

Medicaid Managed Care for Children in Child Welfare

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Children in the child welfare system have an extremely high prevalence of physical and behavioral health problems. This issue brief examines the complex physical and behavioral health care needs and associated costs for children in child welfare and outlines critical opportunities and challenges within Medicaid to better manage care for this high-risk, high-cost population.

Background

Children typically enter the child welfare system after a report of suspected child abuse or neglect. In 2005 approximately five million children in the United States were involved in the child welfare system, with as many as 800,000 children in foster care.¹ Depending on the circumstances, children might remain at home under supervision of the child welfare agency, be in a subsidized adoption, or be placed in out-of-home foster care, kinship care, or other residential programs. These children have an understandably high level of psychosocial needs, but are also highly likely to have chronic physical and behavioral health problems.^{2,3} Access to physical and behavioral health services varies drastically, with some youth receiving too much or disjointed care, and others receiving too little care. Medicaid's costs for these children are disproportionately large relative to this population's share of Medicaid enrollment.⁴

Over the past decade, state Medicaid agencies have increasingly used managed care approaches to improve the delivery of physical and behavioral health services for the child welfare population. Currently 30 states, including Puerto Rico, enroll children in child welfare in Medicaid managed care programs.⁵ Managed care organizations are in a unique position to improve physical and behavioral health care for children in child welfare. In particular, collaborative relationships among managed care organizations and Medicaid, mental health, and child welfare agencies can help provide higher-quality, more efficient, and better coordinated care.

There is one caveat that must be stated up front: Medicaid expenditure data are reported only for children in foster care and those in a subsidized adoption for whom a Title IV-E eligibility payment has been made — effectively half of those involved in child welfare at a point in time. While much of the data herein reflects the experience of children in foster care, the majority of children in the child welfare system — approximately 80 percent — are not in foster care.⁶ However, the complex physical and behavioral health needs of children in foster care are representative of those facing the broader child welfare population.

Health-Related Needs and Costs of Children in Child Welfare

Prevalence of Physical Health Needs

A 2005 national study examining children entering child welfare found that nearly 90 percent had physical health problems, with more than 55 percent having two or more chronic conditions.⁷ An assessment of children entering foster care found that an estimated 25 percent have three or more chronic conditions.⁸ Common problems include asthma, vision and hearing problems, malnutrition, skin abnormalities, anemia, failure to thrive, dental caries, and manifestations of abuse.

This issue brief, made possible through support from the Annie E. Casey Foundation, describes the complex needs of children in child welfare and outlines how states and health plans can customize managed care to effectively and appropriately meet their needs.

Prevalence of Behavioral Health Needs

A 2004 national survey found that nearly half of children ages 2-14 years — for whom child welfare investigations had been completed — had clinically significant emotional or behavioral problems.⁹ Up to 50 percent of children entering foster care were found to have significant emotional and behavioral health problems, yet only 25 percent of children with a diagnosis received any mental health care during the prior year.¹⁰ Problems range from relational and coping difficulties to emotional and behavioral disturbances, most commonly including conduct disorder, attention disorder, aggressive behavior, and depression.¹¹

Medicaid Expenditures for Children in Child Welfare

Medicaid expenditures for children in foster care are disproportionately large, relative to their share of Medicaid enrollment. On average states spend three times more for this population than for non-disabled children in Medicaid — approximately \$4,336 for children in child welfare versus \$1,315 for the general child population without disabilities.¹² In California, for example, Medicaid-eligible children in foster care accounted for 53 percent of all psychological visits, 47 percent of psychiatry visits, 43 percent of the public hospital inpatient hospitalizations, and 27 percent of all psychiatric inpatient hospitalizations among the program's entire child population.¹³ A Pennsylvania study found that Medicaid mental health-related expenditures for children in foster care are nearly 12 times greater than costs for non-foster children. This study found that utilization rates, expenditures, and prevalence of psychiatric conditions for children in foster care were comparable to those of children with disabilities (i.e., children receiving Supplemental Security Income), suggesting that reimbursement rates and care management for children in foster care need to be reexamined to ensure adequacy given the intensity and types of service needs.¹⁴

Challenges of Managing the Care of Children in Child Welfare

Environmental instability is too often a fact of life for children in child welfare, thus limiting their access to appropriate physical and behavioral health services. The care they receive is typically disjointed and sporadic due to frequent and sometimes abrupt changes in child welfare supervision, living arrangements, program eligibility, and lack of coordination with physical and behavioral health plans and providers.

Children in child welfare systems may churn in and out of Medicaid managed care eligibility depending on the administrative practices in a given state or county program. The role of the court in determining service plans and the focus on achieving placement permanency can complicate the delivery of health and behavioral health-related services. Child welfare case workers play a critical role in helping children and their families access necessary services and supports. Frequent case worker turnover, however, undermines the ability to coordinate consistent care, adequately supervise and follow-up on children, and, perhaps most importantly, to forge trusting relationships. The central role of the family in ensuring a child's access to and follow-up with care is often complicated by the array of family members — including birth, kin, foster, guardian, and adoptive families — who need to be involved in the child's care.

Children in child welfare are more likely to be involved in multiple child-serving public systems, such as juvenile justice, public mental health, and special education. Lack of formal communication mechanisms among these agencies, Medicaid, and the child welfare agency impedes the ability to provide coordinated care. Furthermore, the lack of sufficient home- and community-based behavioral health and child psychiatric service capacity in virtually every state presents additional barriers to appropriate care.

As indicated by the federal Child and Family Services Reviews (CFSR), child welfare agencies across the country are not meeting federal well-being standards. Since the CFSR process was begun in 2001, only one state — Delaware — achieved a rating of “substantial conformity” in meeting the physical and behavioral health needs of the children in its care.¹⁵ These system shortcomings have even greater consequences for children in racial and ethnic minority groups who are disproportionately represented in the child welfare population and are more likely to experience poor health status.¹⁶

Legislative Challenges: Medicaid Financing of Services for Children in Child Welfare

Two of the services most frequently used by children in child welfare are optional under Medicaid — targeted case management and rehabilitative services. At least 40 states include one or both of these services in their state Medicaid plans to better address the needs of children in child welfare, especially those with behavioral health needs. Yet these two services are at the center of a national debate on federal reinterpretation of Medicaid policy that could severely restrict the ability of states to provide these services to children in child welfare.

Targeted case management (TCM) assists eligible beneficiaries in gaining access to needed medical, social, educational, and other services. Nearly 40 states currently offer targeted case management benefits for foster children.¹⁷ On December 4, 2007, the Centers for Medicare & Medicaid Services (CMS) issued an interim final rule that implements Deficit Reduction Act (DRA) changes regarding targeted case management services. If this proposed rule is implemented, it would be very difficult to provide targeted case management to children in child welfare who are eligible for this service under Medicaid. Maine, Maryland, New Jersey, and Oklahoma have filed a joint lawsuit challenging this CMS rule.

The Medicaid Rehabilitative Services (rehab) option, which allows states to tailor community-based care to address specific physical and/or mental disabilities, seeks to ensure that those covered by the benefit can achieve their best possible functioning level. States that include the rehab option in their state Medicaid plan are eligible to receive partial federal reimbursement for behavioral health services and supports such as crisis services, in home services, respite and similar supportive services that are provided in the community rather than in institutional settings. In the Notice of Proposed Rulemaking, CMS specifically states that the Medicaid Rehabilitative Services benefit should not be used for services already included in the provision of foster care, such as case planning. In this proposed rule, CMS maintains that therapeutic foster care is not considered a medically necessary service under Medicaid, which would require unbundling of the components of the service to distinguish what CMS deems as Medicaid-reimbursable services from those that are deemed as not reimbursable.

The House recently approved legislation to delay the implementation of both the TCM and rehab option rules, among five others, until April 2009. Similar legislation is pending in the Senate.

An analysis of the CFSTRs for 35 states identified common challenges faced by child welfare agencies in improving outcomes for children.¹⁸ Common hurdles included an insufficient number of doctors and dentists willing to accept Medicaid and a lack of mental health services for children, as well as agency inconsistency in providing preventive health and/or dental services and in conducting appropriate and timely physical and mental health assessments. A subsequent 2007 analysis of state CFSTRs indicated that in each of the 52 programs reviewed, the child welfare system had an urgent need to reform its approach to mental health services.¹⁹ Encouragingly, nearly all of those programs addressed this need in their improvement plans with many proposing to bring mental health staff onto their teams.

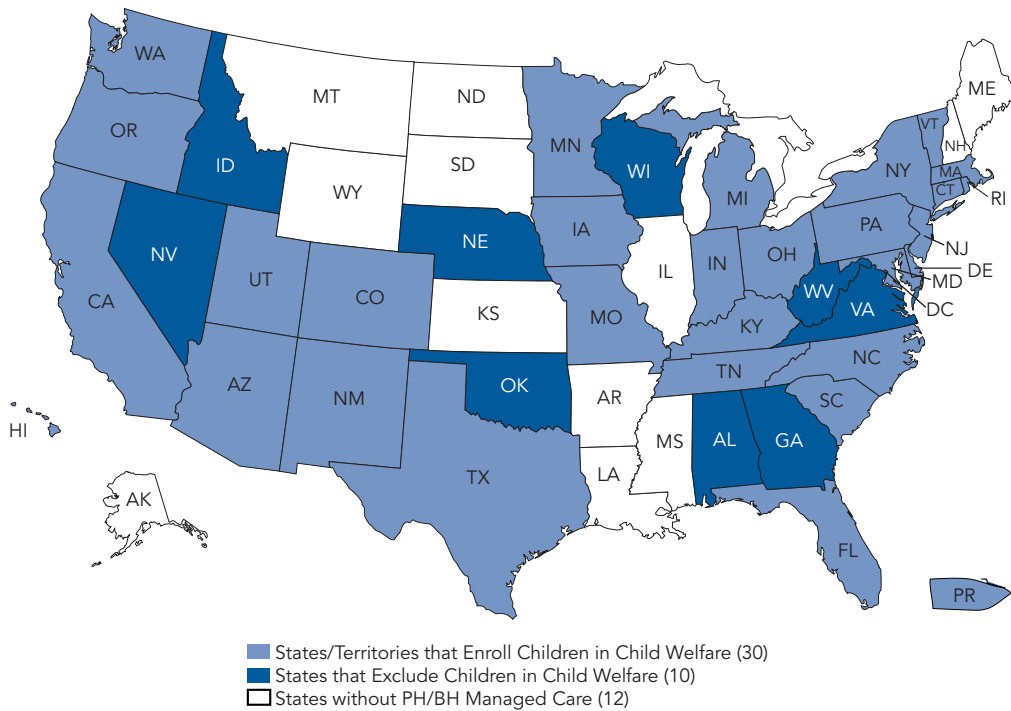
Use of Managed Care within Child Welfare

Managed care delivery systems that use appropriate care management, financing mechanisms, utilization review, and information systems are uniquely positioned to improve access and provide coordinated care for populations with complex needs, including children in child welfare. During the past decade, states have taken advantage of the flexibility provided under waiver authority and more recently by the Balanced Budget Act of 1997 (BBA) to enroll the child welfare population into managed care. As of 2007, 30 states, including Puerto Rico, were providing physical and behavioral health services to the child welfare population through managed care²⁰ models on either a voluntary or mandatory basis, with only 10 states explicitly excluding this population from their managed care programs.²¹

Approaches to Managed Care for Children in Child Welfare

Children in foster care may be enrolled mandatorily in managed care only under the authority of a federal waiver. The BBA, however, granted states the authority to mandatorily enroll non-foster care children — and to enroll foster children voluntarily — through the less onerous process of a Medicaid state plan amendment. This greater flexibility has encouraged more states to enroll children in child welfare in managed care arrangements. Programs initiated under the BBA have used private, not-for-profit, and in some instances, governmental managed care organizations to organize, administer, and deliver care to the child welfare population. These programs essentially serve as “population carve-outs” from the general Medicaid managed care program. Other states have created

Figure 1: Managed Care for Children in Child Welfare



Source: National Summary of State Medicaid Managed Care Programs (as of June 30, 2006). Centers for Medicare and Medicaid Services. www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/nationalsummrport06.pdf.

special managed care programs to meet the health needs of either part of or the entire child welfare population. Currently, Florida and Tennessee have special needs programs in place and Texas launched a managed care program for foster children in March 2008. Wisconsin has specialized managed care programs for subsets of the child welfare population in two counties.

Services such as timely screening and assessments for physical, behavioral and/or oral health needs that are relevant for children in child welfare — and are often required under state child welfare regulations — are typically not found in standard Medicaid managed care contracts. In 2001, the George Washington University Center for Health Services Research and Policy, in consultation with the federal Substance Abuse and Mental Health Services Administration, published *Optional Purchasing Specifications: Medicaid Managed Care for Children in Substitute Care*.²² The purchasing specifications were developed through a consensus process that included purchasers, managed care organizations, providers, consumers, and advocates. The contract language recommendations clearly outline the roles, responsibilities, and compliance measures associated with the provision of physical and behavioral health services to children in out of home placements. Operational issues related to enrollment, initial screening and assessment, case management, assignment to a primary care provider, standards for access, relationship to other agencies (i.e., the child welfare agency), and data collection, reporting and confidentiality are addressed in the sample contract specifications.

At-a-Glance: State Managed Care Approaches for Child Welfare Populations

Following are examples of state programs designed for the child welfare population:

- **Florida:** This managed behavioral health care program is designed to meet the needs of an estimated 40,000 children in the state's child welfare system. The managed care entity administering the program contracts with the community-based care organizations that provide child-welfare services.
- **Tennessee:** This statewide managed care program is designed to meet the physical health care needs of children in child welfare. The program's "Best Practice Unit" supports the special primary care network of providers developed to serve as "medical homes" for the child welfare population.
- **Texas:** This managed care program, launched in March 2008, is a statewide integrated delivery system designed to meet the health and behavioral health care needs of foster care children.

Whether operating under a waiver or the BBA, managed care programs designed for children in child welfare may forge close relationships with child welfare agencies, employ dedicated child welfare liaison staff, establish a specialized provider network, and offer case management services for the highest-risk children. Some have also established close relationships with family, consumer, and natural helper networks. Some managed care programs incorporate risk adjustment mechanisms, including risk-adjusted capitation rates and/or case-rate financing tied to outcomes. By focusing on this group of high-need, high-cost children, managed care programs have a significant and unique opportunity to establish medical homes, create a locus of care management accountability and improve quality and outcomes.

Program Design Considerations for Child Welfare Populations

Children in the child welfare system can benefit greatly from managed care approaches that coordinate their complex physical and behavioral health needs. The Child Welfare League of America identified a set of tasks for managed care organizations to effectively serve children in foster care,²³ and the Child Welfare Impact Analysis (part of the Health Care Reform Tracking Project)²⁴ proposed several criteria that should be in place to meet the needs of this population. Both of these emphasize the need for states and managed care organizations to address barriers that may impede effective managed care delivery. Following are key considerations identified by CHCS for states that are developing managed care approaches for the child welfare population:

- **Develop Risk-Adjusted Financing Mechanisms.** A 2003 study by the Health Care Reform Tracking Project found that only 10 percent of managed care programs surveyed had used risk-adjusted rates for the child-welfare population.²⁵ As appropriate, risk-adjusted mechanisms should be used to better reflect the potentially high costs and elevated service needs of this population.
- **Identify Non-Foster Children.** States are constrained by the available data in Medicaid enrollment files and are often unable to identify Medicaid-eligible non-foster children in child welfare and to report on their service utilization. This is primarily due to the lack of Medicaid enrollment codes that map appropriately to the different categories of child welfare status. Determining how to identify this high-risk group can ensure more appropriate and timely health care services and potentially avoid placement disruption or use of more costly services.
- **Establish Appropriate Data-Sharing Protocol.** The exchange of health-related data across systems is an essential element for care coordination. Appropriate data-sharing agreements need to be in place to protect the privacy of children and families and to ensure that their medical information is handled judiciously and used only for the purpose of providing the most appropriate care.

Critical Considerations for Health Plans Serving Child Welfare Populations

When provisions are in place that address the issues outlined above, managed care plans can develop programs that appropriately tailor care for child welfare populations. Through the *Improving Outcomes for Children Involved in Child Welfare* national initiative (see description last page), CHCS has identified important considerations for managed care organizations to ensure that programs meet the needs of the child welfare population. The following issues can be addressed in contracts and memoranda of understanding among state purchasers, plans, and their subcontractors.

Leverage Existing Mandates

- Work collaboratively with state Medicaid and state or local child welfare agencies to improve outcomes for members in the child welfare system.
- Recognize the relevance of the federal Child and Family Services Review's well-being assessment for the state and use its goals to engage the child welfare agency.
- Partner with other child welfare agencies and organizations to ensure the timely provision of information related to required screenings and services to birth, kinship, foster, guardian, and adoptive families as appropriate.

At-A-Glance: Promising Program Design for the Child Welfare Population

Following are brief descriptions and outcomes for two managed care programs for children in child welfare:

Wraparound Milwaukee: Since 1995, this county-based managed care program has served children in either the child welfare or juvenile justice systems who have serious behavioral health needs placing them at-risk of being placed in a residential treatment program. It uses both capitation and case rate financing from multiple payers including Medicaid, mental health, child welfare, and juvenile justice. Recently the county department of education contracted with Wraparound Milwaukee to provide a similar set of services to a special needs group of children at risk for special education involvement referred from the county schools.

OUTCOMES: Data from this program show that children have significantly reduced lengths of stay in intensive levels of treatment, show improved clinical and functional outcomes, have fewer school absences, and high levels of family satisfaction.²⁶ The program accrues significant cost savings to the public purchasers (Medicaid, child welfare and juvenile justice) which fund its services by effectively treating children, avoiding deep-end placements, and increasing community safety by reducing subsequent involvement in the juvenile justice system.

Mental Health Services Program for Youth (MHSPY): This program, operated by Neighborhood Health Plan of Massachusetts since 1998, provides a physical and behavioral health home and care management services for children in child welfare who are at high risk for residential treatment and hospital care. Initially launched in two Massachusetts communities, MHSPY has expanded to serve children in five areas in and around Boston. It uses case rate financing from multiple state purchasers including Medicaid, mental health, child welfare, education, and juvenile justice to integrate physical and behavioral health care and social supports.

OUTCOMES: Children involved in the program have shown improved scores on a number of tests measuring symptoms, problem behavior, and ability to function; three-fold reductions in hospitalizations and residential care; a near three-fold reduction in the use of foster care; and significant cost savings for the public purchasers financing the MHSPY services.²⁷

Information Sharing

- Request data-sharing agreements that meet state and federal privacy standards, including HIPAA, but also allow for the flow of information among relevant agencies. Similarly, state regulations should allow the appropriate sharing of information among various stakeholders.

Knowledge of the Child Welfare Population

- Ensure that processes for accessing services are tailored to the unique needs of children and families involved in child welfare, and take into account the likelihood that the physical residence of the child may change at any time.
- Offer continuing education to ensure that providers understand the importance of specific services to this population, the unique role — and different constellations — of family, the provision of legally-mandated services within required timeframes, and the availability of evidence-based practices.

Customized Access Mechanisms

- Provide expedited access to primary care and behavioral health providers for members in the child welfare system.
- Implement effective referral and tracking mechanisms to ensure that needed services are authorized and provided in a timely fashion.
- Ensure that the provider network includes non-traditional providers who have experience working with children in child welfare.

Adequate Financing

- Negotiate adequate rates with state and local purchasers to administer and provide care.

Conclusion

Children in child welfare often have an array of unmet needs, including chronic social, physical, and behavioral health issues. Yet, as this brief illustrates, these children may not receive appropriate and timely care due to the frequent changes in placement and care transitions. Failure to anticipate the high need for services among these children can potentially lead to over utilization and related high costs for emergency room, hospital, residential treatment, and/or pharmacy services. This group of children, who so often do not receive the attention they deserve, can benefit greatly from care management programs that customize care. By focusing on this often neglected population, states and health plans can improve access and care coordination, potentially control costs and better allocate limited resources by avoiding unnecessary utilization, and, ultimately, improve health outcomes for at-risk children.

Endnotes

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- 4 *Fiscal Year 2004 National MSIS Tables, Table 4: FY 2004 Medicaid Eligibles by Basis of Eligibility*. Centers for Medicare and Medicaid Services. Available at: <http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/msisables2004.pdf>. Note: 2004 Medicaid data indicated that of the program's nearly 28 million child beneficiaries, only three percent were foster children.
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About the Center for Health Care Strategies

The Center for Health Care Strategies is a nonprofit health policy resource center dedicated to improving the quality and cost effectiveness of health care services for low-income populations and people with chronic illnesses and disabilities. CHCS works with state and federal agencies, health plans, and providers to develop innovative programs that better serve people with complex and high-cost health care needs.

CHCS' *Improving Outcomes for Children Involved in Child Welfare* initiative, a 24-month national collaborative made possible by the Annie E. Casey Foundation, is working with 10 managed care organizations to enhance the delivery of physical and mental health care for children in child welfare. The participating plans are developing and piloting promising approaches to meet the health and behavioral care needs of the nearly 100,000 children and youth in the child welfare system in their membership. Quality focus areas include medical home implementation, appropriate use of psychotropic medications among children in child welfare, and coordination of care across physical and behavioral health domains. Approaches developed by the organizations participating in the *Improving Outcomes for Children Involved in Child Welfare* that prove innovative and effective will be disseminated publicly.

For more information and related resources, visit www.chcs.org.

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