



ISSUE BRIEFS | JANUARY 2022

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

Children and youth in foster care often have significant health-care needs (Bilaver et al., 2020). Provisions in the [Patient Protection and Affordable Care Act \(ACA\)](#) and [Family First Prevention Services Act \(FFPSA\)](#) have increased access to and affordability of health care for some of our most vulnerable children and youth.

This issue brief reviews the eligibility pathways that enable children and youth in foster care to receive Medicaid or other health-care coverage and includes resources to help youth and young adults understand their health-care options. It also provides resources for child welfare agencies to assist children, youth, and families in accessing health-care services, including resources related to the COVID-19 pandemic.

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HEALTH-CARE NEEDS OF CHILDREN AND YOUTH IN FOSTER CARE

The American Academy of Pediatrics declared that children in foster care are "children with special health-care needs" due to their high rates of physical and mental health problems, some of which could have been caused by the maltreatment itself or the disruption caused by removal from the home and placement in foster care (Szilagyi et al., 2015). As children experience more [adverse childhood experiences](#)—including child maltreatment, parental substance use disorder, parental divorce or separation, parental incarceration, and domestic violence—they are at an increased risk for long-term and lifelong medical issues, such as adulthood heart disease, stroke, cancer, respiratory diseases, diabetes, depression, and other conditions (Merrick et al., 2019).

The following are examples of the disparities in conditions and treatment for children and youth in foster care compared with those not in foster care:

- Children in foster care are significantly much more likely to have developmental delays; asthma; obesity; speech, hearing, and vision problems; attention-deficit/hyperactivity disorder; anxiety; behavioral problems; depression; and other health and mental health issues (Turney & Wildeman, 2016).
- Children in foster care have significantly more hospitalizations and subspecialty office visits than children not in foster care and higher health-care charges on average (\$14,372 versus \$7,082) (Bennett et al., 2020).
- Children in foster care have higher rates of dental problems, and one-third of children in care have not had a dental visit in the past year (Finlayson et al., 2018).
- In 2018, only 54 percent of noninstitutionalized youth who were enrolled in Medicaid or the Children's Health Insurance Program (CHIP) and who experienced a major depressive episode received mental health treatment (Medicaid and CHIP Payment and Access Commission [MACPAC], 2021).
- Many children in out-of-home care who may qualify for early intervention and special education services do not receive them (Casanueva et al., 2020).

Family First Prevention Services Act

FFPSA¹ enhances support services for families to help children remain safely at home instead of entering foster care. Under FFPSA, States, territories, and Tribes have the option to use title IV-E funds for time-limited, evidence-based prevention services for a child who is a candidate for foster care, a pregnant or parenting youth in foster care, and the parents or kin caregivers of those individuals. Some of these services are health related, such as mental health and substance use disorder prevention and treatment services.

For more information on FFPSA, refer to the following:

- [Planning Title IV-E Prevention Services: A Toolkit for States](#) (Office of the Assistant Secretary for Planning and Evaluation)
- [Implementing the Family First Prevention Services Act: A Technical Guide for Agencies, Policymakers and Other Stakeholders](#) (Children's Defense Fund)
- Information Memorandum [ACYF-CB-IM-18-02](#), Program Instruction [ACYF-CB-PI-18-07](#), and [Title IV-E Prevention Program](#) [website] (Children's Bureau)
- [Family First Prevention Services Act \(FFPSA\)](#) [website] (Capacity Building Center for States)

MEDICAID COVERAGE—PATHWAYS TO ELIGIBILITY

Medicaid, as authorized by title XIX of the Social Security Act (SSA), is a program funded jointly by Federal and State governments to provide health-care coverage to low-income citizens who meet certain additional criteria. States determine their eligibility criteria within broad Federal guidelines. Most children and youth in foster care are eligible for Medicaid. While States are not permitted to use Federal child welfare funds to pay for medical expenses of children in care or who have left care due to achieving permanency or aging out, they can receive some reimbursement from Medicaid to help defray the costs of covering children in foster care (Stoltzfus et al., 2014). (For additional information about State's Medicaid and CHIP programs, including eligibility criteria, see the [State profiles](#) maintained by the Centers for Medicare & Medicaid Services [CMS].) This section outlines how children and youth in foster care meet those eligibility requirements.

TITLE IV-E AND FOSTER CARE

The most common eligibility pathway to Medicaid for children and youth in foster care is through title IV-E eligibility (Child Welfare Information Gateway, 2015). Title IV-E of the SSA provides funding to support safe and stable out-of-home care for children who are removed from their homes, but it does not provide Medicaid funding. Children and youth for whom title IV-E foster care or guardianship assistance payments are made, or who are subject to a title IV-E adoption assistance agreement,

¹ The [Family First Transition Act](#) (Transition Act) was passed in 2019 to help States, territories, Tribes, and Tribal organizations transition to a prevention-focused child welfare system and implement the FFPSA. Basic information about the Transition Act is detailed in Children's Bureau Information Memorandum [ACYF-CB-IM-20-01](#).

are categorically eligible for Medicaid in their State of residence, including a youth up to age 21 (Children's Bureau, 2010). Such a youth is eligible for Medicaid whether or not the title IV-E agency in their State of residence has taken the option to provide extended title IV-E assistance.

If a youth in foster care whose costs are covered by title IV-E foster care maintenance payments is or becomes a parent, that youth's child is categorically eligible for Medicaid in the State where they live. This continues to hold true regardless of whether the title IV-E agency in that State has elected to [extend foster care assistance](#) to youth aged 18 and older. If the State has placement and care responsibility for both the parent and the child, title IV-E eligibility must be determined individually for each (Children's Bureau, 2019). Title IV-E categorical eligibility for Medicaid is detailed in Program Instruction [ACYF-CB-PI-10-11](#) and Information Memorandum [ACYF-CB-IM-15-08](#).

OTHER WAYS CHILDREN/YOUTH IN FOSTER CARE OR YOUNG ADULTS FORMERLY IN FOSTER CARE MAY QUALIFY FOR MEDICAID

Children and youth in foster care who are not eligible under title IV-E may be eligible to receive Medicaid in other ways.

Mandatory Medicaid eligibility for children under age 19. States are required to provide Medicaid coverage for children under age 19 whose household income is no more than 133 percent of the [Federal poverty level](#) (FPL) or a higher income limit established by the State based on the child's age (under age 1, aged 1 through 5, or aged 6 through 18). For a child placed in foster care (especially if the parents do not intend to claim the child as a tax dependent for the current tax year), only the child's income is often considered for Medicaid eligibility. Therefore, most children under age 19 in foster care who do not qualify for Medicaid through title IV-E eligibility do qualify for this other mandatory eligibility group. Many States set a higher income limit (e.g., \$50,000 per year for a family of four) and cover children up to age 19 under [CHIP](#), as authorized by title XXI of the SSA.

Youth formerly in foster care and under age 26. The ACA provides a mandated eligibility pathway for Medicaid that became effective in 2014 for the "former foster care" group, which enables older youth to receive Medicaid until their 26th birthday. This coverage is similar to that of other young adults with no foster care connection who are able to remain on their parents' health-care plans until age 26. Youth formerly in foster care are eligible for their State's full Medicaid coverage, regardless of their income and whether the State where they live opted to cover or declined to expand Medicaid coverage under the "adult group." This provision applies to individuals under age 26 who were enrolled in Medicaid and in foster care under the responsibility of the State or Tribe where they currently live upon attaining either age 18 or such higher age as the State or Tribe has elected for termination of Federal foster care assistance under title IV-E. As of 2016, CMS established a waiver process to allow States to opt to cover youth who were in foster care and/or enrolled in Medicaid in another State than where they currently live. As of 2019, 10 States received such a waiver (Fernandes-Alcantara & Baumrucker, 2020). The [Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act](#), enacted in 2018, amended the ACA so that, effective January 1, 2023, youth formerly in foster care will be eligible for Medicaid until age 26 regardless of which State they currently reside.

States that opt to cover eligible youth who relocate from other States alleviate potential financial concerns that come with mobility restrictions, as exemplified by the following:

“I had [health insurance] while I was still in Wyoming, but as soon as I transferred to Portland State University...Wyoming Medicaid ended and Oregon didn’t honor health care to 26 if I wasn’t in the State’s care at any time, so I had to pay for college health insurance, which was expensive and didn’t cover what I needed and made me delay visiting doctors and mental health professionals.”—Youth formerly in foster care

Youth who age out of foster care in States that offer the Chafee option. The John H. Chafee Foster Care Independence Program (renamed by the FFPSA to the John H. Chafee Foster Care Program for Successful Transition to Adulthood [Chafee] program)² provides services and supports to help youth aging out of foster care make a successful transition to adulthood and independence. The Chafee Foster Care Independence Act of 1999 amended the SSA to authorize the option for States to provide Medicaid to certain youth who were in foster care when they attained age 18 (referred to in this document as the "Chafee option"). States have the option to determine the maximum age of eligibility under Medicaid for this group of "independent foster care adolescents" (up to ages 19, 20, or 21) and to establish levels for assets, resources, and income that may not be exceeded. (See 42 U.S.C. 1396a(a)(10)(A)(ii)(XVII) for additional information.)

² See Program Instruction [ACYF-CB-PI-18-06](#) for additional changes to the Chafee program.

Comparison of the ACA's Coverage for Mandatory Former Foster Care Group and the Chafee Option

Some overlap exists between the Medicaid coverage some States provide through the Chafee option for older youth who have left foster care and the coverage mandated by the ACA for the group of older youth and young adults formerly in foster care.

	Chafee Option	ACA
Title IV-E and Medicaid receipt	Youth receiving title IV-E foster care or, at the State's option, State- or Tribal-funded care, when they turned age 18 are eligible.	Young adults are eligible if they received title IV-E foster care or State- or Tribal-funded foster care and were enrolled in Medicaid at age 18 or when they aged out of care.
Income requirement	Young adults with an income above a certain level are not eligible if the State has an income test for this group.	There is no income requirement.
State of residence	Young adults are not required to have been in foster care in the same State where they are seeking coverage unless the State imposes such a requirement.	Young adults are eligible only in the State in which they aged out of foster care, unless the State received a waiver. ^a
Upper age limit	Coverage goes up to ages 19, 20, or 21, at the State's option.	Coverage is provided until the person's 26th birthday.

^a The [Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act](#), enacted in 2018, amended the ACA so that, effective January 1, 2023, youth formerly in foster care will be eligible for Medicaid until age 26 regardless of which State they currently reside.

Young adults who meet eligibility requirements under both the Chafee option and the ACA groups should be enrolled in the ACA group for children formerly in foster care. See [Medicaid and CHIP FAQs: Coverage of Former Foster Care Children](#) for more information.

Medicaid eligibility for the adult group. States have the option to cover the "adult group" added by the ACA for nonpregnant individuals aged 19 through 64 whose household income is no more than 133 percent FPL. As of August 2021, 38 States and the District of Columbia [cover this eligibility group](#) (MACPAC, n.d.). Because youth in foster care aged 19 or older often are considered as belonging to a household of one for Medicaid eligibility, their income is usually within the limit for this group, if it is covered by their State of residence.

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

- [Pregnant women](#) are covered with the same income requirement as Medicaid coverage to children in families with incomes at or below 133 percent FPL or a higher income limit established by the State. States are also required to cover parents and other caretaker relatives of dependent children and certain children with severe disabilities who are receiving Supplemental Security Income from the Social Security Administration. In addition, if a woman has Medicaid when she gives birth, her newborn is automatically enrolled in Medicaid coverage and will remain eligible for at least a year. Visit HealthCare.gov's [Health Coverage If You're Pregnant, Plan to Get Pregnant, or Recently Gave Birth](#) webpage for more details.
- Youth may qualify through the "Ribicoff amendment," which allows States to extend coverage to youth under 21 who meet State-defined income limits.
- A child or youth adopted from foster care and covered by an adoption assistance agreement funded solely by the State or Tribe (rather than through title IV-E) may be eligible for either Medicaid or a program with benefits equal to Medicaid if the State has determined the child cannot be placed with an adoptive family without medical assistance because the child has special needs for medical, mental health, or rehabilitative care (see [SSA 471\(a\)\(21\)](#)).

See [Children in the Child Welfare System](#) on the MACPAC site for a broad overview of eligibility pathways.

OTHER HEALTH-CARE COVERAGE (NON-MEDICAID)

While the majority of children and youth in foster care are eligible for Medicaid, those who are not may be eligible for other subsidized programs or other health-care coverage (Child Welfare Information Gateway, 2015). Children not in foster care but whose families are involved with child welfare may also be eligible for other kinds of government-sponsored coverage.

CHILDREN'S HEALTH INSURANCE PROGRAM

Like Medicaid, CHIP is a State-administered program jointly funded by the State and the Federal Government. CHIP provides free or low-cost health-care coverage to children (through age 18) whose families earn too much to qualify for Medicaid. In most States, this means that children in families with incomes above 133 percent FPL and up to 250 percent FPL or higher might qualify for CHIP. The Federal Government website [InsureKidsNow.gov](#) describes both Medicaid and CHIP eligibility and benefits.

HEALTH INSURANCE MARKETPLACE AND PRIVATE HEALTH-CARE COVERAGE

Health insurance purchased through the Health Insurance Marketplace (also known as the "exchange")—which was made available through the ACA—or through an employer may be the answer to health-care coverage for some children and youth with adoption assistance agreements, some young adults who have aged out of foster care but do not meet eligibility requirements for the Chafee option or for Medicaid, and some families receiving child welfare services but who are not eligible for Medicaid. The ACA has made private health-care coverage more attainable by more people and has removed some restrictions—such as denial of coverage for preexisting conditions and dollar limits on essential benefits—that kept citizens from purchasing or fully using health insurance. To view plans available on the Marketplace, visit [HealthCare.gov](https://www.healthcare.gov), and to view private plans available outside of the Marketplace, visit the [Plan Finder](#) website.

Young adults who age out of care without Medicaid. Young adults who do not meet the eligibility requirements for the Chafee option (or are not living in a State that provides it) or the eligibility requirements for other Medicaid groups can purchase private health-care insurance through their employers, if employed, or through the Marketplace. Those with lower incomes or larger households may qualify for plans at a reduced cost. The Federal Government offers a [tool](#) that provides a quick view of income levels that qualify for premium savings based on household size, estimated household income, and the State or territory where someone lives.

Support During the COVID-19 Pandemic

The American Rescue Plan Act includes several provisions, including tax credits, to make health-care coverage more affordable and accessible for families and individuals—including youth formerly in foster care—struggling during the COVID-19 pandemic. To learn more about how this law can help, refer to the CMS factsheet [American Rescue Plan and the Marketplace](#).

For information on other resources available to support children, youth, and families, visit the Children's Bureau's [COVID-19 Resources](#) webpage and Information Gateway's [Supporting Youth in Foster Care Through the Pandemic](#) webpage.

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

COVERAGE BENEFITS

Children need a broad spectrum of health-care coverage that includes both preventive and treatment services. Screening services are essential for the prevention and early detection of health issues. This section discusses the general benefits that Medicaid and other health-care insurers offer to children and youth in foster care or those who have aged out of foster care.

MEDICAID BENEFITS

State Medicaid programs offer an array of services, including mandatory services such as physician, inpatient hospital, and lab and x-ray services as well as optional services such as dental services, physical therapy, and clinic services. As such, State Medicaid programs differ from State to State. The Medicaid website lists both the [mandatory and optional benefits](#). In general, the services for children and youth in foster care include preventive, screening, diagnostic, and treatment services necessary to ensure optimal physical and behavioral health.

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

- Screening services, including the following:
 - Comprehensive health and developmental history, including assessment of both physical and mental health development
 - A comprehensive unclothed physical
 - Appropriate immunizations
 - Laboratory tests, including blood lead level assessment
 - Health education, including anticipatory guidance
- Vision services, including diagnosis and treatment for defects in vision, such as eyeglasses
- Dental services, which, at a minimum, includes relief of pain and infections, restoration of teeth, and maintenance of dental health
- Hearing services, which, at a minimum, include diagnosis and treatment for defects in hearing, including hearing aids
- Any other medically necessary health care, diagnostic services, or treatment coverable under section 1905(a) of the SSA to correct or ameliorate defects and physical and mental illnesses and conditions, whether or not such services are otherwise provided in the State's Medicaid plan

States determine their own individual medical necessity criteria for the services listed above. They also must establish a schedule for medical, dental, vision, and hearing screenings and ensure that enrolled children and their families are notified about the availability of screenings.

Medicaid dental and vision care provided to youth up to age 26 are important health-care services, but they can be difficult to access, as addressed below:

“For the dental and vision, there is not a clear understanding of what [was] covered... what I would pay...[and] what kind of work and treatment and expenses. Eventually, once communicating with insurance companies, I was able to see where I [could] get services. The unfortunate part was it was over an hour away from me to receive dental care.”

—Youth formerly in foster care

Behavioral health and trauma services. The child welfare field emphasizes identification and treatment of trauma in children and youth in foster care. As with other mental and behavioral health issues, trauma responds best to early diagnosis and individualized treatment. These kinds of services are covered under the Medicaid EPSDT benefit. Services may include screening, therapy and counseling, medication, substance use disorder treatment, and inpatient services. For more information, refer to [Coverage of Behavioral Health Services for Youth With Substance Use Disorders](#), a joint informational bulletin issued by CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2015, and [Prevention and Early Identification of Mental Health and Substance Use Conditions](#), an informational bulletin issued by CMS in 2013.

Additionally, the Administration for Children and Families (ACF), CMS, and SAMHSA issued a [joint letter](#) in 2013 to State directors on the topic of trauma. The letter provides background information on trauma experienced by children in foster care, discusses tools to screen for trauma and assess service needs, and provides recommendations for interventions to meet those needs.

Intergenerational Trauma

Intergenerational trauma (also known as “historical trauma”) affects populations who have experienced cumulative and collective trauma over multiple generations, such as in African-American and American Indian/Alaska Native communities. Although intergenerational trauma is not a diagnosis itself, children within these families may exhibit signs and symptoms of trauma—such as depression, grief, guilt, and anxiety—for which they may need treatment. Children may exhibit these symptoms even if they have not personally experienced the traumatic events.

For more information, refer to the following Information Gateway products: [Child Welfare Practice to Address Racial Disproportionality and Disparity](#), [The Indian Child Welfare Act: A Primer for Child Welfare Professionals](#), and [The Importance of a Trauma-Informed Child Welfare System](#).

Home- and community-based services. Some health-care services that previously might have been provided in an institutional setting may now be provided in the home of a child or youth or in a community-based setting. A joint letter from ACF, CMS, and SAMHSA (2013) outlines how States may offer a [State Plan Home and Community Based Services \(HCBS\) benefit](#) to provide home- and community-based services for the treatment of behavioral health issues, including trauma, for individuals, including children in foster care, whether or not they qualify for an institutional level of care as long as they have significant need.

The letter also outlines how States may use an [HCBS waiver](#) to cover similar services and serve individuals with significant needs who *do* meet an institutional level of care criteria but prefer to receive services in a home or community setting. These waivers allow States to provide comprehensive or "wraparound approach" care for children and youth with disabilities who might otherwise require institutionalization (CMS, 2014).

Psychotropic medications. Although the cost of prescribed psychotropic drugs, as well as other prescribed medications for children and youth in foster care, is generally covered as a medical benefit by Medicaid, the child welfare field has become increasingly concerned about the high numbers of children and youth in foster care who take prescribed psychotropic medications. Children in foster care receive psychotropic medications at a higher rate than other children (Park et al., 2019).

The [Child and Family Services Improvement and Innovation Act of 2011](#) required States to establish protocols for the appropriate use and monitoring of psychotropic medications with children and youth in foster care. To help States develop these protocols, the Children's Bureau issued Information Memorandum [ACYF-CB-IM-12-03](#) in 2012 to promote "the Safe, Appropriate, and Effective Use of Psychotropic Medication for Children in Foster Care." A review by the U.S. Department of Health and Human Services (HHS) Office of Inspector General (2018), however, found that one in three children in foster care who were treated with psychotropic medications received neither treatment planning nor medication monitoring as required by States.

For more information about the use of psychotropic medications in children in foster care, refer to the following:

- [Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care \(Spanish version\)](#) (Children's Bureau)
- [Supporting Youth in Foster Care in Making Healthy Choices: A Guide for Caregivers and Caseworkers on Trauma, Treatment, and Psychotropic Medications \(Spanish version\)](#) (Children's Bureau)
- [Improving the Appropriate Use of Psychotropic Medication for Children in Foster Care: A Resource Center](#) (Center for Health Care Strategies)
- [Understanding Psychotropic Medications](#) (Information Gateway)

Health Coverage for American Indians and Alaska Natives

The ACA expanded the range of health-care options for American Indians in [federally recognized Tribes](#) and for [Alaska Native Claims Settlement Act](#) corporation shareholders as well as for others of American Indian descent. For American Indian children and youth in foster care, these benefits may be in addition to those already available because of the child's foster care status. Visit the following Federal health-care websites for more information about these special protections and benefits:

- [Health Coverage for American Indians & Alaska Natives](#)
- [Medicaid & CHIP for American Indians and Alaska Natives](#)
- [Coverage Resources for Your Tribal Community](#)
- [American Indian/Alaska Native Center](#)
- [Indian Health & Medicaid](#)
- [Native Youth](#)

For general information about American Indian and Alaska Native children and families in relation to the child welfare system, see the following resources:

- [Capacity Building Center for Tribes](#)
- [Tribal Information Exchange](#)
- [The Indian Child Welfare Act: A Primer for Child Welfare Professionals](#) (Information Gateway)

Reproductive and sexual health services. Female teens who had experienced foster care are more likely to become teenage parents than their counterparts not in foster care, and although there is less research on teen pregnancy regarding males in foster care, some studies have found high rates among that population, too (Combs et al., 2018). Therefore, easy access to reproductive health services is crucial for them. Family-planning services are a [mandatory benefit](#) under the Federal Medicaid program. While each State may determine the specific services and supplies that will be covered under its Medicaid State plan, any definition must include services to prevent or delay pregnancy and be sufficient in amount, duration, and scope to reasonably achieve the purpose of the benefit. Examples of covered services are counseling services and patient education, examination and treatment by medical professionals, laboratory tests, and pharmaceutical supplies and devices. The services must be available to men as well as women and to individuals under age 21 eligible for EPSDT services. To promote contraceptive use to prevent unplanned pregnancy and improve pregnancy timing and spacing, the Center for Medicaid and CHIP Services established the [Maternal and Infant Health Initiative](#).

Health homes. Through the optional [health homes](#) Medicaid State plan benefit, the ACA expanded treatment options for individuals with chronic medical conditions who are covered by Medicaid. States may opt to use a health home model to coordinate comprehensive physical and behavioral health care (including treatment for mental health and substance use disorders) and to provide linkages to long-term services and supports, including social services, for eligible persons. Health homes operate under a "whole-person" philosophy, caring for both clinical and nonclinical needs. This option may apply to youth in or formerly in foster care with serious and persistent mental illness, serious emotional disturbance, or certain chronic conditions who live in States that have opted to design health homes. States that opt to establish health homes through Medicaid must submit a State plan amendment to CMS for approval. More information is available on the [CMS Health Home Information Resource Center](#) site.

Other services covered by Medicaid. In addition to direct health services, Medicaid includes services that help a child or youth access necessary care. Examples include coverage of transportation services to take a child and their family to a practitioner's office and coverage of language translation or interpreter services at a medical appointment. Although interpreter services are not classified as mandatory [1905\(a\) coverable services](#), many States provide translation and interpretation services or require Medicaid health plans to do so.

For more information about other services, read [EPSDT: A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents](#), a CMS guide that helps States and others understand what is covered under Medicaid for children and youth. Additional EPSDT guides, information, and resources are also available on CMS' [Early and Periodic Screening, Diagnostic, and Treatment](#) webpage.

MARKETPLACE AND PRIVATE INSURANCE BENEFITS

For the few children and youth in (or formerly in) foster care who do not qualify for Medicaid, coverage through the Marketplace or private health insurance also covers a variety of preventive and treatment services for medical and behavioral health-care issues. The ACA requires that Marketplace plans cover [10 essential health benefits](#). Some private health-care plans available through employers are [exempt](#) from providing some of these services.

Preventive services. Most health insurers must provide specific preventive services for children (and adults) at no cost. Some of these services include screenings for autism, vision, hearing, developmental issues, and obesity; immunizations for childhood diseases and other diseases, such as measles and hepatitis; and screenings and examinations, as indicated, for adolescents and teens, such as alcohol and drug use assessments, depression screenings, HIV screenings, and sexually transmitted infection counseling and screening.

The full list of mandatory preventive services is available on the [Preventive Care Benefits for Children](#) website. The [Preventive Care Benefits for Women](#) website contains the full list of services for women who are or may become pregnant.

Physical health benefits. The ACA requires Marketplace plans to cover such medical services as pediatric care, outpatient care, hospitalization, necessary surgeries, laboratory services, and prescription drugs; [pregnancy, maternity, and newborn care](#); and rehabilitative services. Other health insurance plans are also required to include specific benefits, although "grandfathered" and self-insured plans may have some exemptions.

Behavioral health-care benefits. [Coverage for behavioral health care](#), including mental health and substance use disorder services, is part of the essential services mandated by the ACA for Marketplace plans. Specifically, the ACA requires that substance use disorder screening, brief intervention, and treatment be offered in all health plans. The ACA also helps beneficiaries by expanding the [Mental Health Parity and Addiction Equity Act of 2008](#) to cover individuals who receive insurance through small employers or purchase it on the individual market (see [45 CFR 156.115\(a\)\(3\)](#)).

See the [What Marketplace Health Insurance Plans Cover](#) webpage for additional information about medical benefits.

Maternal, Infant, and Early Childhood Home Visiting Programs

The Health Resources and Services Administration (HRSA) within HHS houses the [Title V Maternal and Child Health Program](#). While not technically a medical health program, the title V block grant funds many services crucial to the healthy development of vulnerable infants and children. Since 2010, title V has provided funding to States for programs that provide [home visits](#) to families and children by health, social services, and child development professionals. These programs also help improve coordination and referrals for other community-based resources and supports, including those that improve access to health care for pregnant and parenting mothers and their children. Pregnant women and families with children who are newborn to 5 years can qualify for services based on certain factors, such as low income, teen parenthood, or a history of maltreatment. The programs are administered by States—though they are locally managed—and are modeled on evidence-based programs. Trained visitors provide guidance and advice to promote positive parenting, reduce maltreatment, and ensure children are healthy and ready for school.

Visit HRSA's [Home Visiting](#) webpage for more details on these programs.

IMPROVING HEALTH-CARE COVERAGE FOR CHILDREN AND YOUTH IN FOSTER CARE

The coverage available to children and youth in or aging out of foster care may present new or better service options for some individuals. However, identifying those who are eligible, communicating the benefits to them, and ensuring they receive optimal health-care coverage remains a challenge. Additionally, States and jurisdictions need to consider the different funding streams and how they can be used to achieve the best coverage for this population. This section discusses ways in which States and jurisdictions have addressed these issues and provides links to tools for helping inform youth and families about health-care options.

Using Data to Improve Health Care for Children and Youth in Foster Care

In 2021, CMS, in collaboration with the Children's Bureau, launched the [Foster Care Learning Collaborative on Improving Health Care for Children and Youth in Foster Care](#). Through the collaborative, State Medicaid and child welfare agencies, along with their partners, seek to increase their understanding of data-driven interventions to improve timely access to health care and learn about the science of quality improvement. The collaborative includes a webinar series as well as an affinity group for States interested in developing and implementing data-driven quality improvement projects.

Additionally, each State's Comprehensive Child Welfare Information System (CCWIS) must, to the extent practicable, include bidirectional data exchanges with the State systems used to determine Medicaid eligibility and process claims. For more information, refer to [Comprehensive Child Welfare Information System Technical Bulletin #2: Data Sharing Between CCWIS and Child Welfare Contributing Agencies](#).

STATE EXAMPLES OF WHAT WORKS

To meet Federal requirements and provide optimal care for children and families receiving child welfare services, State and Tribal child welfare agencies have developed several programs and systems related to health-care services.

Coordination and documentation of health-care services. As a condition of their title IV-B funding, States and Tribes must submit a plan for how they will provide oversight of health-care services for children and youth in foster care, including how they will ensure coordination with the State Medicaid agency, health-care experts and professionals, and child welfare experts (Children's Bureau, 2010). In addition, SSA section 475(1)(C) requires children's case plans to document their immunizations, health-care providers, and any relevant medical or behavioral conditions and treatments. The following are examples of how some States are transitioning children and youth in foster care to specialized Medicaid managed-care programs to improve care coordination and health-care quality (Thompson, 2021):

- In Georgia, children and youth have a care coordinator and receive access to tailored health-care services for their unique needs, such as clinical trauma screening, wellness visits, and preventive services. Additional services include a dental cleaning twice a year; free, unlimited over-the-counter items; and general education development.
- Illinois assigns children and youth a health-care coordinator to coordinate services, conduct care planning, and perform assessments. Children receive a free gym membership, after-school care, uniforms, and access to community-based health services.
- Both Texas and Wisconsin give children and youth access to a specialized medical home where they have timely access to comprehensive health services for coordinated care. Texas offers rewards for accessing preventive services, while Wisconsin provides ongoing health care for a year after leaving foster care.

Integrated Care for Kids Model

The [Integrated Care for Kids \(InCK\)](#) Model is a child- and family-centered health-care model to improve the quality of care for children covered by Medicaid and CHIP and reduce [health-care expenditures](#) through prevention, early identification, and treatment of behavioral health challenges and physical health needs. The model was developed to help identify and address risk factors for complex physical and behavioral health conditions that often present in environments—such as foster care—that are outside of clinical care and to help integrate care coordination and case management across service providers.

In 2019, CMS awarded \$126 million in InCK Model funding to eight grantees to serve all children covered by Medicaid (and CHIP, if applicable) from the prenatal period up to age 21 who reside with a sub-State geographic area specified by the awardee and approved by CMS. Some programs also serve pregnant women over the age of 21 who are covered by Medicaid

Providing health-care coverage for young adults. The new coverage mandated by the ACA for young adults up to age 26 who have aged out of foster care ensures that most youth leaving foster care with no permanent family continue to remain eligible for health care in the short term. However, challenges remain, especially in identifying and enrolling eligible young adults. States providing the Chafee option have identified some best practices to ensure youth retain their Medicaid coverage. As outlined in an HHS report, States identified the following strategies for ensuring health-care coverage for youth who age out of foster care (Pergamit et al., 2012):

- Collaboration between the child welfare and Medicaid systems³
- Coordinated data systems that automatically notify Medicaid when a young adult is aging out of foster care
- Ongoing training for child welfare and Medicaid staff
- Education of youth about how to enroll and recertify in their State as well as their potential eligibility

The report also notes that some States use an automatic enrollment and annual recertification process that requires no or minimal youth involvement, while others use a life-skills approach that requires youth to be proactive and educated about their benefits and obligations to obtain those benefits. The life-skills approach may offer youth a better opportunity to understand their coverage and seek care, but the automatic process yields higher initial coverage rates. States using an automatic process may want to ensure they are still providing these youth with information about their options and coverage during the transition-planning process.

³ Listen to "[Developing Cross-Agency Collaboration to Better Serve Children in Foster Care](#)," a podcast episode by the Center for Health Care Strategies, to learn how some State Medicaid and child welfare agencies are collaborating.

RESOURCES FOR YOUTH AND FAMILIES

Health-care coverage policies are not easy to understand for most people. Eligibility requirements and application forms may exceed the understanding of young adults who have aged out of the foster care system and may not know about or understand all their benefits and how to access them.

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

- [Coverage to Care](#) (CMS)
- [Medicaid and CHIP FAQs: Coverage of Former Foster Care Children](#) (CMS)
- [Medicaid and CHIP FAQs: Funding for the New Adult Group, Coverage of Former Foster Care Children and CHIP Financing](#) (CMS)
- [Health Care for Former Foster Youth](#) (FosterClub)
- [Medicaid to 26 for Former Foster Youth](#) (Juvenile Law Center)
- [Health & Wellness](#) (Nation Foster Youth Institute)

What Young Adults Need to Do to Enroll in Medicaid

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

1. Contact your [State Medicaid agency](#).
2. Tell them you aged out of foster care and want to sign up for Medicaid.

Visit the Federal Government's [Medicaid & CHIP Coverage](#) web section for more information on enrolling and answers to common questions.

RESOURCES FOR CHILD WELFARE AGENCIES

The following resources can help child welfare professionals better understand how they can ensure children and youth in or formerly in foster care have health-care coverage:

- [Connecting Children, Youth, and Families to Health-Care Coverage](#) (Capacity Building Center for States)
- [Health Insurance: Medicaid, CHIP, and the Affordable Care Act](#) (Information Gateway)
- [EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents](#) (CMS)
- [Access to Healthcare](#) (Juvenile Law Center)
- [Working With Youth to Develop a Transition Plan](#) (Information Gateway)

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DISCLAIMER

While every attempt has been made to be as complete as possible, both Federal and State laws change frequently, so this document may not be up to date on the most recent legislation. For the most recent information, visit the Federal websites cited throughout this document or contact your State [Medicaid](#) or [child welfare](#) agency.

SUGGESTED CITATION

Child Welfare Information Gateway. (2022). *Health-care coverage for children and youth in foster care—and after*. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. <https://www.childwelfare.gov/pubs/issue-briefs/health-care-foster/>



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