kaiser commission on medicaid and the uninsured

Children Discharged from Foster Care

Strategies to Prevent the Loss of Health Coverage at a Critical Transition

Prepared by
Pat Redmond
Center on Budget and Policy Priorities

THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. The Commission, begun in 1991, strives to bring increased public awareness and expanded analytic effort to the policy debate over health coverage and access, with a special focus on Medicaid and the uninsured. The Commission is a major initiative of The Henry J. Kaiser Family Foundation and is based at the Foundation's Washington, D.C. office.

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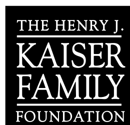

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Executive Summary

Each year, approximately 250,000 children are discharged from foster care. The majority of these children are reunited with their families. Several state-level studies have found that many of these children are at risk of becoming uninsured when they return home to their families. Children returning home after a stay in foster care often remain eligible for Medicaid or other publicly-funded health care coverage, but they may nevertheless become uninsured if their parents must navigate unnecessarily complex procedures for keeping them enrolled in coverage.

Periods without health insurance—even brief gaps in coverage—are especially dangerous for children with the serious health conditions common among children in foster care. Children in foster care offer suffer from poor health and have much higher rates of chronic physical disabilities, birth defects, developmental delays and serious emotional and behavioral problems than children from the same socioeconomic background who are not in out-of-home care.

While in state custody, children are generally enrolled in Medicaid or in state-funded health coverage with benefits equivalent to Medicaid. When children return home, federal rules require that they be evaluated for continuing Medicaid coverage, and coverage should continue if they are eligible. Most children reunited with their families are likely to qualify for Medicaid on the basis of family income. Children not eligible for Medicaid are likely to qualify for the State Children's Health Insurance Program (SCHIP), which provides coverage to low-income uninsured children whose family incomes exceed Medicaid's eligibility guidelines.

Research indicates that families in ordinary circumstances often find it difficult to gather the paperwork necessary to keep their children enrolled in health coverage. Common problems include: frequent eligibility reviews and paperwork; complex forms for renewing coverage; cumbersome renewal procedures; and a lack of coordination upon renewal for children whose eligibility shifts between Medicaid and separate SCHIP programs. Parents undergoing reunification with their children often face particularly difficult circumstances and are unlikely to be prepared to figure out their children's potential eligibility for health coverage and then navigate application or renewal procedures, especially if they are unnecessarily cumbersome. Unless states develop a systemic approach to maintaining coverage when children are reunified with their families, children may lose coverage when or shortly after they return home.

States can modify their Medicaid and SCHIP procedures to help children who are reuniting with their families retain coverage. States can help these children retain Medicaid by: providing 12 months of continuous eligibility; using information in Medicaid files or from other benefit programs to renew eligibility; and providing families with a "grace period" of additional time to complete paperwork and obtain required documents. States can facilitate SCHIP coverage for children not eligible for Medicaid by coordinating the flow of information between child welfare and the agencies responsible for enrollment in health coverage. States can also ensure that private foster

care agencies and dependency court judges know about health coverage programs and are encouraged to help families apply.

States also need to address the needs of young people who leave foster care for independent living, a process that is often termed “aging out.” Approximately 18,000 young people “age out” of foster care each year. Unlike most children who are reunited with their families, young people who age out of the foster care system are not likely to qualify for existing publicly funded health coverage because they no longer are considered “children” for purposes of Medicaid or SCHIP eligibility. Most of these young people are likely to be uninsured, unless their state has taken steps to expand coverage to this group.

States have two options for providing coverage to former foster youth. The Foster Care Independence Act provides states with federal matching funds to provide Medicaid to this group of young people. To date, seven states have chosen to provide Medicaid to former foster care youth under this option: Arizona, California, Mississippi, New Jersey, South Carolina, Texas and Wyoming. These states have developed broad eligibility guidelines, and most have also developed virtually automatic enrollment procedures, thereby assuring that young people can use the coverage that has been made available. A second alternative is to implement a broader eligibility option to a larger group of 19- and 20-year olds through flexibility recently accorded to states under federal Medicaid regulations.

States face difficult choices in these lean economic times. Few are likely to undertake major expansions in health coverage, but an incremental expansion to youth transitioning from foster care to independent living may be a feasible move with the potential to significantly improve young people’s lives. Given their serious health care needs, young people leaving foster care may need urgent or emergency care and, if they remain uninsured, urgent or emergency medical care costs may be borne by the state, local governments, or health care institutions. States that do not expand coverage to former foster care youth forgo federal matching funds to finance their medical care.

Youth transitioning from foster care are among the most vulnerable people in our society. Protecting their health entails that states invest in a modest expansion of Medicaid coverage.

Summary

This paper discusses the importance of maintaining health coverage for children who are discharged from foster care and presents strategies that state child welfare and Medicaid agencies can employ to reach this goal. Most such children are reunited with their families, and that group is the primary focus of this paper. The paper also addresses the needs of children who "age out" of the foster care system at age 18, and discusses state options to expand health coverage to this group.

Because many children discharged from foster care suffer from serious health conditions, even the temporary loss of health coverage can carry considerable risks. The paper briefly reviews the health status of children in this situation and the risks resulting from gaps in health coverage. It then outlines eligibility criteria for Medicaid and the State Children's Health Insurance Program (SCHIP), explaining how most children reunited with their families are likely to be eligible for coverage under Medicaid. Some may qualify for SCHIP. (While in foster care, children generally are covered by Medicaid or a comparable state-funded program.)

Despite their likely eligibility for coverage, procedural problems in state Medicaid and SCHIP programs can cause children leaving foster care to experience gaps in coverage. The next two sections of the paper describe ways states can modify their Medicaid and SCHIP procedures to prevent this from happening. Some of these strategies build upon approaches that states already are adopting to help families in general retain coverage through Medicaid and SCHIP. Other strategies are aimed specifically at helping children who are leaving foster care.

The paper then discusses various outreach partnerships that states and communities can build to help families obtain coverage for their children who are returning from foster care.

The final section of the paper addresses the needs of the group of young people who do not return to their families but rather "age out" of the foster care system on their eighteenth birthday. Compared to the former group, young people who age out of the foster care system are less likely to be eligible for publicly funded health coverage. This section describes state options to extend coverage to these individuals and develop simple enrollment procedures and explains why doing so makes sense for states even in tight fiscal times.

Background

Each year, approximately 250,000 children are discharged from foster care. Almost two-thirds are reunited with their families. A complex experience for families, reunification after foster care is receiving increasing attention in the field of child and family welfare.[1] Researchers and practitioners have identified a range of necessary supports to ease the transition, but many of these are often difficult for families to obtain. Essential supports include concrete assistance with basic needs, such as securing health coverage for children.

There are no national data on the number of children discharged from foster care who return home uninsured, but several state-level studies point to foster care discharge as a risk point

for losing coverage. Research using data from three sample states in the mid-1990s showed one-third to one-half of children without Medicaid in the month after they left foster care.[2] More recently, a study in Connecticut noted that children in foster care are in danger of losing health coverage when their involvement with the child welfare system ends,[3] and a national survey conducted by the UCLA Center for Healthier Children, Families and Communities found that most states do not automatically continue Medicaid when children leave out-of-home placement.[4]

While in state custody, children are generally provided Medicaid or state-funded health coverage with benefits equivalent to Medicaid. Although health coverage is not guaranteed to children reunited with their families after foster care, federal rules do require that Medicaid coverage not end until the state has examined whether the child may still be eligible.[5] When children return home, they should be evaluated for continuing Medicaid eligibility, and coverage should continue if they are eligible. Most children reunited with their families are likely to remain eligible for Medicaid based on their family's income. Children not eligible for Medicaid are likely to qualify for the State Children's Health Insurance Program (SCHIP). SCHIP provides health coverage to children in low- and moderate-income families with income too high to qualify for Medicaid but generally not higher than twice the federal poverty level.

Information from state child welfare and Medicaid agencies obtained for this paper suggests that loss of health coverage when children are reunited with their families may not be uncommon. Some state agencies, for example, indicate that families need to reenroll a child after discharge from foster care unless the family has an open Medicaid case for another family member. Such a requirement, which increases the risk that gaps in coverage will emerge, may conflict with federal regulations declaring that states must review the child's eligibility based on information available to the state.[6]

Unless states adopt a systemic approach to maintaining coverage at foster care discharge, children who lose coverage when or shortly after they return home may remain uninsured simply because their families do not know they continue to qualify. A recent Urban Institute study found that more than half of low-income parents — 53 percent —either are not aware of children's health coverage programs in their state or do not know that welfare participation is not a precondition of enrollment.[7] Even if reunited families understand that their children may be eligible, they may not be able to keep their children continuously enrolled, either because they cannot gather the necessary documents and complete the paperwork or because there is a delay between submitting the information and getting coverage.

Three Groups of Children Discharged from Foster Care

Most of the 250,000 children discharged from foster care each year fall into one of three groups:

1. Approximately seven percent are emancipated or "age out."

The term emancipation refers to all young people who have left the foster care system either by formal release from the system at their request or by turning 18, known in the child welfare field as "aging out." Young people "aging out" or emancipated by their own request number about 18,000 annually. Connecting youth who are emancipated before age 18 to existing coverage programs requires states to focus outreach on this population, while providing coverage to youth over age 18 will require states to implement modest health coverage expansions. Only seven states have adopted a relatively new federal option to expand Medicaid to young people aging out of foster care. The needs of this group and steps some states have taken to assist them are discussed in the final section of this paper.

2. Approximately 10 to 15 percent are adopted.

Children adopted from the foster care system generally have special needs that qualify them for either federal or state-funded adoption assistance. Children who are adopted and receive *federal* adoption assistance are categorically eligible for Medicaid.[8] Children who receive *state-funded* adoption assistance are also eligible for publicly funded health coverage, which must provide a benefits package equivalent to Medicaid.[9] Most children eligible for Medicaid and adopted from the foster care system continue Medicaid when they are adopted.[10]

3. Almost two-thirds are reunited with their families.[11]

The almost two-thirds of discharged children who are reunited with their families after foster care risk interruptions in coverage, unless their state has implemented procedures that assist these children in keeping Medicaid or enrolling in SCHIP. Their needs and opportunities for states to assist them are discussed below.

Lack of Health Coverage Poses Serious Risks for Children Leaving Foster Care

Children discharged from foster care are likely to need ongoing, and perhaps immediate, medical care. Studies over the past twenty years reveal that children in state protective custody often suffer from poor health and have much higher rates of chronic physical disabilities, birth defects, developmental delays and serious emotional and behavioral problems than children from the same socioeconomic background who are not in out-of-home care.[12] According to an often-cited GAO report, these children are, as a group, "sicker than homeless children or children living in the poorest sections of inner cities."[13]

Periods without health insurance are especially dangerous for children with the serious health conditions common among children in foster care. Even brief gaps in coverage can adversely affect children's health: a recent Commonwealth Fund survey found that people with short-term coverage gaps reported skipping or delaying medical care or leaving prescriptions unfilled because of the costs of care.[14] Without insurance, health care often comes too little or too late, with potentially damaging consequences even for healthy children.

Lack of insurance for the child may also increase stress on the child's family. This is a particularly compelling concern given the other pressures facing reunited families. Families without health insurance are exposed financially, and meeting the needs of their children can be difficult. Again, even relatively short gaps in coverage can be damaging: the Commonwealth Fund survey found serious financial consequences from short-term lapses in health coverage, such as being contacted by a collection agency for unpaid bills or having to borrow money to pay medical bills.[15]

Most Children Leaving Foster Care Remain Eligible for Health Coverage

Children in foster care are generally enrolled in Medicaid or, if they are legal immigrants ineligible for federally funded Medicaid coverage, in state-funded health coverage with benefits that are equivalent to Medicaid. (See the box on page 7 entitled "Medicaid Eligibility for Children in Foster Care.") These children are likely to remain eligible for coverage when discharged from foster care, though the basis for their eligibility may change. Large expansions in the availability of health insurance coverage for low-income children have taken place in the past five years.

Medicaid, the most important public health coverage program for low-income people in the nation, has been broadly available to children in low-income working families since expansions of the program in the late 1980s. In 1997, a bipartisan consensus to provide health insurance coverage to low-income uninsured children resulted in new federal funds that allowed states to expand further their children's Medicaid programs, to create separate children's health insurance programs, or to do both. The enactment of the State Children's Health Insurance Program (SCHIP) made federal funds available at enhanced matching rates for states.

By July 2000, every state had expanded eligibility to children through one of these approaches, so that today, the vast majority of children with income below 200 percent of the poverty line ($30,030 for a family of three in 2002) are eligible for health insurance coverage under Medicaid or SCHIP.[16] In some states, all eligible low-income children qualify through the Medicaid program; in other states, separate SCHIP programs enroll the higher-income (and sometimes older) of these children.

Eligibility for both Medicaid and SCHIP coverage is based on family income (only a handful of states count family assets, such as savings accounts or a car, in determining eligibility). Children in the lowest-income families are likely to qualify for Medicaid, since federal law sets minimum Medicaid eligibility limits (which most states have opted to exceed). Children under age six are eligible for Medicaid if their income is below 133 percent of the poverty line ($19,977 for a family of three in 2002), and older children are eligible for Medicaid if their income is below 100 percent of the poverty line ($15,020 for a family of three in 2002). Most states have expanded Medicaid eligibility for children beyond these minimum limits.

Large numbers of legal immigrant children are likely to be eligible for Medicaid or SCHIP coverage, although confusion regarding their eligibility is widespread. The 1996 welfare law imposed eligibility restrictions on many immigrants, with the result that eligible immigrants

may assume they are ineligible. Most notably, the so-called "five-year bar" prevents states from using federal Medicaid or SCHIP dollars to cover most legal immigrants who entered the country on or after August 22, 1996 during these immigrants' first five years in the country.[17] After these immigrants have been in the country for five years, states have the option of providing them with federally funded Medicaid coverage, and 42 states do so. States *must* provide these immigrants with federally funded SCHIP coverage after the five-year mark if they meet the other SCHIP eligibility criteria.

States may use federal Medicaid funds to cover legal immigrants who entered the country *before* August 22, 1996, and every state except Wyoming does so. States must provide SCHIP coverage to these immigrants if they meet the other SCHIP eligibility criteria.

In addition, almost half of the states have created state-funded "replacement programs" to cover some or all of the legal immigrants made ineligible for federally funded coverage by the welfare law.[18] Nineteen states have state-funded replacement programs for children. Fourteen states have state-funded replacement programs for families. Nineteen states have state-funded replacement programs for pregnant women.[19]

Medicaid Eligibility for Children in Foster Care

Nearly all children in foster care are eligible for Medicaid, although the basis for eligibility may differ from child to child.* Unfortunately, many of those eligible are not enrolled or enrolled quickly enough. Because some foster parents experience delays in obtaining a Medicaid card for the children in their care, it may be useful for states to review their eligibility procedures to eliminate any administrative delays. If needed, states should consider whether taking up one of the targeted eligibility options described below might expedite eligibility for certain children.

States currently provide Medicaid coverage to children in foster care through one of two major pathways: Medicaid eligibility that derives from a child's status as a beneficiary of federal foster care payments under Title IV-E of the Social Security Act, and Medicaid eligibility that is based on poverty, on disability, or some other factor unrelated to foster care status. A child may be eligible under one or more pathways.

Eligibility based on Title IV-E status. Under federal law, all children on whose behalf Title IV-E foster care payments are made are eligible for Medicaid. Title IV-E provides federal matching funds to states for payments on behalf of children who have been removed from their homes and placed in foster care, provided the children either were receiving cash assistance before being removed from their homes or were eligible for cash assistance (even if they did not receive it) under the welfare rules in place in their state in July 1996, before the 1996 federal welfare law was enacted. Title IV-E payments are made on behalf of about half of the children in foster care nationally.** Children can receive Medicaid through this pathway for the duration of their stay in foster care.

Eligibility based on other factors. Children in foster care who are *not* beneficiaries of Title IV-E payments are generally eligible for Medicaid as well, in one of the following ways:

- **Poverty-level category:** The "poverty-level" category includes children in families with incomes below specified income thresholds based on the federal poverty level.*** Under federal rules, the income and resources of foster parents *may not be counted* in determining a child's eligibility for Medicaid. In addition, the income and resources of a child's biological parents may be counted *only for the child's first month in foster care.* Hence, after one month, neither the foster parents' nor the biological parents' income or resources are counted. Unless a child in foster care has substantial income of his or her own, the child thus will have income below the Medicaid income limits.

  As a result, nearly all children in foster care who are not beneficiaries of Title IV-E payments will be eligible for Medicaid either right away or after one month. And since Medicaid covers medical bills for three months *prior* to application, those children who qualify for Medicaid after one month can have medical bills they incur during their first 30 days in foster care covered as well. (The problem is that during this 30-day period they have no Medicaid card or other evidence of coverage, which may make providers reluctant to treat them). Furthermore, as explained below, states can make virtually all children eligible for Medicaid during their first 30 days in care, as well as in the months after that.

- **Targeted foster care eligibility options:** States have options to extend Medicaid coverage to virtually *all* children in foster care who are not beneficiaries of Title IV-E payments *and to make such coverage effective immediately*. States also can create a separate Medicaid eligibility category for foster care children who are not having Title IV-E payments made on their behalf.**** These options may be especially important for states to consider if current eligibility pathways result in delays in establishing eligibility for children. As noted earlier, children's medical expenses should be covered regardless of whether eligibility is delayed because Medicaid covers medical bills for three months prior to enrollment. However, without an actual insurance card, foster parents may find it difficult or impossible to obtain immediate medical care for the children in their care.

- **Disability categories:** Children may also qualify for Medicaid through specific eligibility categories for children with disabilities. Children with disabilities who have Medicaid coverage prior to foster care placement may continue to qualify for Medicaid through one of these pathways. Children with disabilities who do not have Medicaid coverage prior to entry into foster care may be able to enroll in Medicaid through one of these categories.

State-funded coverage for legal immigrant children. The 1996 welfare law made some legal immigrant children ineligible for Medicaid. Some states have chosen to cover certain immigrants not eligible for Medicaid under federal law with state-funded Medicaid "replacement programs."***** Children not eligible for Medicaid under the pathways described above because of their immigration status may qualify for state-funded Medicaid replacement programs developed for legal immigrants. In addition, some states that lack Medicaid replacement programs provide state-funded health insurance to children in foster care who cannot qualify for Medicaid because of their immigration status.

Note: * The material in this box borrows from a more detailed discussion in Andy Schneider and Kristen Fennel, "Medicaid Eligibility Policy for Children in Foster Care," National Academy for State Health Policy, March 1999. ** Kathy Barbell and Madelyn Freundlich, *Foster Care Today*, Casey Family Programs, 2001. *** States may set their Medicaid income limits no lower than 133 percent of the federal poverty line for children under six and 100 percent of the poverty line for children aged six through 18. **** This option is described by Schneider and Fennel in the report referenced above. ***** Kimberly Chin, Stacy Dean, and Kathy Patchan, "How States Have Responded to the Eligibility Restrictions on Legal Immigrants in Medicaid and SCHIP," Kaiser Commission on Medicaid and the Uninsured, June 2002.

Gaps in Coverage Can Emerge When Children Are Reunited with Their Families

While most children returning home after foster care remain eligible for health coverage, gaps in coverage can emerge when families face procedural barriers to keeping the coverage. Research conducted in 2001 indicates that although most states have made children's health insurance programs more accessible for families by simplifying *application* processes, *renewal* processes (i.e., processes for renewing eligibility after an initial period on the program) often remain burdensome.[20] Complicated procedures for renewing health coverage can pose problems for families generally, but they can be especially difficult for families dealing with the challenge of a child's return home from foster care. Common problems include:

- frequent eligibility reviews and paperwork,
- complex forms for renewing coverage,
- cumbersome renewal procedures,
- and lack of coordination upon renewal for children whose eligibility shifts between Medicaid and separate SCHIP programs.[21]

Certain strategies that states can use to address these problems for families in general will also benefit children leaving foster care. In addition, states can adopt other strategies specifically designed to ensure that children leaving foster care who remain eligible for coverage stay enrolled.

Obtaining Coverage for Reunited Children: One Mother's Experience

The four children of Bernadette Brown (not her real name) were placed in foster care in March 1999. Between February and September 2001, they were individually returned to her custody: her four-year-old was returned in February, the 15-year-old in June, the 16-year-old in July, and the 12-year-old in September. The four-year-old child has asthma; the 12-year-old has a behavioral health condition requiring medication and psychotherapy. The family was enrolled in TANF and Medicaid before the children entered foster care. Ms. Brown received food stamps while her children were in foster care.

Ms. Brown reports that she visited the welfare office to obtain cash and Medicaid for each of her children when they returned home. When the 12-year-old was returned in September 2001, Ms. Brown's foster care caseworker accompanied her to the office to help her with the process. Ms. Brown recalls that the Medicaid cases took longer than a month to be activated after she visited the office. As she waited for action on each of the younger children's Medicaid cases (seven months apart), Ms. Brown relied on a neighborhood clinic for asthma treatment for the four-year-old and once visited the emergency room for treatment and medication for her 12-year-old. The 12-year-old's psychotherapy was interrupted, since Ms. Brown had no way to pay for the sessions.

The children are now enrolled in Medicaid. A number of medical and foster care professionals in Ms. Brown's state have reported interruptions in coverage for children who eventually qualified for Medicaid after returning home from foster care.*

* Personal communication with "Bernadette Brown," 8/13/02.

The next two sections describe ways states can modify their Medicaid and SCHIP procedures to help ensure that children discharged from foster care do not experience gaps in coverage.

Helping Children Retain Medicaid Coverage after Foster Care: Four State Strategies

Since most children in foster care are enrolled in Medicaid until they are discharged from foster care, Medicaid should be the "first stop" in the attempt to ensure their continuing health coverage. Federal rules require that Medicaid coverage not end automatically just because an enrollee's status changes: the state needs to examine whether that person may remain eligible before acting to end coverage.[22] Moreover, Medicaid is not just the logical first stop from a legal perspective, but the best health insurance for children with serious or complex medical needs. Children discharged from foster care are likely to have needs that private insurance, or even a state's separate SCHIP program, might not cover.

Medicaid's comprehensive benefits package for children is termed the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT). Through this program, Medicaid provides a package of health care services that is uniquely suited to the needs of children discharged from foster care. The scope of covered services under EPSDT is more comprehensive than private insurance plans or states' separate SCHIP programs. (However,

states that used SCHIP funds to expand Medicaid eligibility provide EPSDT benefits to children enrolled in SCHIP-funded Medicaid.)

EPSDT provides a federally-mandated full package of preventive tests, regular check-ups, and medically necessary follow-up care for children under 21 enrolled in Medicaid. Virtually all medically necessary care must be covered for children enrolled in Medicaid. Unlike conventional insurance plans, Medicaid's EPSDT program also requires that children be offered such supplemental but critical services as transportation assistance. Given their health status and the issues their families face, the EPSDT guarantee of comprehensive care may well be the only route to essential care for children discharged from foster care.

Significantly, children who do have access to private insurance can also qualify for Medicaid, as long as they meet the eligibility guidelines. This means that families with Medicaid as secondary insurance for their children can get benefits they might otherwise not be able to obtain. For example, many private health insurance plans do not cover dental, vision, or behavioral health services for family members. Filling such holes in private health coverage could make a significant difference in the well being of children who have come home from foster care.

Federal Medicaid rules allow states considerable flexibility in designing the procedures that are used to renew eligibility for children already enrolled in the program. Three retention strategies used to varying degrees throughout the country are likely to assist children in reunified families. One of these strategies, the review of eligibility using information available to the state from other sources, such as food stamp files, is federally required. A fourth step, identifying inappropriate Medicaid terminations by conducting what is known as alternative negative case reviews, may also help states seeking to assess the issue and monitor progress.

1. Provide 12 months of continuous coverage to children enrolled in Medicaid.

The Balanced Budget Act of 1997 gave states the option of enrolling children in Medicaid for 12 months, regardless of fluctuations in family income, assets, or other circumstances. This option is one of the most important and basic mechanisms to improve retention of children's health insurance and can be especially important to children leaving foster care. As of January 2002, 18 states had adopted this policy in their Medicaid programs.[23] The following states provide 12 months of continuous eligibility to children enrolled in Medicaid: Alabama, California, Connecticut, Idaho, Illinois, Indiana, Kansas, Louisiana, Maine, Mississippi, Nebraska, New Mexico, New York, North Carolina, South Carolina, Washington, West Virginia, and Wyoming. Federal rules require that a state adopting 12 months of continuous eligibility apply the procedure to all children in the program, including children in foster care.[24]

Providing 12 months of continuous eligibility may allow states to reduce administrative costs. According to a recent study by Mathematica Policy Research, this policy reduces staff time involved with processing applications and handling related paperwork.[25] States that do not provide continuous coverage for children may need to take other, often more complicated steps to ensure that children discharged from foster care are able to retain coverage.

A child discharged from foster care in a state that provides 12 months of continuous Medicaid eligibility for children should continue Medicaid without interruption regardless of whether the discharge is to a parent, a guardian, another relative, or an adoptive parent. The child's coverage should continue until the end of the 12-month period, allowing the family some time to follow through with requirements to renew the coverage. At the end of the 12 months, parents or caretakers will need to renew Medicaid or enroll the child in SCHIP coverage (if the household income exceeds Medicaid income limits).

Some states, however, have recently found inconsistencies in the implementation of their continuous eligibility policies for reunified children. For instance, children in foster care may be explicitly excluded from a state's continuous eligibility policy, even though such a practice is contrary to federal law. A state with this policy should correct the policy to ensure that foster care children are included in the guarantee of 12 months of continuous eligibility. In other cases, computer problems have resulted in children returning home with the right to continuous eligibility, but without an "automatic" continuation. When a state's computer system does not automatically continue eligibility for this group, foster care agencies and physicians report breaks in eligibility — even when local offices are instructed to correct the situation manually. Assuring that a continuous eligibility policy works properly for children leaving foster care may require a state to investigate whether this group has been overlooked, either in policy development or in programming automated eligibility systems.

States that do not ensure 12 months of continuous eligibility need other strategies to safeguard coverage at foster care discharge.

2. Use information in Medicaid files or from other benefit programs to renew eligibility.

Once children are enrolled in Medicaid, states must review their eligibility at least once every 12 months, or whenever the state learns of a change in household circumstances that could affect eligibility (if the state has not adopted the continuous eligibility option).[26] In states without a policy of 12 months of continuous enrollment, foster care discharge will prompt an eligibility review, and potentially, loss of coverage for an eligible child. Eligibility reviews often require families to complete new paperwork and supply documents verifying their sources of income within a specific timeline. These requirements — difficult for many families in ordinary circumstances —may overwhelm families coping with the logistical and emotional impact of children returning to the home.

States can make the renewal process much easier for many families, including those with children returning home from foster care, by using information that has already been collected by Medicaid or other programs, so that the family does not have to resubmit this information. This internal review of eligibility based on information available to the state is called an *ex parte* redetermination.

Under federal Medicaid regulations, states must rely on information already available to the state before requesting new information from a family. States are required to make "all reasonable efforts" to obtain information from Medicaid files and other sources, including food

stamp and TANF records, wage and payment information, and information from the Social Security Administration. States that have access to other sources of information, such as state child care, child support, and motor vehicle files, should also use these sources.[27]

Some states have developed effective strategies in this area. For instance, in Illinois and Washington State, information from a family's reports to the Food Stamp Program is routinely used to update Medicaid eligibility information and extend Medicaid eligibility.

An *ex parte* review may be especially effective for maintaining eligibility for children leaving foster care without requiring the family to complete new paperwork or submit documents. There are several likely sources of information that states can use for this purpose. For example:

- *Current or recent Medicaid, food stamp, or TANF case files.* Most children who are discharged have had relatively short stays in foster care. Half of the children who were discharged in 2000 were in foster care for less than a year, and 36 percent were discharged after less than five months.[28] Many were enrolled in Medicaid before entering foster care; many are likely to have been receiving food stamps, or to come from households that continued to receive food stamps after the children were removed. States may find that there is sufficient information in case records — either current or recently closed — to renew some children's Medicaid benefits at discharge from foster care without requiring additional steps from the family.

    - *Income and household composition information on file with the child welfare agency.* Standard practice guidelines promoted by the Child Welfare League of America indicate that in some cases, much of the information needed for a Medicaid eligibility review — including current household composition, residence, parental or caretaker means of support, and child's immigration status — should be available in a child's foster care records if the goal is for the child to return home.[29]

    - *Supplemental Security Income (SSI) eligibility information on file with the Social Security Administration.* The Supplemental Security Income program pays monthly benefits to children with serious disabilities whose families have limited income. Children who received SSI before entering foster care and who do not receive Title IV-E payments or whose Title IV-E payment is lower than the SSI benefit may still receive SSI while in foster care. The amount of the SSI payment will be reduced dollar-for-dollar by the amount of any Title IV-E payment. Children whose foster care payments come from Title IV-E and equal or exceed the SSI level will not receive SSI, but may resume receipt of SSI after discharge under certain conditions.

      Although some children will receive SSI after they leave foster care, it should not be assumed that Medicaid benefits for these children will

continue automatically. Although in most states, children who qualify for SSI also qualify for Medicaid, currently 11 states have Medicaid eligibility requirements that are more restrictive than SSI. Seven states have separate applications for Medicaid and SSI.

States may be able to assist a number of these children in keeping Medicaid when they are reunited with their families. Children discharged from foster care after a short period may have recent household income and other eligibility information on file with the Social Security Administration. Federal guidance specifically notes that SSA financial information can be used to renew Medicaid eligibility. This information is available to state Medicaid agencies through a data exchange with the Social Security Administration.[30]

Parent or caretaker wage information available through state Income and Eligibility Verification systems. State Medicaid agencies must comply with federal Medicaid regulations requiring them to have an Income and Eligibility Verification System (IEVS) in place. State IEVS systems contain information on earnings obtained from state Departments of Labor and the Internal Revenue Service. If the state has the other necessary information regarding a child's Medicaid eligibility (such as household composition and citizenship or immigration status), but lacks information on income, the wage information from a state's IEVS review might enable the child's Medicaid case to continue without interruption or action by the family after the discharge from foster care.

Oregon: Keeping Children Insured at Reunification

Oregon is focusing on ways to retain health insurance for children going home after foster care. Oregon's plans to promote health coverage after foster care are a result of the state's recent integration of child welfare and self-sufficiency services, which include Medicaid eligibility. State workers assigned to Medicaid or child welfare services will have access to computer systems from both programs and will be located in the same local office. Currently, special attention is paid to the health care needs of Oregon children in the foster care system through a project called the Children's Medical Project.

When a child in Oregon is about to return home from foster care, child welfare staff will notify Medicaid staff. Medicaid staff will then be able to add the child to a family's existing Medicaid case where appropriate. Workers will also use information from food stamp records to assess a family's income, and, where possible, maintain a child's eligibility. The next step will be to expand the process to include children whose families are not currently enrolled in either health coverage or food stamps. These families are currently provided with an application for the Oregon Health Plan and assisted in completing it. The vision, according to Oregon officials, is for children whose families do not have open benefits cases to retain health coverage with minimum paperwork, provided they are eligible. Income and other information in child welfare files could prove helpful here, particularly as the computer systems for the two areas begin to "talk to" each other more extensively.

For more information, contact Laurie Price, Oregon Department of Human Services: (503) 945-6613.

3. Provide families with a “grace period” of additional time to complete paperwork and obtain required documents.

When there is insufficient information to renew a child’s coverage without the family providing new forms and documents, the state may choose to provide a period of time after discharge during which the child’s coverage is extended. A state could put the child’s eligibility in a “pending” status while conducting an ex parte review and providing outreach to the family.[31] In addition to giving the family the opportunity to reunite without worrying about health insurance, a “grace period” reinforces the message that health coverage is available after the child returns home. A state may also use the grace period to conduct outreach to the family about health coverage and other benefits and to provide assistance to the family in completing the necessary paperwork.

Pennsylvania: “Grace Period” for Children Discharged from Foster Care

Concerned about the health issues facing children discharged from foster care, Pennsylvania developed a pilot project, with input from advocates and the City of Philadelphia, to extend a “grace period” of extended Medicaid eligibility to children discharged in Philadelphia. The pilot project, currently underway, provides Medicaid eligibility automatically to children for 60 days after they return home and notifies parents and caregivers that there is a need to renew Medicaid eligibility sometime during the 60-day period. If children are returning to families with open Medicaid or food stamp cases, information from these cases is used to renew the eligibility. Pennsylvania is hopeful that this effort will result in easier reentry of the child into the community and increase the number of children and families receiving Medicaid and other benefits. The state intends to gather information on the success of the pilot project, and if it proves successful, to implement the 60-day “grace period” statewide.

For more information, contact Donna Roe, Pennsylvania Department of Public Welfare: (717) 787-1696

4. Monitor loss of coverage at foster care discharge through an alternative case action review.

Under the Federal Medicaid Eligibility Quality Control program (MEQC), states are required to review a sample of denied, terminated, and suspended Medicaid cases to determine if the reason for action was correct and if the notice of negative action was sent within the required time frame.[32] It should be noted, however, that a majority of states operate pilot quality control programs under which the above requirements are suspended. As part of the overall quality control program, states have the option to conduct alternative case action review programs, in which they can focus on specific issues or populations. Given the lack of information on children discharged from foster care, an alternative case action review might be an appropriate step for a state to take as it considers ways to close coverage gaps for these children.

A sample of cases of children discharged from foster care might provide a state with initial information about whether there is a problem, as well as ongoing information about the impact of procedures adopted to improve retention. States might follow up their review with

interviews or focus groups of reunified families to gain a deeper understanding of how Medicaid renewal requirements impact families undergoing this transition.[33]

Helping Children Obtain SCHIP Coverage After Foster Care: Three State Strategies

Children discharged from foster care whose family income is too high for Medicaid will often qualify for their state's separate SCHIP program. Thirty-two states have used SCHIP funds to create or expand a child health insurance program that is separate from Medicaid. The following discussion of strategies for facilitating enrollment in SCHIP programs among children returning home from foster care applies only to states with separate SCHIP programs. States in which SCHIP funding has been used to expand the Medicaid program for children do not need to consider how to move children's applications from Medicaid to SCHIP.

Since 1997, when funding for SCHIP was enacted, millions more children have enrolled in Medicaid and separate state SCHIP programs. Awareness of both programs has been increasing, due in part to state and community outreach efforts. Still, many parents of eligible children do not know about the programs or do not understand that their children qualify.[34] Like other families, those involved in reunification may not know that health coverage from SCHIP is available if their income is too high for Medicaid.

Even if reunified families are informed about SCHIP, they may have difficulty figuring out how to enroll in the program. Although almost all states with separate SCHIP programs have designed a joint application for children's Medicaid and SCHIP, families with children coming home from foster care may not have seen this application, or may assume that because their child was ineligible for Medicaid, the child does not qualify for either program. States can provide families with a clear message and help in applying for SCHIP by taking the following steps.

1. Transfer the child's eligibility information to SCHIP, if the child is found ineligible for Medicaid.

Many states are working to improve coordination between their Medicaid and separate SCHIP programs at renewal. A coordinated renewal process can assure that children who are no longer eligible for the program in which they have been enrolled are evaluated for the other program and, if eligible, are enrolled without a new application or any lapse in coverage.

Federal rules require that the state Medicaid agency develop a process that facilitates enrollment in SCHIP, if a child is determined ineligible for Medicaid at either application or redetermination (renewal).[35] States employ different strategies to coordinate transfer of information when a child's application needs to be renewed. Some, such as Arizona, have developed methods of transferring some information electronically from Medicaid to the SCHIP program. Other states, such as Kansas and Michigan, place eligibility workers for both programs in the same location to eliminate delays in transferring information from one program to another.

Ideally, a coordinated renewal process would work well for children discharged from foster care if it is working well for children in general. However, states may find that it is more difficult to create a smooth pathway from Medicaid to SCHIP for children leaving foster care. Some reasons include:

- *Three state agencies must coordinate*. If the process is to go forward without additional steps from the family, three state agencies may need to transfer information about the child before Medicaid coverage ends and SCHIP coverage begins. The state child welfare agency will need to notify Medicaid that the child is discharged and provide any relevant information; the Medicaid agency will need to evaluate the child for Medicaid; and then the Medicaid agency will need to transfer information to SCHIP.

- *The family may not be able to afford to initiate coverage.* Some separate state SCHIP programs require a premium payment before coverage begins. Research indicates that higher premiums depress participation in SCHIP programs,[36] and a recent survey found that about 40 percent of families that disenrolled from SCHIP reported having difficulty paying premiums. Among those who had to pay $20 or more per month, the proportion having difficulties was 50 percent.[37] (It should be noted that the majority of states apparently do *not* currently charge premiums of $20 or more per month.[38]) Recently reunified families may have considerable expenses associated with regaining custody, such as child care, and may have difficulty paying premiums.

- *Families will need basic information about the program.* Families will need to know, for instance, that SCHIP coverage cannot be used as secondary insurance. If a child becomes insured through a parent's employer, the child will be ineligible for SCHIP. Families will also need to be aware that the SCHIP program may not cover all of the treatment their child has been receiving while in foster care, since SCHIP benefit packages are not always as comprehensive as the Medicaid benefit package.

2. Develop official Medicaid notices that are easy to read and include information about the child's potential eligibility for SCHIP coverage.

Most families with children discharged from foster care who are found ineligible for Medicaid will receive an official denial notice from Medicaid. These notices are federally required, and are an important vehicle for informing families of their legal rights as applicants for the program. Formal notices from Medicaid, however, are often legalistic and confusing. Some states are revising these notices to improve their readability and clarity, and also are including information about their separate SCHIP programs in the mailing to families. Given the whirlwind of paperwork that may descend upon families regaining custody, clear messages that

children ineligible for Medicaid may still be eligible for SCHIP are essential in states with separate SCHIP programs.

3. Integrate health coverage applications into foster care discharge planning sessions.

Formal transition planning sessions that include the child's caseworker, attorney, foster parent(s), and others provide an opportunity to initiate health coverage before a child leaves foster care. Much of the information needed to file an application for SCHIP coverage should be available to the participants in these meetings. Child welfare agencies could facilitate the continuation of coverage after discharge by completing and submitting relevant paperwork during the transition planning stage.

Children Going Home from Relative or "Kinship" Care

Relative or kinship care refers to households in which a grandparent or other relative is raising a child whose birth parents are unable or unwilling to do so. In 1999, approximately 2.3 million children lived with relatives without a parent present.* The vast majority of children in these kinship care families are being raised outside of the foster care system. The barriers that informal kinship caregivers face to obtaining health insurance for their children, as well as steps that states have taken to address them, are discussed in detail in "Healthy Ties: Ensuring Health Coverage for Children Raised by Grandparents and Other Relatives," a report of a national survey conducted by the Children's Defense Fund (www.childrensdefense.org).

Many relatives also care for children through the formal foster care system. If the child cared for by a relative has been taken into state custody, that child is part of the formal foster care system. Approximately 25 percent of the children in the formal child welfare system are currently placed in relative foster homes.** These children are entitled to Medicaid on the same basis as other children in foster care (see the box on page 7 entitled "Medicaid Eligibility for Children in Foster Care").

When they return home to the families from which they were removed, children from relative foster homes face the same risks of losing coverage as children in non-relative foster care. In fact, because various studies have shown that relative caregivers tend to be isolated and have few services and supports, these children may be more likely to lose health coverage than others leaving foster care.*** States will need to ensure that steps to improve retention of health coverage among children leaving foster care address the needs of relative caregivers, and organizations working to educate families about coverage should ensure that relative caregivers are included in their outreach activities and educational materials.

Note: * Jennifer Ehrle and Rob Geen, *Children Cared for by Relatives: What Services Do They Need?* Urban Institute, June 2002. ** U.S. Department of Health and Human Services, Adoption and Foster Care Analysis and Reporting System, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Interim FY 2000 Estimates as of August 2002 (7). *** Mary K. Bissell and Mary Lee Allen, Healthy Ties: Ensuring Health Coverage for Children Raised by Grandparents and Other Relatives, Children's Defense Funds, 2001.

Outreach Partnerships Can Promote Coverage for Children Returning Home

In addition to the changes in Medicaid and SCHIP procedures described in the previous two sections, another way states can help maintain health coverage for children being reunited with their families is by adopting various outreach strategies. Organizations contracting with the state's child welfare agency sometimes provide counseling or other services to families whose children have returned home, and some foster parents maintain contact with their former foster children and the children's parents or guardians. States and communities might consider the following steps to get the word to relevant groups, and to engage key actors in the child welfare system who are not currently focusing on health care coverage after discharge.

Promote State Health Coverage Programs to Foster Care Organizations

All states have developed promotional materials, and some have developed catchy advertisements, for their children's health coverage programs. But because children in foster

care are generally enrolled in Medicaid, states may not have thought to promote health coverage through the state's child welfare agency or private non-profit foster care agencies. Many of these organizations provide a wide range of services to families and might be willing not only to post flyers or distribute applications but also to assist with the Medicaid and SCHIP enrollment process.

Outreach through these groups might reach families with children who have returned home as well as children in foster care, since these families will still be receiving services. Some organizations provide services to families for a period of time after reunification and could be instrumental in assuring that health coverage continues. Promoting coverage through foster care agencies may also assist families involved with the child welfare system whose children remain at home. A large number of children are monitored in their own homes by state child welfare agencies, and some foster care agencies provide mandatory and voluntary parenting classes to families whose children have not been removed. A significant number of these children may be eligible for Medicaid or SCHIP coverage but uninsured.

Maine: Foster Care Agency Helps Families Obtain Health Insurance

Community Health and Counseling Services (CHCS) views linking families to health insurance as an integral part of supporting the families it serves in Bangor, Maine. CHCS, a non-profit agency, has been serving families in Bangor, Maine and the surrounding areas since 1883. CHCS employs 30 social workers who offer a variety of services to children and families including foster care, crisis intervention, case management, and individual, group and family therapy.

During the intake process, families are routinely asked if they have health insurance. If staff finds that a child is uninsured, the social worker assigned to the case may assist the family in obtaining insurance coverage. The CHCS social worker will provide assistance and support throughout the application process. When children placed in CHCS treatment foster care are reunified with their families, CHCS will transfer treatment services when appropriate and so long as the family resides in the CHCS service delivery area. Before CHCS terminates services with a family, the CHCS social worker will make sure that the family is informed about the renewal process for health care coverage.

For more information, contact: Jim Carlisle, CHCS at 207-947-0366.

2. Engage Dependency Court Judges and Staff in the Courts

States and community groups may also want to consider outreach to inform family court judges about the availability of health coverage for many children who return home after foster care. Many judges may not be aware that their state provides publicly funded health coverage to children with incomes significantly above the poverty line. Judges who are aware of a child's potential eligibility for Medicaid or SCHIP could increase the likelihood that the child will leave foster care with health coverage.

In some states, the law empowers the judiciary to order services for a child at the time of discharge from foster care, and judges can require that steps be taken so that eligible children retain Medicaid or enroll in SCHIP. In most states, judges do not order services, but must

approve the child welfare agency's plan for discharge. Judges in these states may inquire about the provision of necessary services, including health coverage, when children are about to return home.

Basic information about Medicaid and SCHIP, including an explanation of rules for continuing a child's coverage without a new application, would allow judges to consider whether an eligible child is missing out on health coverage during the discharge process. A one-page tool that suggests basic questions for dependency court judges to ask about health insurance is provided in Appendix A of this paper.

In some courts, it may make sense for a state eligibility worker to provide assistance with health coverage applications and renewals at family court, thereby allowing families and staff the opportunity to ask questions and resolve problems. Alternatively, a community agency could provide health coverage application and renewal assistance to families, although the community group could not officially determine eligibility. This approach has been in place in New York since 1993: Children's Centers in family courts throughout the state link families to a range of vital services, including health care coverage.

New York: Obtaining Health Coverage at Family Court

Recognizing both the need for a "safe haven" for children in the courts and the opportunity to link children to vital services — including health insurance — the New York State Permanent Judicial Commission on Justice for Children in 1993 spearheaded the creation of a state system of Children's Centers in the courts. The idea for Children's Centers in New York courts developed from a series of simple observations. Courtrooms and waiting rooms were no place for children, yet parents or caregivers often had no alternative but to bring children with them while they conducted business at court.

Staff from the Commission also knew that most children brought to court are five years old or younger, poor, and not receiving services that they need (including, in some cases, health insurance and linkages to appropriate health providers). The Children's Centers, staffed by individuals trained in child care who are sensitive to the needs of children and families in crisis, offer drop-in child care and referrals to vital services. Often, they offer on-site assistance in enrolling in Medicaid or Child Health Plus, New York State's SCHIP program.

There are currently 32 Children's Centers in courts throughout New York State. All provide families with information and referrals to publicly funded health insurance. Many also serve as sites for community based "facilitated enrollers" who provide families with hands-on application assistance. In some sites, the child care teachers are the facilitated enrollers.

For more information, contact Patricia Kennedy, New York State Permanent Judicial Commission on Justice for Children: (845) 486-6520

Providing Health Coverage for Young People "Aging Out" of Foster Care

While most children discharged from foster care are reunited with their families, each year approximately 18,000 young people leave foster care for independent living, a process that is often termed "aging out." Unlike most children who are reunited with their families, young people who age out of the foster care system are not likely to qualify for existing publicly funded health coverage, unless their state has taken steps to expand coverage to this group. Ensuring that they retain coverage thus presents states with a different set of challenges.

Young people who age out of foster care often confront the demands of adult life with few marketable skills and no family support or access to social services. They are unlikely to find jobs that provide health insurance and are likely to be low-income. Although there are few studies of this population, the limited information available indicates high levels of poverty and unemployment and low educational attainment.[39] Publicly funded health insurance is likely to be their only option for health coverage.

State Options to Extend Eligibility and Link Youth to Coverage

The Foster Care Independence Act of 1999 provides states with federal matching funds to provide Medicaid to this group of young people. If a state takes full advantage of this Medicaid option, all "independent foster care adolescents" can be eligible for Medicaid without regard to their income status. For the purposes of Medicaid eligibility, The Foster Care Independence Act defines "independent foster care adolescent" as an individual:

(a) who is under 21 years of age;
(b) who, on the individual's 18th birthday, was in foster care under the responsibility of the state; and
(c) whose assets resources and income do not exceed such levels (if any) as the state may establish. . . .[40]

States may — but do not have to — impose an income or resource test on this group of youth. In addition, states may, but do not have to, limit eligibility to a "reasonable category" of young people aging out of foster care (rather than all of those aging out), such as youth up to age 20 or youth who had qualified for Title IV-E services while they were in foster care.[41]

To date, seven states have chosen to provide Medicaid to former foster care youth under this option: Arizona, California, Mississippi, New Jersey, South Carolina, Texas and Wyoming.[42] Six of these seven states use neither an income nor an asset test for this group, and all seven states cover independent foster care adolescents up to their 21st birthday. Most of these states thus have adopted broad eligibility guidelines, as well as virtually automatic enrollment procedures, for these young people, assuring that the coverage offered will actually be used.

Medicaid Eligibility and Selected Enrollment Procedures in States That Have Expanded Coverage to Former Foster Care Youth Under The Foster Care Independence Act

State	Income/Asset Limits	Age Limit	Are youth enrolled before leaving foster care?	Simple renewal form/process just for this group?
Arizona	None	21	Yes	Yes
California	None	21	Yes	Yes
Mississippi	None	21	Yes	Yes
New Jersey	None	21	No	Yes
South Carolina	None	21	Yes	Yes
Texas	400% FPL; Asset limit $10,000	21	Yes	Yes
Wyoming	None	21	Yes	No

Notes:

1. New Jersey does not require an application or interview. Youth are informed about the program by letter and through outreach conducted to child welfare caseworkers and caregivers. Youth can enroll by calling a toll free hotline and verifying data over the phone: date of birth, social security number, and an address where they can receive mail.

2. Oklahoma has adopted but not implemented an expansion of coverage to former foster care youth. Oklahoma's legislature directed that Oklahoma Health Care Authority submit a State Medicaid Plan Amendment to provide medical coverage for youth aging out of foster care, to become effective fiscal year 2003. The statute says that former foster care youth will be eligible when funds become available. To date, the state has not implemented this expansion.

Some states that have not expanded Medicaid to former foster care youth do offer health insurance coverage to low-income childless adults, thereby providing an alternative route to coverage for this group. (Youth who are pregnant or are custodial parents can qualify for Medicaid or SCHIP under their state's eligibility guidelines for pregnant women or low-income families.) States with health insurance programs that might cover former foster care youth should consider outreach and application assistance specifically targeting this group, since they are likely to have low incomes and serious health care needs. Oregon, for instance, mails information about the Oregon Health Plan to youth transitioning from foster care to independent living. States and organizations working with foster care youth should also consider providing application assistance before youth leave foster care.

California: Broad Eligibility and Simple Enrollment Procedures Protect Youth

Young people aging out of foster care can continue their Medicaid coverage in California until they turn 21. As of October 2001, when the state first implemented the new eligibility category established by the Foster Care Independence Act, former foster care youth over age 18 have been eligible for coverage from the point at which they are discharged from care until their 21st birthday. No income or asset limits apply.

California youth leaving foster care after age 18 are automatically enrolled in the new coverage category when they are discharged. County eligibility offices are responsible for transferring a young person's coverage to the new category; no form or documentation is required. Youth are notified by the county three months prior to discharge that coverage will continue, and a large number of foster care provider and youth advocacy agencies also work to spread the word. A one-page renewal form is used for annual reviews of eligibility until the youth reaches 21.

As of January 2002, some 3,674 California youth who were formerly in foster care were enrolled in the new Medicaid coverage category.

For more information, contact Carl Miller, California Department of Health Services: (916) 657-0562

Finally, states can also expand Medicaid to former foster care youth through a broader option that extends eligibility to a larger group of 19- and 20-year-olds. This option is a fairly recent and highly technical change to federal regulations. Prior to May 2001, states had little flexibility to expand Medicaid eligibility to 19- and 20-year-old youth. Although states could elect to cover older youth aged 19 and 20, a state could not set income eligibility limits for these youth higher than 133 1/3 percent of the most generous welfare payment the state paid prior to enactment of the welfare law. The resulting limits were very low. In the typical (or median) state, this rule results in a Medicaid income limit for 19- and 20-year-olds equal to 44 percent of the poverty line ($6,600 per year for a family of three).

Regulations issued in May 2001, however, provide states a way to bypass this very low income limit for 19- and 20-year old youth. States are given flexibility under the regulations in how they count income for youth, which effectively permits states to raise the income eligibility level to any level they elect.[43]

It appears that no state has yet taken advantage of the flexibility permitted under these new regulations to provide health insurance to older children aged 19 and 20. A critical opportunity to cover youth leaving foster care along with many other uninsured young people is being missed.

Why Expand Coverage to Former Foster Youth in Tough Budget Times?

State budgets are suffering from the impact of rising costs and lower revenues. A number of states have planned or implemented cutbacks in Medicaid eligibility or benefits, and some may feel compelled to adopt further Medicaid cutbacks during the course of the coming year.

As states consider the difficult choices ahead, few are likely to undertake major expansions in health coverage. An incremental expansion, however, to youth transitioning from foster care to independence is a feasible move with the potential to significantly improve young people's lives. Even in this difficult period, states could provide health coverage to this small group with high needs. In Kansas, for instance, the Governor's FY 2004 budget proposal includes funds to expand Medicaid coverage to youth aging out of foster care. States might consider the following reasons to expand coverage to this group, despite the fiscal pressures they face:

- *Young people aging out of foster care are an exceptionally needy population, with little likelihood of obtaining health insurance on their own.* Jobs that youth are able to obtain are likely to pay low wages and not likely to offer health insurance.

- *The small numbers in need of coverage suggest that the cost of extending coverage should be modest.* California, with the largest foster care population in the country, provides Medicaid to 3,674 former foster youth; Arizona's enrollment amounts to only about 500 youth. Nationally, about 18,000 youth transition from foster care to independence each year.

- *States that do not expand coverage to former foster youth forgo federal matching funds to finance their medical care***.** Given their serious health care needs, these young people may need urgent or emergency care and costs may be borne by the state, local governments, or health care institutions.

- *Struggling, sick young people are not able to be reliable employees.* Youth transitioning from foster care to independence have historically received little help in the process of becoming adults. If they are to be productive citizens, their basic needs, such as health care, must be met.

Preserving Medicaid benefits for the most vulnerable remains essential even as states confront shrinking budgets. Youth transitioning from foster care are among the most vulnerable people in our society. Protecting their health entails that states invest in a modest expansion of Medicaid coverage.

Conclusion

Children returned to their families after foster care are likely to need ongoing, perhaps immediate health care. For these children to lack health insurance for any period of time represents a serious and largely unnecessary risk to their health and the success of their transition. The risk is unnecessary, not only because coverage is available for most low-income children, but also because these particular children are known to their state. States have the tools to assist families in this situation and to remove from parents and caretakers some of the burden of maintaining health coverage for these children.

Research indicates that families in ordinary circumstances often find it difficult to gather the paperwork necessary to keep their children enrolled in health coverage.[44] To require parents undergoing reunification to figure out their children's potential eligibility for health insurance on their own and then navigate application or renewal procedures is to disregard the needs of these families and the obligations that states have to promote their welfare. State child welfare and Medicaid agencies can assist families by designing systems in which keeping health coverage is a routine procedure during discharge from foster care. Organizations working with families involved with the child welfare system can develop partnerships with health coverage programs in their state and devise ways of integrating assistance with health insurance into their ongoing operations.

Maintaining health coverage for young people who age out of the foster care system requires a greater commitment on the part of states, since most of these individuals currently are ineligible for coverage. Nevertheless, for several reasons, including the considerable needs of these young people and their relatively small numbers, it makes sense for states to extend coverage to this group.

Appendix A

Preventing the Loss of Health Coverage at Foster Care Discharge: A Checklist for Family Court Judges

Health Coverage for Children Discharged from Foster Care

1. Has the Medicaid agency reviewed the child's eligibility for Medicaid on a basis other than being in foster care?

____ Yes ____No

If "no," the Medicaid agency is required to do this before terminating coverage.

2. If yes, will the child's eligibility continue after the child is discharged?

____ Yes ____No

3. If no, does the household to which the child is returning have affordable health insurance for the child?

____ Yes ____No

4. If the child has been determined ineligible for Medicaid, and if the child does not have health insurance, is the child in the process of applying for coverage under the State Children's Health Insurance Program (SCHIP)?

____Yes ____No

If no, note that the child may be eligible for SCHIP coverage.

Exceptions: Children Not Eligible for Public Coverage

1. Some legal immigrant children are ineligible for coverage. Many, however, do qualify for coverage.
2. Undocumented immigrant children are ineligible for federally funded public health insurance, except for Medicaid in emergency situations. These children need to be linked to a community health center or other source of low-cost or free health care.

Appendix B

Risk Points and Strategies to Promote Coverage of Children Returning Home from Foster Care

Risk Point	Strategies to Promote Coverage
A state's 12-month continuous eligibility policy is not being applied to children discharged from foster care or the state's automated eligibility system does not support 12 months of continuous eligibility for children in foster care.	States that have adopted the 12-month continuous eligibility option are required to provide 12 months of continuous eligibility to children discharged from foster care. 12-month continuous eligibility needs to be supported by the state's automated eligibility system.
The family is asked to submit an application to Medicaid in order to initiate coverage once the child returns home.	A new application should not be required. The child's eligibility should continue until the state has determined whether the child can qualify under another Medicaid eligibility category. The state can then request information from the family, but must limit the request to circumstances that might change and may affect eligibility.
The family is not informed (or is only told verbally) about the need to provide information to the Medicaid agency in order to continue coverage.	The state must send a written notice to the family before terminating Medicaid coverage. Notices should be clear, written in the family's language, and free of legal jargon. Notices should include information about SCHIP and explain that the child may qualify for it, if the state operates a separate SCHIP program.
The family has difficulty responding promptly to the state's request for information.	The state should attempt to use information already collected in order to review the child's eligibility. In addition, the state can provide a "grace period" during which coverage continues so that the family has time to respond.
The family faces literacy, language, or other barriers that result in problems with paperwork.	(1) The state should attempt to use information already collected in order to review the child's eligibility; (2) the child welfare agency can obtain family income and other information prior to discharge and assist the family with Medicaid paperwork during the discharge planning stage; or (3) the Medicaid agency can outstation an eligibility worker at the court to assist families.
The family's income is too high for Medicaid.	The Medicaid agency should inform the family about the child's possible eligibility for SCHIP and transfer relevant information to SCHIP.
The child is being adopted.	If the child is considered to have special needs, the child should be eligible for Medicaid. Otherwise, the state should attempt to use information already collected to review the child's eligibility, and the state can provide a "grace period" during which coverage continues so that the family has time to respond.
The youth is being discharged on the basis of "aging out."	The state can opt to provide continuing Medicaid coverage to youth in these circumstances and develop procedures that make coverage easy to obtain and renew.

[1] The 1997 Adoption and Safe Families Act generally eliminated long-term foster care as a permanency planning goal for children. Long-term foster care is allowed as a permanancy planning goal as an exception in certain cases. Reunification is now the primary goal.

[2] Margo Rosenbach, *Children in Foster Care*, Cambridge, MA: Mathematica Policy Research, Inc. 2000.

[3] Children's Health Council, *Health and Health Care in Husky A for Children in the Care and Custody of The Connecticut Department of Children and Families*, January 2002.

[4] Neal Halfon, Moira Inkelas, R. Flint, K. Shoaf, A. Zepeda, T. Franke. 2002. *Assessment of factors influencing the adequacy of health care services to children in out-of-home care*. UCLA Center for Healthier Children, Families, and Communities, October 2002.

[5] These rules are set forth in federal Medicaid regulations. In addition, in August 2001, the U.S. Department of Health and Human Services published a policy guide explaining these issues. See, Centers for Medicare and Medicaid Services, *Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage*, August 2001.

[6] States must rely on information that is available to conduct a review of eligibility rather than requiring families to resupply this information. 42CFR 435.930 (b). For an explanation of this requirement, see *Continuing the Progress: Enrolling Children and Families in Health Care Coverage*, p. 13.

[7] Genevieve Kenney, Jennifer Haley, and Lisa Dubay, *How Familiar are Low-Income Parents with Medicaid and SCHIP?*, Urban Institute, May 2001.

[8] Children who are adopted and receive Title IV-E adoption assistance are categorically eligible to receive Medicaid in the state in which they reside whether or not it is the state providing the adoption assistance. Social Security Act, Section 473(b) (1) and 1902(a)(10)(A) (ii) (VIII).

[9] For children who are not eligible for Title IV-E adoption assistance but are receiving state-funded adoption assistance, the state providing the adoption assistance must provide health insurance coverage equivalent to Medicaid to these children if it is determined that due to the child's special needs for medical, mental health, or rehabilitative care, the child cannot be placed with adoptive parents without medical assistance. Section 471 (a) (21) of the Social Security Act.

[10] Personal communication, Liz Oppenheim, American Public Human Services Association, 9/3/02. Adoptive families may be confused by Medicaid's renewal process, as the adoption assistance program, unlike Medicaid, does not require annual reviews of eligibility.

[11] U.S. Department of Health and Human Services, Adoption and Foster Care Analysis and Reporting System, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Interim FY 1999 Estimates as of June 2001 (6)

[12] Robin Chernoff, Terri Combs-Orme, Christina Risley-Curtiss, Alice Heisler. *Assessing the Health Status of Children Entering Foster Care*, Pediatrics. Vol 93, No. 4, April 1994, pp. 594-604. Kathy Barbell and Madelyn Freundlich, *Foster Care Today*, Casey Family Programs, 2001, pp. 6-7.

[13] U.S. General Accounting Office*. Foster Care: Health Needs of Many Young Children are Unknown and Unmet.* GAO/HES-95-114 (1995).

[14] Lisa Duchon, Cathy Schoen, Michelle Doty, Karen Davis, Erin Strumpf, and Stephanie Bruegman. *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk,* New York, Commonwealth Fund, Dec. 2001.

[15] Lisa Duchon, Cathy Schoen, Michelle Doty, Karen Davis, Erin Strumpf, and Stephanie Bruegman. *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk,* New York, Commonwealth Fund, Dec. 2001.

[16] Lisa Dubay, Jennifer Haley and Genevieve Kenney*, Children's Eligibility for Medicaid and SCHIP: A View from 2000*, Urban Institute, March 2002.

[17] A very small number of legal immigrants, such as veterans, are exempt from the five-year bar and thus are eligible for Medicaid and SCHIP on the same basis as native-born citizens.

[18] Kimberly Chin, Stacy Dean, and Kathy Patchan, *How Have States Responded to the Eligibility Restrictions on Legal Immigrants in Medicaid and SCHIP*, Kaiser Commission on Medicaid and the Uninsured, June 2002.

[19] Not all states that provide replacement programs to children do so for pregnant women, and not all states that provide such programs to pregnant women do so for children. For a list of state Medicaid replacement programs, see Chin, Dean, and Patchan, *How Have States Responded to the Eligibility Restrictions on Legal Immigrants in Medicaid and SCHIP*, Kaiser Commission on Medicaid and the Uninsured, June 2002.

[20] Donna Cohen Ross and Laura Cox, *Enrolling Children and Families in Health Coverage*: *The Promise of Doing More*, Kaiser Commission on Medicaid and the Uninsured, June 2002.

[21] Leighton Ku and Donna Cohen Ross, *Staying Covered: The Importance of Retaining Health Insurance for Low-income Families*, Commonwealth, forthcoming.

[22] 42CFR 435.930(b)

[23] Donna Cohen Ross and Laura Cox, *Enrolling Children and Families in Health Coverage*: *The Promise of Doing More*, Kaiser Commission on Medicaid and the Uninsured, June 2002.

[24] Section 1902(e)(12) of the Social Security Act requires that states that have adopted the option of 12- month continuous eligibility provide the coverage to all children in the program, with the exception that a state may opt to provide this length of coverage only to a specified age group. If a state elects to do this, it must provide 12 months of continuous coverage to the youngest children in the program.

[25] Carol Irwin, Deborah Peikes, Chris Trenholm, and Nazmul Khan, *Discontinuous Coverage in Medicaid and the Implications for 12-Month Continuous Coverage for Children*, Cambridge, MA: Mathematica Policy Research, October 24, 2001.

[26] 42CFR 435.916

[27] *Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage.* U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, August 2001.

[28] U.S. Department of Health and Human Services, Adoption and Foster Care Analysis and Reporting System, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau,

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http://www.acf.dhhs.gov/programs/cb/publications/afcars/report7.pdf.

[29] CWLA *Standards of Excellence for Family Foster Care Services*, 1995 CWLA Press.

[30] Judith Moore, Dear State Medicaid Director, U.S. Department of Health and Human Services, Health Care Financing Administration, April 22, 1997.

[31] Federal guidance describes this as one strategy states can use to assure that families leaving TANF do not lose Medicaid benefits. See Timothy Westmoreland, Dear State Medicaid Director, U.S. Department of Health and Human Services, Health Care Financing Administration, April 7, 2000.

[32] 42CFR 431.812

[33] A description of states' recent alternative case action review programs is available at www.cms.gov/Medicaid/regions/mqchmpg.htm. A review of the website indicates that in the recent past, no alternative case action review programs focused on the foster care population.

[34] Genevieve Kenney, Jennifer Haley, and Lisa Dubay, *How Familiar are Low-Income Parents with Medicaid and SCHIP?*, Urban Institute, May 2001.

[35] 42CFR 431.636(b)(4)

[36] Leighton Ku and T. Coughlin, *Sliding Scale Premium Health Insurance Programs: Four States' Experiences*, Inquiry, 36 (4): 471-80, Winter 1999/2000.

[37] Cynthia Pernice, Trish Riley, Michael Perry, and Susan Kannel, *Why Eligible Children Lose or Leave SCHIP: Findings from a Comprehensive Study of Retention and Disenrollment*, National Academy for State Health Policy, February 2002.

[38] Unpublished review of state SCHIP plans conducted by the Center on Budget and Policy Priorities, 2001. CBPP is currently collecting updated information on premiums and cost sharing in separate SCHIP programs.

[39] Abigail English and Kathi Grasso, *The Foster Care Independence Act of 1999: Enhancing Youth Access to Health Care*, Journal of Poverty Law and Policy, July/August 2000.

[40] Foster Care Independence Act, § 121 (a)(2), (c)(5), 113 Stat. 1822, 1829, 1830, *adding a new subsection* 42 U.S.C. § 1396d(v)(1).

[41] Montoya and Westmoreland, Dear State Child Welfare and Medicaid Director, U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, December 1, 2000.

[42] Phil Ladew, *Chafee Medicaid Extensions for Emancipated Foster Youth*, Youth Law News, March/April 2002.

[43] 66 Fed. Reg. 2316 (January 11, 2001) amending 43 CFR § 435.1007. The original effective date was March 12, 2001 but it was delayed until May 11, 2001 as part of the Administration's overall review of pending regulations. 66 Fed. Reg. 14343 (March 12, 2001).

[44] Cynthis Pernice, Trish Riley, Michael Perry, and Susan Kannel, *Why Eligible Children Lose or Leave SCHIP: Findings from a Comprehensive Study of Retention and Disenrollment*, National Academy for State Health Policy, February 2002.

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