required to cover parents and other caretaker relatives of dependent children (through which individuals aged 19 or older may be covered) and certain children with severe disabilities who are receiving Supplemental Security Income (SSI) from the Social Security Administration (see <http://www.medicaid.gov/medicaid-chip-program-information/by-population/pregnant-women/pregnant-women.html>).
- In some States, youth who are 19–20 years old may qualify for Medicaid under the Ribicoff pathway of optional reasonable classifications of children under 42 CFR 435.222. Each State makes its own decision about this eligibility and defines the income and other qualifications. Twenty States cover, under this provision, certain children in State- or Tribal-funded foster care who do not qualify for the mandatory Medicaid eligibility groups (especially those aged 19 or 20). Ten of those States do not apply an income limit for this group.
- A child or youth adopted from foster care and covered by an adoption assistance agreement funded solely by the State or Tribe (not IV-E) may be eligible for either Medicaid or a program with benefits equal to Medicaid if he or she is a child “who the State has determined cannot be placed with an adoptive parent or parents without medical assistance because such child has special needs for medical, mental health, or

rehabilitative care” (Social Security Act 471(a)(21) at http://www.ssa.gov/OP_Home/ssact/title04/0471.htm). Every State but one has elected to cover the optional Medicaid eligibility group for children with State- or Tribal-funded adoption assistance agreements in effect who are under age 18, 19, 20, or 21. All but three States either do not have an income test for this Medicaid group or base eligibility on whether the child was Medicaid-eligible at the time of the adoption.

Other Health-Care Coverage (Non-Medicaid)

While the great majority of children and youth in foster care are eligible for Medicaid, those who are not may be eligible for other subsidized programs or other health-care coverage. Children not in foster care but whose families are involved with child welfare may also be eligible for other kinds of government-sponsored coverage.

The Children’s Health Insurance Program (CHIP)

Like Medicaid, CHIP is a State-administered program jointly funded by the State and the Federal Government. CHIP provides free or low-cost health-care coverage to children (through age 18) whose families earn too much to qualify for Medicaid. In most States, this means that children in families with incomes above 133 percent FPL and up to 250 percent of the FPL or higher might qualify for CHIP. The Federal Government provides a website, Insure Kids Now, that describes both Medicaid and CHIP eligibility and benefits, as well as a map of all the States with links to each State’s specific Medicaid and CHIP information (visit <http://www.insurekidsnow.gov/state/index.html>).

Private and Marketplace Health-Care Coverage

The ACA has made private health-care coverage more attainable by more people and has removed some restrictions—such as denial of coverage for preexisting conditions and dollar limits on essential benefits—

that kept citizens from purchasing health insurance. Health insurance purchased through an employer or through a marketplace health exchange may be the answer to coverage for some children and youth in adoption assistance agreements, for some young adults who have aged out of foster care but do not meet eligibility requirements for the Chafee option or for Medicaid, and for some families receiving child welfare services who are not eligible for Medicaid.

Young adults who age out of care without Medicaid. Young adults who do not meet the eligibility requirements for the Chafee option (or are not living in a State that provides it) or for other Medicaid groups can purchase private health-care insurance through their employer, if employed, or through the marketplace. Those with lower incomes and larger households may qualify for plans at a reduced cost. The website [HealthCare.gov](http://www.healthcare.gov) provides a chart that shows qualifying income and household size for Medicaid and for reduced-cost private health plans: <https://www.healthcare.gov/qualifying-for-lower-costs-chart/>.

Families receiving child welfare services. While there is no special health-care coverage for families with child welfare involvement, the ACA provides new opportunities for lower-to-middle income and other families who may not have had reliable health insurance in the past. Tax credits and subsidies are also available to help make insurance more affordable for families. To explore the options for coverage made available by the ACA, visit the Federal Government's health-care website at <https://www.healthcare.gov>.

Coverage Benefits

Children need a broad spectrum of health-care coverage that includes both preventive and treatment services. Screening services are essential for the prevention and early detection of health issues. Children who enter foster care may have an even greater need for the benefits that full health-care coverage can offer. This section discusses the general benefits that Medicaid and

other health-care insurers offer to children and youth in foster care or those who have aged out of foster care.

Medicaid Benefits

State Medicaid programs offer an array of services, including mandatory services such as physician, inpatient hospital, and lab and x-ray services, as well as optional services such as dental services, physical therapy, and clinic services. As such, State Medicaid programs differ from State to State. The Medicaid website lists both the mandatory and optional services at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/medicaid-benefits.html>.

In general, the services for children and youth in foster care include preventive, screening, diagnostic, and treatment services necessary to ensure optimal physical and behavioral health.

Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). The EPSDT benefit is a mandatory service under the Federal Medicaid program and defined at section 1905(r) of the Social Security Act. EPSDT is the Medicaid program's comprehensive and preventive benefit for children and youth under the age of 21, enrolled in Medicaid. EPSDT includes the following:

- Screening services, including:
 - Comprehensive health and developmental history (including assessment of both physical and mental health development)
 - A comprehensive unclothed physical
 - Appropriate immunizations
 - Laboratory tests (including blood lead level assessment)
 - Health education (including anticipatory guidance)
- Vision services (including diagnosis and treatment for defects in vision, including eyeglasses)
- Dental services (which, at a minimum, include relief of pain and infections, restoration of teeth, and maintenance of dental health)

- Hearing services (which, at a minimum, include diagnosis and treatment for defects in hearing, including hearing aids)
- Any other medically necessary health care, diagnostic services, or treatment coverable under section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions, whether or not such services are otherwise provided in the State's Medicaid plan.

Note: States determine the individual medical necessity criteria within their State for the services listed above.

Detailed descriptions of the EPSDT services listed above can be found on the Centers for Medicare and Medicaid Services (CMS) Medicaid website at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>. The goal of EPSDT services is to identify and treat children and adolescents' health problems as early as possible (CMS, 2014). States must establish a schedule for medical, dental, vision, and hearing screenings and must ensure that enrolled children and their families are notified about the availability of screenings. Additional information on EPSDT services and requirements may be found in the *EPSDT Guide for States*, released in June 2014. See http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt_coverage_guide.pdf.

Mental/behavioral health services and trauma

services. The child welfare field has put emphasis on the identification and treatment of trauma in children and youth in foster care. As with other mental and behavioral health issues, trauma responds best to early diagnosis and individualized treatment. These kinds of services are covered under the Medicaid EPSDT benefit (see above). These services may include screening, therapy and/or counseling, medication, substance abuse treatment, and, for some children, inpatient services. On March 27, 2013, CMS issued additional information through a CMS Informational Bulletin regarding the coverage of Mental Health and Substance Use Disorder Screening under the EPSDT benefit (see <http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf>).

Additionally, in July 2013, the Administration for Children and Families (ACF), CMS, and the Substance Abuse and Mental Health Services Administration (SAMHSA) sent out a joint letter to State Directors on the topic of trauma. The letter provides background information on trauma experienced by children in foster care, discusses treatment and services for trauma, and outlines funding for services (see <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf>).

Home- and community-based services. Some health-care services that might have previously been provided in an institutional setting may now be provided in the home of a child or youth or in a community-based setting. The joint letter from ACF, CMS, and SAMHSA (2013) covers the topic of providing and funding home- and community-based services for the treatment of behavioral health issues, including trauma, for children in foster care. The letter notes that health-care coverage in the Medicaid State Plan can extend beyond the Medicaid EPSDT services; this extended coverage is granted in section 1915 of the Social Security Act (http://www.ssa.gov/OP_Home/ssact/title19/1915.htm):

“[Section 1915(i)] permits States to provide a full array of home and community-based services to individuals whether or not they qualify for an institutional level of care, as long as they have significant need. This can include individuals with mental health or substance use disorders [...] A State can also use section 1915(c) home- and community-based services waiver programs to cover similar services and serve individuals with significant needs who meet institutional level of care criteria. Examples of services and supports beyond those covered under Medicaid's EPSDT services may include psychosocial rehabilitation, respite care, transition services, and social skill development.” (ACF et al., 2013)

Waiver programs vary by State, but States can combine services available under a waiver with EPSDT services to provide comprehensive or “wraparound approach” care for children and youth with disabilities who might otherwise require institutionalization (CMS, 2014).

Benefits of Home- and Community-Based Services

In 2013, the CMS joined with SAMHSA to distribute an informational bulletin on covering the costs of behavioral health services for children and youth with significant mental health conditions who are treated with home- and community-based services, rather than in residential settings. The bulletin points to two demonstration programs that illustrate the benefits of early treatment and care that is community-based, coordinated among agencies (wraparound approach), addresses trauma, and involves peer services, among other things. The bulletin also describes how Medicaid coverage can be used to cover the costs of these intensive home- and community-based services and how these services may result in better outcomes for children and families.

The bulletin, *Coverage of Behavioral Health Services for Children, Youth, and Young Adults With Significant Mental Health Conditions* is available at <http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf>.

Psychotropic medications. The child welfare field has become increasingly concerned with the high numbers of children and youth in foster care who take prescribed psychotropic medications. A number of studies have shown that psychotropic drugs are prescribed for children and youth in foster care at a higher rate than for other children, and the combinations of drugs and the young ages at which the drugs are sometimes

administered do not always follow best practices (e.g., Government Accountability Office [GAO], 2011).

In response, the Child and Family Services Improvement and Innovation Act of 2011 required States to establish protocols for the appropriate use and monitoring of psychotropic medications with children and youth in foster care (Information Gateway, 2012). To help States develop these protocols, the Children’s Bureau issued an Information Memorandum in 2012 to promote “the Safe, Appropriate, and Effective Use of Psychotropic Medication for Children in Foster Care” (see <http://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf>). In addition, the Children’s Bureau published a booklet to help youth in foster care better understand these medications and alternatives to them: *Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care*, which is available—in both English and Spanish—on the Child Welfare Information Gateway website at <https://www.childwelfare.gov/pubs/makinghealthychoices/> (English) and <https://www.childwelfare.gov/pubs/makinghealthychoices-sp/> (Spanish).

The cost of prescribed psychotropic drugs, as well as other prescribed medications for children and youth in foster care, is generally covered as a medical benefit by Medicaid.

Reproductive and sexual health services. For a variety of reasons, teens in—or formerly in—foster care are more likely to become teenage parents than their counterparts not in foster care (Friedman, 2013). Therefore, easy access to reproductive health services is crucial for these teens.

While Medicaid benefits vary by State, family planning services are a mandatory benefit under the Federal Medicaid program. Services are required to be provided to eligible individuals of child-bearing age (including minors who can be considered to be sexually active) (section 1905(a)(4)(c) of the Social Security Act). Family planning services are defined by each State and must be consistent with overall State policy and regulation regarding the provision of family planning services.

While each State may determine specific services and supplies that will be covered under its Medicaid State plan, any definition must include services to prevent or delay pregnancy and be sufficient in amount, duration, and scope to reasonably achieve the purpose of the benefit. Examples of covered services are counseling services and patient education, examination and treatment by medical professionals, laboratory tests, and pharmaceutical supplies and devices. The services must be available to men as well as women and to individuals under age 21 eligible for EPSDT services.

Health homes. Through the optional health homes Medicaid State plan benefit, the ACA expanded treatment options for individuals with chronic medical conditions who are covered by Medicaid. States may opt to use a health home model in order to coordinate comprehensive physical and behavioral health care (including treatment for mental health and substance use disorders) and to provide linkages to long-term services and supports and social services for eligible persons. Health homes are responsible for operating under a “whole-person” philosophy, caring for both clinical and nonclinical needs. The focus of this coverage is a coordinated team-based approach to care with strong support in the community to improve health outcomes and quality of life for individuals with chronic conditions. This option may apply to youth in or formerly in foster care with serious and persistent mental illness/serious emotional disturbance or certain chronic conditions who live in States that have opted to design health homes. More information is available on the CMS site (<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html>) and on the Health Home Information Resource Center site (<http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/health-home-information-resource-center.html>). States that opt to establish health homes through Medicaid are required to submit a State plan amendment to CMS for approval.

Other services covered by Medicaid. Besides direct health services, Medicaid includes services that help a child or youth access necessary care. One example is coverage of transportation services for the child and family to a practitioner’s office. While not a 1905(a) coverable service, language translation services at a medical appointment are often another service available to beneficiaries. Although interpreter services are not classified as mandatory 1905(a) services, all providers who receive Federal funds from the U.S. Department of Health and Human Services for the provision of Medicaid services are obligated, under Title VI of the Civil Rights Act, to make language services available to those with limited English proficiency. As a result, many States elect to reimburse for translation services. For more information, CMS published a guide to help States and others understand what is covered under Medicaid for children: *EPSDT: A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf).

Health Coverage for American Indians and Alaska Natives

The ACA expanded the range of health-care options for American Indians in federally recognized Tribes and for Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders, as well as for some others of Indian descent. For American Indian children and youth in foster care, these benefits may be in addition to any already available because of the child’s foster care status. Visit the Federal Government’s Health Care website for more information about these special protections and benefits <https://www.healthcare.gov/american-indians-alaska-natives/coverage/>.

Private and Marketplace Insurance Benefits

For the few children and youth in (or formerly in) foster care who do not qualify for Medicaid, coverage through the Health Insurance Marketplace or private health insurance also covers a variety of preventive, screening, and treatment services for medical and behavioral health-care issues. The ACA requires that Marketplace plans cover 10 categories of essential health benefits (see <https://www.healthcare.gov/blog/10-health-care-benefits-covered-in-the-health-insurance-marketplace/>). Some private health-care plans available through employers are exempt from providing some of these services (Federal Register, Vol. 78, 12834; also see <https://www.healthcare.gov/coverage/what-marketplace-plans-cover>).

Preventive services. Most health insurers must provide specific preventive services for children (and adults) at no cost. Some of these services include screenings for autism, vision, hearing, developmental issues, and obesity; immunizations for childhood diseases and other diseases such as measles and hepatitis; and screenings and examinations as indicated for adolescents and teens, such as alcohol and drug use assessments, depression screenings, HIV screenings, and sexually transmitted infection counseling and screening. The full list of mandatory prevention services is available on the Federal Government’s Health Care website at <https://www.healthcare.gov/preventive-care-benefits/children/>.

Medical benefits. The ACA requires that Marketplace plans cover such medical services as pediatric care, outpatient care, hospitalization, necessary surgeries, laboratory services, prescription medications, maternity and newborn care, and rehabilitative services. Other health insurance plans are also required to include specific benefits, although “grandfathered” and self-insured plans may have some exemptions. See <https://www.healthcare.gov/coverage/what-marketplace-plans-cover/> (scroll down).

Mental/behavioral health-care benefits. Coverage for behavioral and mental health care, including substance abuse treatment services, is part of the essential services mandated by the ACA for Marketplace plans. Specifically, the ACA requires that substance use disorder screening, brief intervention, and treatment be offered in all health plans. The ACA also helps beneficiaries by expanding the 2008 Mental Health Parity and Addiction Equity Act to cover individuals who receive insurance through small employers or purchase it on the individual market (45 CFR 156.115(a)(3)). For more information, visit the HealthCare.gov website at <https://www.healthcare.gov/coverage/mental-health-substance-abuse-coverage/>.

Maternal, Infant, and Early Childhood Home Visiting Programs

The U.S. Health Resources and Services Administration (HRSA) houses the Title V Maternal and Child Health Program. While not technically a medical health program, the title V block grant funds many services that are crucial to the healthy development of vulnerable infants and children. Since 2010, title V has funded States for programs that provide home visits by health, social service, and child development professionals to vulnerable families and children. Pregnant women and families with children who are newborn to 5 years old can volunteer for the programs and qualify based on certain at-risk factors such as low income, teen parenthood, a history of child abuse or neglect, or living in an at-risk community. The programs are administered by States but locally managed and are modeled on evidence-based programs that have shown positive results for vulnerable families. Trained visitors provide guidance and advice designed to promote positive parenting, reduce child abuse and neglect, and ensure that children are healthy and ready for school.

For details, visit the HRSA webpage on these programs at <http://mchb.hrsa.gov/programs/homevisiting/>.

To learn more about the effectiveness of home-visiting programs, visit HHS’s website at <http://homvee.acf.hhs.gov/Default.aspx>.

Improving Health-Care Coverage for Children and Youth in Foster Care

Changing health-care coverage presents new options for some children and youth in foster care, as well as for those who age out of foster care. However, identifying those who are eligible, communicating the changed benefits to them, and ensuring that they receive optimal health-care coverage remains a challenge. States and jurisdictions also need to consider the different funding streams and how they can be used to achieve the best coverage for this population. This section discusses some ways that States and jurisdictions have addressed some of these issues, and it provides links to tools for helping to inform youth and families about health-care options.

State Examples of What Works

In order to meet Federal requirements and to provide optimal care for children and families receiving child welfare services, State and Tribal child welfare programs have developed a number of programs and systems related to health-care services.

Coordination and documentation of health-care services. As a condition of their title IV-B funding, States and Tribes are required to submit a plan for how they will provide oversight of health-care services for children and youth in foster care, including how they will ensure coordination with Medicaid and health-care professionals (ACF, 2010). In addition, the Social Security Act's section 475(1)(C) requires children's case plans to document their immunizations, health-care providers, and any relevant medical or behavioral conditions and treatments (http://www.ssa.gov/OP_Home/ssact/title04/0475.htm). The following are examples of how some States are meeting these requirements:

- In Arizona, CPS and Medicaid systems are set up to share data, and data are transferred nightly between systems (Golonka, 2010). Arizona also developed practice protocols for Medicaid providers regarding the health-care needs and benefits of children in child welfare (Pires & Stroul, 2013).
- Both Michigan and New Jersey place health experts onsite in child welfare agencies to help determine eligibility and coordinate care for children. Michigan places both health liaison officers and mental health clinicians in county child welfare offices, while New Jersey has Child Health Units staffed by nurses in its child welfare offices (Pires & Stroul, 2013).
- Texas is one of a number of States that have established "health passports" for children and youth in foster care. Health passports provide a way for health records and information to follow a child through different placements. In Texas, a child's electronic health passport is available to authorized providers and medical stakeholders, including caseworkers. While it does not substitute for complete electronic medical records, the health passport can give a good indication of conditions and treatments. Visit the Texas health passport website at <http://www.fostercaretx.com/health-passport/> to learn more.
- Massachusetts provides a program called Special Kids ♥ Special Care for children in foster care who have complex medical needs. Through the program, a pediatric nurse practitioner works with the foster parents, social workers, and physicians to develop an individualized health plan, coordinates the care, and makes home visits. For more information, see <http://www.mass.gov/eohhs/docs/dcf/health-med-services/summary-of-program.pdf>.

Providing health-care coverage for young adults.

The new coverage mandated by the ACA for young adults up to age 26 who have aged out of foster care ensures that most youth leaving foster care with no permanent family remain eligible for health care for a number of years. However, challenges remain, especially with identifying and enrolling eligible young adults. States providing the Chafee option have identified some best practices to ensure that youth retain their Medicaid coverage, and these practices may help States in identifying and enrolling young adults in ACA-mandated Medicaid after they have left foster care. In a report commissioned by HHS's Office of the Assistant Secretary for Planning and Evaluation, Pergamit et al. (2012) identified the following strategies:

- Collaboration between the child welfare and Medicaid systems
- Coordinated data systems that, ideally, would automatically notify Medicaid when a young adult was aging out of foster care
- Ongoing training for child welfare and Medicaid administrators
- Educating youth about how to enroll and recertify in their State, and ensuring young adults are informed about their potential eligibility

The report also notes that States will need to make decisions about whether they want the enrollment and annual recertification to be as simple as possible (requiring no or minimal youth involvement) or whether it is better to use a life skills approach that requires youth to be proactive and educated about their benefits and obligations in order to obtain those benefits (Pergamit et al., 2012).

States and advocacy groups have taken a variety of steps to identify and notify eligible young adults about the ACA health-care option. For instance, in Florida, a youth leadership group whose members are or were in foster care has been using social media to tweet about the new eligibility for Medicaid (Vestal, 2014). The Juvenile Law Center (JLC) publishes a list of State resources

and policies on this topic and updates the list as new brochures, factsheets, and webpages become available. Visit the JLC website for more information at <http://jlc.org/coveredtil26PA/applyingotherstates#stateinfo>.

American Academy of Pediatrics' Bright Futures Program

Many States look to the American Academy of Pediatrics' Bright Futures website for guidance on developing their statewide frequency and service schedules. Statewide frequency and service schedules are required for children receiving Medicaid services to ensure routine and appropriate care is being received. Bright Futures began in 1990, led by the Maternal and Child Health Bureau of the U.S. Department of Health and Human Services, to promote best practices in children's health. The Bright Futures website offers a variety of resources, including toolkits on mental health for adolescents, at <http://brightfutures.aap.org/index.html>.

With regard to reproductive health services, States that are following Bright Futures guidelines for providing EPSDT services will find a number of tools for screening and education on sexuality issues that can be used with adolescents and teens and to establish protocols for providing care (see http://brightfutures.aap.org/tool_and_resource_kit.html).

Resources for Youth and Families

Health-care coverage policies are not easy to understand for most people. Eligibility requirements and application forms may exceed the understanding of young adults who have aged out of the foster care system and may not know about or understand all of their benefits and how to access them. Those still in foster care have the advantage of professional child welfare advocates in the form of their caseworkers and, for some, their foster parents. But once they transition out, these young adults are no longer eligible for Independent Living services and the advice and guidance that accompanies them.

The following are some resources that may help older youth and young adults in or formerly in foster care and their families and foster families to better understand health-care options:

- Healthy Foster Care America (website sponsored by the American Academy of Pediatrics): <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/default.aspx>
 - Handout on transitioning out of care: <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/AgingOut%20FINAL.pdf>
- Juvenile Law Center’s list of State outreach materials: <http://jlc.org/coveredtil26PA/applyingtootherstates#stateinfo>
- *Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care* (Children’s Bureau, 2012): <https://www.childwelfare.gov/pubs/makinghealthychoices/>
- *Medicaid and CHIP FAQs: Coverage of Former Foster Care Children* from the CMS: <http://www.medicaid.gov/State-Resource-Center/Downloads/Medicaid-and-CHIP-FAQs-Coverage-of-Former-Foster-Care-Children.pdf>
- *Medicaid and CHIP FAQs: Funding for the New Adult Group, Coverage of Former Foster Care Children and CHIP Financing* from the CMS: <http://medicaid.gov/federal-policy-guidance/downloads/faq-12-27-13-fmap-foster-care-chip.pdf>
- *Shanice Explains the Importance of the Former Foster Care Provision of the Affordable Care Act* (video, 2014, Schuyler Center for Analysis and Advocacy): <http://www.scaany.org/media/video/>

What Young Adults Need to Do to Enroll in Medicaid

All young adults who were enrolled in Medicaid when they aged out of foster care are eligible for Medicaid until age 26. This is true even if there has been a gap in their coverage. They are eligible in the State in which they were enrolled when they aged out. (Some States also cover out-of-State young adults.) To enroll:

1. Contact your State Medicaid office. You can find out how to contact them by typing your State into the box at this website, <https://www.healthcare.gov/medicaid-chip/eligibility/>, or you can find your State Medicaid director at <http://www.medicaiddirectors.org>.
2. Tell them you are a youth who aged out of foster care and you want to sign up for Medicaid.
3. Another option is to contact your State’s Independent Living (IL) services coordinator. Find your State’s IL coordinator on the Information Gateway resource list at https://www.childwelfare.gov/organizations/?CWIGFunctionaction=rols:main.dspROL&rolType=Custom&RS_ID=38.

Resources for Child Welfare Agencies

The following list is a selection of resources on providing health-care coverage to older youth in or formerly in foster care:

- *The Affordable Care Act and Youth Aging Out of Foster Care: New Opportunities and Strategies for Action* (Emam & Golden, 2013, State Policy Advocacy and Reform Center): <http://childwelfareparc.org/wp-content/uploads/2014/07/3-The-Affordable-Care-Act-and-Youth-Aging-Out-of-Foster-Care.pdf>
- *Child Welfare Funding Opportunities: Title IV-E and Medicaid* (Valentine, 2012, First Focus): <http://firstfocus.org/resources/report/child-welfare-funding-opportunities-title-iv-e-and-medicaid/>
- *EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (CMS, 2014): http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf
- *Making Medicaid Work for Children in Child Welfare: Examples From the Field* (Pires & Stroul, Center for Health Care Strategies): http://www.chcs.org/media/Making_Medicaid_Work.pdf
- *Medicaid and Children in Foster Care* (Allen & Hendricks, 2013, State Policy Advocacy & Reform Center): <https://childwelfareparc.files.wordpress.com/2013/03/medicaid-and-children-in-foster-care.pdf>
- *Medicaid Outreach Toolkit* (Walz & Chapman, 2013, State Policy Advocacy & Reform Center), a toolkit that provides sample social media messages, links to resources for youth, and strategies for reaching out to youth about their health-care benefits: <http://childwelfareparc.org/wp-content/uploads/2013/09/SPARC-Medicaid-Outreach-Toolkit.pdf>
- *Medicaid to 26 for Youth in Foster Care: Key Steps for Advocates* (2013, State Policy Advocacy & Reform Center): <http://childwelfareparc.org/wp-content/uploads/2013/09/Medicaid-to-26-for-Youth-in-Foster-Care.pdf>

- State contacts for CMS and EPSDT: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt-contacts.pdf>
- *Working With Youth to Develop a Transition Plan* (Child Welfare Information Gateway, 2013): <https://www.childwelfare.gov/pubs/transitional-plan/>

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