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# Child Welfare Systems Policies and Practices Affecting Medicaid Health Insurance for Children

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# Child Welfare Systems Policies and Practices Affecting Medicaid Health Insurance for Children: A National Study

Anne M. Libby Kelly J. Kelleher Laurel K. Leslie Joan O'Connell Patricia A. Wood Jennifer A. Rolls John Landsverk

ABSTRACT. This study presented national data on financing policies and practices for health and mental health care among children in child welfare settings, including those who are not placed out of the home. Our three objectives were to: examine variation in the provision of health insurance with a specific focus on placement status; describe mechanisms for assuring timing of coverage; and compare Medicaid expansionary practices to innovations in financing and organization of services for youth. Expansionary Medicaid practices were associated with managed care and innovations in the financing and organization of mental health services such as carve-outs. doi:10.1300/J079v33n02\_04 [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <a href="http://www.HaworthPress.com">http://www.HaworthPress.com</a> © 2006 by The Haworth Press, Inc. All rights reserved.]

**KEYWORDS.** Foster care, mental health, Medicaid, youth, child, adolescent, child welfare, insurance, health care finance

Medicaid public health insurance—a joint federal and state program that finances health care services for low-income and vulnerable individuals—is the largest insurer of children's health care (Newacheck, Pearl, Hughes, &

Halfon, 1998; Yudkowsky & Tang, 1997). In 2001, there were approximately 76 million children under age 19 in the U.S.; 17 million of the poorest and disabled of these were insured through their state Medicaid program or through

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Supplemental Child Health Insurance Program (SCHIP), the state-regulated supplemental insurance program for children that may involve either Medicaid expansions or private alternatives (Bhandari & Gifford, 2003). Access to health care through public health insurance programs such as Medicaid has been linked to improved health and mental health outcomes, conceptually and empirically, for more than three decades (Aday & Andersen, 1974; Andersen, 1968, 1995; DiGiuseppe & Christakis, 2003; Phillips, Morrison, Andersen, & Aday, 1998).

One specific vulnerable and often low-income population is children and adolescents involved with child welfare. Children in contact with child welfare systems have been show to be particularly vulnerable to health and mental health problems, have a history of poor access to care, and may experience trauma associated with removal from their home and known family (Klee, Soman, & Halfon, 1992). Children in foster care, compared to children from similar socioeconomic backgrounds, have significantly higher rates of chronic physical disabilities, serious emotional and behavioral problems, developmental delays, and poor school achievement (Halfon, Berkowitz, & Klee, 1992a; Horowitz, Simms, & Farrington, 1994; Rosenfeld et al., 1997; Simms & Halfon, 1994). Children involved with child welfare systems and who remain in their homes are also at higher risk of emotional disorders and developmental problems (Burns et al., 2004; James, Landsverk, Slyman, & Leslie, 2004). Although almost no cost or use data are available on child welfare cases who remain in the home, foster children have very high health and mental health care use with corresponding costs (Halfon, Berkowitz, & Klee, 1992b; Harman, Childs, & Kelleher, 2000; Takayama, Bergman, & Connell, 1994). However, there is still ample evidence that many youth in need are not reached; for example, placements with relatives (kinship care) reduces access to specialty mental health services (James, Landsverk, Slyman, & Leslie, 2004; L. K. Leslie et al., 2000).

Medicaid/SCHIP has been a critical link in health and mental healthcare services for children and adolescents involved with the child welfare system, including both youth placed in foster care as well as those who remain in their home of origin following investigation for possible abuse/neglect (Leslie, Kelleher, Burns, Landsverk, & Rolls, 2003). Indeed, this link between child welfare services and healthcare has even been suggested as a facilitated gateway to care for low-income children with unmet health care needs (Snowden, Cuellar, & Libby, 2003) and has generated mounting fears that children may come into contact with the child welfare system explicitly for this reason (U.S. General Accounting Office, 2003). There are several challenges, however, related to the provision of coverage through Medicaid for children engaged in the child welfare system. First, no federal law guarantees that comprehensive Medicaid coverage be available for all children who enter the child welfare system; it is assumed that these youth are covered by Title IV-E provisions of the federal Medicaid regulations. Title IV-E only covers children entering foster care, however, whose birth parents fall within a certain income range. Most states utilize a patchwork of mandatory and optional categories to cover the needs of children who do not qualify under Title IV-E. For example, children who remain in their home of origin can apply for Medicaid under low-income or disability categories but it is unclear how many and what proportion of these children have access to Medicaid through these mechanisms. Thus, there may be important variation in child welfare strategies to access health care coverage for children in their care.

Medicaid eligibility may not be enough, however, to obtain health and mental health care for youth involved with the child welfare system. Discontinuities in coverage and care are highly associated with the nature of these children's system involvement. Little may be known about a child's medical history (Leslie, Kelleher, Burns, Landsverk & Rolls, 2003). Furthermore, many children may have inconsistent health insurance coverage due to placement changes while in the child welfare system (Leslie, Kelleher, Burns, Landsverk & Rolls, 2003). Placement changes pose another potential obstacle to care. The average length of stay in foster care is two years; half of the children involved in the system experience one placement change and nearly a quarter involved have three or more placement changes (DiGiuseppe

& Christakis, 2003). Lastly, states have considerable latitude in managing Medicaid resources and expanding the pool of eligible children in two ways. Firstly, states may choose to offer expansionary practices that provide coverage for youth who would not qualify due to income limitations, such as expanding health insurance coverage through SCHIP, e.g., 150 or 200 percent of the federal poverty income level (Brach et al., 2003; Holahan, 2002). Secondly, states may engage in other innovative practices for benefit design or service delivery. Two specific types of innovations in Medicaid benefit design-managed care and capitated or carve-out programs—have been the focus of much attention. These have been especially prevalent in public specialty mental health systems across the U.S. in the last decade, and have had significant effects on the type and amounts of services received, as well as on the budgets for that care. For example, youth involved with the child welfare system in Colorado were shown to have the strongest response to capitated mental health benefits via decreased inpatient services and increased outpatient services, compared to youth not involved with child welfare or youth involved with juvenile justice (Cuellar, Libby, & Snowden, 2001).

Thus, states have flexibility regarding their Medicaid programs in three areas that may significantly impact the health and mental health outcomes of youth active to child welfare—their use of Medicaid as a health insurance mechanism, their policies related to immediate and continuous eligibility, and their use of innovative mechanisms. The current literature base sheds little light on these areas. First, no national data on the use of Medicaid insurance for highly vulnerable youth in the child welfare system exist. The common assumption that insurance is not a barrier for such youth has not been evaluated nor is it clear how much variation exists from state to state. Second, published literature on the health and mental health of this population has focused on the smaller proportion of children active to the child welfare system, namely, those children placed out-of-home in foster care, rather than the approximately 85 percent of cases who remain in-home, with or without services. Third, while previous studies of Medicaid policy and states' willingness to engage in expansionary and innovative practices have demonstrated clear patterns of innovation that differentiate states by their willingness to expand coverage and explore alternative methods of service delivery for most Medicaid recipients (Holahan & Pohl, 2002) has not been linked to child welfare services.

This paper uses a national probability sample of the child welfare system and the State Medicaid offices in the United States to describe policies and procedures with respect to public health insurance via Medicaid for youth in the child welfare system. A national perspective is important due to wide variation in state level programs and contributions for youth involved with child welfare, including direct service expenditures. For example, states spent between \$67 and \$785 per capita for youth involved with child welfare, reflecting variation in the federal and the state contributions to these services, the latter of which accounted for between \$4 and \$504 per capita (Bess, Andrews, Jantz, Russell, & Geen, 2002). We investigated variation in the provision of health insurance to youth involved with the child welfare system, examining (a) source of Medicaid eligibility; (b) timing of coverage; (c) use of Medicaid expansionary practices and innovation in financing and organization of medical and mental health services in the public sector for these states.

## **METHODS**

## Sample

The Caring for Children in Child Welfare (CCCW) study that provided data for this paper was a supplemental study to the National Survey of Child and Adolescent Well-being (NSCAW), a longitudinal study of more than 6,000 children who were involved with Child Welfare Services (Barth et al., 2002; Biemer, Liu, Iannacchione, Bryron, & Cano, 1998). The CCCW study used the same sampling frame as the NSCAW so that contextual data was linkable to the individual level survey data collected in NSCAW. NSCAW used a national probability sampling strategy to select primary sampling units (PSUs), from which the sample of children would be drawn. PSUs were de-

fined as geographic areas that encompassed the population served by a single child welfare agency. A total of 100 PSUs were selected from a national sampling frame and 92 ultimately collected child-level data. Because the CCCW study collected contextual information for each PSU included in the NSCAW, in almost all cases the PSU and the county were identical. Exceptions included three very large counties that provided multiple PSUs per county and a number of very small counties that were aggregated into a small set of PSUs. The 92 PSUs was comprised of areas in 36 states and constituted a nationally representative sample of child welfare systems. Further details of the NSCAW sampling plan and procedures have been published elsewhere (Barth et al., 2002; Biemer, Liu, Iannacchione, Bryron, & Cano, 1998; Dowd et al., 2002).

The CCCW study team collected survey data in the NSCAW PSUs on programs and policies in child welfare, Medicaid, SCHIP, and public mental health systems that were hypothesized to influence services for children involved in the child welfare system. Data from interviews were supplemented with information from written documents, made available to the study by service sector representatives via their websites or internal publications. This paper reports specific results from two survey modules that addressed Medicaid insurance eligibility, enrollment and timing, as the association between managed care and other expansionary efforts to insure for low income and vulnerable populations.

#### **Procedures**

Following receipt of IRB-approved consent, trained research assistants collected detailed contextual data at the state and local levels on the organization and financing of mental health care for children and adolescents involved with the child welfare system from three main sources: (1) semi-structured interview data with key informants in relevant agencies at the county or local level, (2) publicly available information placed on websites by state and local agencies or state level data in published or unpublished reports, and (3) local area indicators available from national secondary data sets (Landsverk, Kelleher, Burns, Leslie, & Burl-

burt, 2002). This analysis included data from all three sources. Each module could have been completed using more than one interviewee; the average number of informants was one informant, ranging from one to three.

Detailed telephone surveys were conducted with agency staff, investigating policies, procedures, and linkages within the child welfare and public specialty mental health systems and Medicaid and SCHIP agencies with special attention to in-home or out-of-home differences. Specific respondent agencies and domains of interest are described in detail elsewhere (Landsverk, Kelleher, Burns, Leslie, & Burlburt, 2002). Publicly available information from electronic sources were collected on each of the targeted PSUs in the context of the CCCW data collection; in addition, state-level information was collected on all 50 states and the District of Columbia to provide a national snapshot of policy and practice. A brief survey of state and local websites was completed to determine the availability of data. Extant data from work on health insurance coverage for low-income persons were used to further consider dimensions of Medicaid expansionary practices for youth involved in the child welfare system (Holahan, 2002; Holahan & Pohl, 2002), and was merged to the contextual data by linking with (blinded) state identifiers from a published list of data by state. These innovation measures were merged to the CCCW data using PSU geographic (state) indicators by NSCAW investigators and de-identified linked data were returned to CCCW investigators for analysis to maintain confidentiality even at the state and PSU level.

#### Measures

Data on Medicaid eligibility were derived from two modules of the CCCW interview, one asked of a key informant at the Mental Health Agency regarding the structure of child services and funding sources, reimbursement and managed care in the provider system, and one asked of respondents at the State Medicaid agency about eligibility, enrollment, and managed care and programs specific to children in child welfare. Both modules had similar structures, first asking questions regarding children in out-of-home placement and next asking the same questions for in-home cases. In the

Medicaid Module, for example, the respondent was asked "What percentage of Children receive Medicaid coverage through FEDERAL eligibility categories; through STATE categories; through LOCAL; NOT ELIGIBLE for Medicaid coverage through any Federal, state, or county mechanism?" and so forth. Respondents were asked about mechanisms to minimize delays in achieving Medicaid enrollment in a list to endorse, and then open-ended to allow for other possibilities. Timing to achieve enrollment was asked using predetermined categories of immediate; within three days; within seven days; greater than seven; and parental responsibility to enroll. Mental Health Agency respondents were asked about whether the county in which they were located had implemented a county mental health carve-out with a capitation. These indicated some type of risksharing arrangement in the mental health sys-

Information was gathered about the local policy environment using a published measure of "expansionary innovation" developed by Holohan and colleagues to characterize a broad range of practices that as a whole was indicative of concrete steps taken to expand Medicaid coverage of vulnerable populations (Holahan & Pohl, 2002). We hypothesized that implementing system change such as managed care would be associated with these expansionary practices. This "Medicaid innovation" measure was appended to CCCW data at the state level, was a four-level scale that matched a typology using Medicaid expansionary practices beyond the federally mandated minimums, and ranged from *one* to *four*, going from most to least expansionary practices (Holahan & Pohl, 2002). This typology was based on the following three criteria: coverage of non-parents to at least 100 % of the federal poverty level, children above 200% of the poverty level, and parents to at least 150% of the poverty level. Again, we used Holohan's published rankings and linked to the PSUs at the state level; we did not construct the ranking.

#### Analyses

Descriptive measures of characteristics of Medicaid benefits were completed using SAS statistical package (SAS Institute Inc., 2001).

All measures of association or difference were conducted using SPSS (Norusis, 2001) and STATA (StataCorp, 2003) to account for stratification and sampling in the CCCW study design. The design-based Pearson F statistic was used to test for association using weighted measures. For responses from the child welfare agencies, the resulting point estimates of means and proportions had fairly wide confidence intervals due to the sample size (n = 89) and the study design. Because the CCCW agency level data was linked to the NSCAW child level data, we were also able to use the weights to estimate the numbers of U.S. children affected by agency policies and procedures. The purpose of the weights was to adjust for sampling bias and non-response (Cochran, 1977).

#### RESULTS

#### Examination of Medicaid Coverage

Our first objective was to examine variation in the provision of health insurance with a specific focus on placement status. Table 1 reports estimates by key informants in child welfare agencies regarding the proportions of youth in contact with child welfare that were eligible for Medicaid and had Medicaid insurance coverage. Consistent with common understanding of the categorical eligibility of youth in out-ofhome placements, the majority of children involved with child welfare and in out-of-home care (76%) were covered by Medicaid based on federal criteria. The majority of those meeting federal criteria (also 76%) were based on Title IV-E funding; other federal eligibility included disability benefits (11%) through Social Security Supplemental Security Income (SSI) and poverty-related eligibility (14%). The remaining children in out-of-home placements were covered by Medicaid based on state or local criteria so that 99% of the total child welfare cases in out of home placement were covered by Medicaid. It should be noted that the majority of youth in contact with child welfare participating in the NSCAW study represented inhome cases (85%); the remaining youth were in out-of-home care (Barth et al., 2002).

2. PSU refused to participate

in study Total

| _  | Child Placement      |     |  |                      |     |  |  |
|--|----------------------|-----|--|----------------------|-----|--|--|
|  | Out-of-home          |     |  | In-home              |     |  |  |
| Medicaid eligibility                       | Percent <sup>1</sup> | SE  | Estimate #<br>of U.S.<br>Children<br>Covered | Percent <sup>1</sup> | SE  | Estimate #<br>of U.S.<br>Children<br>Covered |  |
| Eligible for coverage                      |                      |     |  |                      |     |  |  |
| Type of coverage                           |                      |     |  |                      |     |  |  |
| Federal                                    | 76.4%                | 4.7 | 139,726                                      | 66.1%                | 3.5 | 624,845                                      |  |
| Title IV-E                                 | 75.6%                | 4.2 |  | n/a                  |     |  |  |
| SSI  | 10.5%                | 2.0 |  | 18.2%                | 5.6 |  |  |
| Poverty or AFDC                            | 13.8%                | 3.5 |  | 81.8%                | 5.6 |  |  |
| State                                      | 19.1%                | 4.4 | 24,325                                       | 16.9%                | 4.5 | 47,889                                       |  |
| County                                     | 3.4%                 | 2.1 | 966  | 0.7%                 | 0.6 | 2,714  |  |
| Not eligible for coverage                  | 0.9%                 | 0.6 | 965  | 16.3%                | 5.0 | 222,213                                      |  |
| Total with known<br>Medicaid Coverage data | 100.0%               |     | 167,897                                      | 100.0%               |     | 897,661                                      |  |
| Information not available                  |                      |     |  |                      |     |  |  |
| Respondent unable to<br>provide estimate   |                      |     | 1,914  |                      |     | 824,119                                      |  |

TABLE 1. Medicaid Coverage of Youth Involved with Child Welfare Services

47,028

214,925

In contrast to out-of-home cases, reports of in-home insurance coverage were lower with 66% reported to be eligible for Medicaid and covered through federal mechanisms, 17% were covered through state mechanisms, and less than 1% through county mechanisms. Thus, the total estimate regarding children with Medicaid coverage when data were available was 84%, leaving 16% reportedly ineligible for Medicaid. In comparison to the types of eligibility associated with youth in out-of-home placements, those in-home are more commonly covered based on poverty (82%) and disability related to SSI (18%). For children who were uninsured, respondents described accessing health care services through public health clinics and community organizations including charity care, grant-funded programs, and faithbased programs suggestive of a patchwork of service providers and funding. Because the CCCW data is linked to the weighted NSCAW data, Table 1 also provides estimates regarding the number of U.S. children active to child welfare with Medicaid; 166,932 children in outof-home care and 675,448 children with inhome placement status were estimated to be covered by Medicaid.

Table 1 also indicates patterns related to missing data for these estimates. Child welfare

system respondents were unable to provide estimates regarding and equivalent of 1,914 out-of-home children and for 824,119 in-home children. This reflects an informational bias for children in in-home care compared with out-of-home care. In contrast, missing data from agencies that refused to participate in the NSCAW study were roughly equivalent for out-of-home placement (22%, n = 47,028 children) and in-home placement (21%, 450,715 children).

450,715

2,172,495

# Timing of Coverage

We next examined child welfare policies and procedures that related to the timing of enrollment in Medicaid for youth, and how that varied by placement setting. Table 2 reports child welfare policies or practices that might facilitate access to health services. Nearly all respondents (98%) answered affirmatively to the question of whether there were mechanisms in place to ensure that children received care immediately on entry into the child welfare system. Of these, most mechanisms involved immediate and presumptive eligibility for Medicaid (93%); retrospective provider reimbursement for services using non-Medicaid funds (62%); an agreement or memorandum of un-

<sup>1</sup>Percents were weighted to adjust for sampling and non-response bias; this and rounding error may make totals add to more than 100 percent.

TABLE 2. Mechanisms to Facilitate Health Services Immediately Upon Involvement with Child Welfare

|   | N  | Percent <sup>1</sup> | SE   |
|---|----|----------------------|------|
| Any mechanism to ensure health care immediately | 69 | 97.6%                | 2.3  |
| Immediate and presumptive Medicaid eligibility  | 56 | 93.2%                | 3.7  |
| Retrospective provider reimbursement            | 43 | 62.1%                | 11.9 |
| MOU with health plan for reimbursement          | 15 | 47.2%                | 12.0 |
| Contract with single point of entry             | 15 | 6.3%                 | 2.6  |

<sup>&</sup>lt;sup>1</sup>Percents were weighted to adjust for sampling and non-response bias.

derstanding with a health plan to guarantee reimbursement (47%); and a small percentage reported a single point on entry (6%).

Table 3 displays similar reports by placement type. For out-of-home cases the most frequently reported mechanisms to minimize delays in achieving Medicaid enrollment were immediate or presumptive eligibility (93%); a minimum time required to initiate the Medicaid application by child welfare staff (80%); a computer link between child welfare and Medicaid (70%); trained child welfare staff able to certify for eligibility (57%) and uniform intake applications for child welfare and Medicaid (50%). Many fewer of these mechanisms were in place for in-home cases. Approximately one-third of respondents reported the following four mechanisms for in-home cases: child welfare staff able to certify eligibility, computer link between agencies, immediate or presumptive eligibility, and uniform intake applications.

The lower half of Table 3 reports on timing of Medicaid application by placement type. Among out-of-home cases, just over a third of respondents reported Medicaid coverage immediately upon placement (36%); another third reported that a caseworker would have applied for Medicaid within a week of activating a file on the child (33%); the balance stated that applying for Medicaid would take longer than a week. For in-home cases, half of the agencies reported that it was the parent's responsibility to enroll their child (49%), and a third reported that enrollment would take longer than one week (34%). We also examined the issue of recertification for all youth involved with the child welfare system irrespective of living situation. A majority of respondents (64%) reported that recertification for Medicaid happened every year without regard to placement changes

or upon reunification with the family (79%); fewer (21%) reported recertification every six months (not reported in table).

# Medicaid Financing and Organization and Implications for Children in Child Welfare

Our third objective focused on comparison of Medicaid expansionary practices to innovations in financing and organization of services for youth. We turned from examination of PSU level data to state level data because the majority of decisions regarding Medicaid coverage are made at the state level. Analyses at the state level were important for assessing variation in Medicaid because policy decisions and regulatory approaches to implementing Medicaid are operationalized at the state and federal levels. States varied in expansionary practices to make Medicaid/SCHIP health insurance available for families involved with the child welfare system and other low-income populations. Using the typology of "Medicaid Innovation" developed by Holohan and colleagues as described in the Methods section, Table 4 displays states and their associated PSUs, and demonstrated an even distribution across the expansionary groups.

Expansion beyond the minimum standards required by Federal regulations for Medicaid often is associated with the use of managed care financial arrangements to control costs and improve coordination of services in medical settings. To our knowledge, this is the first to link this information to practices in child welfare systems. The financing and organization of the Medicaid mental health benefit was cross-tabulated with the level of innovation, also in Table 4. Two specific types of innovations in Medicaid

TABLE 3. Mechanisms and Timing of Medicaid Enrollment Application Relative to Case Opening or Placement

| -   | Child placement      |      |         |      |  |
|---|----------------------|------|---------|------|--|
|   | Out-of-              |      | In-home |      |  |
| Mechanisms to minimize delays in achieving<br>Medicaid enrollment | Percent <sup>1</sup> | S.E. | Percent | S.E. |  |
| Immediate or presumptive Medicaid eligibility                     | 92.9%                | 3.5  | 30.7%   | 12.4 |  |
| Minimum time required to initiate application by CW staff         | 80.4%                | 9.9  | 7.8%    | 3.8  |  |
| Computer link between CWS and Medicaid                            | 70.1%                | 8.9  | 33.4%   | 12.3 |  |
| CW staff can certify eligibility                                  | 56.8%                | 11.3 | 33.8%   | 12.4 |  |
| Uniform intake forms for CWS and Medicaid                         | 50.6%                | 11.1 | 30.2%   | 12.6 |  |
| Medicaid card required within 72 hours of entry                   | 22.9%                | 7.5  | 5.3%    | 2.8  |  |
| Medicaid staff outstationed at CWS                                | 22.3%                | 7.7  | 12.6%   | 6.2  |  |
| Other mechanism not listed  | 29.2%                | 11.9 | 17.7%   | 7.4  |  |
| N   | 72                   |      | 60      |      |  |
| Time between child CWS entry and Medicaid application submission  |                      |      |         |      |  |
| Immediate coverage  | 36.1%                | 11.8 | 2.2%    | 2.3  |  |
| Within 3 days   | 20.0%                | 6.8  | 6.2%    | 4.1  |  |
| Within 7 days   | 12.9%                | 6.3  | 8.6%    | 8.2  |  |
| Greater than 7 days   | 30.9%                | 10.4 | 34.0%   | 15.4 |  |
| Parent responsibility to enroll                                   |                      |      | 49.0%   | 14   |  |
| Total   | 100%                 |      | 100%    |      |  |
| N   | 66                   |      | 49      |      |  |

<sup>&</sup>lt;sup>1</sup>Percents were weighted to adjust for sampling and non-response bias.

TABLE 4. Medicaid Expansionary Practice Rating and Managed Care Mechanisms

| Expansionary innovation | State Me         | State Medicaid managed care penetration |                                     |                      | Medicaid county mental health carve-out or capitated program <sup>1</sup> |                                   |  |
|-------------------------|------------------|---|-------------------------------------|----------------------|---|-----------------------------------|--|
|                         | Number of States | Number<br>with high<br>penetration      | Percent<br>with high<br>penetration | Total number of PSUs | Number<br>with either<br>program  | Percent<br>with either<br>program |  |
| (1) High                | 13               | 10                                      | 76.9%                               | 12                   | 10  | 100%                              |  |
| (2) Moderate            | 11               | 7                                       | 63.6%                               | 26                   | 20  | 50%                               |  |
| (3) Low                 | 14               | 3                                       | 21.4%                               | 33                   | 24  | 31%                               |  |
| (4) Minimal             | 12               | 3                                       | 25.0%                               | 12                   | 5   | 43%                               |  |
| Total                   | 50               | 23                                      | 46.0%                               | 83                   | 59  | 57%                               |  |
| Pearson F-statistic     |                  |   | 3.89                                |                      |   | 9.74                              |  |
| Probability             |                  |   | < 0.01                              |                      |   | < 0.01                            |  |

<sup>&</sup>lt;sup>1</sup>Percents were weighted to adjust for sampling and non-response bias.

benefit design—managed care and capitated or carve-out programs—were considered. Expansionary eligibility practices were positively associated with state managed care penetration for all health services (p < 0.01) and with use of mental health capitated or carve-out programs at the county level (p < 0.01). State Medicaid managed care penetration was 77% in the 13 states with the highest level of Medicaid expansionary practices, and 64% in the 11 states with the second highest level of expansionary prac-

tices. Managed care penetration dropped to 21% and 25% for the states with the least expansionary practices. All 12 high-innovation states reported capitated or carve-out arrangements for mental health services, suggesting that these were leaders in innovation in other aspects of services procurement and delivery. Respondents reported common involvement with managed care for Medicaid insured clients in both medical care (78%) and behavioral health (76%) (not reported in table). Most often (80%)

to 99%) children involved with child welfare systems were folded into larger Medicaid managed care programs for all Medicaid children regardless of placement type; exceptions were youth that had been adopted (67%) and those placed out of state (47%). Although nearly half (46%) of respondents were not involved in initial or on-going planning of the Medicaid managed care program in which their children received services, two-thirds (66%) reported training or orientation about the goals and operation of the redesigned systems.

#### **DISCUSSION**

This study presented the first national data on financing policies and practices for health and mental health care among children in child welfare settings, including those who are not placed out of the home, i.e., in home cases with or without services. Our first objective was to examine variation in the provision of health insurance with a specific focus on placement status. Proportional estimates indicated that although most children in out-of-home placement were reportedly eligible for Medicaid insurance, many of those remaining at home were not eligible.

A second objective examined mechanisms for assuring timing of coverage. Besides overall eligibility, many states did not have in place methods to assure continuity and coordination of coverage for child welfare children experiencing placement moves such as rapid enrollment or presumptive eligibility. The assumption that all children involved with child welfare systems are adequately served by Medicaid coverage could not be confirmed from these data.

Our third objective focused on comparison of Medicaid expansionary practices to innovations in financing and organization of services for children in child welfare systems. Expansionary Medicaid practices were associated with managed care and innovations in the financing and organization of mental health services such as carve-outs. This linked state policy with county or local practices, and shows consistency in innovation and expansionary practices between these levels of decision-making. Thus, one could use state level indica-

tors as suggestive of the willingness or ability to bring innovation in financing or organization to local agencies.

The common assumption that youth involved with child welfare are all insured by Medicaid was not supported by this study, especially for those youth who remain in the own home during their involvement. Children in foster care are at risk, however, for discontinuity of coverage due to short stays (shorter than the eligibility process takes) or changing eligibility associated with placement changes. Because such transitions could disrupt insurance and care, and be frequent and short-lived, this poses an important dynamic.

Child welfare systems and their public counterparts have multiple fiscal and regulatory mechanisms available to enhance affordability and access to mental health services. Respondent agencies showed the use of incentives or policies to provide public funds through optional Medicaid or SCHIP programs; presumptions of eligibility and early enrollment programs for Medicaid or SCHIP upon key transitions for youth involved in the child welfare system; optional Title IV-E fund availability; and shielding child welfare cases from behavioral managed care plans where prior utilization management, cost sharing and limited networks may decrease use of specialty care, as have been considered in the literature (Newacheck, Pearl, Hughes, & Halfon, 1998).

All 12 high-innovation states reported capitated or carve-out arrangements for mental health services, suggesting that these are leaders in innovation in other aspects of services procurement and delivery. Holahan and Pohl reported that most of the high innovation states were creative in the use of patchwork funding to build a cohesive larger whole. States that lead in taking on risk-based financing and management of a capitated or carve-out mental health system may have also exhibited similar characteristics. This may imply positive aspects attributed to managed care such as coordination and case finding rather than reducing benefits (Catalano, Libby, Snowden, & Evans, 2000).

# LIMITATIONS AND FUTURE RESEARCH

We lacked important data on in-home cases; for example, the extent to which child welfare systems facilitates Medicaid enrollment when enrollment is left to the parents was not asked. Nationally, early state efforts to implement SCHIP were disappointing in part because of unexpected challenges in reaching and engaging parents and eligible families to pursue the enrollment process (English, Morreale, & Larsen, 2003; Swigonski, 2001). The extent to which similar challenges face in-home cases was unknown from this study, but it may be plausible that many efforts used to improve enrollment statewide could be used for families involved in the child welfare system.

While the largest study of its kind, this research was limited by a small number of key informant respondents in 92 PSUs. It was the first to examine in-home versus out-of-home insurance eligibility. Respondents discussed issues facing selected communities that comprised a sampling frame for youth involved with the child welfare system in the U.S.; thus, they reported perspectives on policies and practices in communities that serve a nationally representative sample of youth. We were unable to speak to dynamic influences on health insurance and access to care such as changes in custody and emancipation, but we were able to address a critical missing link by investigating in-home cases as separate from the more commonly reported out-of-home cases. These results may provide a platform to address other key policy and practice issues facing youth involved with the child welfare system with an eye to reducing barriers and enhancing access to needed care.

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