ACF Administration for Children and Families	**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES** **Administration on Children, Youth and Families**	
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INFORMATION MEMORANDUM

To: States and Indian Tribes, Indian Tribal Organizations or Indian Tribal Consortia Administering or Supervising the Administration of titles IV-B and IV-E of the Social Security Act.

Subject: Linking health care to children, youth, and families who come in contact with the child welfare system.

Related References: Sections 422(b)(15), 471(a)(21), 472(h)(2), 473(b)(1), 473(b)(3), 473A(b)(4), 475(5)(H), 475(8)(B), and 477(b)(3) of the Social Security Act; ACYF-CB-PI-10-10; ACYF-CB-PI-10-11; Public Law (P.L.) 111-148 (The Patient Protection and Affordable Care Act).

Purpose: This Information Memorandum (IM) provides information to title IV-B and title IV-E agencies regarding ways in which children, youth, and families who are involved with the child welfare system may be eligible for health insurance coverage under title XIX (Medicaid), the Children's Health Insurance Program (CHIP) and health care coverage under the Patient Protection and Affordable Care Act (ACA).

Background: Under the ACA, millions of Americans have access to quality, affordable health insurance coverage. Title IV-B and IV-E agencies can play a vital role in ensuring that children, youth, and families who come in contact with the agency are either enrolled in the title XIX program (Medicaid) or provided resources that help them apply for affordable private health care coverage through either state or federal health insurance Marketplaces.

Many of the children, youth, and families who come into contact with title IV-B/IV-E agencies have physical and mental health needs that, if treated, may help improve their safety, permanency and well-being outcomes. In July, 2012, the Congressional Research Service reported that between 35 and 60 percent of children entering foster care have at least one chronic

or acute physical health condition that needs treatment.[1] As many as one-half to three-fourths of children entering foster care have behavioral or social competency problems that may warrant mental health services.[2] Just over half of children adopted from foster care have special health care needs and 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.[3]

Appropriately assessing and addressing the health and mental health needs of the children, youth, and families involved with title IV-B/IV-E agencies is an essential component of an effective child welfare system. The Children's Bureau (CB) monitors how states perform in the area of child and family well-being through the Child and Family Services Reviews. As part of this review, CB determines how states perform on the following measures:

- Well-Being Outcome 1: Families have enhanced capacity to provide for their children's needs
- Well-Being Outcome 3: Children receive adequate services to meet their physical and mental/behavioral health issues.[4]

We encourage title IV-B/IV-E agencies to review the information in this IM and consider whether their child welfare practices and procedures can be strengthened to better facilitate family or child's access to such health care coverage, and how access to health care may prevent children from entering out of home care or other agency involvement and facilitate reunification and other permanency options.

I. Health care coverage for children and youth involved in the child welfare system prior to the ACA.

Medicaid coverage continues to play an important role in providing health care services to children served by title IV-B/IV-E agencies. Information collected between October 2009 and January 2011 indicates that nearly all children living in formal kin care (96.5 percent), foster care (94.3 percent), or residential treatment settings (98.6 percent) had Medicaid coverage.[5] Children who are in or have been in foster care may be eligible for Medicaid through the following eligibility pathways:

- Categorical Medicaid eligibility for children receiving title IV-E. Under title IV-E of the Social Security Act (the Act), a child or youth on whose behalf title IV-E foster care maintenance payments or guardianship assistance payments are made, or who is

[1] Congressional Research Service. (July 24, 2012). *Child Welfare: Health Care Needs of Children in Foster Care and Related Federal Issues.* Report for Congress retrieved from: http://greenbook.waysandmeans.house.gov/sites/greenbook.waysandmeans.house.gov/files/2012/R42378_gb.pdf
[2] Ibid.
[3] Ibid.
[4] For more information on the CFSRs, see http://www.acf.hhs.gov/programs/cb/monitoring/child-family-services-reviews
[5] Office of Planning, Research and Evaluation, Administration for Children and Families (ACF), U.S. Department of Health and Human Services. (July 16, 2012) *National Survey of Adolescent and Child Wellbeing II Wave 2 Report: CHILDREN'S SERVICES.* Retrieved from http://www.acf.hhs.gov/programs/opre/resource/nscaw-ii-wave-2-report-childrens-services

subject to a title IV-E adoption assistance agreement is categorically eligible for the title XIX Medicaid program, including a youth up to age 21 per section 475(8)(B) of the Act. Such a youth is eligible for Medicaid (if available for such youth) whether or not the title IV-E agency in the state of residence has taken the option to provide extended assistance per section 475(8)(B) of the Act. See sections 472(h)(1) and 473(b) of the Act; ACYF-CB-PI-10-11; and Child Welfare Policy Manual (CWPM) section 8.2B.8.

- Medicaid for a child of a minor parent or child of a youth over age 18 in foster care. A child of a minor parent or youth age 18 or older in foster care whose costs are covered by the title IV-E foster care maintenance payment is categorically eligible for the Medicaid program in the state of residence, regardless of whether the title IV-E agency in the state of residence has also elected to extend title IV-E assistance to youth up to age 21 per section 475(8)(B) of the Act. See section 472(h)(2) of the Act; ACYF-CB-PI-10-11; and CWPM Section 8.3A.5.

- Medicaid for state or tribal funded foster care. Non-IV-E eligible foster children in state or tribal funded foster care may also be eligible for Medicaid consistent with the Social Security Act.[6] Most children under age 19 who are in foster care but not receiving foster care maintenance payments under title IV-E of the Act are eligible for Medicaid because usually only the child's income is considered for eligibility. Also, states' Medicaid income limit for children under age 19 is at least 133 percent of the federal poverty level (FPL). If a child receives Supplemental Security Income (SSI) benefits, the child is often Medicaid eligible on that basis. If a child is age 19 or 20 and lives in one of the states (29 of them as of July 2015) which has expanded Medicaid by covering the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act, the child is usually eligible under this group (if not eligible for the former foster care group or another mandatory group), because the income limit is 133 percent FPL. As of August 2015, 20 states cover non-IV-E foster care children as an optional reasonable classification of children under Medicaid, in accordance with 42 CFR 435.222, and 10 of these states do not have an income test for such children.

- Health Insurance for state or tribal funded adoption assistance agreements. As a condition of receiving title IV-E federal financial assistance, states and tribes must provide health insurance coverage with the same kind of benefits as Medicaid for children with special needs who also have special medical, mental health or rehabilitative care needs and with whom the state or tribe enters an adoption assistance agreement with adoptive parents on the child's behalf. In both instances, the child has to be determined to have special needs. See sections 471(a)(21) and 1902(a)(10)(A)(ii)(VIII) of the Act. As of August 2015, two states had not elected to cover this Medicaid group. Nineteen states do not have a Medicaid income test for this group, 27 require that the child was Medicaid-eligible when adopted, and 3 have an income limit for this group.

[6] Congressional Research Service. (July 24, 2012). Child Welfare: Health Care Needs of Children in Foster Care and Related Federal Issues. See pages 6-7. Report for Congress retrieved from: http://greenbook.waysandmeans.house.gov/sites/greenbook.waysandmeans.house.gov/files/2012/R42378_gb.pdf

- Former foster care children. The ACA required states, effective January 1, 2014, to cover the former foster care group under section 1902(a)(10)(A)(i)(IX) of the Act. This Medicaid eligibility group provides full Medicaid coverage to individuals with no income test up to age 26 if they were in foster care and enrolled in Medicaid when they attained either age 18 or any higher age that IV-E foster care ends in that state.

- Chafee Medicaid option. Under the Chafee Foster Care Independence Act of 1999, states have the option to provide expanded Medicaid coverage to youth up to age 21 or any lower age elected by the state, who were in foster care when they attained age 18 (the Chafee option).[7] See 42 U.S.C. 1396(a)(10)(A)(ii)(XVII).[8] This eligibility group is less important now that a similar population is covered under the mandatory former foster care group.

II. Provisions for children youth and families involved with the child welfare system under the ACA.

President Obama signed the ACA into law on March 23, 2010. Several provisions of the law directly impact children, youth, and families involved with child welfare agencies. Specifically, the ACA:

- Requires health care services coordination and transition planning for children in foster care. States and tribes receiving title IV-B, subpart 1, must develop a Health Care Oversight and Coordination Plan for children in foster care.[9] The ACA now requires that the plan also include as part of the transition planning process: options for health insurance and information about a health care power of attorney, health care proxy, or other similar document recognized under state law. The title IV-B/IV-E agency must also provide the child with the option to execute such a document. See ACYF-CB-PI-10-10; ACYF CB-PI-14-04; and ACYF CB-PI-14-03 for more information.

- Requires health care education in transition planning for older youth in foster care. Prior to a youth's emancipation from foster care, title IV-B/IV-E agencies are statutorily required to develop a transition plan that is personalized. The ACA now requires that the plan also include "information about the importance of designating another individual to make health care treatment decisions on behalf of the child if the child becomes unable to participate in such decisions and the child does not have, or does not want, a relative who would otherwise be authorized under state law to make such decisions, and provides the child with the option to execute a health care power

[7] Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. (November 2012) *Providing Medicaid to Youth Formerly in Foster Care under the Chafee Option: Informing Implementation of the Affordable Care Act*. Retrieved from aspe.hhs.gov/hsp/13/ChafeeMedicaidReport/rpt2.cfm

[8] As of August 2015 30 states provide the Chafee option, and 26 of them have no income test for this group. Under this provision for the Chafee option, states have the option either to not have an income test or to place a limit on income the youth may have (as long as the level is not lower than that established by the state for eligibility of parents and other caretaker relatives under section 1931 of the Act

[9] Section 422 (b)(15) of the Social Security Act.

of attorney, health care proxy, or other similar document recognized under state law." See section 475(5)(H) of the Act and ACYF-CB-PI-10-10; ACYF CB-PI-14-04; and ACYF CB-PI-14-03 for more information.

- Requires health care education for older youth under the Chafee Foster Care Independence Program. The ACA amended section 477(b)(3) of the Act to require title IV-B/IV-E agencies to ensure that an adolescent participating in the Chafee program is provided with education about the importance of designating another individual to make health care treatment decisions on behalf of the adolescent if the adolescent becomes unable to participate in such decisions and the adolescent does not have, or does not want, a relative who would otherwise be authorized under state law to make such decisions, whether a health care power of attorney, health care proxy, or other similar document is recognized under state law, and how to execute such a document if the adolescent wants to do so." See ACYF-CB-PI-10-10 for more information.

- Provides Medicaid eligibility for former foster youth up to age 26. The ACA provides mandatory Medicaid coverage to individuals who are under the age of 26, were in foster care at age 18 or such higher age (up to 21) as elected for termination of title IV-E foster care assistance, and were enrolled in Medicaid or under a waiver of the plan while in foster care (former foster youth provision).[10]

- Provides prevention services. All Marketplace health plans and many other plans must cover a wide range of preventative services for children. Some of those include:
    - Behavioral assessments for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years,
    - Depression screening for adolescents,
    - Developmental screening for children under age 3,
    - Medical History for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years , 5 to 10 years , 11 to 14 years , 15 to 17 years[11].

In addition, health coverage under the ACA prohibits most health insurance plans that cover children from excluding, limiting or denying coverage to a child under age 19 solely based on a health problem or disability that the child developed before applying for coverage.

Although not new under the ACA, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is Medicaid's comprehensive preventive child health service. The EPSDT benefit is included in this discussion of preventive services because Medicaid continues to be an important source of reimbursement for services and support to children and youth who have experienced complex trauma and have behavioral health

[10] Section 1902(a)(10)(A)(i)(IX) of the Social Security Act.
[11] *What are my preventative care benefits?* Retrieved from https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=3

needs requiring treatment. EPSDT benefits apply to Medicaid-eligible children under age 21, and include Medicaid reimbursement for covered services.[12]

- Provides the option to expand Medicaid for adults under age 65. Former foster youth who do not qualify for health coverage under either the Chafee option or the former foster youth provision may be able to access health coverage through the 'Medicaid expansion' for certain adults under age 65. The ACA provides states with the option of additional federal funding to expand their Medicaid programs to cover adults under 65 who make up to 133 percent of the federal poverty level.

- Provides access to health insurance Marketplace coverage. Former foster youth who do not qualify for health coverage under either the Chafee option, the former foster youth provision, or the Medicaid expansion, may qualify for low cost private health insurance plans through the health insurance Marketplace. Young adults that are not eligible for Medicaid and have an income of more than 100% of the federal poverty level may buy a private health insurance plan in the Marketplace and may get lower costs based on household size and income. See https://www.healthcare.gov/what-if-my-state-is-not-expanding-medicaid/ for more information.

- Provides funding for maternal, infant and early childhood home visiting programs. Federal funds will help states expand home visiting programs, which recent research demonstrates can prevent child abuse and neglect, and reduce the need for foster care placement. These programs are also expected to improve the coordination and referrals for other community resources and supports, which include improving access to health care for pregnant and parenting mothers and their children living in high risk communities. See http://mchb.hrsa.gov/programs/homevisiting/ for more information.

- Provides funds to create health homes. Federal funds are available to create "Health homes" for children and adults with chronic health conditions (including mental health conditions and substance abuse) in order to provide coordinated and person-centered health care and social services. Creating health homes, which include children in out-of-home placements among others with chronic health conditions, helps ensure their health needs are addressed with a trauma-informed, flexible and coordinated approach to referring individuals to evidenced-based practices and services unique to the needs of each participant.[13]

- Increases flexibility to provide home and community-based services. The Deficit Reduction Act established and the ACA amended Medicaid state plan home and community-based services (HCBS) under section 1915(i) of the Act.[14] Under this Medicaid authority, since 2007, states have been able to cover HCBS as a state plan

[12] Ibid.
[13] See *Health Homes* retrieved from http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html; see also http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-11-23-11.pdf;
[14] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html

option. Now, as a result of the ACA, states will have greater flexibility to cover HCBS for targeted populations such as children and youth if they choose to exercise this option.

- Extends CHIP and increases CHIP funding. CHIP provides health coverage to children in families with incomes too high to qualify for Medicaid, but who cannot afford private health insurance coverage. The ACA extends CHIP funding until October 1, 2015 when the already enhanced CHIP federal matching rate increases. The Medicare Access and CHIP Reauthorization Act of 2015 extended funding for CHIP through October 1, 2017.

III. Important considerations for coordinating implementation of the ACA.

Title IV-B and IV-E agencies should consult with the state Medicaid agency when considering how to support implementing the ACA to ensure that potentially eligible children, youth and families are made aware of the ACA's health coverage. Here are some issues that title IV-B and IV-E agencies may want to explore:

- Child welfare and Medicaid collaboration. We encourage title IV-B/IV-E agencies to collaborate with Medicaid agencies to implement the ACA, better understand Indian Health and the ACA impacts on tribal communities and to work jointly in designing procedures to ensure families are made aware of the health care coverage available to them.

- Coordinating data systems and forms. Title IV-B/IV-E agencies can consider what options exist in automated systems to facilitate a youth's enrollment in Medicaid prior to a youth aging out of care. States that have elected to implement a statewide Automated Child Welfare Information System (SACWIS) must use the mandatory interface required under the SACWIS regulations to support this exchange of data.

- Training administrators and front-line staff. Youth aging out of foster care represent a very small proportion of the Medicaid population. Providing ongoing training to Medicaid and child welfare administrators and staff may be critical to children and youth in foster care, especially transitioning youth.

- Helping youth maintain coverage. The title IV-B/IV-E agency may want to consider how to ensure youth know they are eligible as former foster youth, even if they are initially enrolled under a different coverage category (which is important if they lose coverage for any reason); and how to maintain coverage among a highly mobile population characterized by frequent moves and unstable living arrangements.

- Assessing family needs for health insurance. Unmet medical and mental health needs of a caregiver can increase stress in the family and can potentially lead to family instability. The prevention and treatment of health and mental health issues can be critical to ensuring a child has a long-term stable placement. In a recent national study only about half (44.8 percent) of caregivers reported that they were in good or excellent health, with informal kin caregivers describing themselves as least healthy.[15] In order to support the families they serve, title IV-B/IV-E agency front line staff and staff from the state's or tribe's Maternal, Infant and Early Childhood Home Visiting program may want to consider providing information on health care insurance from HealthCare.gov, HealthCare.gov/tribal, and Healthy-Tribes.org that explain the basics of coverage through the health insurance Marketplace, Medicaid, and CHIP.

[15] Office of the Assistant Secretary for Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. (September 15, 2011) *NSCAW II Baseline Report: Caregiver Health and Services.* September 15, 2011. Retrieved from http://www.acf.hhs.gov/programs/opre/resource/nscaw-ii-baseline-report-caregiver-health-and-services-final-report

CB encourages title IV-B and IV-E agencies to become familiar with the new ACA provisions, consider whether child welfare practices and procedures can be strengthened to facilitate access to health care coverage, and work with state Medicaid agencies to employ a seamless transition to adulthood for foster children, youth, and families being served. Additional child welfare and Medicaid related resources may be accessed through the Child Welfare Information Gateway Clearing House at https://www.childwelfare.gov/systemwide/service_array/health/insurance.cfm. ACA resources may be accessed at HealthCare.gov, HealthCare.gov/tribal, and Healthy-Tribes.org.

INQUIRIES: Children's Bureau Regional Offices, Administration for Children, Youth, and Families, Administration for Children and Families.

/s/
Rafael López
Commissioner
Administration on Children, Youth and Families

Attachment A: Children's Bureau Regional Program Managers

Regional Program Managers – Children's Bureau

1	**Region 1 - Boston** Bob Cavanaugh bob.cavanaugh@acf.hhs.gov JFK Federal Building, Rm. 2000 Boston, MA 02203 (617) 565-1020 **States:** Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	6	**Region 6 - Dallas** Janis Brown janis.brown@acf.hhs.gov 1301 Young Street, Suite 945 Dallas, TX 75202-5433 (214) 767-8466 **States:** Arkansas, Louisiana, New Mexico, Oklahoma, Texas
2	**Region 2 - New York City** Alfonso Nicholas alfonso.nicholas@acf.hhs.gov 26 Federal Plaza, Rm. 4114 New York, NY 10278 (212) 264-2890, x 145 **States and Territories:** New Jersey, New York, Puerto Rico, Virgin Islands	7	**Region 7 - Kansas City** Deborah Smith deborah.smith@acf.hhs.gov Federal Office Building Room 349 601 E 12th Street Kansas City, MO 64106 (816) 426-2262 **States:** Iowa, Kansas, Missouri, Nebraska
3	**Region 3 - Philadelphia** Lisa Pearson lisa.pearson@acf.hhs.gov 150 S. Independence Mall West - Suite 864 Philadelphia, PA 19106-3499 (215) 861-4030 **States:** Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	8	**Region 8 - Denver** Marilyn Kennerson marilyn.kennerson@acf.hhs.gov Byron Rogers Federal Building 1961 Stout Street – 8th floor Denver, CO 80294-3538 (303) 844-1163 **States:** Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
4	**Region 4 - Atlanta** Shalonda Cawthon shalonda.cawthon.acf.hhs.gov 61 Forsyth Street, SW – 4th Floor Atlanta, GA 30303-8909 **States:** Alabama, Mississippi, Florida, North Carolina, Georgia, South Carolina, Kentucky, Tennessee	9	**Region 9 - San Francisco** Douglas Southard douglas.southard@acf.hhs.gov 90 7th Street - 9th Floor San Francisco, CA 94103 (415) 437-8425 **States and Territories:** Arizona, California, Hawaii, Nevada, Outer Pacific—American Samoa Commonwealth of the Northern Marianas, Federated States of Micronesia (Chuuk, Pohnpei, Yap) Guam, Marshall Islands, Palau
5	**Region 5 - Chicago** Barbara Putyra, Acting barbara.putyra@acf.hhs.gov 233 N. Michigan Avenue, Suite 400 Chicago, IL 60601 (312) 353-9672 **States:** Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	10	**Region 10 - Seattle** Tina Naugler tina.naugler@acf.hhs.gov 701 Fifth Avenue, Suite 1600, MS-73 Seattle, WA 98104 (206) 615-3657 **States:** Alaska, Idaho, Oregon, Washington