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How State Medicaid Programs Serve Children and Youth in Foster Care

Children and youth in foster care (CYFC) often benefit from targeted services and supports. Yet, many receive fragmented or limited access to care, contributing to higher rates of unmet health needs.^{1,2} In the past decade, historic numbers of children entered foster care due in large part to the opioid epidemic.^{3,4} While these numbers have recently declined, states are still serving a large number of children in their child welfare systems. In response to the growing recognition of the value of investing in strategies that better serve children in or at-risk of out-of-home placement, a number of federal initiatives have emerged, resulting in significant changes to child welfare and spurring renewed efforts to better integrate care across child-serving systems.^{5,6,7} Even before these reforms, there have been longstanding actions made at the state level to improve the health and well-being of CYFC. As states continue to explore opportunities to address the unique needs and circumstances of CYFC, many states are implementing specialized health care delivery models and enhanced services for CYFC within their Medicaid programs, primarily through managed care.



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Background

Nearly all CYFC⁸ are eligible for state Medicaid programs through categorical eligibility pathways under [Title IV-E of the Social Security Act](#),⁹ Medicaid eligibility based on household income, or expanded Medicaid eligibility for former foster care youth up to age 26 who were under the responsibility of the state at age 18 or older. State Medicaid programs provide coverage of a variety of delivery models for CYFC. CYFC may be mandatorily or voluntarily enrolled in Medicaid managed care (MMC), or excluded from enrollment in MMC entirely, thereby receiving their services through fee-for-service (FFS) programs. Other states may use a combined approach with MMC and FFS delivery features. The specific structure and program features of a state's Medicaid delivery system may affect how health care is provided to CYFC.

Overall, CYFC are twice as likely to have complex health conditions,¹⁰ with 80 percent experiencing serious behavioral health needs.¹¹ CYFC are also much more likely to be prescribed psychotropic medication than the general child population.¹² While CYFC tend to have more behavioral health diagnoses, the necessity of these medications is not well understood, suggesting that at least some of these medications may be inappropriately prescribed.^{13,14} Moreover, few CYFC with behavioral health needs receive treatment in home or community-based settings, with many accessing care in more restrictive, residential settings (e.g., residential congregate settings or inpatient psychiatric hospitals).¹⁵ These health care needs are exacerbated by high rates of trauma, including histories of abuse and neglect, exposure to violence, and removal from their biological parent(s) or caregiver(s).¹⁶

Due to the complexities of out-of-home placement and the need to bridge multiple child-serving systems, many CYFC receive fragmented or limited access to health care services.¹⁷ Since the vast majority of CYFC are enrolled in and receive services through state Medicaid programs, these programs are critical to ensuring that CYFC receive high-quality care.¹⁸ Yet, almost 30 percent of CYFC enrolled in state Medicaid programs did not receive at least one required health screening over a one-year period.¹⁹ Barriers to health care mainly result from complex factors that precede and often persist into foster care, including foster care placement disruptions, incomplete or unavailable health information, and difficulty authorizing consent for services.^{20, 21} These logistical barriers are particularly challenging given that many CYFC enter out-of-home placement with one or more health care needs, some of which may have gone undiagnosed or untreated.²²



CYFC AND HEALTH

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METHODOLOGY

This policy brief is based on a 50-state analysis of state Medicaid delivery systems that serve CYFC. NASHP analyzed the following program features:

- The structure and selection of Medicaid service delivery models serving CYFC
- The use of specialized MMC programs
- The provision of services, including the availability of enhanced services for CYFC

NASHP reviewed publicly available Medicaid managed care contracts and other state policy documents, including Medicaid policy manuals and provider updates. State Medicaid officials were provided an opportunity to review their state's information for accuracy. For state-specific information referenced in this brief, see the companion 50-state chart, "[How State Medicaid Programs Serve Children and Youth in Foster Care.](#)"

Structure of Medicaid Service Delivery Models

States have historically served individuals with special health care needs through FFS systems due to the complexity and number of specialty services required. As states have become more adept at operating MMC models, many have transitioned individuals with special health care needs to MMC to better coordinate care, control costs, and improve health care quality. Most states provide some or all care for Medicaid beneficiaries, including children with special needs, through some form of MMC.²³ This analysis found that this trend is also true for CYFC. In 2007, 29 states provided health care services to children in child welfare through MMC.²⁴ As of 2021, most states (42 states and DC)²⁵ use some form of MMC (e.g., managed care organizations, primary care case management, prepaid ambulatory health plans, and prepaid inpatient health plans) to serve some or all CYFC.

Many states provide physical and behavioral health services to CYFC under MMC. However, 11 states and DC provide some services through MMC and others through FFS. Eight states²⁶ serve CYFC exclusively using an FFS delivery system. While most states that serve CYFC through MMC use standard MMC programs, almost one-third of states (14 states and DC) enroll all or some CYFC in specialized MMC programs (see text box below). These specialized MMC programs are designed to exclusively serve either CYFC²⁷ or Medicaid populations with chronic and complex conditions,²⁸ including those in foster care.



TYPES OF MEDICAID SERVICE DELIVERY MODELS

Standard MMC: Standard MMC is a type of health care delivery system designed to manage costs, utilization, and quality of care. Standard MMC models provide services through contracted arrangements between state Medicaid programs and a managed care entity (e.g., managed care organizations, primary care case management, and prepaid health plans) in exchange for a set per member per month (PMPM) payment.²⁹

Specialized MMC: States with specialized MMC operate similarly to standard MMC models, in that they contract with a managed care entity to provide services through a PMPM payment. Specialized MMC programs are often designed to meet the unique needs of Medicaid beneficiaries with chronic and/or complex conditions (e.g., CYFC). Through this arrangement, state Medicaid programs can require the provision of certain targeted benefits (e.g., specialized care coordination or specific screenings), reporting requirements, and quality measures beyond what is typically offered under a standard MMC approach.

Medicaid FFS: Under a Medicaid FFS model, the state Medicaid program pays providers directly for services rendered to Medicaid beneficiaries. Providers serving CYFC in this model would need to be enrolled as Medicaid providers and accepting new patients. There is typically no organized provider network or care management requirement.³⁰

Assignment of CYFC into Medicaid Service Delivery Programs

Once a child or youth in foster care is enrolled in Medicaid, states must decide which service delivery program (standard MMC, specialized MMC, or FFS) is the most appropriate to serve them. States make this determination using a variety of criteria (e.g., out-of-home placement status, health complexity, or geographic location). Foster care-specific criteria are particularly prominent among states with specialized MMC programs. Depending on the state Medicaid program, a youth's involvement in foster care may trigger their enrollment into a certain MMC program or exclude them from MMC entirely.

While most states enroll all CYFC into a single Medicaid service delivery program, at least 14 states and DC operate multiple Medicaid service delivery programs to serve CYFC.

Relatedly, there is variability in the extent to which states mandate enrollment of CYFC into Medicaid service delivery programs. States must seek and receive approval from the Centers for Medicare and Medicaid Services (CMS) to enroll CYFC in MMC on a mandatory or voluntary basis (through a state plan amendment or waiver). While many states mandate MMC enrollment for CYFC, other states (ID, IN, KY, MA, MO, WA, WI) allow CYFC to voluntarily enroll in a particular Medicaid delivery program (e.g., MMC or FFS). Among states with voluntary enrollment provisions, enrollment decisions are often made by the state on behalf of the CYFC, as their legal guardian.

While most states enroll all CYFC into a single Medicaid service delivery program, at least 14 states and DC operate multiple Medicaid service delivery programs to serve CYFC (Table 1). Selection of a particular program over another is typically based on the child's specific needs and/or preferences. Among states with multiple Medicaid delivery programs for CYFC, most operate a primary program (i.e., foster care (FC)-specific specialized MMC) to enroll the majority of CYFC, with one or more secondary programs serving sub-groups of CYFC (i.e., non-FC specific specialized MMC). These secondary programs are most common for CYFC with complex needs, including those receiving long-term care services. Criteria for enrollment in a particular primary or secondary service delivery program may include the child's eligibility for Supplemental Security Income (SSI) or 1915(c) waiver services; the location of the child (not all MMC plans are statewide); or the discretion of the state's Medicaid or child welfare agency.

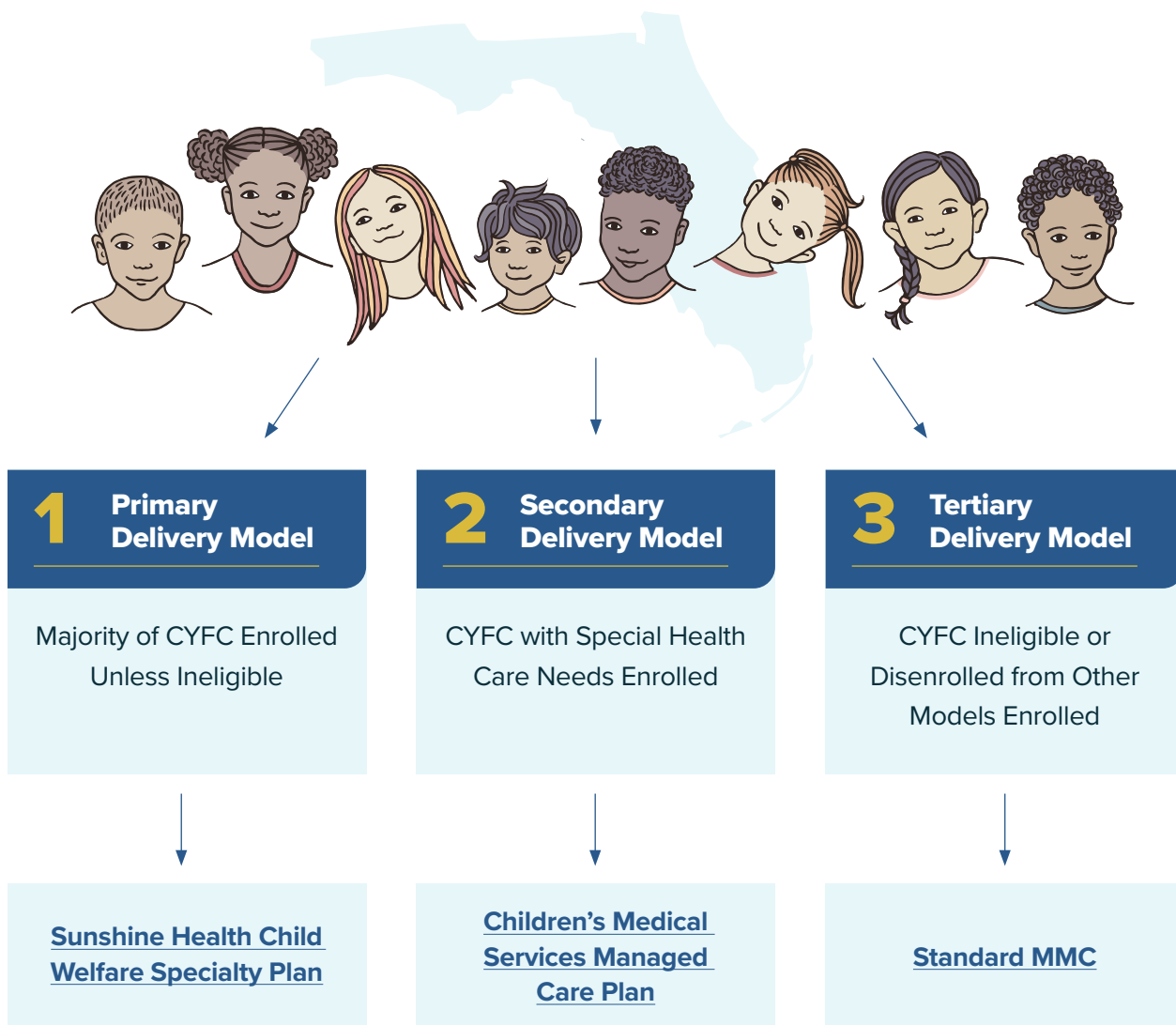
Table 1: States with Multiple Medicaid Service Delivery Programs Serving CYFC

| Delivery Programs | States with Primary Delivery Models | States with Secondary and Tertiary Delivery Models |
|------------------------|---|---|
| Specialized MMC | 5 states (AZ, FL, KY, WA, WI*) serve most CYFC through a specialized MMC program (FC-specific or non-FC specific). | 5 states (AZ, FL, IN, MA, VA) and DC serve some CYFC through a specialized MMC program (FC-specific or non-FC specific). |
| Standard MMC | 8 states (CO, MA, MN, MO, MS, OR, UT, VA) serve most CYFC through a standard MMC program. | 5 states (CO, FL, KY, MA, WA) serve some CYFC through a standard MMC program. |
| FFS Medicaid | DC and IN serve most CYFC through FFS Medicaid . | 6 states (MN, MO, MS, OR, UT, WI) serve some CYFC through FFS Medicaid . |

*Wisconsin's specialized MMC program, Care4Kids, is not statewide. For areas of the state not covered by Care4Kids, CYFC are served by Medicaid FFS.

Florida's Medicaid Managed Care Programs for CYFC

Florida operates multiple Medicaid MMC programs to serve CYFC. The Florida Agency for Health Care Administration (AHCA) — the state Medicaid agency — assigns CYFC to a service delivery model depending on the specific needs of the child. The majority of Florida's CYFC are assigned to the Sunshine Health Child Welfare Specialty Plan, the state's FC-specific specialized MMC program. However, CYFC with special health care needs may be enrolled into the Children's Medical Services Managed Care Plan, which is a non-FC specific specialized MMC program. While the majority of the beneficiaries are enrolled in the specialty health plans, Florida Medicaid recipients have choice counseling available through the state's choice counseling vendor. Medicaid beneficiaries are able to review all plan options and choose their own plan during the open enrollment times in the state.





Specialized MMC Programs

Nearly one-third of states operate some form of specialized MMC programs to better coordinate and address the unique needs and circumstances that many CYFC experience. Ten states operate FC-specific specialized MMC programs, whereas six states and DC operate non-FC specific specialized MMC programs (see Table 2). FC-specific specialized MMC programs serve only CYFC and other child populations involved with child welfare and/or juvenile justice. A few states serve CYFC through [specialized MMC programs to serve Children and Youth with Special Health Care Needs](#) (CYSHCN), including those with more complex physical, emotional, and behavioral needs (e.g., SSI or 1915(c) eligibility). While CYSHCN-focused MMC programs are not specific to CYFC, some CYFC are considered an eligible subgroup either due to their involvement in foster care or their health care needs.

Specialized MMC programs provide, to varying extents, tailored benefits to some or all CYFC that are typically not available through states' standard MMC programs. Due to the intensity of care provided, specialized MMC programs typically provide participating plans with a higher PMPM payment rate than standard MMC programs would receive.³¹ This analysis found that program provisions often include specific contract requirements, quality measures, eligibility criteria, and enhanced benefits designed to meet the unique needs of CYFC. While FC-specific specialized MMC program provisions are designed exclusively for CYFC, non-FC specific MMC programs serving CYFC generally include some child welfare-focused provisions as well (e.g., referral

30%

Nearly one-third of states operate some form of specialized MMC programs.

to therapeutic foster care). Additionally, many specialized MMC programs require the contracted MMC entity to meet certain reporting and quality benchmarks, which may include documentation of services provided and timeliness of those services, health outcomes, or foster care-specific performance improvements. By leveraging specialized MMC programs, state Medicaid programs may be better equipped to promote greater accountability for the care provided to CYFC, thereby strengthening timely access to high-quality services and improving health outcomes.

Behavioral Health Services

Due to the high prevalence of behavioral health needs among CYFC, CYFC typically use behavioral health services at much higher rates than the general child population.³² For all Medicaid populations, states have historically been more likely to carve out behavioral health services from their MMC programs and deliver these services through distinct behavioral health organizations (BHO)³³ or through FFS arrangements.³⁴ However, many states are integrating behavioral health and primary care services and increasingly providing behavioral health services exclusively through their managed care organizations (MCOs).³⁵ These trends are also being seen in state Medicaid programs' approach to delivering behavioral health services to CYFC.

As of 2021, this analysis identified most states carve in behavioral health services under their MMC programs serving CYFC. This is particularly evident among specialized MMC programs, which are intentionally designed to provide all services needed by CYFC, including comprehensive behavioral health services. This analysis found that specialized community-based behavioral health services, including intensive care coordination using Wraparound (see text box), crisis stabilization, and [therapeutic foster care](#), are often carved into states' MMC programs serving CYFC. Provision of these services through managed care delivery systems may strengthen access to integrated care, which could help to improve outcomes and reduce avoidable residential care among CYFC with severe behavioral health needs.^{36,37}

Alternatively, some states (nine states and DC³⁸) continue to carve out some or all behavioral health services from their MMC programs serving CYFC through FFS. Among states that carve out behavioral health services, acute behavioral health services (e.g., inpatient and residential services) are the most commonly carved-out service that is typically delivered through FFS. CYFC use inpatient and residential services more than the general Medicaid child population.³⁹

Most states carve in behavioral health services under their MMC programs serving CYFC.

Enhanced Services

Three-quarters of states (36 states and DC) provide enhanced services for CYFC enrolled in their Medicaid programs. These enhanced services are largely specialized adaptations of traditional Medicaid benefits covered under states' respective Medicaid state plans (e.g., [Early and Periodic Screening, Diagnostic, and Treatment](#)). While it is possible to provide enhanced services through FFS, the vast majority of states providing enhanced services for CYFC do so through MMC. At least one state, Massachusetts, offers enhanced services for CYFC under its Medicaid FFS system.⁴² All specialized MMC programs serving CYFC offer at least some enhanced services and are generally more robust than non-specialized MMC programs. Coverage of enhanced services varies widely across states and includes:

- Care Coordination and Case Management:** The most common enhanced service provided to CYFC is care coordination and/or case management. Nearly two-thirds of states (31 states and DC) require MMC to provide care coordination to oversee the needs of CYFC. Approaches to care coordination vary across the states and include targeted case management, integrated care coordination, specialized care coordination, and intensive care coordination. Depending on the Medicaid program, care coordinators serving CYFC may be required to receive specific child welfare training, participate in periodic meetings with the state child welfare agency, or facilitate referrals to other needed services (e.g., social services and supports). Several states (KY, OR, WA, WI) integrate wraparound services within their care coordination approaches.
- Targeted Engagement of Child Welfare and/or Behavioral Health Partners:** At least seven states require MMC programs to provide targeted outreach and engagement with behavioral health and/or child welfare partners. Two states (MA and VA) require that dedicated liaisons participate in direct practice services for CYFC (e.g., trauma-informed care planning), whereas other states (LA, MD, MN, MS, NY) require their MCOs to promote system-level coordination (e.g., routine meetings with local child welfare agencies).



Using Wraparound Approach to Care Coordination

Wraparound is an intensive, holistic approach to care coordination that is specifically designed for youth with complex needs, including CYFC, to allow them to remain safely in their community. Wraparound models vary widely, but common services include case management, counseling, crisis care, special education services, caregiver support, psychiatric consultation, health services, legal services, residential treatment, and respite care.^{40,41}

All specialized MMC programs serving CYFC offer at least some enhanced services and are generally more robust than non-specialized MMC programs.



- **CYFC-specific Assessments and Screenings:** At least 14 states require specific health assessments for CYFC upon entering foster care. While most states that require assessments focus on CYFC's physical and behavioral health care needs, some states (GA, OR, TX, WV) screen for trauma and/or psychosocial needs through targeted screening tools (e.g., [Child and Adolescent Needs and Strengths Assessment](#)). States typically require completion of these assessments within a specific timeframe (e.g., 30 days) of the youth entering foster care.

- **Psychotropic Medication Monitoring:** Many states monitor psychotropic medication use among Medicaid child population(s) as part of states' reporting under the federal Drug Utilization Review (DUR) programs.^{43,44} Under federal law,⁴⁵ each state is required to develop a DUR program to help reduce clinical abuse and misuse of outpatient drugs covered under the state Medicaid program.⁴⁶ At least 12 states include specific language in their MMC contracts requiring the targeted monitoring and/or reporting of psychotropic medication among CYFC by MMC plans. Targeted monitoring and/or reporting may include obtaining informed consent, requiring clinical oversight of medication requests to assess appropriateness, and the creation of medication monitoring plans.⁴⁷ These efforts may serve as examples to other states exploring ways to strengthen oversight of psychotropic medications among CYFC, as encouraged by joint federal guidance released in 2011 ([SMD-11-23-11](#)).⁴⁸

75%

Three-quarters of states (36 states and DC) provide enhanced services for CYFC enrolled in their Medicaid programs.

- **Dedicated Foster Care Transition Services:** Out-of-home placement is intended to be time-limited, with CYFC transitioning out of foster care through reunification, adoption, or aging out. While in foster care, it is not uncommon for CYFC to move between placements. To help CYFC navigate these changes, at least five states (FL, KY, MN, NH, VA) require some level of dedicated foster care transition services and supports by their MMC programs. Required transition services vary by state Medicaid program and include:

- care planning,
- one-time financial stipends,
- evaluation of educational options,
- assessment of home and community supports,
- medication compliance, and
- initiation of enrollment in other services (e.g., [Home and Community-based Services waiver](#)).

CYFC leaving out-of-home placement face unique challenges, with many experiencing worse outcomes compared to the general child population.⁴⁹ Requiring dedicated foster care transition services by MMC programs can help equip CYFC with the resources necessary to meet their health care needs once they leave state custody.

- **Non-medical Services and Supports:** FC-specific specialized MMC programs in at least four states (FL, GA, IL, KY) provide non-medical enhanced services, including case grants or rewards, Boys and Girls Club memberships, or supplies (e.g., personal care items or electronics). While the payment structure varies, these non-medical enhanced services are typically administered as value-added services by the contracted MMC entity. Value-added services are benefits offered at the discretion of the contracted MMC entity beyond Medicaid-covered services required under the MMC program.⁵⁰ Health plans often provide these non-medical enhanced services to help address the broader socioeconomic barriers that CYFC often encounter.^{51,52}



TRANSITION SERVICES

5+ States

To help CYFC move between placements, at least five states (FL, KY, MN, NH, VA) require some level of dedicated foster care transition services and supports by their MMC programs.

FC-specific specialized MMC programs in at least four states (FL, GA, IL, KY) provide non-medical enhanced services, including case grants or rewards, Boys and Girls Club memberships, or supplies (e.g., personal care items or electronics).

Strategies for State Medicaid Programs Serving CYFC

Regardless of the type of Medicaid service delivery model states have in place, there are numerous opportunities to design targeted delivery features, plan provisions, and enhanced services for CYFC. As states explore how to refine or adapt their Medicaid service delivery system to serve the unique needs of CYFC, they can consider the following:

- **Type of Medicaid Service Delivery Model:** State Medicaid programs operate many different service delivery models, including Medicaid FFS, MMC, or a combination of approaches. As state Medicaid programs explore how best to serve CYFC, they may want to consider the strengths and limitations of each respective approach. While Medicaid FFS delivery systems may provide flexibility, there is typically no organized provider network to oversee care coordination. Relatedly, while it is possible to implement specialized services or provider requirements in Medicaid FFS systems, there may be fewer opportunities to do so compared to managed care arrangements. Conversely, MMC models provide state Medicaid programs a variety of pathways to target care and services for CYFC, including specific plan provisions, reporting requirements, and quality initiatives. However, modifying existing MMC programs to include CYFC-specific delivery features, or designing entirely new specialized MMC programs, can be a significant lift and may take years to implement. Additionally, states need [federal authority](#) to enroll CYFC in MMC. Depending on the type of MMC and population served, states may need to pursue a waiver authority (i.e., §1915(a), §1915(b), §1115) or state plan authority (i.e., §1932(a)).⁵³ The specific federal authority may affect whether states voluntarily or mandatorily enroll CYFC into MMC, among other considerations. See [this NASHP chart](#) for the federal authorities used by several FC-specific specialized MMC plans.
- **Defining CYFC within MMC Contracts:** States typically target services to CYFC due to the unique challenges of their out-of-home placement and intensity of health care needs. Consequently, state Medicaid programs may want to consider how, if at all, they define CYFC within MMC contracts. In selecting a definition, states could categorize CYFC based exclusively on their involvement in foster care, as a [sub-group of CYSHCN](#), or decide against assigning any definition. These distinctions may have implications for how CYFC are identified and served in Medicaid. Foster care-specific definitions capture CYFC exclusively and are designed to reflect the unique nature of their out-of-home placement. CYSHCN-based definitions focus on broader child populations with chronic and complex health care needs, which may include some or all CYFC. States will want to consider the extent to which the definition can appropriately identify CYFC, as well as reflect the nuances of out-of-home placement and specific health care needs.

- **Availability of Enhanced Services for CYFC:** State Medicaid programs may want to consider how, and to what extent, they can adapt their service delivery models to include enhanced services for CYFC. States may opt to modify existing services provided to Medicaid child populations such as care coordination and screenings by adding CYFC-specific requirements or develop entirely new services available only for CYFC. In designing enhanced services, state Medicaid programs will want to consider how these services complement or align with other services provided by CYFC-serving entities. State Medicaid programs will also want to consider the fiscal impact of these enhanced services and the mechanism for reimbursement, which may vary depending on the type of service. While more traditional Medicaid services (e.g., well-child visits) may benefit from being carved into MMC under the PMPM, other non-traditional services (e.g., personal care items) may need to be structured differently, such as through a value-added service.
- **Leveraging Partnerships with Child Welfare and Behavioral Health within MMC Programs:** Most state Medicaid programs have, to varying degrees, existing partnerships with their state child welfare and behavioral health agencies, such as data sharing (e.g., placement status) between child welfare information systems and Medicaid.⁵⁴ Detailing these partnerships within state MMC contracts (e.g., identifying roles and oversight) can help foster greater shared oversight and integrated care for CYFC. When discussing partnerships with child welfare and behavioral health agencies in MMC contracts, states may want to explore the focus of these partnerships (e.g., system-level versus direct practice-level) as well as the specific roles and responsibilities for each CYFC-serving agency, including the contracted MMC entity. States that outline the role of other agencies in their MMC contracts specify foster care-specific training for key staff, define meeting timeframes, impose reporting requirements, and dedicate liaisons, among others. By leveraging MMC entities' contractual obligations, state Medicaid programs, in collaboration with child welfare and behavioral health, may design and implement specific mechanisms to centralize responsibility and strengthen effective cross-agency partnerships.

In designing enhanced services, state Medicaid programs will want to consider how these services complement or align with other services provided by CYFC-serving entities.

Conclusion

Many states are transitioning children and youth in foster care from FFS to MMC programs to better coordinate care, control costs, and improve health care quality. To address the unique and often complex needs of CYFC, states are increasingly implementing specialized Medicaid managed care service delivery models for CYFC, with most opting to incorporate at least some targeted requirements for CYFC. As state Medicaid programs explore opportunities to better serve CYFC, they will want to consider, in conjunction with their child welfare and behavioral health partners, how CYFC-specific provisions and requirements can be leveraged within their service delivery models. In doing so, state Medicaid programs may be better equipped to oversee the care provided to CYFC, thereby improving timely access to high-quality services and strengthening integration across child welfare-serving systems.

Table 2: 50-State Summary of Medicaid Program Features for CYFC

The table below summarizes key trends across states' Medicaid programs serving CYFC. Notable information includes the type of Medicaid service delivery model serving CYFC, MMC delivery features, and CYFC-related MMC contract provisions. Several states have multiple Medicaid service delivery programs serving CYFC, resulting in some duplication and/or variation in the figures below. These and other insights can be found in [NASHP's 50-State chart and map](#).

| Exclusively MMC | MMC with carve-out FFS | Some MMC / Some FFS Medicaid | Exclusively FFS Medicaid |
|---|--|--|---|
| <p>26 states (AL, AZ, DE, FL, GA, HI, IA, ID, IL, KS, KY, LA, MD, MI, NE, NH, NM, NY, OH, RI, SC, TN, TX, VT, WA, WV) serve CYFC exclusively under MMC.</p> | <p>DC and 11 states (AR, CA, CO, ME, NC, NJ, OR, PA, UT, VA, WI) serve CYFC in MMC with carve-out FFS for specific services.</p> | <p>DC and 8 states (IN, MA, MN, MO, MS, OR, UT, WI) serve some CYFC under MMC and other populations of CYFC are served by FFS Medicaid.</p> | <p>8 states (AK, CT, MT, ND, NV, OK, SD, WY) serve CYFC exclusively using FFS Medicaid.</p> |

MMC MODEL TYPE:

- **DC and 35 states** (AZ, CA, CO, DE, FL, GA, HI, IA, IL, IN, KS, KY, LA, MA, MD, MI, MN, MO, MS, NE, NH, NJ, MN, NY, OH, OR, PA, RI, SC, TN, TX, UT, VA, WA, WV) use risk-based capitated **managed care organizations** (MCO) to deliver some or all services to CYFC.
- **7 states** (AL, AR, CO, ID, MA, ME, NC) use **primary care case management** (PCCM) plans.
- **3 states** (VT, WI, WY) use **prepaid health plans**, with VT and WI using prepaid inpatient health plans and WY using a prepaid ambulatory health plan.

MMC DELIVERY MODEL FEATURES:

Of the states that use MMC for CYFC:

- **10 states** (AZ, FL, GA, IL, KY, MA, TX, WA, WI, WV) operate **FC-specific specialized MMC programs**.
- **DC and 6 states** (AZ, FL, IN, TN, VA, WY) operate **non-FC specific specialized MMC programs**, which include at least some CYFC.
- **34 states** (AL, AR, CA, CO, DE, FL, HI, IA, ID, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, NC, NE, NH, NJ, NM, NY, OH, OR, PA, RI, SC, UT, VA, VT, WA) operate **standard MMC programs**.

MMC PROVISIONS RELATED TO CYFC:

- **33 states** (AL, AZ, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, MI, MN, MO, MS, NC, NE, NH, NM, NY, OH, PA, RI, SC, TN, TX, VT, WA, WV) **provide behavioral health services** for CYFC under some form of MMC (including BHOs).
- **DC and 9 states** (AR, CA, CO, ME, NJ, OR, UT, VA, WI) **carve-out some or all behavioral health services** from MMC (i.e., carve-out FFS or county health plans).
- **DC and 36 states** (AL, AZ, CA, DE, FL, GA, HI, IA, IL, KS, KY, LA, MA, MD, MI, MN, MO, MS, NC, ND, NH, NJ, NM, NY, OH, OR, PA, SC, TN, TX, UT, VA, VT, WA, WI, WV) require at least some **enhanced benefits** specifically for CYFC in the MMC contracts.
- **19 states** (FL, GA, IL, KY, MA, MD, NO, NC, NE, NH, OR, PA, TN, TX, UT, VA, WA, WI, WV) include **definitions of CYFC in MMC contracts**. **12 states** (GA, IL, KY, MD, MO, NC, PA, TN, TX, UT, WA, WI, WV) include **specific definitions for CYFC** whereas **7 states** (FL, MA, NE, NH, OR, VA, WA) define CYFC as a **subgroup of CYSHCN**.

Endnotes

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- ³“AFCARS Report,” U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children’s Bureau, November 2021. www.acf.hhs.gov/sites/default/files/documents/cb/afcarsreport28.pdf
- ⁴“Number of Children in Foster Care Continues to Increase,” U.S. Department of Health and Human Services, Administration for Children and Families, November 30, 2017. www.acf.hhs.gov/archive/media/press/2017/number-children-foster-care-continues-increase
- ⁵Veronica Thompson, “Implementing the Family First Prevention Services Act: What to Watch in 2021,” *National Academy for State Health Policy*, January 22, 2021. www.nashp.org/implementing-the-family-first-prevention-services-act-what-to-watch-in-2021
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- ⁷“Integrated Care for Kids (InCK) Model,” U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Accessed November 5, 2021. <https://innovation.cms.gov/innovation-models/integrated-care-for-kids-model>
- ⁸“Health Care Coverage for Youth in Foster Care and After,” U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children’s Bureau, May 2015. www.childwelfare.gov/pubPDFs/health_care_foster.pdf
- ⁹Title IV-E does not provide Medicaid, but children and youth in foster care who receive title IV-E payments are categorically eligible for Medicaid in every state.
- ¹⁰Luca A Bilaver, Judy Havlicek, Matthew M. David, “Prevalence of Special Health Care Needs Among Foster Youth in a Nationally Representative Survey,” *Journal of the American Medical Association*, May 2020, 174 (7) 727-729. <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2765817>
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