

Opportunities for Child Welfare and Medicaid Collaboration: Strategies for Reducing Placements and Improving Child Health

InCK Marks and CSSP Resource Brief

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**Center for the
Study of Social Policy**
Ideas into Action

Take-Away Messages for InCK Applicants Regarding Foster Care and the Integrated Care for Kids (InCK) Model

1. The InCK model emphasizes Medicaid's potential role in reducing out-of-home foster placements (and Medicaid costs), but a state's child welfare system and its IV-E financing have the major responsibility in placement decisions. **Applicants need to understand current state policies and practices in child welfare to prevent placement and then determine how Medicaid might strengthen these actions.**

2. States vary widely in their child welfare systems both in terms of foster placement rates (from 1.5 per 1,000 children in Illinois to 12.6 per 1,000 children in West Virginia) and use of Medicaid as a funding source for child welfare services (from none in several states up to 27 percent in Tennessee). **The potential for both reducing placement rates and achieving any Medicaid cost savings is very state-specific, but there are opportunities in all states to use Medicaid and IV-E to improve child health, safety, permanency, and well-being.**

3. The latest federal child welfare law, the Family First Prevention Services Act (FFPSA), has new requirements and opportunities for states to reduce placements into foster care, including how Title IV-E funding can be deployed. **As applicants look to develop alternative payment models under Medicaid for InCK and particularly for the child welfare population within InCK, applicants need to ensure this work is aligned with child welfare system's work in implementing FFPSA.**

4. A growing array of evidenced-based programs and practices (and principles behind those practices) that have succeeded in preserving families when children are at imminent risk of placement, and there many others that can strengthen families and respond to child and family conditions so they do not progress to the point of imminent risk of placement. **Applicants do not need to start from scratch in developing alternative responses but can and should draw upon exemplary programs and their attributes to improve child health. In most instances, these programs and practices are eligible for funding under Medicaid or Title IV-E or both and deserve to be part of alternative payment models developed through InCK, whether or not they result in specific Medicaid spending offsets due to reducing placements.**

Preface

The Center for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation's (CMMI) Integrated Care for Kids (InCK) Model provides a federal funding opportunity to improve the health and well-being of children covered by Medicaid. The InCK model is designed to test whether combining and integrated service delivery model with an alternative payment model can improve the quality of care and health outcomes and reduce Medicaid expenditures. The Notice of Federal Opportunity (NOFO), which provides application instructions to states, requires that applicants develop both service and funding model approaches to improve child outcomes and secure cost savings within a geographic area for Medicaid children birth to 21 in that area.

The NOFO emphasizes that applicants must develop strategies for reducing out-of-home placements of children into foster care and that the child welfare system must be part of the integrated service strategy developed. This policy brief offers an introduction to the child welfare system and its role in the context of the InCK model and the role that Medicaid can play.

While the InCK Model comes from CMS and draws primarily from tools and strategies in the medical care financing system, the child welfare and foster care system has its own financing system – with the single largest source of funding from Title IV-E, a federal entitlement program like Medicaid.

For states and communities to be successful in addressing the special issues and concerns related to children involved in the foster care and larger child welfare systems, they will need to have an understanding of the evolving nature of those systems – and the successive advances at the federal and state level in child welfare to place greater emphasis upon placement prevention, reunification, and speedy permanency through adoption and guardianship, when reunification is not possible. Some of the requirements in the InCK Model, such as establishing mobile crisis response teams, are not new to child welfare. In fact, there are a growing number of evidenced-based programs developed within child welfare to prevent placements and to go beyond that to prevent the family and child conditions and behaviors that place children at risk of placement.

The InCK Model requires a “root cause” analysis related to placement, particularly into foster care. A first level of “root cause” analysis must be around the current inability to respond to children and families at the point of imminent risk of placement in ways that can prevent placement. To prevent such placements requires creating responses that can keep children safe without placement – and there are a growing array of programs and practices that have proven their ability to do so. The most recent reauthorization of the Foster Care and Adoption Assistance Act, the Family First Prevention Services Act (FFPSA) of 2018, provides new direction and funding opportunities under Title IV-E to this end.

A deeper level of “root cause” analysis, however, is around how to prevent the child or family getting to that point of imminent risk of placement – through earlier responses that can prevent or mitigate those conditions. An array of more preventive services have proved effective to this end.

As the InCK Model looks at foster care through a Medicaid lens, FFPSA looks at foster care through a child welfare lens. While the objectives of each are aligned with respect to children in the foster care system, it is essential that they work together and recognize that the child welfare system is charged with the major responsibilities around children's safety, permanence, and well-being.

While the InCK Model and the NOFO do not explicitly reference Title IV-E or other child welfare funding sources (IV-B, Child Abuse Prevention and Treatment Act-CAPTA, Social Services Block grant-

SSBG, Temporary Assistance to Needy Families-TANF, etc.), these certainly come into play in determining how best to use Medicaid to help prevent placement, in the immediate and longer term.

This Resource Brief, commissioned by InCK Marks, provides an overview of the opportunities for reducing placement and improving children's health from the perspective of what the child welfare system's current role in doing so is and how it and Medicaid might, through the InCK Model, better achieve these ends.

As there are 50 state Medicaid systems, with substantial differences, there also are 50 state child welfare systems, with even greater differences. The financing of child welfare services, if anything, is more complex than the financing of Medicaid services. In some states, there are more opportunities for using Medicaid dollars to avert placements than in others.

Any state, however, can benefit from strengthening both its Medicaid financing of services for children in or at risk of entering foster care AND its child welfare system's financing of services that contribute to reducing the need for placements and that advance child safety, permanence, and well-being. Moreover, the more these can be aligned and insure that there are no gaps in services or delays in effective referrals, the more children and families in both systems will benefit.

In addition to spelling out how the InCK Model can support child welfare in preventing placement and achieving permanency, this policy brief also describes the growing field of evidenced-based programs and practices that achieve these goals. It further describes how the FFPSA provides new requirements and opportunities to do so, within and beyond Title IV-E.

Whether new strategies are funded through Medicaid, Title IV-E, or a braiding of different funding sources, they are the key to improving child health for some of the country's most vulnerable children. As the resource brief also shows, while the percentage of children on Medicaid who are in the child welfare system is small (2.4 percent of all children on Medicaid), their costs to Medicaid are disproportionately larger (5.6 percent of all Medicaid expenditures on children) and their overall costs (in IV-E and other dollars) are even greater. While a numerically small share of the child Medicaid population, the child welfare population is one that most needs services. Clinical services for physical, behavioral, and mental conditions often are ones that Medicaid is both positioned and mandated to provide.

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This report was made possible with generous funding from the Robert Wood Johnson Foundation and the Perigee Fund for the establishment of InCK Marks, but all opinions and views expressed are those of the authors and not necessarily of the funders. InCK Marks is not affiliated with the Center for Medicaid and Medicare Innovation nor should it be considered an authoritative source in addressing any issues or application requirements in the InCK Notice of Funding Opportunity (NOFO). The purpose of InCK Marks is to support child health champions – child advocates, practitioner leaders, family and community voices, health experts, Medicaid agency staff, and policy makers – in reviewing the InCK opportunity and to promote policies and practices that will advance child health.

Opportunities for Child Welfare and Medicaid Collaboration: Strategies for Reducing Placements and Improving Child Health

Introduction

The goal of child welfare systems is to promote the safety, permanency, and well-being of children by working with families to care for their children safely when there are concerns of abuse or neglect. Whenever possible, state child welfare agencies make efforts to support families so that children can remain in their homes safely; however, there are times when this is not possible and children must enter foster care. Foster care is intended to be a temporary placement for children while their parents work to provide a safe environment to which they can return. When a child cannot safely return to their parents, child welfare agencies must work to achieve permanency through guardianship or adoption. Unfortunately, despite the mandate of ensuring all children have a permanent family connection, each year approximately 20,000 youth age-out of the foster care system to independence without having achieved positive permanency.

Across the country states blend federal, state, and local dollars to support the health and well-being of children and families who both come to the attention of or are at-risk of coming to the attention of the child welfare system. Children in foster care (and special needs adoptions, where many achieve permanence after being in foster care) are categorically eligible for Medicaid as their health coverage.^{1,2} This funding includes the use of Medicaid dollars for residential and community-based behavioral and physical health services. These services not only work to ensure healthy development but also help reduce unnecessary placements in restrictive settings or out-of-home care, thereby supporting permanency for the child.

The Integrated Care for Kids (InCK) Model represents a new opportunity for states to think across systems and financing streams to support the health and well-being of children. Specifically, the recently released Notice of Funding Opportunity (NOFO) highlights goals for the model which are directly in line with child welfare goals: improve the health of children and reduce the need for placement of children in out-of-home settings. Further, the InCK model requires the coordination and integration of services across systems, including child welfare. This provides the opportunity for reinforcing current work in child welfare to prevent placement and achieve permanency through enhanced service integration and available supports.

The remainder of this paper provides additional context on the current state of child welfare, including current financing streams, and discusses opportunities for state child welfare and Medicaid agencies to partner to support the health and well-being of children. Specifically, the paper includes strategies for reducing the number of children in out-of-home settings, particularly in settings that are more restrictive within the context of the recently passed Family First Prevention Services Act (FFPSA). This significant piece of federal legislation brings child

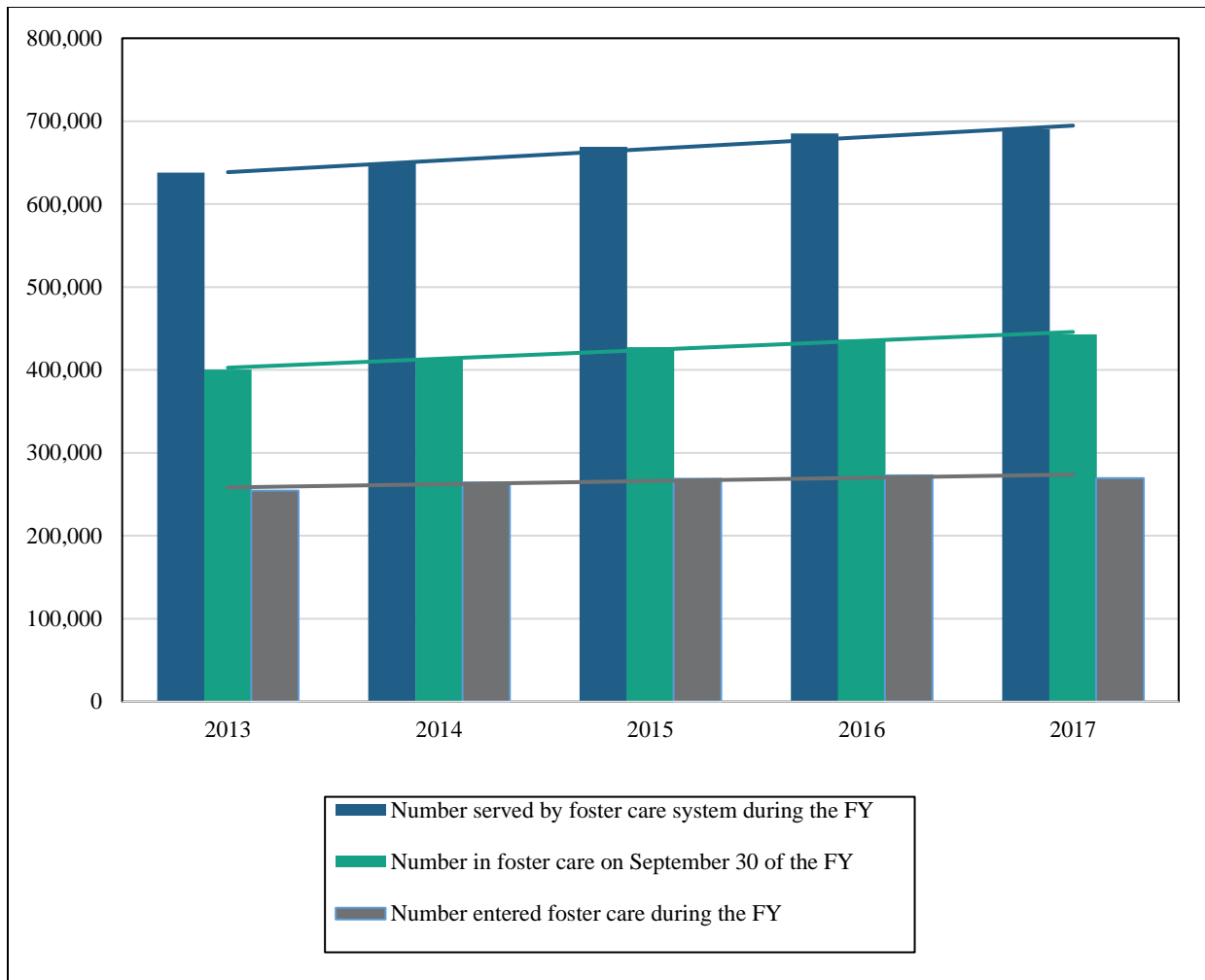
welfare financing into alignment with what research tells us is best for children and youth – to remain in their homes whenever safe and possible, and when children have to be removed and placed in foster care, that they are placed in the least restrictive, most family-like setting that meets their needs.

Child Welfare System Overview

According to national data, 690,548 children were served by state child welfare systems during FY2017.³ This increase from FY2016 continues a recent trend of increasing numbers of children being served each year over the past five years (see Figure 1 below). This increase is in contrast to the declining annual numbers of children in foster care prior to FY2013. Additionally, on the last day of FY2017 there were 442,995 children in foster care,⁴ which also represents an increase since FY2013. Some have attributed the increase to the opioids epidemic, and the increase in the number of parents addicted to opioids certainly has had an impact upon the child welfare system.⁵ Still, the FY2017 foster care population is still much lower than in FY2006 when 505,279 children were in care on the last day of the fiscal year. This progress is in part because of efforts by states both to reduce placements through more concerted actions at the time of imminent risk of placement and to promote timely permanency through either reunification, guardianship, or adoption.

Despite the national increase over the past five years, not all states have seen this increase within their own state foster care population. For example, states including California, Illinois, and Virginia have all seen a decrease in their foster care population, while states including Indiana, Tennessee, and West Virginia have all seen an increase.^{6,7} Additionally, state foster care entry rates⁸ vary significantly, with Illinois and Virginia having the lowest entry rates in FY2016 of 1.5 and 1.6 respectively (per 1,000 children) and Montana and West Virginia having the highest entry rates at 9.5 and 12.3 respectively – nearly a tenfold variation.

Figure 1: Child Welfare Overview, FY2013—FY2017



Source: Administration for Children and Families, “Adoption and Foster Care Analysis and Reporting System (AFCARS) FY 2017 Data.” 2018.

Children who entered foster care in FY2017 and who were in care on the last day of the fiscal year are disproportionately children of color. Specifically, 23 percent of children in care on the last day of FY2017 were African American and three percent were American Indian/Alaska Native (AI/AN) with disproportionate rates of 1.64 and 2.0 respectively.⁹ This trend has remained constant, as institutional and systemic racism have played, and continue to play, a significant role in children of color being disproportionately placed into foster care; and, once in care, experiencing poorer outcomes, including longer stays in care and increased placement instability.^{10,11}

Young children (under five years old) represented the largest portion of children (44%) to enter care in FY2017, with children under one representing 19 percent of new entries. This is also consistent with historical data, as young children continue to represent the largest proportion of new entries into foster care. Young children are uniquely at-risk of child neglect or abuse due to vulnerabilities associated with their age and may be removed from their homes for allegations that would not bring an older child into care due to the young child’s age and inability to protect themselves from harm. In addition, children may come into care due to abandonment or a

demonstrated inability to provide basic care and safety, which usually is detected very early in the child's life. Of note, children ages 13 to 17 years old represented 22 percent of new entries in FY2017.¹²

Prior to removing a child and placing them in foster care, states are required, in all but the most serious cases, to make “reasonable efforts” to prevent the removal of a child from their home and placement in out-of-home care.^{13,14,15} States are also required to make reasonable efforts to reunify a family when temporary placement in out-of-home care is necessary to ensure the child's safety. Reasonable efforts may include referring or putting in place individual, group, or family counseling, drug or alcohol use treatment and counseling, parent education, health-care services, homemaker services, or child care. For American Indian/Alaska Native children, the Indian Child Welfare Act of 1978 requires that states make “active efforts” prior to removing a child from their home.¹⁶ There have been a number of judicial decisions that further explain “reasonable efforts” and “active efforts.”¹⁷ As a general point of practice, active efforts require additional efforts to engage the family and connect them to services rather than simply providing a referral. Many advocates argue that simply providing a family with a referral to a service does not always constitute reasonable efforts.

Further, when children enter foster care, states must make efforts to place that child in the least restrictive, family like setting possible that is able to meet their needs. The majority of children in foster care (81 percent in FY2017) are placed in family foster or pre-adoptive homes, with 32 percent placed in a relative home. In practice, however, some children may be placed in a non-family setting due to the lack of available family foster homes or community-based therapeutic or medical services to maintain a child within a family-like setting. As of the last day of FY2017, seven percent of children were placed in an institution and six percent were placed in a group home.¹⁸ The FFPSA is the latest iteration of child welfare legislation to reinforce the importance of placement within a family foster home and has increased the responsibility of the state to ensure children are only placed into a congregate care setting when it is therapeutically or medically necessary, by tying the federal financial reimbursement to a clinical assessment conducted by a neutral party.¹⁹

The Intersection between Medicaid and Child Welfare

Children in foster care must receive primary child health services that meet their medical and clinical needs, including mental health and substance abuse treatment services. Because placements may result in movements outside the child's current neighborhood or community, it is essential there be continuity of primary child health services and basic medical care. There are substantial requirements within federal law for children in foster care to receive timely check-ups and medical services. In addition, Medicaid has been employed within some states to finance services directed to the special needs of children in foster care, to augment or substitute for services which otherwise could be provided under the child welfare system's primary funding source, Title IV-E. These are discussed separately, below.

Financing to support the health care needs of children and youth in foster care

State child welfare and Medicaid agencies are required by federal regulations to ensure that the health and well-being needs of children and youth in foster care are met. Specifically, state child welfare agencies are required to:

- have a written plan for each child in foster care that includes the child's regularly reviewed and updated health related records;
- develop a strategy that addresses the health care needs of each child in foster care in coordination with the state Medicaid agency; and
- provide youth who age out of foster care with a copy of their health record, as well as information about health insurance options, including categorical eligibility for Medicaid through the Affordable Care Act.

The vast majority of children in foster care are eligible for Medicaid under mandatory eligibility pathways through either the Title IV-E program or the Supplemental Security Income program. When children are not eligible through one of these pathways, they generally qualify under alternative pathways implemented by the state, such as the Ribicoff amendment, the state Child Health Insurance Program, or an 1115 Medicaid waiver.^{20,21,22} For FY2011, the Medicaid and CHIP Payment and Access Commission (MACPAC) reported Medicaid spending of \$4.5 billion to provide services to children in foster care. Importantly, analyses of these data show that while foster care children only represented 2.4 percent of all Medicaid child recipients, they accounted for 5.8 percent of expenditures for children enrolled in Medicaid.²³ Additionally, expenditure data consistently have shown that Medicaid costs for children in foster care are driven more by behavioral than physical health care needs. The same MACPAC report shows the average Medicaid spending for a child in foster care with behavioral expenditures was \$11,097 per year, while the average Medicaid spending for a child in foster care with no behavioral expenditures was \$2,499 per year.²⁴

As a result of the federal requirements and the clear health care needs of children in foster care, state child welfare and Medicaid agencies must have a working relationship to support the financing associated with providing health-related services. What this administrative relationship looks like varies across states and is based on a variety of factors, including whether Medicaid-funded services are housed within the child welfare, health, or behavioral health agency and whether the state uses a fee-for-service or a managed care system.

Financing to support child welfare system responses to children

The working relationship between state child welfare and Medicaid agencies often includes both supporting and coordinating the financing for direct health care services provided to children on Medicaid (including physical and behavioral health services) and other health-related, non-direct health care services funded specifically through the child welfare agency for children (including rehabilitation services, targeted case management, and therapeutic foster care and residential services). Whether such services are financed through Title IV-E or through Medicaid varies significantly by state. Child welfare agencies are financed through a combination of federal and state dollars, with state financing structures and formulas varying widely from state to state. Some state child welfare agencies are predominately funded by federal dollars (for example Louisiana is 78 percent and Missouri is 73 percent federally funded), and others are predominately funded by state and local dollars (for example Delaware is 17 percent and

Pennsylvania is 22 percent federally funded).²⁵ The largest source of federal financing comes from Title IV-E of the Social Security Act, with additional federal dollars allocated through Title IV-B of the Social Security Act, the Child Abuse Prevention and Treatment Act (CAPTA), and Victims of Child Abuse Act. In addition to these specific child welfare funding streams, states' child welfare systems also use funding through Medicaid, the Social Services Block Grant, and Temporary Assistance to Needy Families. Historically, in providing services to meet reasonable and active efforts requirements, states have had to use non-Title IV-E financing sources, including Medicaid, CAPTA, Title IV-B, SSBG, and TANF. In recent years, however, many states have been granted a Title IV-E waiver that has allowed them to redirect Title IV-E dollars to support prevention and reunification activities that, outside of the waiver, would not be reimbursable under Title IV-E. Moving into FY2020, states will for the first time have the opportunity through FFPSA to utilize Title IV-E dollars to support reasonable and active efforts for preventive services aimed at keeping families together.

Based on SFY2016²⁶ data, there was significant variation in how states utilized federal Medicaid dollars to finance services provided through their child welfare system, ranging from Medicaid representing 27 percent of Tennessee's child welfare budget and 13 percent of Rhode Island's budget to zero percent of Ohio's and Wyoming's budgets.²⁷ Again, this does not mean that children in foster care in Ohio and Wyoming are not receiving Medicaid-funded physical and behavioral health services, but rather that the financing structure in these states results in Medicaid dollars not being used for services within their child welfare agency budgets. As states attempt to implement an InCK model to reduce out-of-home placements and achieve Medicaid cost savings, the state's current use of Medicaid for child welfare services needs to be recognized.

According to a national survey conducted by Child Trends, in SFY2016 state child welfare agencies in 37 states reported spending a collective \$867.2 million in federal Medicaid funds for child welfare activities. Twelve states reported that their state child welfare agency did not use Medicaid dollars directly.²⁸ States also reported that in SFY2016 the top three uses of Medicaid funds for child welfare involved children were to pay for targeted case management, rehabilitative services, and services for children in treatment or therapeutic foster care. States also reported using Medicaid to finance the costs associated with case management and referrals to medical providers, health clinics specifically for children in foster care, nurses based within the child welfare agency to coordinate medical care, and Medicaid administrative activities.²⁹ And over time states have made greater use of Medicaid to finance those services. For both Title IV-E and for Medicaid, states are able to claim at the state's federal financing participation (FFP) rate.³⁰

Evidenced-Based Programs and Approaches to Reduce Placement in Foster Care and Achieve Timely Permanency

In supporting the health and well-being of children, youth, and families involved with child welfare, there has been, and continues to be, advances in understanding what works to support young people and their well-being, including reducing unnecessary placements in out-of-home care and achieving timely permanency. These advances are critical as they reinforce what research says is best for the health and well-being of children and youth: to be living in their

communities with their families, or, if that is not possible, to be in the least restrictive settings where they are connected to family, friends, and community. Additionally, keeping children in the community and providing prevention services also is often financially beneficial to states, as placement into residential settings can be very costly.

There is a number of evidence-based programs and approaches that have been shown to lead to positive outcomes for children and families, including reducing risk of abuse or neglect, improving health outcomes, and promoting family functioning. These programs are targeted to the specific needs of children and families. Some focus on addressing underlying causes of trauma in the child or family, while others focus on addressing immediate risks that can lead to the placement of children into out-of-home care.

There is also a growing number of programs and approaches that have been found to be effective in preventing the need for placement in out-of-home care. Examples include intensive family preservation services (including [Homebuilders®](#)), wraparound services, family group decision-making, crisis response and stabilization (including [C.A.R.E.S. – Coordination, Advocacy, Resources, Education and Support, and S.T.A.R.T. – Sobriety Treatment and Recovery Teams](#)). [Child FIRST](#) is another home visiting program that has been effective working with systems-involved families of young children who experience high levels of stress. These interventions, among others, address risk factors and/or immediate crises that allow for the child to remain safely in their home with their parent rather than be placed in out-of-home care. The insert provides a brief description of these programs, which share a common characteristic of working intensively with the child and family to equip them to avoid future problems and crises. The InCK Model places emphasizes developing integrated care models to prevent placements and producing cost savings.

SELECT EVIDENCED-BASED PLACEMENT PREVENTION PROGRAMS AND THEIR ATTRIBUTES

Several referenced examples of evidenced-based programs that have proven success in preventing placements through crisis-response are shown below. While each represents a distinct model, they also share common characteristics or attributes to which they attribute their success – timeliness of response at the point of crisis (imminent risk of placement), intensive actions that fully engage parents (and other key people in the child’s life) in developing plans to keep the child safe and secure, commitment from parents and family members to make changes to implement the plans and be accountable for making those changes, systemic support in providing needed ongoing services, and systemic responses to address concrete needs (such as in the home environment) also needed to implement the plans.

Homebuilders is the flagship home- and community-based intensive family preservation program structured to step in at the time of imminent risk of placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. Homebuilders engages families at times when they are most receptive to learning and enlists them as partners in assessment, goal setting, and treatment planning, providing intensive problem solving and treatment to address the crisis and to set in place ongoing strategies to prevent future crises. Homebuilders also provides its workers with flexibility to address concrete issues related to the home environment.

Wraparound Milwaukee is one of a number of wraparound service programs designed to provide what is needed to enable families to meet their children’s needs, often by enlisting others in the community to

provide support and providing basic concrete supports related to housing and the home environment. Wraparound Milwaukee's primary focus is to serve children and adolescents who have serious emotional disorders and who are identified by the child welfare or juvenile justice system as being at immediate risk of residential or correctional placement or psychiatric hospitalization. Wraparound Milwaukee stresses family inclusion in treatment programs, with collaboration among child welfare, education, juvenile justice and mental health in the delivery of services.

Family Group Decision-Making (FGDM) enlists the child's overall "family group," including parents and relatives and close friends and mentors, in decision-making to ensure the child's safety, permanency, and well-being. In the FGDM process, a trained coordinator brings together the family group and agency personnel to create and carry out a plan to ensure child safety and support, with responsibilities and accountability assigned through the process. Agency personnel organize service providers to access needed resources for implementing the plans and monitoring it.

Sobriety Treatment and Recovery Teams (START) serves families with at least one child under 6 years of age who are in the child welfare system and have a parent whose substance use is determined to be a primary child safety risk factor. START pairs child protective services (CPS) workers trained in family engagement with family mentors (peer support employees in long-term recovery) using a system-of-care and team decision-making approach with families, treatment providers, and the courts. Essential elements of the START model include quick entry into services to safely maintain child placement in the home and rapid and timely access to intensive addiction/mental health assessment and treatment.

Source: Charles Bruner memo excerpt, March, 2019.

Within child welfare systems, the [Infant Toddler Court Team Program](#) emphasizes judicial leadership and utilizes a Community Coordinator to support families and system providers. This approach works closely with families, often using family team meetings, to support reunification by promoting quality parent-child visits and placement with kin when possible and has been shown to promote family well-being, timely permanency, and healthy child development. The Annie E. Casey Foundation's Family-to-Family Initiative showed how concerted efforts to place children close to their homes, with extended families, and with active family reunification efforts and visits beginning as soon as possible after placement, reduced lengths-of-stay in foster care, promoted greater permanence, and reduced the separation trauma that placements produce in children.

There also is a number of evidence-based programs that have been shown to support youth with behavioral challenges, which can reduce the need for long-term placement in a residential setting. These programs, which include [Multidimensional Family Therapy](#), [Multisystemic Therapy](#), and [Functional Family Therapy](#), are designed to support children and adolescents ages 11 and older, although there is some variation in the target age-group depending on the model. In addition, [Treatment Foster Care Oregon](#) has been identified as an evidence-based program for youth who cannot remain safely in their homes to create opportunities for them to successfully live in foster families rather than in group or institutional settings, and to simultaneously prepare their parents to care for them after a temporary stay in foster care. Such programs not only create greater connection to community, but, like those preventing placements in the first place, also can result in significant cost savings by preventing placement in costly residential programs.

In addition to these client-specific interventions, there are evidence-based models that can be implemented across an agency to increase worker and agency awareness and responsiveness to trauma experienced by a child and family. Such models include [Trauma Systems Therapy](#) and the [Sanctuary Model](#), both of which have been evaluated and the evidence has shown that practice change leads to improved outcomes for children and youth.

Evidenced-Based Programs and Approaches to Prevent or Reduce Involvement in the Child Welfare System

In addition to the more intensive evidence-based programs discussed above, there are evidence-based programs that have been shown to be effective in reducing the risk of abuse or neglect – generally by addressing family stresses and risks that can be root causes for neglect or abuse. These programs include [Safe Environment for Every Kid \(SEEK\)](#), [SafeCare®](#), [Nurse Family Partnership](#), [Triple P Positive Parenting](#), [CICC’s Effective Black Parenting Program](#). In addition, [Combined Parent-Child Cognitive Behavioral Therapy](#), [Child Parent Psychotherapy](#), [Parent Child Interaction Therapy](#), and [Trauma-Focused Cognitive Behavioral Therapy](#) all of which have been shown to support the mental and behavioral health needs of children and parents.

Many of the above mentioned evidence-based programs have been catalogued and rated in existing databases including the [California Evidence-Based Clearinghouse for Child Welfare](#), [SAMHSA’s Evidence-Based Practices Resources](#), [Treatments that and Practices from The National Child Traumatic Stress Network](#), [Office of Juvenile Justice and Delinquency Prevention’s Model Programs Guide](#), the [HHS Teen Pregnancy Prevent Evidence Review](#), and the [What Works Network in the United Kingdom](#). It is anticipated that in spring/summer of 2019, the Children’s Bureau will publish the first version of the Clearinghouse of evidence-based programs as required through FFPSA. These databases can and should serve as a starting point for states and communities looking to identify evidence-based programs that can meet the needs of children and families within their community.

Beyond the programs discussed above, there are setting to promote the health and well-being of parents and their children. There is a growing number of programs that start with the primary care visit with the ultimate goal of preventing a family’s entry into child welfare generally.³¹ The models include [Healthy Steps](#); [Project DULCE](#), which utilizes a family support worker in a pediatric setting to support families in meeting their concrete needs; [Help Me Grow](#), which is designed to support states and communities through linking families to community-based services that support healthy child development. Such models like these that focus on the social determinants of health and integrate a child development framework can help ensure that a family’s comprehensive needs are identified and addressed. Further, these models are supporting the foundation of healthy child development, responding to social determinants of health, building protective factors, and responding to vulnerabilities before children experience adversities and trauma. Expanding these services, under Medicaid or other funding, could have long-term benefits including reducing the demand for placements in the future. In most instances, Medicaid can finance the above services, or at least significant aspects of those services.³² The Medicaid EPSDT benefit itself requires financing of more preventive services. In the case of services designed specifically to prevent placement or improve timely reunification and permanence, states may have options to provide financing under Medicaid or Title IV-E. In

the case of more preventive services (often before there has been any involvement of the child welfare system), Medicaid can be a significant source of coverage.

Opportunities Moving Forward to Align and Integrate Medicaid and Child Welfare Responses

Moving forward, there are significant opportunities for state Medicaid and child welfare agencies to partner and collaborate to support the health needs – physical and behavioral – of children and youth who are at-risk of placement in foster care. State Medicaid and child welfare agencies can promote the health and well-being of children and youth at risk of out-of-home placements by focusing on prevention (both prevention of placement into foster care and prevention of placement into non-family, residential settings) and increasing the protective and promotive capacities of caregivers and youth. As part of a long-term and more comprehensive prevention agenda, systems would benefit from investing in services that build parent protective factors and target children and families with risk factors or emerging concerns to mitigate risk and prevent possible future placement in out-of-home care. Medicaid systems can provide additional resources to this end, but Medicaid also must recognize and build upon work underway within the child welfare system to achieve these same goals.

Regardless of the array of services that a system elects to implement and expand, it is necessary that in meeting the goal of reducing out-of-home placements and improving health outcomes, states pay attention to disaggregating their data by race and ethnicity and implement supports and services that are proven effective in serving children and families of color. As mentioned above, data clearly show these families continue to be disproportionately involved with child welfare and experience disparate outcomes.

Specific Opportunities to Build Upon the New Provisions within FFPSA

The FFPSA makes many changes to child welfare and Title IV-E financing that are pertinent to the InCK Model and can contribute to meeting InCK’s overall goals – but these require even greater attention to aligning Title IV-E and Medicaid financing.

Through FFPSA, states soon³³ will be eligible to draw down Title IV-E reimbursement for select evidence-based programs³⁴ for children and their caregivers who are candidates for foster care, to prevent unnecessary foster care placement, and to support pregnant and parenting youth in foster care. Evidence-based services that are eligible for Title IV-E reimbursement include in-home skill-based parenting programs, mental health prevention or treatment programs, and substance abuse prevention or treatment programs. The FFPSA also allows states to provide those services without requiring eligibility based upon current, outdated Title IV-E maintenance payments. In many respects, this opens up a new financing opportunity for states which do not currently use Medicaid to finance child welfare services.

It is important that states implement a range of programs that support comprehensive service delivery within diverse settings and communities, as there is no single evidence-based program that exists that would be able to meet the needs of every unique family. Child welfare, Medicaid,

and health and behavioral health agencies should work together to examine the data to determine the populations most in need of preventive services and to identify evidence-based programs that are not currently included in their State Medicaid Plan that would meet the evidence and target outcome requirements of FFPSA.

Jurisdictions that are implementing the InCK model will benefit from involving child welfare leadership at both the state and community level. This will help ensure that there is alignment between the goals of FFPSA and InCK and that respective roles for both Medicaid and child welfare are understood. It is also essential that the current financing of child welfare services and the current efforts being undertaken to reduce placement in foster care and improve permanency are recognized within InCK planning. At both the state and local site level, it will be helpful to map all federal, state, and community funding sources for prevention and foster care expenditures. In addition to working together to identify a continuum of prevention services, state Medicaid and child welfare agencies should partner closely to ensure proper administration and reimbursement of these programs particularly since as states implement FFPSA some programs currently financed or that will be eligible under Title IV-E could be expanded to contribute to the InCK Model's goals for reducing foster placement. As clarified by the Children's Bureau in a Program Instruction (PI) on FFPSA released on November 30, 2018, Title IV-E will be the payer of last resort for these programs. Specifically the PI states that, "if a public or private program providers (such as private health insurance or Medicaid) would pay for a service allowable under the Title IV-E prevention program, those providers have the responsibility to pay for these services before the Title IV-E agency would be required to pay." Given the requirements of FFPSA related to the percentage of Title IV-E funding that must support well-supported programs and guidance related to Title IV-E as the payer of last resort, it is critical that state child welfare and Medicaid financing staff work closely to determine the best way to finance a comprehensive continuum of prevention services that promotes keeping children from ever coming to the attention of child welfare, and if they do, from entering foster care.

States will need to work closely together to ensure the proper administration of evidence-based prevention programs for candidates of foster care and their caregivers. States will have to conduct detailed fiscal analyses and projections in order to ensure they are maximizing federal reimbursement for prevention programs under both Medicaid and Title IV-E and meeting requirements outlined within FFPSA, including that 50 percent of expenditures must go to supporting well-supported evidence-based programs.

In addition to being able to draw down Title IV-E dollars to support the provision of prevention services to children and their caregivers when the child is a candidate of foster care, FFPSA will also allow for the reimbursement of a candidate child's placement with a parent in a residential substance use treatment facility. This will help promote keeping families together as parents engage in necessary treatment. Unfortunately, there are limited parent-child treatment facilities across of the country and virtually no parent-child programs for fathers. In order to prevent children from entering foster care, states must explore current capacity and invest in building the infrastructure to meet the need.

Given that FFPSA requires that children be placed in the most family-like, least restrictive setting that meets their needs, state Medicaid and child welfare agencies will need to work together to ensure that there are a variety of home-based therapeutic and treatment services readily available to meet the needs of children in foster care so that they can remain in a family-based setting. These services can include in-home therapeutic interventions, Mobile Stabilization Services, and supports for resource caregivers (foster parents). Having a variety of services available to support the physical and behavioral health care needs of children in their foster home placement is critical to reducing placements in more restrictive, congregate care settings.

FFPSA also requires that in order for a state child welfare agency to receive the federal Title IV-E maintenance payment for a child's placement³⁵ in a congregate care setting, the setting must meet the definition of a Qualified Residential Treatment Program (QRTP).³⁶ FFPSA requires additional oversight and focused treatment while a child is placed at a QRTP and upon discharge, the QRTP must provide family-based services to the child and family for six months after the child returns to the community. State Medicaid and child welfare agencies need to ensure that the services of QRTPs are delivered with quality to families and that any administrative barriers that may exist – for example which agency is financing the service – are removed.

Finally, while national rates of adolescent pregnancy have declined, youth in foster care still have high rates of births while they are in foster care and after transitioning out of the child welfare system.³⁷ According to findings from the Midwest Evaluation – which surveyed former foster youth from Iowa, Illinois and Wisconsin during their transition to adulthood – adolescent women in foster care were 2.5 times more likely to become pregnant by age 19 than their peers not in foster care and approximately half of 21-year-old males transitioning out of foster care reported getting a partner pregnant compared to 19 percent of their non-foster care peers.³⁸ Through FFPSA, states will now be able to claim Title IV-E reimbursement for evidence-based prevention services provided to pregnant and parenting youth in foster care regardless of whether or not their child is deemed a candidate for foster care. Currently, half of all births are covered under Medicaid, and the InCK Model allows applicants to cover pregnant women 21 and older, as well as requiring coverage of pregnant women under 21.³⁹ State Medicaid and child welfare agencies have an opportunity to implement targeted services that support the healthy development and well-being of both the parent and child. Particularly for young parents, these services should support the healthy development of the parent as both a parent and adolescent.

Final Comments

Health care models that meet the needs of both the parent and child can increase positive health outcomes for parents and children and ensure that parents are active participants in their child's health care and healthy development. Research shows that parents are more likely to ensure their child has access to the appropriate health care services if their own health needs are being met.⁴⁰ The InCK Model NOFO builds on this research and places a priority and indicates preference for applications that adopt two-generation strategies that do not focus exclusively on the health conditions and needs of the child.

Research strongly supports efforts to strengthen parental protective and promotive factors in order to prevent or mitigate factors, including stress, which can increase risk of child abuse or

neglect. Reducing the impact of toxic stress and child abuse and neglect is associated with positive health and well-being outcomes across the life span – and are central goals of both state Medicaid and child welfare agencies. Moving forward, states should explore opportunities to integrate parental protective and promotive factors into coordinated health care settings for children and parents – within child welfare and before families reach the point of becoming involved in child welfare. This should include identifying strategies to support the concrete needs of parents – as families in poverty are more likely to come into contact with child welfare. States and communities do not have to start from scratch – there are many evidenced-based programs and approaches to replicate or adapt.

It is also critical that when implementing evidence-based program models and the approaches, practices, and attributes which make them effective.⁴¹ States should employ rigorous continuous quality improvement strategies to ensure that the program is leading to the intended outcome(s) and that any adaptations necessary to achieve those outcomes are closely tracked and evaluated. This requires being intentional in ensuring that services are implemented and available for those children and families who are disproportionately impacted by child welfare and who experience disparate outcomes – including longer stays in foster care and poor health outcomes.

This includes ensuring culturally and linguistically appropriate services for families of color and non-Native English-speaking families as well as services that are affirming of every child, youth, and adult’s sexual orientation, gender identity, and gender expression. To both build the evidence and reduce disproportionalities and disparities along health and well-being outcomes, state Medicaid and child welfare agencies should identify interventions that work to achieve positive outcomes for *all* children and families and invest in growing the evidence about effectiveness for different populations.

As there is no “one size fits all” evidence-based program, it is critical that states invest in evaluations of evidence-based programs that include disciplined adaptation to meet the needs of different populations including across race, ethnicity, language and culture, and in different settings. In doing so states will contribute to building the evidence for innovative programs and services that will meet the diverse needs of children and families. Because many evidence-based programs have been tested for the effectiveness only on specific populations and not on others, like immigrant and AI/AN children and families, testing adaptations of evidence-based programs that meet the unique needs of different populations becomes even more important. It is clear that program effectiveness is dependent upon providing culturally and linguistically responsive services in addressing the impacts that personal, institutional, and structural racism and discrimination, marginalization, and separation have on children and families. While a program may be evidenced-based, it also needs to incorporate attributes that ensure it is linguistically and culturally responsive and anti-bias in its operation.

Many states and communities currently invest in community-based prevention services that have strong outcome data or have anecdotal evidence that the intervention works, but which aren’t may not meet specific rating criteria. These services deserve recognition and support. States have an opportunity under FFPSA to invest in growing the evidence of those existing programs within their community so that future children and families can benefit and so that states can receive Title IV-E reimbursement in the future.

Finally, in order for state Medicaid and child welfare agencies to be able to effectively serve all children and families and identify which children and families are not currently being served well, there needs to be ongoing and formalized mechanisms for sharing and analyzing data. Forums where these data can be discussed and solutions identified can serve as a venue for state Medicaid and child welfare agencies to establish coordinated continuous quality improvement plans to ensure the services lead to the intended outcomes for children and families and that any gaps in services can be addressed.

Endnotes

¹ Mandatory pathways for Medicaid coverage include children and youth in foster care who are Title IV-E eligible and those who are eligible based on income. For children and youth who may not be Medicaid eligible based on these mandatory pathways, optional pathways to coverage include the Ribicoff amendment, disability or other state-determined optional pathways, or coverage through the Children's Health Insurance Program.

Children and youth who may not be eligible for Medicaid include those without legal status and those with accountable income above 138 percent FPL

² Stoltzfus, E., Baumrucker, E., Fernandes Alcantara, A., & Fernandez, B. (2014). Child Welfare: Health Care Needs of Children in Foster Care and Related Federal Issues. Congressional Research Service.

³ "The AFCARS Report No. 25." Administration for Children and Families, August 10, 2018. Available at: <https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport25.pdf>.

⁴ There were 73.6 million children (0-17) in the United States in 2017 and therefore, approximately 0.6 percent were in foster care as of September 30, 2017. All states are required to cover eligible children 0-17 in their state foster care systems, but states have the option of going to higher age ranges (although the numbers of children are small). The 0.6 percent is based on using the denominator of 73.6 million children 0-17.

⁵ Brundage, S., Levine, C. (2019). The Ripple Effect: The Impact of the Opioid Epidemic on Children and Families. United Hospital Fund and Milbank Memorial Fund.

⁶ For a comprehensive list of state data over the past ten years through FY2017, please see:

<https://www.acf.hhs.gov/cb/resource/trends-in-foster-care-and-adoption>

⁷ "Trends in Foster Care Adoption." Administration for Children and Families, August 10, 2018. Available at: <https://www.acf.hhs.gov/cb/resource/trends-in-foster-care-and-adoption>.

⁸ The foster care entry rate is the number of children who entered into foster care for at least one day during that fiscal year per the population of 1,000 children in that state. For state specific information, please see:

<https://cwoutcomes.acf.hhs.gov/cwdatasite/byState>

⁹ Disproportionality refers to the differences in the percentage of children of a certain racial or ethnic group in the country as compared to the percentage of the children of the same group in the child welfare system. The disproportionate rate here is the ratio of children from a particular racial or ethnic group in foster care compared to the representation of that group of children in the population.

¹⁰ Minoff, Elisa. "Entangled Roots: The Role of Race in Policies that Separate Families." Center for the Study of Social Policy, October 2018. Available at: <https://cssp.org/wp-content/uploads/2018/11/CSSP-Entangled-Roots.pdf>.

¹¹ Martin, Megan and Dana Connelly. "Achieving Racial Equity: Child Welfare Policy Strategies to Improve Outcomes for Children of Color." Center for the Study of Social Policy and Policy for Results.org, 2015. Available at: <https://cssp.org/wp-content/uploads/2018/08/achieving-racial-equity-child-welfare-policy-strategies-improve-outcomes-children-color.pdf>.

¹² *The AFCARS Report No. 25.*

¹³ "Reasonable efforts" requirements were introduced into child welfare proceedings by the Federal Adoption Assistance and Child Welfare Act of 1980, Public Law 96-272 (AACWA). Since then, reasonable efforts has been a core concept in American child welfare and practice. The Adoption and Safe Families Act of 1997, Public Law 105-89 (ASFA), maintained but refined this concept. ASFA provides that: reasonable efforts shall be made to preserve and reunify families prior to the placement of a child in foster care, to prevent or eliminate the need for removing the child from the child's home; and to make it possible for a child to safely return to the child's home; if continuation of

reasonable efforts of the type described in subparagraph (B) is determined to be inconsistent with the permanency plan for the child, reasonable efforts shall be made to place the child in a timely manner in accordance with the permanency plan, and to complete whatever steps are necessary to finalize the permanent placement of the child. [42 U.S.C. 671(a)(15).]

¹⁴ There are certain situations outlined in ASFA that do not require a state to make reasonable efforts. These include situations where: the parent subjected the child to aggravated circumstances as defined by State law (the definition of aggravated circumstances may include, but is not limited to, abandonment, torture, chronic abuse, and sexual abuse); the parent committed murder of another child of the parent; the parent committed voluntary manslaughter of another child of the parent; the parent aided or abetted, attempted, conspired, or solicited to commit such a murder or voluntary manslaughter; the parent committed a felony assault that resulted in serious bodily injury to the child or another child of the parent; the parental rights of the parent to a sibling of the child were terminated involuntarily. In addition, several states, provide one or more additional grounds for not making reasonable efforts.

¹⁵ Child Welfare Information Gateway. (2016). *Reasonable efforts to preserve or reunify families and achieve permanency for children*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

¹⁶ The Indian Child Welfare Act of 1978 (ICWA) ((Pub.L. 95–608, 92 Stat. 3069, enacted November 8, 1978), codified at 25 U.S.C. §§ 1901–1963).

¹⁷ National Indian Law Library. “A Practical Guide to the Indian Child Welfare Act.” Retrieved from: <https://narf.org/nill/documents/icwa/faq/active.html#Q4>

¹⁸ Ibid.

¹⁹ Family First Prevention Services Act (Pub. L. 115-123, enacted February 9, 2018 as part of the Bipartisan Budget Act).

²⁰ Citrin, Alexandra. “Protect Medicaid: Critical Opportunities to Support Children, Youth and Families Involved with Child Welfare.” Center for the Study of Social Policy, March 2017. Available at: <https://cssp.org/wp-content/uploads/2018/08/Medicaid-Opportunities.pdf>.

²¹ Stoltzfus, Emilie et al. “Child Welfare: Health Care Needs of Children in Foster Care and Related Federal Issues.” Congressional Research Service, November 19, 2014. Available at: <https://fas.org/sgp/crs/misc/R42378.pdf>.

²² MACPAC. Report to Congress on Medicaid and CHIP. June, 2015. See: Chapters 3 and 4. Available at: <https://www.macpac.gov/publication/june-2015-report-to-congress-on-medicaid-and-chip/>

²³ Ibid. Numbers derived from Tables in Behavioral Health section.

²⁴ Pires, Sheila et al. “Making Medicaid Work for Children in Child Welfare: Examples from the Field.” Center for Health Care Strategies, Inc., June 2013. Available at: <https://www.chcs.org/resource/making-medicaid-work-for-children-in-child-welfare-examples-from-the-field/>.

²⁵ Rosinsky, Kristina and Sarah Catherine Williams. “Child Welfare Financing SFY 2016: A Survey of Federal, State, and Local Expenditures.” Child Trends, December 2018. Available at: https://www.childtrends.org/wp-content/uploads/2018/12/CWFSReportSFY2016_ChildTrends_December2018.pdf.

²⁶ SFY2016 in this context is based on a state’s definition of their fiscal year for the year (FY2016). In some states the FY2016 began July 1, 2016 and in others it began October 1, 2016.

²⁷ Ibid.

²⁸ Ibid.

²⁹ Pires, Sheila et al, *Making Medicaid Work for Child in Child Welfare*.

³⁰ As outlined in FFPSA, PAYMENTS UNDER TITLE IV–E. Section 474(a) of such Act (42 U.S.C. 674(a)) is amended to outline the reimbursement structure for evidence-based programs included in a state’s approved Title IV-E Prevention Plan. Beginning October 1, 2019 through September 30, 2026, states will be reimbursed for 50% of the total amount expended for the approved evidence-based programs. Beginning October 1, 2026 states will be reimbursed for the total amount of expenditures of the evidence-based programs included in their approved Title IV-E Prevention Plan at an amount equal to the Federal medical assistance percentage.

³¹ Bruner, C., et.al. (2017). Transforming Child Health Care Primary Practice: Building Upon Evidence and Innovation. Health Equity and Young Children Initiative, Child and Family Policy Center.

³² Johnson, K. & Bruner, C. (2018). A Sourcebook on Medicaid’s Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health. Healthy Equity and Young Children Initiative: Child and Family Policy Center.

³³ States are eligible to begin claiming for reimbursement beginning October 1, 2019, however, in order to do so, a state must have an approved Title IV-E prevention plan and be in compliance with the congregate care requirements within FFPSA

³⁴ In accordance with FFPSA legislation, the Children’s Bureau is currently working to define and manualized the criteria that will be used to rate programs and interventions as a well-supported, supported, and promising evidence-based practice.

³⁵ In order to receive any federal Title IV-E reimbursement for a child’s placement in foster care, the state must also determine that the child meets the eligibility requirements for Title IV-E including the income requirement.

³⁶ Other requirements include that the services needed to support the child’s behavioral health care needs cannot be provided in the community, the child must be evaluated by a neutral clinician who finds that placement in a Qualified Residential Treatment Program is the least-restrictive placement for the youth, and that the Qualified Residential Treatment Program meets the requirements outlined in FFPSA. (Family First Prevention Services Act (Pub. L. 115-123, enacted February 9, 2018 as part of the Bipartisan Budget Act)).

³⁷³⁷ Browne, Charlyn Harper. “Expectant & Parenting Youth in Foster Care: Addressing Their Developmental Needs to Promote Healthy Parent and Child Outcomes.” Center for the Study of Social Policy, 2015. Available at: <https://cssp.org/wp-content/uploads/2018/08/EPY-developmental-needs-executive-summary.pdf>.

³⁸ Courtney, Marc E et al. “Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 26.” Chapin Hall at the University of Chicago, 2011. Available at: <https://www.chapinhall.org/wp-content/uploads/Midwest-Eval-Outcomes-at-Age-26.pdf>.

³⁹ Bruner, C. & Johnson, K. (2018). Federal Spending on Prenatal to Three: Developing a Public Response to Improving Developmental Trajectories and Preventing Inequities. Center for the Study of Social Policy.

⁴⁰ Citrin, Alexandra. “Improving Health Care Services: Opportunities within Medicaid to Support Child Welfare Involved Expectant & Parenting Youth.” Center for the Study of Social Policy, 2017. Available at: <https://cssp.org/wp-content/uploads/2018/08/Improving-Health-Care-Services-EPY.pdf>.

⁴¹ Kinney, J., Bruner, C., *et.al.* (nd). Beyond the Buzzwords: Key Attributes of Effective Practice. National Center for Service Integration Working Paper. Schorr, L. (1987). Within Our Reach: Breaking the Cycle of Disadvantage. Random House.