Enhancing a System of Care for Children, Adolescents and Young Adults in Foster Care

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INTRODUCTION

Children in foster care experience significant trauma and face a number of other social and environmental factors that impact their longer-term health and well-being. Many children, adolescents and young adults in foster care or adoption assistance (collectively referred to throughout this paper as children in foster care) have extensive physical health and mental health conditions, intellectual and/or developmental disabilities, and substance use disorders. These children also experience unique social challenges that result from their lack of environmental stability due to removal from their family and often multiple foster placements.

More often than not, before children are placed in foster care they have been raised in environments of violence and poverty and have experienced abuse and neglect. Furthermore, when removed from their homes, these children typically experience feelings of anger, guilt, rejection, shame and abandonment — all of which contribute to psychological difficulties that impact health, safety, permanency and well-being.

Findings from the landmark Adverse Childhood Experiences Study, which is one of the largest investigations to assess the links between childhood maltreatment and longer-term health and well-being, suggest certain experiences in childhood can be major risk factors for the leading causes of illness and death later in life. According to the study, childhood maltreatment can lead to numerous negative outcomes, including but not limited to:

- Improper brain development
- Impaired cognitive (learning ability), socio-emotional (social and emotional skills), and language development
- Anxiety, depression, post-traumatic stress disorder, conduct disorder, as well as difficulties with learning, attention and memory
- Higher risk for heart, lung and liver diseases; obesity; cancer; high blood pressure; cholesterol
- Greater risk of juvenile arrest and higher likelihood of adult criminal behavior and violent crime
- Smoking, alcoholism, and drug abuse

Statistically, children in foster care represent 1.5 percent of both Medicaid beneficiaries and Medicaid expenditures overall. However, these children are among the more complex and costly Medicaid beneficiaries (on a per-capita basis), due in part to the prevalence of mental health and substance use disorders, as well as other mental illness (referred to collectively throughout this paper as behavioral health conditions, although specific interventions and treatment approaches vary across the type of conditions). Children in foster care are also among the more costly Medicaid beneficiaries due to high placement rates in psychiatric residential treatment facilities and other therapeutic settings. When these individuals’ health care and social support needs (which include but are not necessarily limited to child welfare, education, housing, employment, transportation and juvenile justice services) are not appropriately and effectively addressed, the children may experience further trauma, which exacerbates acute problems and often extends them into adulthood. For instance, although not limited to children in foster care, the average additional lifetime costs associated with nonfatal childhood maltreatment is roughly $210,000 per child — which reflects health and child welfare spending, criminal justice and special education costs, as well as loss of productivity. Providing children in foster care with the services they need during childhood and making sure their needs are adequately assessed, diagnosed and treated by professionals who understand trauma will help address acute health conditions and set them up for a successful adulthood.

An integrated, coordinated, trauma-informed system of care is crucial to improving the health, safety, permanency and well-being of children in foster care. Yet, traditional Medicaid fee-for-service (FFS) seldom provides the level of care management intensity...
An integrated, coordinated, trauma-informed system of care is crucial to improving the health, safety, permanency and well-being of children in foster care.

- Coordinating with state agencies that support children in foster care (e.g., child welfare, education, juvenile justice) and partnering with community-based organizations to ensure supports, including specialty care, are available
- Identifying in coordination with case workers the most appropriate — not just readily available — services each child needs to help ensure their safety, permanency and well-being
- Delivering continuity of care and consistency of services for children who have experienced complex trauma; may have early brain development issues; and/or are at risk for poor development, adjustment and health outcomes
- Building successful transitions into adulthood given the significant challenges for children who “age-out” of the foster care system, including identifying supports in adult service systems if needed
- Serving as a valuable partner and resource to child welfare agencies as they meet federal requirements regarding coordination of health care services, development of personalized transition plans prior to emancipation, and case plans ensuring stability and educational supports

A managed care approach that uses a single, statewide MCO working in close partnership with state Medicaid, child welfare, education and other critical agencies offers an effective solution for states seeking to realize positive outcomes for children in foster care.

MEDICAID’S ROLE IN THE HEALTH CARE OF CHILDREN IN FOSTER CARE

Medicaid plays an important role in meeting the health and supportive service needs of children in foster care. On average during 2011, the most recent year for which complete data are available, nearly 900,000 children in foster care were receiving Medicaid coverage at any given point in time. (See Appendices A and B for more information.) Among children in foster care covered by Medicaid at any point during 2011, 75 percent were covered continuously by Medicaid throughout the year. In contrast, just 61 percent of other children (excluding those with disabilities) who were on Medicaid the whole year. Although children may transition in and out of foster care and other parts of the child welfare system, they typically remain enrolled in the Medicaid program due to low family incomes. Coverage through a single MCO can help establish continuity of care and stability for children in foster care.

Medicaid expenditures for children in foster care totaled $5.6 billion nationwide during federal fiscal year (FFY) 2011.
Children with low costs may in fact have a number of unaddressed needs that care coordination can help meet, while children with the highest-cost clinical complexities will especially benefit from intensive care and service coordination with individualized care plans and dedicated multidisciplinary care teams.

**Exhibit 1.**
**Distribution of 12-Month Costs of Children in Foster Care, FFY 2011**

<table>
<thead>
<tr>
<th>12-Month Costs</th>
<th>Percent of Costs</th>
<th>Percent of People</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$1,000</td>
<td>1.7%</td>
<td>40.0%</td>
</tr>
<tr>
<td>$1,000 – $9,999</td>
<td>20.4%</td>
<td>45.2%</td>
</tr>
<tr>
<td>$10,000 – $49,999</td>
<td>35.2%</td>
<td>11.3%</td>
</tr>
<tr>
<td>$50,000 - $99,999</td>
<td>17.6%</td>
<td>2.1%</td>
</tr>
<tr>
<td>$100,000+</td>
<td>25.1%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: Menges Group tabulations using data from a large state Medicaid program.

According to recent research, 35 to 60 percent of children in foster care have acute or chronic physical conditions — such as complex chronic conditions or illnesses, neurological problems, hearing loss, vision loss, obesity, asthma, growth failure and sexually transmitted diseases. Between 30 and 60 percent of children in foster care have developmental delays that range from minor developmental delays to significant intellectual, developmental and physical disabilities. Additionally, an evaluation of children formerly in foster care found that more than 54 percent had at least one mental health condition; nearly a quarter of these children had post-traumatic stress disorder. Tabulations from a large state indicated that during 2011, behavioral health services accounted for 66 percent of all Medicaid spending on children in foster care.

Each state determines how children in their state’s foster care receive services, whether through an unmanaged FFS system, through waiver programs or through comprehensive Medicaid MCOs. There is variation across states, including in the intensity of services offered. To date, several states have adopted managed care models to serve most of their children in foster care: Florida, Georgia, Illinois, Louisiana, South Carolina, Texas, Virginia and Washington. (See Appendix C for state-by-state figures.) Ample opportunity exists for other states to use a tailored managed care model to more effectively coordinate services for children in foster care. It is an approach that is gaining traction across the country as a growing number of states are evaluating the benefits of delivering services to children in foster care using MCOs.
ENHANCING A SYSTEM OF CARE FOR CHILDREN IN FOSTER CARE: THE VALUE PROPOSITION

An integrated health management program builds on key principles and best practices for children in foster care, including but not limited to approaches such as the High Fidelity Wraparound (HFW) model. Incorporating the tenants of HFW or other similar approaches into a managed care program offers the greatest promise for enhancing children’s access to a system of care comprised of comprehensive services and social supports. This approach creates a single point of service coordination that provides for comprehensive, person-centered planning. The MCO can work with the child welfare system to enhance access to medical services while coordinating closely on — and augmenting where appropriate — the social supports already being provided by the child welfare system. This approach can address barriers while enhancing:

- Access to and coordination of comprehensive health services and social supports (e.g., primary care physician, dental, LTSS, other community-based services and social supports)
- Quality of and access to specialized care and services, including care coordinators and providers educated and trained in trauma-informed and trauma-responsive services
- Attainment of safety, permanency and well-being through wrap-around services and intensive coordination processes
- Continuity of care and facilitation of transitions in care
- Coordination with other agencies and support systems (e.g., child welfare, juvenile justice and education)
- Support for foster families and birth families, such as supplemental training on the effects of trauma, safety and crisis planning to help the child achieve stability and permanency
- Integration of behavioral health services
- Outcomes monitoring and tracking

While each state has different strategies and processes developed specifically for their foster care population, comparable needs exist in each state that are addressed through focused coordination and integration. The following highlights ways in which an MCO can enhance the system of care and work with other state agencies and support systems to better support children in foster care.

**Bridging Gaps Between Health Care and Social Services**

Reducing fragmentation and uncoordinated care should be a key goal of delivering comprehensive services and social supports to children in foster care. Service providers, care managers and case workers often do not know about other agencies’ benefit programs for which children in foster care are eligible. Additionally, given how frequently children in foster care move or are relocated, they may experience disruptions or lack of continuity of care due to inconsistent exchange of clinically important information between providers.

A comprehensive managed care program facilitates access to and coordinates needed services in numerous ways. MCOs deliver a person-centered, fully integrated model that seamlessly links children in foster care to the services and social supports that meet their needs and improve their health outcomes. A managed care organization provides access to a one-stop resource for managing and coordinating all service and social supports needs, directing person-centered planning, and tailoring care plans based on a child’s specific needs. Through managed care, children gain access to other services they may not typically access under the Medicaid FFS system. A comprehensive approach that effectively coordinates services and supports provides

**Managed Care Perspectives**

*Bridging Life Transitions to Independent Living*

An Amerigroup Georgia care coordinator arranged primary care, dental and psychiatrist appointments for an 18-year-old member recently released from jail who was transitioning from living with his parents to living independently. The care coordinator helped the member get connected to local housing information and other community programs to support his independence.

Source: Program information from the Amerigroup Georgia health plan.
children with consistency and continuity of care, helping to decrease placement disruptions. For example, when a child moves from one foster family to another, the MCO can share important information with new providers in a timely fashion to help reduce further disruptions and difficulties the child may experience.

For example, through the Amerigroup Georgia health plan, children in foster care benefit from a number of key services and social supports delivered through a managed care program that uses the HFW model. These services and social supports include:

- Care coordination team
- Enhanced provider network
- 24/7 dedicated foster care intake communication center
- Focus on transition for children aging out of the foster care system
- Ombudsman program, which serves as the MCO’s own confidential, informal, impartial and independent resource where members and their families or caregivers can go with their concerns
- Professional and behavioral health expertise provided to the state agency staff and judges within the child welfare system
- Health promotion team
- Psychotropic medication management program
- Dental and medical homes
- Better coordinated and comprehensive services and social supports

An MCO’s approach to comprehensive service coordination can also more quickly link members to the services they need. For instance, states require that medical, dental and vision exams occur soon after placement. MCOs can be valuable in facilitating these prompt assessments and providing appropriate, ongoing access and care coordination to treat and/or more fully assess all identified health concerns.

An important component of comprehensive service coordination is an emphasis on cultural competency. For example, the Amerigroup Georgia health plan tracks the cultural and linguistic needs of members to ensure they are paired with culturally and linguistically appropriate services. Care coordinators who reflect the diverse composition of the communities and understand the cultural characteristics of the child’s birth family help identify and connect the child to appropriate services and supports.

In addition to case managers, supporting the foster families who serve as the primary caregivers of each child in foster care is also critical. Given the array of other life demands and stressors these families balance in addition to being foster parents, they too can benefit from a comprehensive managed care approach. An effective care coordination program for children in foster care will include many elements directed at informing and supporting caregivers, such as respite support, organizing and facilitating caregiver support groups, and connecting caregivers to available community resources. For instance, the Amerigroup Georgia health plan provides respite benefits for caregivers, which include a temporary break from their regular caregiving responsibilities.

Managed Care Perspectives

Individualized Care Planning

“Jessica” is a 14-year-old girl in foster care who was hospitalized with major depressive disorder, end-stage renal disease and suicidal ideation. When she was ready for step-down to a lower level of care, no psychiatric residential treatment facility was equipped to accommodate Jessica’s medical needs, and no medical facility had adequate services to address her psychiatric needs.

Her Amerigroup Georgia case manager collaborated with an array of community resources to facilitate a step-down. After extensive consultation with the child welfare agency and numerous providers, a residential program agreed to accept Jessica, with Amerigroup Georgia arranging for Jessica’s regular transportation for dialysis services, ensuring provision of adequate medical equipment at the residential center and training their staff regarding medical monitoring.

When Jessica arrived at the residential treatment facility, her care plan was already in place and a smooth transition was achieved. Amerigroup’s care coordinator has met with Jessica and the facility staff at least once a month, and Jessica did not subsequently experience any adverse medical effects while being treated for her behavioral condition.

Source: Program information from the Amerigroup Georgia health plan.
Note: Names are fictitious to protect the identity of the member.
to help alleviate the high risk of emotional or physical stress or to offer temporary assistance to those unable to provide care due to illness or family emergency. Another example is Health Services for Children with Special Needs, a Medicaid health plan operating in the District of Columbia, which hosts a male caregivers meeting every Wednesday evening where attendees can support one another and share information and experiences about engaging with their children. This health plan also organizes numerous activities available to all family caregivers.

Enhancing and Unifying the System of Care Through Better Coordination

The child welfare agency is a critical partner in the coordination of services and social supports for children in foster care. Managed care models have the expertise, experience and flexibility in program design, desire and motivation to work with the child welfare agency, as well as the other agencies involved in the children’s lives, to jointly develop the most effective and comprehensive system of care. A system of care aims to integrate the child’s full experience — health care, child welfare, education, career preparation for transition-age youth, and other social services and supports. Providers in a FFS system are less likely to be aware of or engage with these agencies, exacerbating the effects of poor cross-agency coordination and a lack of relevant data. When there is a clear, single point of accountability, there is a significantly increased likelihood for improved outcomes, such as safety, stability and child well-being. In the FFS setting, one or more care coordinators may be assigned, but there is no single individual or agency accountable for managing and coordinating across the continuum of services and social supports. An MCO is consistently involved across placements and services and is accountable whenever a child in foster care changes placement — especially when a state elects a single, statewide MCO.

An MCO, as part of its comprehensive approach to enhancing the system of care, facilitates communication at a state agency level. Better collaboration at the state agency level improves service coordination across supportive and affordable housing, education, employment opportunities, the juvenile justice system and other services that help a child achieve safety and well-being — including as they transition out of foster care. This coordination is particularly crucial as youth prepare to exit the foster care system but still require support to begin employment, post-secondary education or to establish critical community-living supports in the adult system.

There are a variety of key ways in which a single, statewide MCO can support a more coordinated, integrated system for children in foster care. For example, the Amerigroup Georgia health plan, which serves as the single statewide MCO, engages in the following activities to bolster coordination:

- Facilitation of bi-weekly conference calls with agencies that serve children in foster care — including the Department of Child and Family Services
- Co-location of clinical and administrative support staff in select high-volume offices of the state child welfare agency in targeted counties cross the state, dedicated clinical discharge planning staff in the Psychiatric Residential Treatment Facilities (PRTFs) and assigned care coordinators for large group homes. This arrangement enhances collaboration and coordination, facilitates transitions in care, and increases the health plan’s understanding of the needs of the state child welfare partners. Building on this experience, the health plan — in collaboration with the state — developed a process to enhance relationships with state agencies, improve communication, facilitate information sharing and reduce the administrative burden for the state child welfare agency and its partners. This approach also facilitates timely member access to screenings, assessments, services and supports.
- Facilitation of training opportunities for multiple state agencies (e.g., child welfare, juvenile justice, community health and education) that ultimately improves care for members. A recent example is a partnership with the Department of Juvenile Justice (DJJ) to educate their placement staff on how to request and use psychological testing for members enrolled in the Amerigroup Georgia health plan. Health plan staff worked with DJJ to create the training content and then participated in one
of DJJ’s joint meetings with providers to train them on the new parameters. The health plan also provides education for law enforcement regarding techniques when a child needs to be removed from his/her home and how to address challenges that arise when called to intervene in child’s living situation.

Lastly, MCOs have the resources, expertise and relationships to act as a centralized access point for stakeholders. MCOs analyze data and generate reports that can be shared across state agencies to keep stakeholders informed and to identify issues and opportunities for improving the delivery of health services and social supports. Given that the child welfare system has access to numerous funding streams that are used to serve children in foster care — such as Medicaid, mental health block grants and child welfare funding — MCOs can also apply their expertise with public health program financing to work with the state to align financing streams to ensure the appropriate resources are available as needed.

**Fully Integrating Physical and Behavioral Health Services and Supports**

As discussed earlier, many children in foster care have behavioral health conditions, often in addition to co-occurring physical health conditions. There is limited capacity and few structures in place in the FFS setting to effectively integrate and manage physical and behavioral health services. The absence of a coordinated approach to service delivery can often result in critical gaps, such as a failure to incorporate customized screening, assessment and/or evidence-based interventions into delivery systems or provide enhanced support and resources to primary care and behavioral health care providers that can assist with better diagnoses and treatment of childhood trauma.26 The absence of information sharing between behavioral health specialists and primary care providers can exacerbate fragmentation of services and social supports.

Managed care focuses on the integration of physical and behavioral health needs — coordinating services and social supports that meet the child’s needs in a comprehensive manner. For example, as part of its role as the single MCO serving children in foster care in Georgia, the Amerigroup Georgia health plan has several programs specifically designed for members with complex health care needs, including a comprehensive care coordination team comprised of specially trained and educated staff, telemedicine, peer supports, and Patient-Centered Medical Home (PCMH) initiatives.27

Some Medicaid MCOs promote access to needed services by engaging young adult and adult “peer navigators” who have themselves experienced many of the same issues when they were children. Amida Care, a New York City Medicaid special needs plan, uses peer specialists and community health outreach workers in this manner.28 Co-location of services has been shown to have a positive impact on children’s health care — with the most frequently co-located services being mental health and child development.29 Though each MCO may have its own particular approach, several Medicaid MCOs also support co-location of behavioral therapists in physical health care settings where this model is realistically achievable.30

One of the most critical challenges to serving children in foster care is oversight of the use of psychotropic medication to address behavioral health concerns.31 Nationally, prescription drugs are the second-highest component of Medicaid spending for children in foster care, behind only physician/clinic services.32 State officials and other staff who coordinate care for children in foster care have often observed that some children are over-medicated, particularly with regard to psychotropic regimens.33 This perspective
Enhancing a System of Care for Children, Adolescents and Young Adults in Foster Care is substantiated by research. For instance, a Government Accountability Office report found that “foster children who lived in group homes or residential treatment centers had much higher rates of psychotropic medication use than foster children living in nonrelative foster homes or formal kin care — 48 percent versus 14 percent and 12 percent, respectively.”

Better management and coordination of medications can bring immediate value to the child and to the state through improved quality of life. When children need medications, MCOs operate programs to facilitate adherence to the prescribed schedule and dosage and help optimize the clinical benefits of the therapeutic regimen. One approach is the use of psychotropic medication management programs. Components of an effective program typically include monitoring to identify instances of medicating young children or prescribing multiple medications of the same class and ensuring the appropriate medication/diagnosis combination. Effective programs also incorporate peer review with the prescriber and regular data monitoring reports. The Amerigroup Georgia health plan operates a Psychotropic Medication Coaches (PMC) program that aims to improve therapy outcomes for children.

### Managed Care Perspectives

**Amerigroup Georgia’s Pathway to Permanency Program**

Amerigroup Georgia health plan’s Pathways to Permanency program was developed to provide enhanced services for members under the age of 18 with significant or complex behavioral health challenges. This may include children and youth residing in PRTFs, psychiatric hospitals or crisis stabilization units; with one or more admissions to these types of facilities; or those at high-risk for admission or readmission to one of these facilities. The program is a joint initiative between the health plan and several community-based organizations — Chris Kids, Youth Villages and the Multi-Agency Alliance for Children (MAAC) — that provide an array of trauma-informed health care services and social supports to at-risk youth and children in foster care.

Pathways to Permanency was launched in February 2015 and provides a collaborative team approach to accessing and coordinating intensive, community-based behavioral health services, placement and supports to stabilize the youth including movement toward permanence. Amerigroup Georgia enrolled 30 youth in the Pathways to Permanency program with a 2015 program goal of serving 100 youth. Each eligible member’s care team is comprised of a trauma-informed, licensed therapist and an intensive community interventions coordinator (ICIC), who are both available on a 24/7 basis. Key components of the program include:

- Team facilitation and evaluation tracking for all youth by MAAC
- Chris Kids Pathways to Recovery program for youth whose parents’ rights have been terminated and/or have no identified or potential family placement
- Youth Villages Intercept program for youth who have an identified or potential family placement
- Trainings on trauma and mental health first aid are provided to all placement providers, foster care families of enrolled youth, Department of Children and Family Services case managers, direct care staff, and care management organization clinical staff members through direct coaching and monthly telephonic contact
- Providers are trained on intervention strategies based on best practices, such as the Attachment, Self-Regulation and Competency (ARC) Model

Program outcomes goals include a reduction in days in a facility or hospital, increase in days spent in a community placement, and members ultimately discharged from the program due to a permanent placement.

Recent feedback received from a foster care case manager with the DFCS speaks to the positive impact that the program has had to date: “I just want to say that whoever is responsible for creating and supporting the Pathways to Permanency program — job well done! It was the key to getting “Billie” and his family back together after two years! The aftercare program will also be instrumental in sorting through issues that arise when children finally return home. This is a very thought-out, refreshing program that can make a huge difference.”

Source: Program information from the Amerigroup Georgia health plan.

Note: Names are fictitious to protect the identity of the member.
who take behavioral medications and are at risk for medication-related problems. The PMC program works to improve medication adherence, detect and reduce adverse drug events, monitor and reduce patterns of overuse, and provide frequent and routine outreach for high-risk members. MCOs can also serve as the most experienced assessor — making sure decisions to prescribe medications are made while considering all circumstances of the child and foster family.

MCOs take a broader view when it comes to assessing a child’s medication needs and prescribing psychotropic medications, ensuring other services and supports are in place for the child. After careful consideration and with preference for nonpharmacologic services and social supports as the first option, effective management and coordination of psychotropic medications requires that critical services and social supports remain in place — or are added — to help the individual avoid a crisis. MCOs have flexibility, expertise and insight across the member’s full range of care to make sure children, their foster family and providers have the right mix of services available to support the child at home and fill any potential gaps. The MCO works closely and collaboratively with the child welfare case manager, behavioral health provider, and foster or adoptive parents to develop crisis plans that specify the services and supports available to the child that can be accessed before reaching a critical crisis point.

Enhancing Continuity of Care, Stability and Permanency

Continuity of care is essential when supporting children in foster care. Frequent changes in placements and caregivers cause instability in children’s lives and further exacerbate the fragmented health and social services and supports. For transition-age youth in foster care, coordination across multiple agencies and types of supports, including services and supports for adults, is crucial. Within and across agencies, identifying whom to contact to secure needed information and/or decisions can be challenging. Given the movement within and between service systems, MCOs can play a key role in assisting children maintain continuity of services as they move from one placement to another (e.g., transfer from a PRTF to the community but need services while waiting for a placement, transition from the juvenile justice system to the community, transition from an inpatient hospital setting back to the community); move between caregivers; move from one geographic area of the state to another; or age out of the foster care system altogether. Proactive planning and coordinating services and social supports prior to transition are critical activities that an MCO can perform effectively — especially as a single, statewide approach.

One way in which MCOs can effectively support transitions and stability is by supporting and participating in the development of permanency plans, which are created by the child welfare agency. A permanency plan is one of several plans required for children in foster care. The plan includes the child’s permanency goals as well as the tasks and responsibilities of the people involved — all oriented toward maintaining a child with their birth family or with another permanent family. In supporting the planning process, MCOs can engage directly with the other agencies and support systems that serve children in foster care to ensure the child has all of the health and social supports needed to gain permanency and stability in the community. MCO participation in permanency planning, as well as other planning processes, helps bolster the system of care for children in foster care and ensures the service plan reflects the needs of the child and foster family.

Transitions for children, youth and young adults in the foster care system are critical due to the potential for additional trauma and the potential for service disruptions. Without a comprehensive and coordinated transition plan for services and social supports, youth aging out of the foster care system “fall off the cliff” and often end up homeless, in jail or experiencing other poor outcomes. In one study, approximately 11 percent of participants leaving the foster care system reported at least one episode of homelessness by age 19, 22 percent by age 21, and 36 percent by age 26.
homelessness by age 19; that number grew to 22 percent by age 21, and to 36 percent by age 26. These negative outcomes can be avoided through proactive planning.

MCOs can help transition-age youth as they move into Medicaid coverage as an adult, which they are eligible for up to age 26 as former children in foster care. For instance, MCO care coordinators can assist with the enrollment process to ensure there are no interruptions in their health coverage.

MCOs can also cultivate a variety of opportunities that help children in foster care transition successfully out of the child welfare program and achieve permanency. The MCO can provide training and interventions that focus on transitions to ensure continuity of care and minimize the trauma for the child. For example, the Amerigroup Georgia health plan has implemented the Coaching and Comprehensive Health Supports (COACHES) program, a coach-driven pilot program that incorporates principles of a wraparound case management model. The COACHES program establishes a comprehensive network of health and social supports around the child — including health, community resources (both natural supports and provider services), child welfare, housing, employment, education, financial, and other key resources in the community. The program is designed to provide youth aging out of foster care with the knowledge and skills to navigate and access their health care services, improve life skills, increase connectedness with at least one identified adult support and gain the skills to live self-sufficiently — all helping lead to better health and quality of life outcomes.

MCOs can enhance stability and permanency by supporting the foster family and other caregivers integral to the child’s well-being. Child welfare agencies or their contractors have the responsibility to train foster families and others (e.g., emergency responders, social workers). However, the MCO also can provide intensive training and technical assistance regarding issues such as the effects of trauma, safety and crisis planning. Training can prepare the family to assist with the child’s health needs (e.g., behavioral health conditions, trauma-informed care and trauma-responsive care) and can offer them techniques for addressing challenging behaviors that the child may demonstrate. This can improve the likelihood that a child remains stable at home and does not cycle in and out of institutional service settings, such as a PRTF, or move in and out of different foster homes. MCOs can also offer this level of training to adoptive families or the biological family, if there is an option of the child being returned to the home. This training supports families maintain an environment of consistency and stability for the child and help the child achieve permanency as they transition home, reducing their risk of returning to the foster care system.

Developing and Ensuring Access to Specialized Provider Networks

MCOs supporting children in foster care must contract with a range of providers including pediatric specialists and subspecialists as well as those having certification or training in treating children and youth who have experienced trauma, sexual abuse, grief and loss, and other challenges. Cultural competency and sensitivity is another important area where health plans add value. MCOs are increasingly adept at matching members with providers who share their ethnicity and/or native language to improve doctor-patient communication, increase the comfort of the child, and engage the members and their caregivers to take active roles in their health and wellness.

The service and support needs of children in foster care can vary greatly, depending on factors such as age, underlying trauma and/or health conditions. MCOs develop targeted programs built on best and promising practices to serve the specific needs of children in foster care. MCOs also have the expertise and resources to collaborate locally and nationally with colleges, universities and organizations — such as Casey Family Program, Child Welfare League of America and the North American Council on Adoptable Children — to evolve and apply best practice models and engage in program evaluation.

For example, the Amerigroup Georgia health plan — in collaboration with community-based providers — is exploring best and promising practices to develop interventions for children in foster care who are between the ages of birth to 5. Flexibility to develop interventions for particular groups of children can improve both short- and long-term outcomes.
Managed care links each enrollee to a primary care provider (PCP) and to a dental home provider when dental services are carved-in. MCOs may also provide incentives to PCPs to improve the quality of care delivered to their members. One way MCOs achieve this is linking payment to performance on measures included in the Healthcare Effectiveness Data and Information Set (HEDIS) quality rating system. HEDIS is used by more than 90 percent of health plans and the federal government to evaluate performance on important dimensions of care and service delivery. More and more, MCOs furnish actionable data to PCPs to assist them in these pursuits, including identifying gaps in receipt of preventive services, and providing real-time links between PCPs, behavioral health providers, and specialty and ancillary providers.

MCOs can also support providers and specialized networks through education and training. Through its Amerigroup Academy outreach and training program, the Amerigroup Georgia health plan offers providers a comprehensive suite of in-person and Web-based education along with informative guides, newsletters, and fact sheets across a range of topics related to children in foster care. This approach gives providers (including PCPs, dental, pharmacy, and behavioral health providers) and state agency staff important training and resources related to: intensive care management and coordination of services and social supports; trauma-informed care; cultural and linguistic competence; child and family involvement in service planning; and individualized services and social supports in the community. MCOs can help transform the delivery of services to children in foster care by providing support and incentives to complete training and implement new practices.

GUIDING PRINCIPLES FOR A SUCCESSFUL FOSTER CARE MANAGED CARE PROGRAM

A successful managed care program incorporates the requirements, experiences and preferences of the child, family members, former foster youth, provider partners, community-based resources, the various state agencies involved with the child and other stakeholders involved in the child’s services and social supports. The guiding principles included below offer ways to improve coordination of services and social supports for children in foster care.

Create a Single Source Managed Care Program for Children in Foster Care

A foundation exists to create a managed care program for children in foster care. The approach described in this paper to develop a tailored system of managed care for children in foster care should drive the MCO selection process as well as the program’s operational requirements.

A number of states are enrolling all children in foster care and adoption services into a statewide managed care program using a single MCO. By using a single MCO statewide, these states are promoting greater stability and continuity of care for children particularly as they move between placements and foster families. For foster parents caring for more than one child, having a single, statewide plan is easier to navigate and reduces the risk of critical services, social supports and information “falling through the cracks.” Additionally, a single, statewide MCO dedicated to serving children in foster care offers regionally focused teams that meet children and caregivers where they are, combined with strong statewide community engagement that addresses needs across both rural and urban areas. Having a single statewide MCO reduces fragmentation and gaps in service as members move around the state. Being able to remain with the same MCO — regardless of the frequency or location of changes — is important for continuity of care.

The single statewide MCO provides the state with a streamlined, less administratively complex program. The Medicaid agency will have a single point of entry for all children in foster care in Medicaid, regardless of region or county. In addition, a single, specialized MCO makes coordination with child welfare and other agencies more effective and efficient, which in turn will cultivate a more unified system of care for the child.
Preserve and Promote an Integrated Benefit Design

Some Medicaid managed care programs exclude — or “carve out” — certain services, such as behavioral health services, dental care or prescription drugs. Carve-outs promote fragmentation. States should enlist MCOs to coordinate care for children in foster care on a holistic, comprehensive basis and avoid carve-outs to the greatest possible extent.

It is particularly important with respect to foster care to integrate physical health and behavioral health services. As described throughout this paper, behavioral health conditions are highly prevalent among children in foster care. An effective system of comprehensive coverage needs to include these services. Similarly, a well-managed prescription drug program is central to the treatment of health conditions for children in foster care — to both ensure access and adherence to needed medications and to avoid inappropriate medications. Inclusion of the prescription drug benefit gives the MCOs valuable real-time data to support these efforts. Including dental services is also valuable in ensuring holistic care, as foster care children are at particular risk of receiving inadequate oral health care. Overall, the MCO should be able to address all of the health care services and social supports the child needs through a comprehensive service plan that takes into account the strengths of the child and their needs across all life domains.

Require a Tailored Model of Care Coordination for Children in Foster Care

The particular needs of children in foster care call for a tailored model of coordinated care. States should articulate requirements in detail, similar to what was outlined in the recent Georgia Families 360° RFP and Texas’s STAR Health solicitations. Other states that currently serve children in foster care through MCOs can serve as important guideposts for program design, even if those states do not utilize a single-MCO approach. Attributes of an effective managed care program and MCO partner include:

- Capability to work with all requisite state and county agencies and engage effectively with community support services on behalf of the children, their caregivers and their front-line clinical providers
- Experience coordinating care for children with significant behavioral health conditions, complex physical health needs, and fragile family and social supports
- Experience delivering holistic care coordination for children who have a complex array of conditions spanning physical and behavioral health and bridging into child welfare, juvenile justice, education and social domains
- Care coordinators and providers who have specialized training and expertise in critical areas like trauma-informed and trauma-responsive care and who can assist members with navigating the system of care
- Resources to produce and follow through on an individualized care plan and transition plan for all children in or leaving the foster care system, including children with complex diagnoses and medication regimens
- Ability to track access to preventive and treatment-related services and to work with all involved parties to address all identified gaps in care
- Coordination with the state ombudsman’s office to advocate for, support and protect the rights of the member
- Medication adherence and psychotropic drug management programs
- Technology and innovative models for engaging and supporting children
- Capacity for quality improvement and reporting and program evaluation activities
State contracts with MCOs to coordinate care for children in foster care also need to include oversight and evaluation mechanisms to ensure the state’s program requirements are being met. Many strong examples of this also exist, as Medicaid agencies have become increasingly adept at monitoring MCOs’ performances and collaborating with them to identify and improve members’ health outcomes.

Utilize Advanced Technologies to Enhance Information-Sharing and Program Performance

Technology partnerships between states and MCOs can greatly enhance the capabilities of the system of care for children in foster care by taking full advantage of available information technologies. Access to relevant data and health care records about these children can be dispersed across providers and numerous state agencies, including schools and the juvenile justice system. Under a well-designed managed care approach, an MCO can:

- Use information provided by the state upon the child’s enrollment to support immediate delivery of services and ensure continuity of care
- Partner with the state to leverage its health information exchange or network to support a comprehensive virtual health record for all children in foster care
- Address the gaps in health information among the key state agencies involved with the child’s care
- Provide data updates to the state Medicaid agency — sharing health care information gathered on the member for purposes of facilitating integration and program monitoring, as well as to support ongoing data collection beyond the child’s enrollment in managed care
- Collaborate with the state agencies to improve data collection on the social determinants of health using sources such as contact information for all key caregivers (in birth and foster families), school records and housing/placement information
- Provide a “one-stop-shop” portal for state agencies and providers that shares important information (e.g., training resources, access to MCO care coordinators) to enhance service delivery for the member

CONCLUSION

States are in the early stages of fully integrating and coordinating the total physical health, behavioral health care, and social services and supports needs of children in foster care. This integrated approach is crucial to improving children’s health statuses and quality of care and services while enhancing access to a system of care and promoting safety, permanency and well-being. MCOs assist states achieve these goals through active engagement, training, collaboration, communication and coordination with the member and the other service systems that play an important role in the child’s care. Managed care also facilitates and supports the level of provider engagement and training necessary to drive further improvements in quality. All of these critical functions undergird the accountable, centralized, comprehensive coordination of services and social supports that an MCO can offer.

For children in foster care, who have complex needs necessitating care and support across an array of specialized services, an MCO serves as a centralized point of contact to assist the child and their caregivers in navigating all needed services and programs in both the health care and child welfare systems. Moreover, an MCO supports its members in developing holistic and comprehensive plans that address their physical, behavioral, cognitive, and social strengths and needs across the spectrum of health care services and social supports. The comprehensive and coordinated approach of MCOs helps provide children in foster care with the foundational supports for independence and self-advocacy. The result is a better system of care for the child, reduction in service gaps, increased stability and well-being, as well as improved health outcomes and quality of life now and later in life.
Appendix A. Coverage and Costs: Children in Foster Care Compared to Other Children in Medicaid With No Disabilities and All Medicaid Beneficiaries, FFY 2011

<table>
<thead>
<tr>
<th>National Totals, FFY 2011</th>
<th>Children in Foster Care</th>
<th>Other Medicaid Covered Children with No Disabilities</th>
<th>All Medicaid Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Persons Covered During Year</td>
<td>838,771</td>
<td>27,234,410</td>
<td>57,118,893</td>
</tr>
<tr>
<td>Total Persons Covered (any point during year)</td>
<td>961,551</td>
<td>33,251,191</td>
<td>72,126,243</td>
</tr>
<tr>
<td>Percent of Persons Covered Throughout Year</td>
<td>74.5%</td>
<td>61.4%</td>
<td>58.8%</td>
</tr>
<tr>
<td><strong>Costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Medicaid Spending</td>
<td>$5,617,452,639</td>
<td>$65,560,142,022</td>
<td>$366,628,087,236</td>
</tr>
<tr>
<td>Capitation Expenditures</td>
<td>$1,081,522,348</td>
<td>$33,433,374,377</td>
<td>$108,827,964,235</td>
</tr>
<tr>
<td>Capitation as % of Total Expenditures</td>
<td>19.3%</td>
<td>51.0%</td>
<td>29.7%</td>
</tr>
<tr>
<td>Costs Per Covered Person Per Year</td>
<td>$6,697</td>
<td>$2,407</td>
<td>$6,419</td>
</tr>
<tr>
<td>Costs Per Covered Person Per Month</td>
<td>$558</td>
<td>$201</td>
<td>$535</td>
</tr>
</tbody>
</table>

Source: Based on an analysis conducted by The Menges Group using data from the Centers for Medicare and Medicaid Services’ Medicaid Statistical Information System (MSIS).

Appendix B. Distribution of Medicaid Children in Foster Care, Nationwide, FFY 2011

<table>
<thead>
<tr>
<th>Age Distribution</th>
<th>Race/Ethnicity Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>Caucasian</td>
</tr>
<tr>
<td>1-5</td>
<td>Black/African-American</td>
</tr>
<tr>
<td>6-12</td>
<td>Hispanic/Latino</td>
</tr>
<tr>
<td>13-14</td>
<td>Other/Unknown</td>
</tr>
<tr>
<td>15-18</td>
<td>Gender Distribution</td>
</tr>
<tr>
<td>19-20</td>
<td>Male</td>
</tr>
<tr>
<td>21+</td>
<td>Female</td>
</tr>
</tbody>
</table>

Source: Based on an analysis conducted by The Menges Group using data from the Centers for Medicare and Medicaid Services’ Medicaid Statistical Information System (MSIS).
## Appendix C. State Summary of Children in Foster Care Enrolled in Medicaid – Coverage, Costs and Use of Capitated Model, FFY 2011

<table>
<thead>
<tr>
<th>State</th>
<th>Children in Foster Care (average during year)</th>
<th>Total Cost</th>
<th>PMPM Cost</th>
<th>Percent Capitated</th>
<th>All Medicaid Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Children in Foster Care</td>
<td>Other Children in Medicaid</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alaska</td>
<td>3,380</td>
<td>$41,459,997</td>
<td>$1,022</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Alabama</td>
<td>10,105</td>
<td>$104,678,852</td>
<td>$863</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Arkansas</td>
<td>7,359</td>
<td>$69,379,056</td>
<td>$786</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Arizona</td>
<td>14,723</td>
<td>$63,905,935</td>
<td>$362</td>
<td>99%</td>
<td>82%</td>
</tr>
<tr>
<td>California</td>
<td>90,775</td>
<td>$460,898,740</td>
<td>$423</td>
<td>9%</td>
<td>56%</td>
</tr>
<tr>
<td>Colorado</td>
<td>17,386</td>
<td>$130,600,287</td>
<td>$626</td>
<td>31%</td>
<td>17%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>5,887</td>
<td>$34,032,826</td>
<td>$482</td>
<td>27%</td>
<td>50%</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>5,431</td>
<td>$42,643,729</td>
<td>$654</td>
<td>23%</td>
<td>78%</td>
</tr>
<tr>
<td>Delaware</td>
<td>1,823</td>
<td>$16,020,038</td>
<td>$732</td>
<td>20%</td>
<td>65%</td>
</tr>
<tr>
<td>Florida*</td>
<td>45,238</td>
<td>$182,675,713</td>
<td>$337</td>
<td>20%</td>
<td>54%</td>
</tr>
<tr>
<td>Georgia*</td>
<td>26,715</td>
<td>$130,312,106</td>
<td>$406</td>
<td>6%</td>
<td>91%</td>
</tr>
<tr>
<td>Hawaii</td>
<td>5,408</td>
<td>$20,802,500</td>
<td>$321</td>
<td>56%</td>
<td>76%</td>
</tr>
<tr>
<td>Iowa</td>
<td>10,356</td>
<td>$64,933,056</td>
<td>$523</td>
<td>23%</td>
<td>9%</td>
</tr>
<tr>
<td>Idaho</td>
<td>3,889</td>
<td>$27,674,069</td>
<td>$593</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Illinois*</td>
<td>49,816</td>
<td>$263,394,587</td>
<td>$441</td>
<td>0%</td>
<td>6%</td>
</tr>
<tr>
<td>Indiana</td>
<td>21,578</td>
<td>$86,768,641</td>
<td>$335</td>
<td>1%</td>
<td>55%</td>
</tr>
<tr>
<td>Kansas</td>
<td>14,025</td>
<td>$110,005,303</td>
<td>$654</td>
<td>27%</td>
<td>73%</td>
</tr>
<tr>
<td>Kentucky</td>
<td>13,785</td>
<td>$172,398,838</td>
<td>$1,042</td>
<td>6%</td>
<td>25%</td>
</tr>
<tr>
<td>Louisiana*</td>
<td>10,747</td>
<td>$54,450,160</td>
<td>$422</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>2,032</td>
<td>$10,232,234</td>
<td>$420</td>
<td>33%</td>
<td>66%</td>
</tr>
<tr>
<td>Maryland</td>
<td>16,377</td>
<td>$170,697,061</td>
<td>$869</td>
<td>20%</td>
<td>60%</td>
</tr>
<tr>
<td>Maine</td>
<td>3,233</td>
<td>$10,485,215</td>
<td>$270</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Michigan</td>
<td>12,010</td>
<td>$61,218,234</td>
<td>$425</td>
<td>47%</td>
<td>77%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>9,959</td>
<td>$104,241,955</td>
<td>$872</td>
<td>12%</td>
<td>82%</td>
</tr>
<tr>
<td>Missouri</td>
<td>28,865</td>
<td>$212,218,937</td>
<td>$613</td>
<td>14%</td>
<td>51%</td>
</tr>
<tr>
<td>Mississippi</td>
<td>5,612</td>
<td>$41,226,589</td>
<td>$612</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>Montana</td>
<td>3,731</td>
<td>$33,243,666</td>
<td>$743</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>North Carolina</td>
<td>18,869</td>
<td>$185,200,684</td>
<td>$818</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>North Dakota</td>
<td>1,846</td>
<td>$15,330,456</td>
<td>$692</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>Nebraska</td>
<td>11,678</td>
<td>$80,535,673</td>
<td>$575</td>
<td>9%</td>
<td>27%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>2,071</td>
<td>$26,633,860</td>
<td>$1,072</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>24,186</td>
<td>$188,016,468</td>
<td>$648</td>
<td>19%</td>
<td>73%</td>
</tr>
<tr>
<td>New Mexico</td>
<td>5,140</td>
<td>$53,004,254</td>
<td>$859</td>
<td>88%</td>
<td>80%</td>
</tr>
<tr>
<td>Nevada</td>
<td>7,880</td>
<td>$95,844,829</td>
<td>$1,068</td>
<td>1%</td>
<td>61%</td>
</tr>
<tr>
<td>New York*</td>
<td>49,669</td>
<td>$468,869,101</td>
<td>$787</td>
<td>6%</td>
<td>57%</td>
</tr>
<tr>
<td>Ohio</td>
<td>30,325</td>
<td>$144,915,790</td>
<td>$399</td>
<td>0%</td>
<td>67%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>8,199</td>
<td>$97,757,316</td>
<td>$994</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Oregon</td>
<td>16,429</td>
<td>$82,888,047</td>
<td>$420</td>
<td>74%</td>
<td>83%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>42,845</td>
<td>$202,132,210</td>
<td>$393</td>
<td>71%</td>
<td>88%</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>4,961</td>
<td>$56,078,026</td>
<td>$942</td>
<td>38%</td>
<td>81%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>12,279</td>
<td>$70,863,729</td>
<td>$481</td>
<td>7%</td>
<td>49%</td>
</tr>
<tr>
<td>South Dakota</td>
<td>3,855</td>
<td>$42,557,545</td>
<td>$920</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>18,522</td>
<td>$71,202,723</td>
<td>$320</td>
<td>63%</td>
<td>87%</td>
</tr>
<tr>
<td>Texas*</td>
<td>70,799</td>
<td>$564,265,309</td>
<td>$664</td>
<td>49%</td>
<td>40%</td>
</tr>
<tr>
<td>Utah</td>
<td>7,897</td>
<td>$44,719,340</td>
<td>$467</td>
<td>9%</td>
<td>26%</td>
</tr>
<tr>
<td>Virginia*</td>
<td>12,591</td>
<td>$120,982,488</td>
<td>$801</td>
<td>1%</td>
<td>50%</td>
</tr>
<tr>
<td>Vermont</td>
<td>2,377</td>
<td>$47,682,422</td>
<td>$1,671</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Washington*</td>
<td>20,844</td>
<td>$70,675,360</td>
<td>$283</td>
<td>3%</td>
<td>68%</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>14,814</td>
<td>$66,381,820</td>
<td>$373</td>
<td>9%</td>
<td>58%</td>
</tr>
<tr>
<td>West Virginia</td>
<td>8,071</td>
<td>$80,757,146</td>
<td>$834</td>
<td>1%</td>
<td>51%</td>
</tr>
<tr>
<td>Wyoming</td>
<td>2,787</td>
<td>$19,565,719</td>
<td>$585</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>U.S. Total</td>
<td>838,771</td>
<td>$5,617,452,639</td>
<td>$558</td>
<td>19%</td>
<td>51%</td>
</tr>
</tbody>
</table>

Source: Based on an analysis conducted by The Menges Group using data from the Centers for Medicare and Medicaid Services’ Medicaid Statistical Information System (MSIS).

Green highlighting denotes states with percentage of capitation spending for children in foster care of fifteen or more percentage points below corresponding percentage for other Medicaid-covered children.

*Denotes states that have substantially increased use of the capitated MCO model for children in foster care since 2011. The category “Other Children in Medicaid” excludes children with disabilities.
ENDNOTES


2. Ibid.


4. Nearly two-thirds of the study population reported at least one experience of childhood abuse, neglect, and exposure to other traumatic stressors, while over 20 percent of children reported three or more experiences. Centers for Disease Control and Prevention, [http://www.cdc.gov/violenceprevention/acestudy/findings.html](http://www.cdc.gov/violenceprevention/acestudy/findings.html) (accessed July 27, 2015).


6. Based on an analysis conducted by The Menges Group using data from the Centers for Medicare and Medicaid Services’ Medicaid Statistical Information System (MSIS) for federal fiscal year 2011. This represents the most recent year of complete state data, at the time of analysis. The lower rate of continuous coverage for other children in Medicaid (excluding children with disabilities) is most likely because these children are in families whose incomes fluctuate, leading to changes in eligibility.

7. Based on an analysis conducted by The Menges Group using data from a large state Medicaid program. This state shared its information on condition that it not be named. The state used mostly traditional fee-for-service payment.


11. Program information from the Amerigroup Georgia health plan.

12. Program information from the Amerigroup Georgia health plan.


14. Program information from the Amerigroup Georgia health plan.


16. This state shared its information on condition that it not be named. Tabulations using the data were conducted by The Menges Group to yield this statistic.

17. Youth and Family Training Institute, “High Fidelity Wrap Around,” [http://www.yftipa.org/high-fidelity-wraparound](http://www.yftipa.org/high-fidelity-wraparound) (accessed August 20, 2015). The High Fidelity Wraparound model is an evidence-based approach that brings together multiple systems (e.g., agencies, providers, natural supports) to build up the child’s strengths and interests and those of the child’s natural support system in order to address complex health and social support needs.


19. The Amerigroup Georgia health plan serves as the lone managed care organization serving children in foster care and adoption assistance in Georgia—a total of approximately 26,000 members.

20. Program information from the Amerigroup Georgia health plan.

21. Ibid.

22. Ibid.


25. Ibid.

26. Ibid.

27. Program information from the Amerigroup Georgia health plan.

Enhancing a System of Care for Children, Adolescents and Young Adults in Foster Care


30. Through Anthem’s affiliated health plans’ Primary Care Integrated Screening, Identification, Treatment, and Evaluation (PC-INSITE) program, a behavioral health provider is embedded in the PCP’s office. Working with typically larger primary care practices, a behavioral health coach (licensed clinical social worker, psychologist, marriage and family therapist) is co-located in the primary care clinic to carry out universal screening on members. A tailored version of this model is being developed for children.


32. MSIS prescription drug costs shown are pre-rebate. Medicaid receives substantial rebates from drug manufacturers on prescription drugs, but these net (post-rebate) costs are not available by eligibility category.


35. Allen and Hendricks, 4.


38. The COACHES program is funded through a cooperative agreement with the Center for Medicare and Medicaid Innovation and was awarded as part of CMS’s Health Care Innovation Awards grant program.


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About the Anthem Public Policy Institute
The Anthem Public Policy Institute was established to share data and insights to inform public policy and shape the health care programs of the future. The Public Policy Institute strives to be an objective and credible contributor to health care innovation and transformation through publication of policy-relevant data analysis, timely research, and insights from Anthem’s innovative programs.

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