Raising the Bar for Health and Mental Health Services for Children in Foster Care: Developing A Model of Managed Care

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Leadership, Voice and Vision for Child Welfare in New York State

NYS HEALTH FOUNDATION

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Executive Summary

Children and youth in New York's foster care system have significant health and mental health needs that are rooted in childhood trauma. This project's findings show that despite an increase in access to health services after entry into foster care and huge expenditures on high-cost services, the children continue to lack access to the preventive and behavioral health services that are recommended by the American Academy of Pediatrics and New York State as a means of addressing their needs, improving outcomes, and managing costs.

This project used a two-pronged approach:

- A review of Medicaid utilization data accumulated over a nine-year period that included 73,000 children and youth in foster care, 38 million days of care, and $2.6 billion in Medicaid expenditures in order to develop an accurate profile of the utilization patterns of children and youth before, during, and after entering the foster care system.
- A review of six major categories of health care delivery that enabled the project workgroups to develop a set of recommendations for implementing a managed care system that prioritizes trauma-informed preventive and mental health services to improve outcomes.

This project found that:

- There has not been a review of quantifiable data relating to the array of services individual children are receiving, the quality of care delivered, or their physical and behavioral health outcomes.
- Medicaid expenditures for these children are exponentially higher than the general pediatric Medicaid population.
- There are disturbing patterns in service utilization before, during, and after exit from foster care, suggesting that gains made during foster care are not being sustained and previous patterns of inadequate care often resurface.

These findings are supportive of a transition to managed care for three primary reasons:

- Managed care offers a means of applying intensive, evidence-based health care management that is crucial to improving outcomes for this population.
- Managed care will enable the State to implement quality performance standards and contractual provisions to enhance the coordination and integration of care and services.
- Managed care will promote the development and integration of specialized networks of practitioners with expertise and experience in addressing the unique needs of this population.

A PROFILE OF CHILDREN AND YOUTH IN THE FOSTER CARE SYSTEM

At present, roughly 21,600 children and youth are in foster care in New York State and approximately 30,000 children and youth pass through the system each year. The amount of time that children spend in foster care varies greatly, as do the needs of each individual child. The system that serves them is complex, highly regulated, and reflective of the changes that have occurred over time with respect to the numbers of children in its care. Since the 1990s, the number of children and youth in foster care has been reduced by two-thirds, from a high of 65,000 to the current 21,600. All foster children are categorically eligible for Medicaid upon entry into the child welfare system.

Most of the children in the system are cared for in foster boarding homes, while others reside in residential campuses and group homes of various types. All are in need of medical and behavioral health care. Permanency (i.e., placement with a legally permanent family) is a high priority, either through re-unification with their birth families (or relatives) or through adoption. Many very young children enter the system (42 percent are less than five-years old and nearly half of those are less than one year of age) and those who remain the longest entered the system when they were less than one-year old. In fact, 25 percent of all care days are for children who entered as infants. The average length of stay in foster care in NYC is 334 days, while the average in the rest of the state is 290 days. A significant percentage of those who exit the system re-enter it again, with more than half of 10 -13 year olds experiencing more than one placement during the time they are in foster care. The most common placement for 14–17 year olds is group homes and other forms of non-family-based care.

Children and youth in the foster care system have a high prevalence of medical, behavioral, and developmental problems and utilize health and mental health services at rates exponentially higher than the general pediatric Medicaid population. The impact of the trauma these children experience is profound, and when coupled with stress and other life circumstances it has significant short and long term impact on a child's physical and mental health along with substantial fiscal consequences for the child welfare, juvenile justice, and health care systems —especially Medicaid.

THE PROBLEM

New York Medicaid spends hundreds of millions of dollars each year providing health-related services (including physical, behavioral, and dental services) for these children before, during, and after their time in foster care, and yet we know far too little about the impact this investment has on the lives of these children. The lack of information about the services and outcomes for these children, as well as the lack of accountability for their health care, is neither defensible nor tolerable. The time for change is long past due.

THE PROJECT

New York State's Medicaid Redesign Team (MRT) recently concluded that all children and adolescents in New York's foster care system should be enrolled in Medicaid managed care. Owing to the many complexities involved in making this transition, stakeholders in the child welfare arena suggested that a careful analysis of the potential impact of the proposed change was warranted, which gave birth to this project. The project assembled a diverse group of clinicians, child welfare agencies, government officials, advocates, legal advisors, consultants, and other stakeholders to engage in a frank series of discussions and deliberations about the relevant issues, potential solutions, and corresponding policy recommendations and considerations. The New York State Health Foundation generously provided funding to the Council of Family and Child Care Agencies for this project.

THE PROCESS

Collectively, more than 1,000 person hours were invested by a large group of participants from a wide range of organizations and backgrounds. Working collaboratively over a period of five months, six workgroups hammered out a series of recommendations based on a number of critical findings that are more fully discussed in this report. The findings and recommendations are supported by a dataset provided by the State that includes the utilization and expenditure patterns of nearly 73,000 children who entered the system over a seven-and-a-half-year period from 2005 through the first half of 2012, accounting for 38 million days of care and $2.64 billion in Medicaid services. The data was reviewed by outside consultants and experts in the fields of child welfare, health care, and actuarial science.

FINDINGS

The analysis reveals many disturbing patterns of care which are detailed in Chapter 4 of this report, including extraordinarily high utilization of inpatient hospital care, emergency room services, and pharmaceuticals coupled with abysmally low levels of primary and preventive care. The most basic health care services that all children need and deserve are woefully under-utilized. The reasons for this vary and certainly include parental neglect, but they also are indicative of poor access to primary and preventive care, inadequate treatment and follow-up for childhood diseases and conditions, a paucity of comprehensive outpatient behavioral health programs and services, and inconsistent access to therapists and psychologists.

Given the high level of spending, the deficiencies in basic service utilization among these children and youth are glaring, contributing to poor health outcomes and the need for even more costly interventions going forward. They also impact children's ability to function well in school and participate in activities that can promote emotional development and social adjustment. There is a clear need for consistent access to high-quality medical homes with

the capacity to integrate all of the services needed by these children, and ensure that when transitions are necessary they happen in a coordinated fashion so that therapies and treatment can continue with a minimum of disruption.

RECOMMENDATIONS

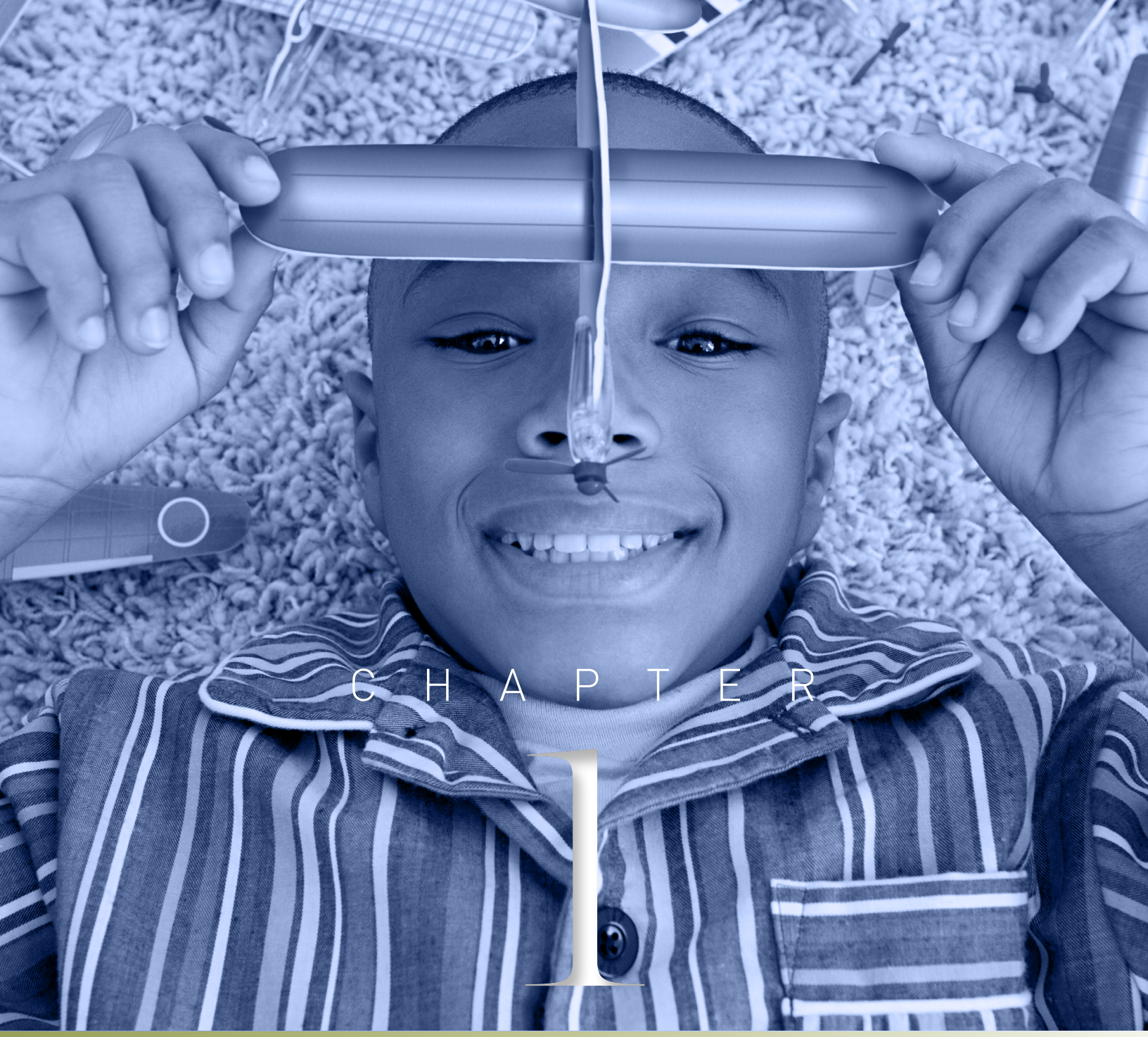
To successfully transition the foster care system to managed care, New York must focus on addressing the deficiencies in the current system and improving the delivery of trauma-informed primary and preventive care as well as evidence-based, behavioral health care services and programs. Managed care plans will need to design interventions that can ensure quick and comprehensive responses to critical incidents as well as avert crises. In order to achieve the State's goals, both government agencies and health care providers must devise and implement a robust strategy for addressing the inappropriate utilization of services, unnecessarily high costs, and poor outcomes.

To this end, the project's Steering Committee endorsed a series of recommendations by workgroup participants that focus on promoting the continuity of care and services, the adoption of evidence-based interventions, and a reform of the current reimbursement systems and methodologies. To ensure the fullest integration of services for these children, the Committee concluded that the inclusion of foster care agencies in the implementation of health and mental health restructuring is essential. A comprehensive discussion of the project's recommendations, including financial recommendations, can be found in Chapter 5 of this report. Noteworthy highlights include:

- The State needs to:
  - Employ a phased-in approach that will allow the managed care plans to gain experience and implement needed changes prior to enrolling the most at-risk children served in the system
  - Encourage the adoption of robust transition processes and IT systems to ensure that health care information is readily available when children are removed from their homes and families, and that timely notification and cooperation among the child's health care providers, managed care plans, and child welfare agencies takes place
  - Expedite the adoption of electronic records in collaboration with the voluntary child welfare agencies so that continuity of care can be improved both while children are in custody and following discharge
  - Implement an extensive quality monitoring program based on a set of metrics that addresses the unique circumstances of children and youth in foster care
  - Set capitation rates that are adequate to enable managed care organizations to offer the level of care and care coordination required, including benefits not ordinarily available

- Medicaid managed care organizations need to:
  - Appoint experienced professionals with expertise in the foster care arena to serve as dedicated liaisons with the government, the non-profit voluntary child welfare agencies, and other providers responsible for these children and youth
  - Prioritize contracting with providers that utilize a Health Home model of care to promote information sharing, care coordination, and referrals
  - Leverage the existing quality health care and mental health care infrastructure within the child welfare agencies to the greatest degree possible (e.g., Article 28 and 31 clinics, Board-certified/licensed clinicians)
  - Ensure that evidence-based, trauma-informed care is available to all children
  - Ensure that referrals for services take place timely so that needed care is provided expediently

New York's Medicaid program has a long and successful history in using managed care as a model for improving health care for children and adults alike. A concerted and collaborative effort between the State, the managed care plans, and the voluntary agencies coupled with the support and cooperation of the provider and child welfare communities represents the most promising path forward for the children and youth who encounter the child welfare system. We owe nothing less to these infants, toddlers, school-age children, and adolescents whose very future depends on our actions.



CHAPTER

1

Introduction and Background

Introduction

At present there are approximately 21,600 children and youth in foster care in New York State, and roughly 30,000 children and youth pass through the system each year. Lengths of stay in care vary widely, as do the needs of each individual child. According to the American Academy of Pediatrics, children in the foster care system have higher rates of birth defects, developmental delay, and physical disability than children from similar socio-economic backgrounds.[1] These children and youth have a high prevalence of medical and developmental problems (Table 1[2,3,4]) and use inpatient and outpatient mental health services at a rate 15 – 20 times higher than the general pediatric Medicaid population.[5] The impact of the trauma these children experience is profound.

Table 1. Select Problems at Entry into Foster Care	
Psychosocial Problems (with a high percentage having experienced childhood adversity and trauma)	100%
Chronic physical health condition	35-45%
Birth defect	15%
Mental health problem	40-95%
Significant dental condition	20%
Family problems	100%
Developmental Delay in child <5yrs	60%
Special ed./underachievement	45%

The numbers of children and youth in foster care in New York is now at the lowest level since data was collected, having declined significantly over the past decade; yet the need for high quality out-of-home care for infants, children, and adolescents remains as essential as ever.

[1] Neal Halfon, Ana Mendonca and Gale Berkowitz, "Health Status of Children in Foster Care: The Experience of the Center for the Vulnerable Child," *Arch Pediatr Adolesc Med* 1995;149(4):386 392.

[2] Moira Szilagyi, "The Pediatric Role in the Care of Children in Foster and Kinship Care," *Pediatrics in Review* 2012;33(11):496-507; quiz 508.

[3] *American Academy of Pediatrics Task Force on Health Care for Children in Foster Care, Fostering Health: Health Care for Children and Adolescents in Foster Care.* (New York: American Academy of Pediatrics, 2005).

[4] Mark D. Simms, Howard Dubowitz and Moira A. Szilagyi, "Health Care Needs of Children in the Foster Care System," *Pediatrics* 2000;106(4 Suppl):909-918.

[5] Dutton M Fiori T, Karl A, Sobelson M. Medicaid managed care for children in foster care. In: Fund Medicaid Institute at United Hospital, editor: UHF; 2013

Meeting the health care needs of the children and youth in foster care has been and continues to be a serious challenge. New York State regulations stipulate that the authorized agency with whom a child is placed is responsible for the provision of medical and health services; however, the reimbursement system currently in place bifurcates payment based on the category of service through the use of both fee-for-service (FFS) and per diem reimbursement methodologies. In addition, the sources of funding are split between the Office of Children and Family Services (OCFS) and the State Department of Health (DOH). There is no single repository of information about the services these children and youth are receiving and there are no required outcome or performance measures. The ongoing lack of an accountable system of care is neither defensible nor tolerable.

There is an urgent need for cross-system collaboration between State, County, and City child welfare agencies, public health and mental health agencies, and coordination and consultation with voluntary foster care agencies, providers of care, health plans, advocates, and other child-serving stakeholders. A major reform of the delivery-of-care models and the payment structures is essential to improving outcomes for this needy and highly vulnerable population of children for whom government agencies have taken legal custody.

It is important to note at the outset that the outstanding work that is accomplished every day by dedicated professionals serving the foster care population is not being questioned in any way. The manner in which the system is currently structured makes it extremely difficult to deliver effective, responsive trauma-informed primary, preventive, and behavioral health care that promotes the best outcomes for these children and youth.

SETTING THE STAGE

In 2011, New York State's Medicaid Redesign Team (MRT) concluded that all children and adolescents in foster care should be enrolled in Medicaid managed care. Owing to many complexities, stakeholders in the child welfare arena argued that a careful analysis of the potential impact of this proposed change was warranted. To this end, the Council of Family and Child Caring Agencies (COFCCA) applied for—and in the fall of 2012 received—a grant from the New York State Health Foundation. The grant's goals are to:

- Facilitate a comprehensive review and assessment of how health care services are currently delivered and funded for children and youth in foster care
- Analyze the issues related to the transition of these children and youth into managed care
- Develop a set of recommendations to the State regarding the most appropriate approach for implementing a managed care initiative for this highly vulnerable population of children and youth

To achieve the goals of the New York State Health Foundation grant, COFCCA subsequently received additional grant funding from the Annie E. Casey Foundation and the Kenworthy Swift

Foundation to conduct an analysis of an extensive, multi-year dataset provided by the State of New York with the support of the Office of Children and Family Services and the Department of Health. The data includes a comprehensive profile of a cohort of children and youth in the foster care system as well as historical Medicaid health care utilization and expenditure patterns before, during, and after this cohort were in foster care. It is important to note that it is the first time that the State of New York has successfully linked a Medicaid data file that includes both FFS claims and managed care encounters with this degree of detail for children in foster care. The dataset will allow for very specific analyses, including length of stay, type of placement, and episodes of placement in care coupled with health care expenditures. While it is not the

intent of this report to analyze all the issues identified by this dataset, and while the analysis is limited by the data provided and collected, this work nevertheless offers a fresh insight and understanding about these children and youth. This data further suggests what may be needed to improve outcomes for this population.

THE NEW YORK STATE HEALTH FOUNDATION FUNDED PROJECT: "RAISING THE BAR"

As mentioned above, in the fall of 2012 the New York State Health Foundation awarded a grant to the Council of Family and Child Caring Agencies (COFCCA) to convene key stakeholders to develop recommendations for integrating foster children and youth into managed care. COFCCA is the principal representative for the voluntary, not-for-profit organizations providing foster care, adoption, family preservation, juvenile justice, and special education services in NYS, working with its 105 member organizations and government partners to ensure quality services. It is with these agencies that most of these children are placed and with whom responsibility, (in conjunction with the local public agency) for the "safety, permanency and well-being" of these children resides. The purposes of the grant are twofold:

- To elicit a clearer understanding of how effectively the current health care system in New York is serving the foster care children for whom it is responsible.
- To solicit thoughtful ideas and identify promising improvements that could be made to the system as the State moves forward with its plans to serve virtually all Medicaid beneficiaries (including children and youth in foster care) through managed care.

To its credit, New York has a long and successful history of providing Medicaid services through managed care organizations. And in recent years the State Department of Health (SDOH), the single state agency for Medicaid in New York, has begun serving additional high-

In the fall of 2012 the New York State Health Foundation awarded a grant to the Council of Family and Child Caring Agencies (COFCCA) to convene key stakeholders to develop recommendations for integrating foster children and youth into managed care.

need and specialty populations through its statewide-managed care program, including the homeless and those with serious mental illness. To date, the foster care population has posed a somewhat unique challenge owing in part to issues surrounding legal custody and public sector responsibility.

With this in mind and with the generous support of the New York State Health Foundation, COFCCA asked the Citizens Committee for Children of New York (CCC) to convene and lead a project Steering Committee chaired by Jennifer March, Ph.D., Executive Director of CCC.

The Steering Committee was fortunate to have the support and participation of the New York State Office of Children and Family Services (OCFS), the New York State Department of Health (SDOH), the State Office of Mental Health (OMH), the New York City Administration for Children's Services (ACS), the NYC Department of Health and Mental Hygiene, and the New York City Mayor's Office as well as foster care providers, child advocates, legal representatives, and the managed care plans, etc. With Steering Committee endorsement, and to make the most efficient use of participants' expertise, six focused workgroups comprised of clinicians, child welfare experts, state and local agency officials, health plans, advocates, and other stakeholders were organized to develop a set of recommendations for the best approach to effectively integrate children and youth in foster care into managed care.

The core of this project involved bringing a broad group of stakeholders and constituents to the "table" to engage in a frank series of discussions and deliberations about the relevant issues, potential solutions, and corresponding policy recommendations and considerations.

Working together, these dedicated professionals have crafted a workable framework for transitioning New York's foster care system into a managed model of care.

THE PROCESS

The core of this project involved bringing a broad group of stakeholders and constituents to the "table" to engage in a frank series of discussions and deliberations about the relevant issues, potential solutions, and corresponding policy recommendations and considerations.

To accomplish this, COFCCA contracted with Silver Health Strategies (Phyllis Silver) and Cyndy Johnson and Associates (Cyndy Johnson and William C. Johnson, PhD) to direct the project, facilitate the series of workgroup meetings, and summarize the findings and recommendations in this report. COFCCA also contracted with Chapin Hall at the University of Chicago (Fred Wulczyn, PhD) and Galloway Solutions (Todd Galloway, FSA) to assist with the development of an evaluation plan for the recommendations and an analysis of a large dataset of linked foster care and Medicaid data provided by New York State for this project. The Steering Committee provided overall direction to the project.

The Steering Committee identified members for the following six workgroups:

- Service Delivery
- Care Management
- Transitions
- Quality and Metrics
- Financial and Actuarial
- Agency Impact

Members of the workgroups met multiple times and collectively invested more than 1,000 person hours in the deliberative process. Workgroup members included:

- Clinical professionals (e.g., physicians, psychologists, nurses, and social workers)
- State and City officials
- Experts in health care, managed care, and child welfare
- Children's advocates
- Attorneys and legal experts representing children in care

All participants actively engaged in the process and contributed lively and thoughtful commentary on potential approaches for integrating managed care with the current foster care system. Despite differing views and frank debate, the groups successfully coalesced in support of a set of recommendations in nine key areas which were agreed to by the Steering Committee during its final meeting in New York City on January 23, 2013.

Background:
Foster Care in New York State

The foster care (and juvenile justice) system in New York is very complex and multi-layered. It is state-supervised and locally administered, with state statutes, regulations, and rate-setting mechanisms controlling the system while decisions are made at the county level by departments of social services (called the Administration for Children's Services or ACS in NYC). The use of non-profit provider agencies to assist in caring for children and youth in foster care also varies considerably from county to county. And finally, when considering medical and behavioral health provisions and costs, factors such as the age of the child, the type of setting, his or her medical condition(s), and the permanency plan (which often influences lengths of stay in care) play very significant roles. The following information has been included to provide some historical context for this report and its recommendations.

WHO ARE FOSTER CHILDREN?

Foster children are, quite literally, our children. They have been removed from their families with the approval of a Family Court judge and placed in the legal custody of a local social services commissioner. The vast majority have been abused or seriously neglected. And while only a small percentage of abused and neglected children are placed in foster care, most are referred to preventive family services to provide assistance to the family to resolve problems while keeping the child safe at home. Some foster children have been placed in care as "persons in need of supervision" (i.e., PINS) or as juvenile delinquents (JDs), many of whom have a history of child abuse and neglect as well.[6]

Another 1,500 children are placed into residential treatment centers (i.e., foster care facilities) by their local school Committee on Special Education (CSE) because the CSE has determined that the needs of the child can only be met in such a school/campus setting. These children are not formally in "foster care," but they do live in these facilities and thus depend on these private non-profit agencies for day-to-day health and behavioral health services.

HOW MANY CHILDREN ARE IN FOSTER CARE?

New York State foster care census data was first collected in the late 1970s, with the numbers peaking in the early 1990s at 65,000 children (51,000 in NYC). On June 30, 2013 OCFS data reflected a total of 21,590 children in foster care (including JDs and PINS in private agency placement), including 13,606 in NYC and 7,984 in "rest of state" counties (data excludes CSE

[6] Szilagyi M. personal communication.

placements). The present census thus reflects a reduction of over two-thirds from peak enrollment. It is generally understood that the children presently in the system represent an especially needy and challenging population.

On June 30, 2013, the age distribution of children and youth in foster care was as follows:

AGE 5 AND UNDER:	AGES 6-9:	AGES 10-13:	AGES 14-21:
6,892	3,328	3,016	8,354

PLACEMENT TYPE

OCFS data indicates that 16 percent of all children in foster care are in direct family-based care under county supervision while 84 percent are placed with a private non-profit agency. (For the last ten years NYC ACS has placed all foster children with private agencies.) Historically, the counties in the rest of the state have operated their own (direct) foster family programs and for the most part have contracted with private agencies for all residential and specialized foster family care. Only recently have several counties outside of NYC eliminated direct foster care and contracted all their family-based care with private agencies.

There are also considerable variations in the type of placement, which in turn impacts the level of health care costs. Some of the variation is the result of the medical and behavioral conditions faced by children and youth of different ages. As an example, there are very few children under the age of 12 placed in residential settings, where almost all care and services are provided on the campus, including extensive nursing services for both routine and emergency interventions as well as medication administration and referral for specialized services in the community, etc. The data is for March 31, 2013 from OCFS:

FAMILY FOSTER CARE (INCLUDING KINSHIP HOMES):	INSTITUTIONS (RESIDENTIAL TREATMENT CENTERS):	COMMUNITY-BASED FACILITIES:	OTHER:
17,615	2,573 (plus about 1500 CSE placed youth)	1,098	304

The proportion of foster children in residential care has declined at an even faster rate than the overall foster care census. It should also be noted that the community-based facility types also include the JDs placed in NYC "Close to Home" settings.[7]

At the time of entry into foster care, the discharge objective is almost always to re-unite the child with his or her birth family. And indeed, that is what happens in the majority of cases; for

[7] Close to Home is the new state law wherein NYC has accepted responsibility to operate most of the juvenile justice system and keep the youth placed in care in local rather than in upstate facilities.

most others the discharge goal changes to adoption. For obvious reasons, a child's discharge objective can have a profound impact on the lengths of stay in foster care. Some adolescents who cannot be re-united with their birth families often remain in foster care until after age 18 and are then discharged to their own responsibility to live independently. Similar to adoption track children, their lengths of stay are considerably longer than average.

In short, the lengths of foster care stay vary significantly, with a large number of children coming into and leaving foster care within weeks or months, while others remain for years.

MEDICAID PAYMENT PROCESSES FOR PRIVATE AGENCY PLACEMENTS

All children in foster care are deemed Medicaid eligible upon entry into the system. Health care costs for children placed with private agencies are paid through two mechanisms: a Medicaid per diem rate paid to the foster care agency for certain services and Medicaid fee for service

(FFS) reimbursement for all other services. State law has barred enrollment in managed care for children placed with private agencies that receive Medicaid funding (Note: a very small number of these agencies do not have a Medicaid per diem rate and all health services are paid through FFS).

On an annual basis, SDOH calculates the per diem rate for each program an agency operates. The rates vary considerably based on the type of setting (family based vs. residential), the type of program (e.g., hard to serve vs. regular), and previous spending (the rates are based on past spending levels and capped by screens on certain costs, e.g., administrative costs, dental, etc.) Certain costs are supposed to be paid only via the per diem rate while other costs are expected to be funded through FFS (see Appendix A); however, over the years the separation of these costs has been impacted by a variety of circumstances. The most noteworthy of these is

In New York, Medicaid is spending billions of dollars on this population of children and youth with outcomes that are largely unknown and disturbing.

the lack of any enforcement mechanism in the payment system, which enables a health care provider with access to a child's Medicaid number to bill the State's FFS system for a service that should be paid through the agency per diem (this expedites payment to the provider and results in lower spending by the foster care agency and thus lower future per diem rates). The overall result is that there is no current assurance that all costs that should be paid via the agency per diem are paid that way.

In New York, Medicaid is spending billions of dollars on this population of children and youth with outcomes that are largely unknown and disturbing. The MRT recommendation to transition this population of children into managed care provides an opportunity not only to make payment more transparent and more appropriately aligned with the needs of these children and youth, but also to improve the health and behavioral health outcomes for these children. To this end, the impending change to managed care must address:

- Access to trauma-informed primary and preventive care services
- The creation of a robust care coordination system
- Assuring a network of community based trauma-informed behavioral health providers

The Steering Committee and workgroup participants concluded that such a systemic reform will promote improved health and mental health outcomes for children and youth in foster care.

The remaining chapters of this report support this conclusion:

Chapter 2

A profile of children in foster care, including age at first entry, length of stay, type of placement, and Medicaid and Managed Care enrollment.

Chapter 3

The results of a financial and actuarial analysis using historical Medicaid claims data from the State Department of Health along with eligibility/enrollment data maintained by Chapin Hall for children and youth served in New York's foster care system.

Chapter 4

A discussion of findings, implications, and challenges for a transition to managed care for New York's foster care population.

Chapter 5

A detailed description of the recommendations of the workgroups as endorsed by the Steering Committee.

CHAPTER

2

Profile of Children in Foster Care

Profile of Children in Foster Care

When a child enters foster care, he or she is categorically eligible for Medicaid. The number of children entering the system, their lengths of stay, and their health care utilization during their time in care have important implications for the manner in which health and behavioral health care services will be structured and financed when these children are enrolled in managed care plans.

The utilization of health care services by New York's foster children is examined in this chapter and the next. Beginning with an overview of admission trends, the analysis turns next to the length of time children and youth stay in placement, and closes with a review of Medicaid eligibility at the time of admission. The data for this review come from a linked data file that includes placement history and Medicaid claims and encounter data for all children and youth who entered the foster care system for the first time between January 2005 and June 2012. The New York State Office of Children and Family Services (OCFS) and the New York State Department

The dollar value accounted for in the file is in excess of $2.6 billion.

of Health (DOH) collaborated on the development of the file used for this study. Working with the Chapin Hall Center for Children at the University of Chicago, OCFS provided DOH with a list of children (unique identifiers) that was used to match Medicaid claims and encounter data managed by DOH. Although the dollar value accounted for in the file is in excess of $2.6 billion, not all claims attributable to foster children are included in the file. For example, the Child Health Insurance program (CHIP) is not included as an eligibility category and certain claims paid for high-cost placements (e.g., OMH residential treatment facilities) are also not included.

For each of these children, access to both a placement history (e.g., level of care, length of stay, permanency planning goal, and reason for discharge) is known as well as Medicaid detail by month of service. For this analysis, 72,813 unique foster care children were identified, all of whom are Medicaid enrollees. With these data, the pattern of health care utilization, including diagnosis codes and the relation to the child's placement in out-of-home care is known.

PLACEMENT IN FOSTER CARE

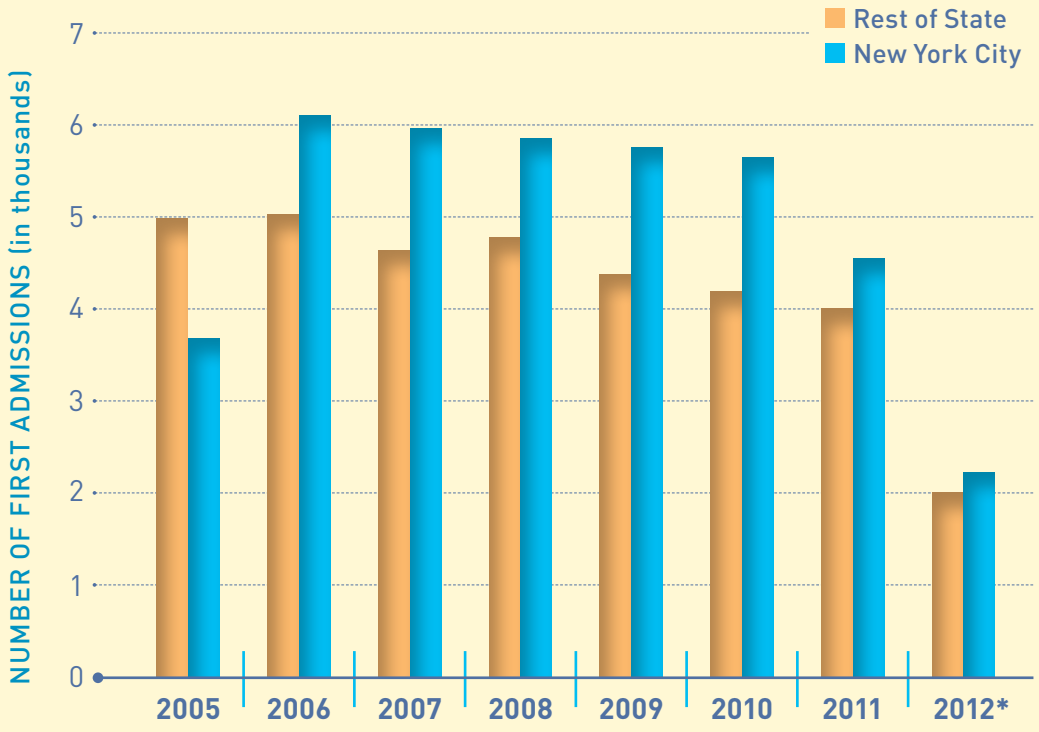
The linked file contains both pre- and post-placement Medicaid spending in addition to spending during the time the children and youth are in out-of-home care.

Entry into Foster Care

- Statewide, new admissions to foster care were about 23 percent lower in 2011 than in 2006. The largest decline was in New York City.

- New York City accounts for about 56 percent of all first admissions. However, among children in care on 6/30/2012, foster children from New York City account for about 64 percent of all children, owing to the fact that length of stay in New York City is longer on average.

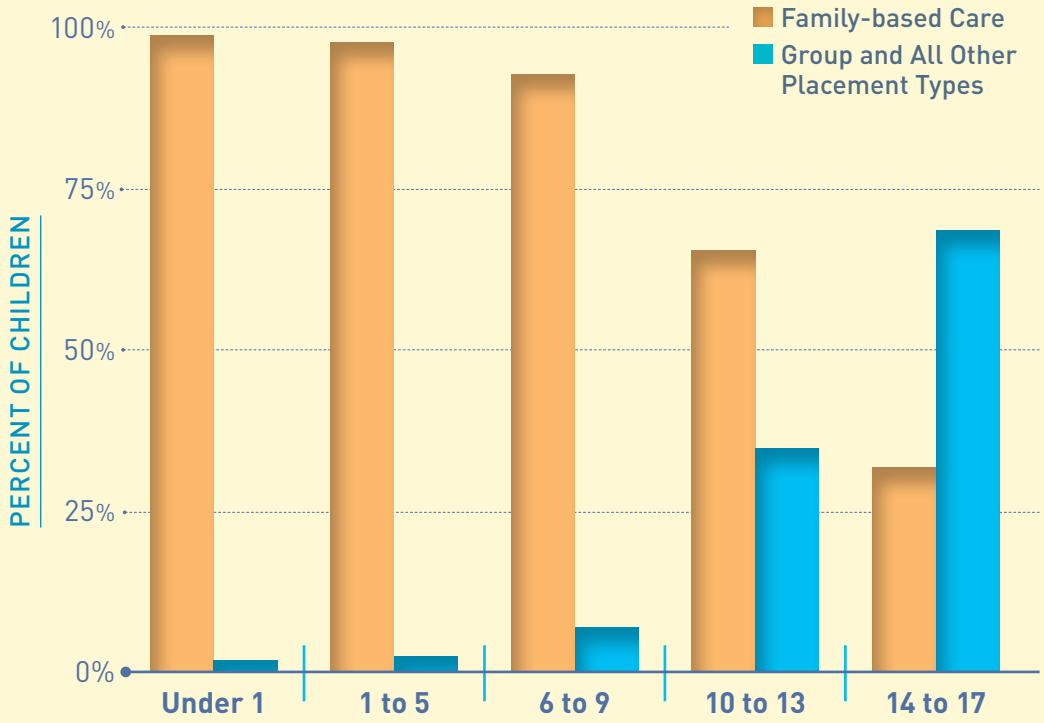
NUMBER OF CHILDREN ADMITTED TO FOSTER CARE FOR THE FIRST TIME BY YEAR OF ADMISSION



* Through June 30, 2012

- In any given year about 64 percent of *all* children admitted are children entering care for the first time. The remaining 36 percent will have had a prior admission.
- Among children under the age 14, family-based care, which includes relative care is the most common placement type. Among 14 to 17 year olds, group and other forms of non-family-based care is the most common placement type. The use of group and other forms of non-family-based care is higher outside of New York City (77 percent for youth age 14 and above) than in New York City (60 percent for youth age 14 and above).

TYPE OF PLACEMENT BY AGE AT ADMISSION

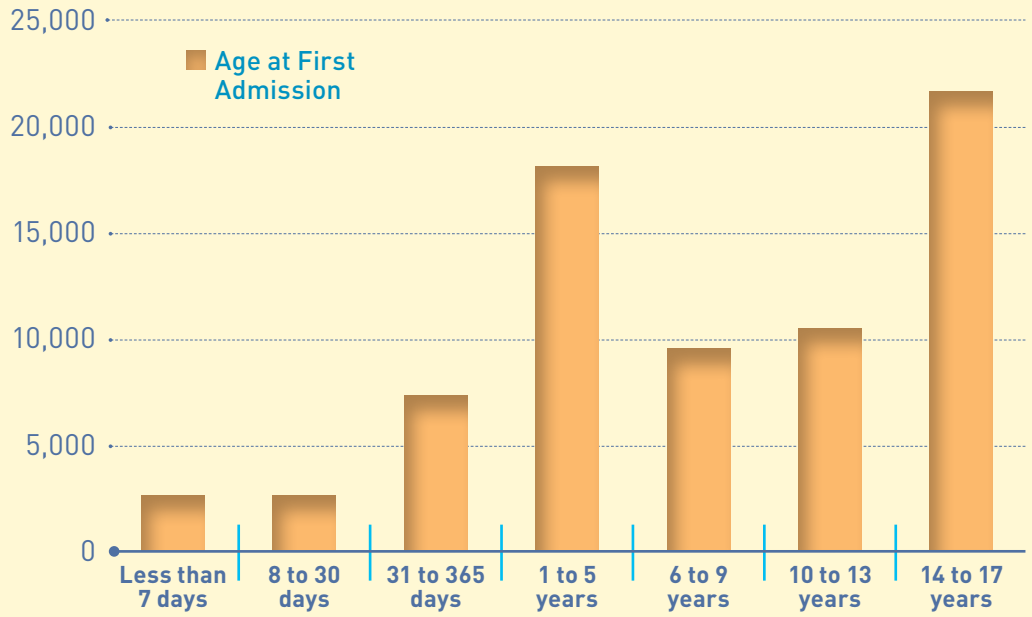


- In NYC, 81 percent of foster care children and youth were in foster boarding homes including kinship care. In the rest of the state there was a much larger percentage of children and youth in residential treatment settings (25% vs. 12%).

AGE AT TIME OF ENTRY

- Forty-two percent of children served in the foster care system in NY State in the past eight and a half years (January 2005 through June 2012) were under five years of age when they entered the foster care system for the first time; nearly 20 percent were less than one year of age.
- In NYC, one in ten admissions involves a child that is less than thirty days old. In the rest of New York, seven percent of all first admissions involve children thirty days old.

BETWEEN 2005 AND 2012 THE NUMBER OF CHILDREN ADMITTED FOR THE FIRST TIME BY AGE AT ADMISSION



LENGTHS OF STAY (for children who first entered the foster care system in 2006)

Length of stay varies considerably depending on the age at admission, placement type, and where in the state the child is living at the time of placement.

- Twenty-five percent of all children who were admitted for the first time between 2005 and 2012 (June) remained in foster care for less than 73 days and twenty-five percent stayed for more than 885 days. The median length of stay for all children was 312 days.

The longest lengths of stay were for infants and children under 12 months of age at entry. In fact, 25% of all care days were for children who entered as infants.

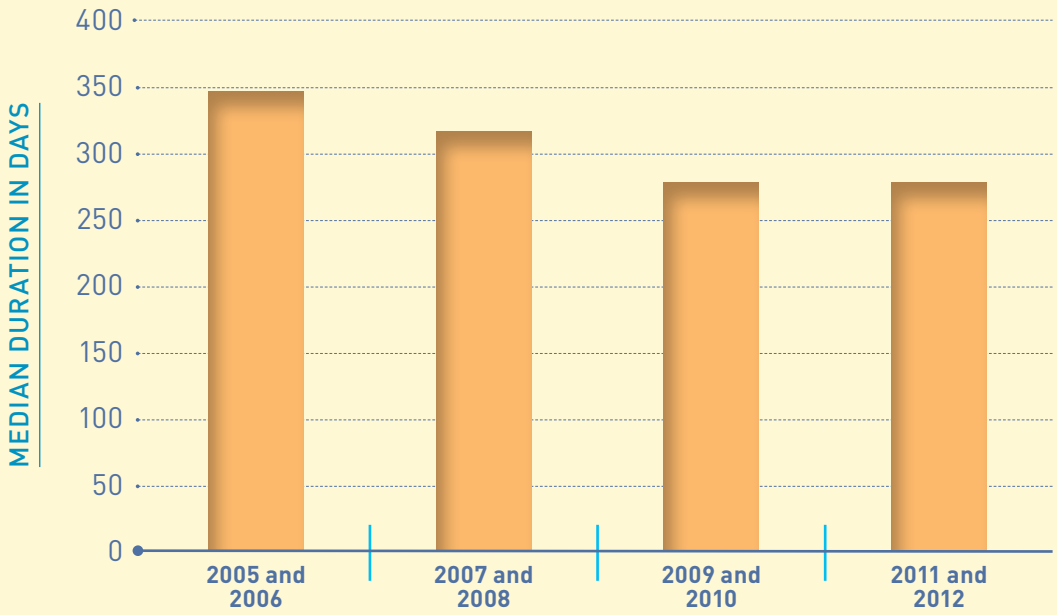
- Age is an important correlate of length of stay. With a median length of stay of 629 days, children under the age of one at admission have the longest length of stay. Youth between the ages of 13 and 17 at admission have the shortest length of stay – the median duration is 257 days.

Profile of Children in Foster Care *(continued)*

- The longest lengths of stay were for infants and children under 12 months of age at entry. In fact, 25 percent of all care days were for children who entered as infants.
- Length of stay in New York City is longer than in the rest of the State, with a median duration of 334 days versus 290 days.
- Among counties outside of NYC, the median length of stay varies by as much 300 days, ranging from 129 to 431 days.
- Placements in family-based care last longer than placements that involve group and other forms of non-family-based care. For family-based care, which includes kinship, the median duration for children admitted between 2005 and June of 2012 was 371 days; for all other children the median time spent in out-of-home care was 245 days.

- From 2005 through 2010, length of stay declined, from a median of 343 days in 2005/6 to 278 days in 2009/2010. More recently length of stay has increased. The median duration for children admitted in 2011 and 2012 was 306 days.

MEDIAN DURATION BY YEAR OF ADMISSION



PLACEMENT STABILITY

- Among the children in the dataset with the longest window of observation—those admitted between 2005 and 2008—about 50 percent experienced only one placement prior to leaving care; the other 50 percent experienced two or more placements.
- Placement changes are almost twice as likely to occur within the first six months of placement rather than at other points in a child's placement history
- Age is correlated with placement stability: infants (55 percent) are more likely to experience one placement than 10 -13 year olds, of whom 56 percent experience more than one placement.

REASONS FOR EXIT FROM FOSTER CARE

- When children leave foster care, about 60 percent are reunified with their parents or other relatives. Reunification rates are highest for older children and lowest for the youngest children.

- Overall, about 10 percent of children are adopted following their first placement in out-of-home care. For children below one year of age at admission, the statewide adoption rate is 30 percent. For children admitted within 30 days of birth, the adoption rate is 38 percent.
- Adoption rates are otherwise relatively low. Among the 73,218 children in the data set, there were 7,816 adoptions as of 12/31/2012. Of those adoptions, 30 percent involved children less than a month old at the time of admission; 50 percent involved children under the age of one; and 83 percent involved children age five and under. Only 1.5 percent of the adoptions involved children above age 13.

FOSTER CARE RE-ENTRY

- Overall, among children who are either reunited with parents or are discharged to the care of relatives, the re-entry rate is 22 percent.
- Among young teenagers, there is a 1 in 3 chance that reunification with family will be followed by a return to foster care.
- About 1/3 of all children who re-enter care do so within 90 days of discharge.

MEDICAID & MANAGED CARE ENROLLMENT

Many, if not most, of the children in this dataset should have been enrolled in Medicaid or CHIP prior to entry into foster care. In addition, most if not all of the children in this data set, if enrolled in Medicaid or CHIP, should have also been enrolled in managed care plans PRIOR to foster care entry. Once a child is placed in foster care with a voluntary agency, they are

Many children and youth do not have Medicaid immediately prior to entering into foster care.

immediately disenrolled from their managed care plan because current State law prohibits enrollment of foster children placed in the care of a voluntary agency. This accounts for over 99 per cent of foster children in NYC and over 55 percent of the children in the rest of the state.

In NYC, when a child enters foster care the child's Medicaid number is terminated and a new Medicaid identifying number is created. Because of what has been described as complex IT system issues, many children and youth (and all of those entering foster care in NYC) are given a new Medicaid number upon entry into foster care and yet another upon discharge. According to a number of government officials, this practice was initiated as an expedient measure to

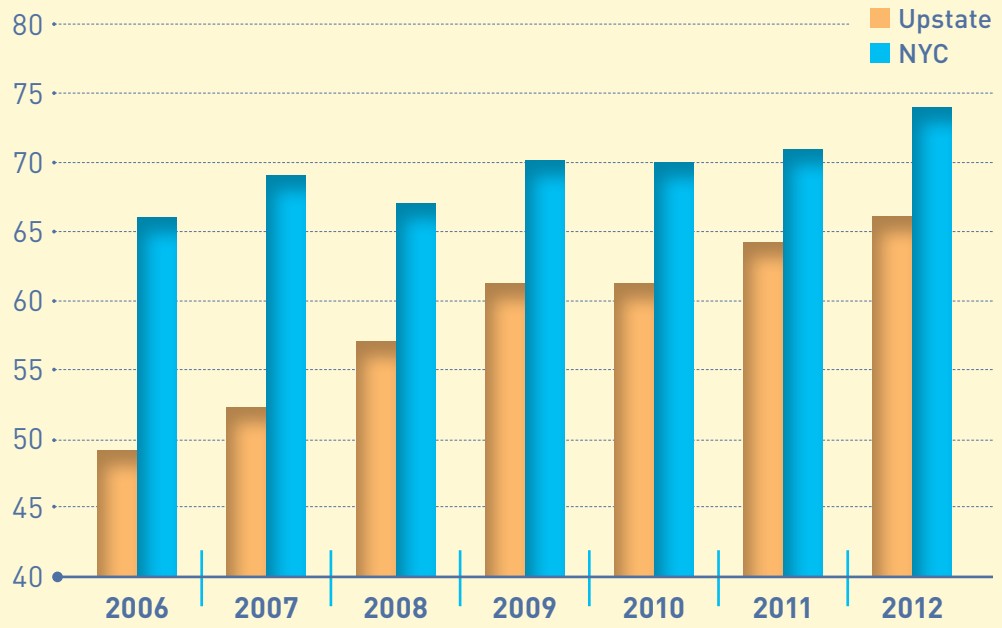
assure appropriate coverage and payment when the eligibility systems were first introduced in NYS in the early 1980s.

- Many children and youth do not have Medicaid immediately prior to entering foster care.
- In NYC, 43.3 percent of children and youth entering foster care were not enrolled in Medicaid during the month immediately prior to their entrance. In the rest of the state, about 25 percent of the children were not on Medicaid during the month immediately prior to entrance.
- The percentage of children with Medicaid who were enrolled in MCOs prior to foster care placement has been rising slowly but steadily over the past seven years. (Note that some of these children may have been enrolled in New York's CHIP program. Children often move between Medicaid and CHIP and it is important to note that CHIP enrollment and claims are not included in this dataset.)
- From January 2005 through June 2012, of those who had Medicaid immediately prior to entry into foster care, slightly more than two-thirds of those in NYC were enrolled in managed care while over half were enrolled in managed care in the rest of the state (ROS).

The percentage of children with Medicaid who were enrolled in MCOs prior to foster care placement has been rising slowly but steadily over the past seven years.

- By 2012, the percentage (of those who had Medicaid) entering the foster care system already enrolled in managed care plans had risen to 74 percent in NYC and 66 percent in the ROS.
- Of those with Medicaid prior to entry into foster care, children aged 1-11 years were most likely to be enrolled in managed care (more than 75 percent in NYC and greater than 63 percent ROS).
- The vast majority of the children who were in managed care are quickly disenrolled from their health plan once they are in foster care. The percentage of children enrolled in managed care one month into their foster care experience drops dramatically (to 18.2 percent ROS and 10.1 percent in NYC).

PERCENT OF CHILDREN WITH MEDICAID ONE MONTH PRIOR TO FOSTER CARE ENTRY WHO ARE ALSO IN MANAGED CARE



Given the information in this chapter, what follows are several considerations and immediate steps that should be taken to promote continuity of care as the State transitions this population of children and youth into managed care:

- State, County, and City agencies must address continuous Medicaid enrollment of this population. The practice of issuing a new Medicaid number is disruptive and potentially hinders continuity of care. Sorting out the systemic problems that require the issuance of a new Medicaid number should be an early priority for resolution by City and State agencies.
- Almost all of these children and youth are disenrolled from managed care plans as soon as they are placed in the custody of a private, non-profit foster care agency. Allowing children to continue to be enrolled in the same managed care plan promotes continuity of care with providers. In addition, given that families are usually enrolled in the same plans, allowing a child to remain in the plan with his or her family means that certain therapies may be provided to children as well as to their family members. Establishing the IT systems and other necessary mechanisms that will assure Medicaid enrollment and continuous coverage in managed care should be another early priority for the State/Counties/City to resolve.

Profile of Children in Foster Care *(continued)*

- Many children and youth in foster care have several episodes of entry/discharge and re-entry into foster care, as well as placement movements while in care. Episodic care and instability, coupled with the short lengths of stay, underscores the importance of continuity for these children and youth. Continuity in providers of medical and behavioral health care is an extremely important goal in the transition to managed care. Given all the other disruptions in these children's lives, continuity of care is even more important for these children than for the general pediatric population.

CHAPTER

3

Service Utilization Patterns and Expenditures

Service Utilization Patterns and Expenditures

Overall Expenditure Patterns

To gain a better understanding of the health care service utilization of children and youth before, during, and after their time in foster care, we have analyzed claims and encounter data. Once again, it is important to note that the analyses are based on the dataset provided. This linking of New York's Medicaid expenditures with a unique group of New York's children in foster care offers a comprehensive but not exhaustive picture of their health care spending.

For the 72,813 unique children and youth who entered care for the first time between January 2005 and June 2012, the dataset includes most Medicaid expenditures processed through New York State's claims system for the children admitted during this period, including expenditures and encounters for the period prior to, during, and following exit from foster care for each child. The dataset includes the Medicaid per diem as well as FFS claims and managed care expenditures.

This chapter looks at the service utilization patterns that can be gleaned from the claims billed to Medicaid. There are services that have been provided within the framework of the per diem payment system for which specific attribution to types of care cannot be made. The patterns are clear, however, for services billed FFS before, during, and after the time in foster care. For example, emergency room use is paid for by the FFS Medicaid system and is significantly higher than expected levels of ER utilization, while medical services prior to and after exiting the foster care system is marked by low levels of expenditures. Most significant is the low utilization of primary and preventive health care for children prior to entry to foster care and the limited number of well-child visits, especially when considering the number of infants in care.

The dataset is ripe for further analysis; for example, high levels of inpatient utilization should be further reviewed to see whether the utilization/days in care are attributable to behavioral health needs, as many have hypothesized, or caused by systemic placement issues (i.e., youth with no where to be discharged). These further analyses will be critical as payment structures are created so that costs can be appropriately attributed to the service needs of these children and youth.

Further, the data does not provide all the necessary descriptive information about the strengths and needs of these children and youth. For example, we can observe increased costs, increased claims, and increased per member per month (pmpm) costs for children and youth who remain in care for a long period of time; however, we cannot say precisely why the increased length of

stay is correlated with increased costs, as the diagnoses and service needs for these children and youth are not clear. What we know is what services were billed, not the needs of the children. Descriptive data regarding the children/youth is limited and the coding of diagnoses is presumed to include some inaccuracies, given the findings. That said, there is still much to be learned from this dataset.

Noteworthy highlights of this analysis include:

- $1.03 billion was spent during the time this unique set of children were in foster care.
- The average total claims per child in the dataset is $36,303.
- The inpatient lengths of stay for mental health admissions are longer than for physical health conditions regardless of whether the admission occurs before, during, or after foster care.

Another way to look at this population from a more current perspective is to view the children in care as of 7/1/2012. While it must be recognized that this is only a 'point in time' snapshot and cannot be used to generalize, it does provide a present day cost per child for those in care on 7/1/2012. Some of these costs will increase because their stay in foster care may continue after 7/1/2012.

- On average the Medicaid claims paid for a child in foster care on 7/1/2012 was $13,124 prior to the day that child entered foster care.

The total Medicaid cost per child would average roughly $50,000 for the time previous to, during, and immediately after foster care.

- On average, the amount Medicaid spent for a child while in foster care on 7/1/2012 was $23,073; *this does not include what they will continue to cost while remaining in foster care (after that day).*
- The average amount of Medicaid expenditures post-foster care (based on those children who exited foster care from 2005 to June 2012) was $13,624.

Therefore, adding the Medicaid dollars spent up to the day these children enter care to the costs during foster care, the average expenditures for the child in care on 7/1/2012 was $36,197. Speculating that the total claims for that child after exiting care will be similar to the average previously reported of $13,624, the total Medicaid cost per child would average roughly $50,000 for the time previous to, during, and immediately after foster care.

- Capitation payments paid to managed care organizations (MCOs) totaled slightly more than $343 million or 13 percent of the total expenditures.

Service Utilization Patterns and Expenditures *(continued)*

- 91 percent of capitation payments were spent before and after these children were placed in out-of-home care.
- Per diem payments to voluntary foster care agencies totaled almost $438 million, or 16.5 percent of the total expenditures. During the time children are in foster care, the per diem represents 37 percent of the total Medicaid dollars spent.
- Nearly one out of every four dollars spent while children are in foster care was for inpatient care.

Service Utilization in Key Areas

Key areas of service utilization are provided as a framework for how the current service delivery system needs to be restructured. The network of providers for this population of children and youth requires a careful review so that patterns of over- and under-utilization can be eliminated. Whether the poor utilization of well-child and dental care is due to a lack of availability of services, parental neglect of these needs, or other causes, the data alone does not tell us. Nevertheless, these children are clearly underserved in this respect and the State's foster care reform initiative must address the lack of primary and preventive care as well the huge unmet dental need. Poor health care during childhood, particularly for the very young, is often a major cost driver as children grow older. Moreover, given the low historic utilization in some key services, there may be a pent up demand for certain services in the early years of the transition to managed care. As the data that follows also clearly illustrates, foster care children and youth in New York are high utilizers of costly ER and inpatient hospital care. A comprehensive outpatient mental health network of trauma trained providers who will be required to utilize evidence-based services to reduce inpatient utilization will also be an essential part of the managed care network.

These children are clearly underserved in this respect and the State's foster care reform initiative must deal with the lack of primary and preventive care as well the huge unmet dental need.

Well-Child Visits

Using a set of well-child visit codes (99381-99397), the dataset was analyzed to determine the level of well-child and preventive care being delivered to these children and youth. The analysis looked at those with six or more months of Medicaid eligibility prior to their first entry into foster care and their well-child care utilization before, during, and after foster care. Highlights include:

- In NYC, on average, only 15.7 percent of children and youth had a least one well-child visit during the 12 months prior to entry into foster care. In the rest of the state there were twice as many children with a least one visit (31.9 percent).
- During the time in foster care the level of well-child care rose, although the claims dataset does not include the visits paid for through the voluntary foster care agency per diem system. Accordingly, we could not determine exactly how much the well-child care visit rate increased. However, we do know that the well-child visits paid for through the claims system increased from 15.7 to 25.2 percent in NYC and from 31.9 to 36.5 percent in the rest of the state.

In the first 12 months after exiting foster care the level of well-child visits fell below even what they were prior to first entrance into foster care (11.9 percent in NYC and 25.4 percent upstate).

Table 3.4 in Appendix C includes the data on well-child care visits by age group before, during, and after foster care placement.

Dental

Similar to well-child care, the receipt of dental services is extraordinarily low. Among children and youth with six or more months of Medicaid eligibility prior to entry into foster care, only 9.6 percent in NYC and 16.4 percent of those upstate had at least one dental visit during the 12 months preceding foster care placement. This rate improved following entry into foster care; however, upon exiting the system the dental utilization rates reverted closer to pre-foster care levels (11 percent in NYC and 19.4 percent upstate).

Table 3.5 in Appendix C includes detailed information on dental utilization rates by age and geographic location.

In NYC, 42.8 percent and in the rest of the state 40.4 percent of children and youth had at least one ER visit during the twelve months prior to entering foster care.

Emergency Room Services

Information about children and youth who were seen in an ER at least once in the 12 months prior to entering foster care (among those who had six or more months of Medicaid eligibility prior to their first entry into foster care) was analyzed. Tables 3.3a, 3.3b, and 3.3c in Appendix C include the ER visits per 1,000 by age group and geographic location before, during, and after foster care, including the three most frequent diagnoses in each cohort and location.

Highlights include:

- In NYC, 42.8 percent and in the rest of the state 40.4 percent of children and youth had at least one ER visit during the twelve months prior to entering foster care.
- During the 12 months after their first entry into foster care, there was only a small diminution in ER utilization in NYC (declined to 38.8 percent) while there was a significant reduction in the rest of the state (declined to 30.9 percent).
- Upon leaving the foster care system, the percentage of children and youth with at least one ER visit in the 12 months after exit was significantly lower than in the 12 months prior to entry (22.3 percent in NYC and 27.6 percent ROS).
- Prior to foster care entry the most frequent diagnostic reason for an ER visit for infants less than one month old was childbirth, indicating that a number of deliveries enter through the Emergency Room.

- For children and youth over one month of age, the most frequent diagnoses include injuries, respiratory problems, and mental illness.[8]
  - Within the first 12 months after entry into foster care, the most common diagnostic categories continue to be injuries, respiratory, and mental illness.
  - Among the very young (those less than one year old) malaise, nausea, and fever begin to emerge as secondary diagnoses.

After entry into foster care, ER visits per 1,000 children and youth that were eligible for Medicaid prior to entry remain very high, although generally lower than before entry. After their last exit from foster care, ER visits continue to be high, but again are generally lower in most age groups than before their first entry. Nationwide ER visits per 1,000 for all children averages 329 (414 in low income communities versus 222 in wealthier communities).[9]

Inpatient Hospital Care

Children and youth in foster care are high utilizers of inpatient hospital care, with admissions and days per 1,000 far exceeding the typical utilization patterns among the general pediatric and adolescent population.[10] Attention Deficit Hyperactivity Disorder (ADHD) was the number one diagnosis for children age 1-5 years, followed by bipolar disorder. For children within 12 months of their first entry into foster care and beginning from roughly age six, the most

Children and youth in foster care are high utilizers of inpatient hospital care, with admissions and days per 1,000 far exceeding the typical utilization patterns among the general pediatric and adolescent population.

frequent reason for an inpatient admission is mental illness,[11] with bipolar disorders as the primary diagnosis statewide followed by depressive disorders. Among infants, the most frequent diagnosis is respiratory related and among toddlers and preschoolers (ages 1-5) it is injuries (ROS) and asthma (NYC). Tables 3.6a, 3.6b, and 3.6c include admissions per 1,000 for children age one year and older before, during, and after foster care.

Table 3.7 contains information on the average inpatient length of stay for children and youth by age cohort and region. The length-of-stay data is grouped according to whether or not the

[8] Mental illness begins to appear in the dataset as a primary or secondary diagnosis for children ≥ 6 years of age.

[9] Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project, "Statistical Brief #52: Pediatric Emergency Department Visits in Community Hospitals from Selected States" (2005).

[10] Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project, "Statistical Brief #118."

[11] With the exception of females age 17+ in NYC where childbirth/pregnancy is the #1 diagnosis for inpatient admissions.

hospitalization was for a physical or mental health diagnosis. The data is further segmented by pre-, during, and post-foster care. Before, during, and after stays in foster care the lengths of stay for mental health admissions are longer than those for physical health conditions.

Costs

Children and youth in foster care are generally more costly to Medicaid that non-foster care children due to their unique health and behavioral health needs. In an article published in *MedPage Today*, Cole Petrochko documents the significant financial burden on the Medicaid system of child abuse and maltreatment.[12] According to Curtis Florence, PhD of the CDC National Center for Injury Prevention and Control, children who were maltreated or were at risk for maltreatment had Medicaid expenditures more than $2,600 higher annually than children who were not subject to, or at risk for, maltreatment.[13]

In New York, the cost differential is similarly significant. Table 3.8 includes information on the per member per month (pmpm) costs of foster care children and youth in the period before, during, and after they exited the system. As the table illustrates, the average cost of foster care

Children and youth in foster care are generally more costly to Medicaid that non-foster care children due to their unique health and behavioral health needs.

children in NYC in the month prior to entering the system is $1,068 pmpm ($1,066 pmpm ROS). During the time they are in foster care, the pmpm cost generally declines somewhat initially and then rises again as their length of stay in foster care increases (i.e., two to three years). Upon exiting foster care total pmpm costs decline again.

For example, children and youth in foster care age one to five years located upstate cost $421 pmpm in the month prior to entry. This amount declines to $359 during the first month in foster care, then rises to a high of $542 for those in foster care for one to two years, falling back to $332 one month post-foster care and to $313 one to two years post-foster care. This pattern varies somewhat depending on the age of the children and their location, but generally there are some trends in these patterns.

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[12] Cole Petrochko, "Child Abuse Takes a Toll on Medicaid," *MedPage Today* (July 1, 2013). http://www.medpagetoday.com/Pediatrics/DomesticViolence/40180?xid=nl_mpt_DHE_2013-07-01&utm_content=&utm_medium=email&utm_campaign=DailyHeadlines&utm_source=WC&eun=g633842d0r&userid=633842&email=markowij@yahoo.com&mu_id=5754822

[13] Curtis Florence, et. al., "Health Care Costs Associated with Child Maltreatment: Impact on Medicaid," *Pediatrics* (July 1, 2013). http://pediatrics.aappublications.org/content/early/2013/06/26/peds.2012-2212.full.pdf

Service Utilization Patterns and Expenditures *(continued)*

In contrast, the NYS Medicaid average pmpm capitation rates for children and youth whose eligibility is based on TANF or CHIP is approximately $200 pmpm. The capitation rate is not age adjusted.

While a separate foster care capitation rate grouping will be needed for the enrollment of this population in managed care, these differences highlight how much more expensive these children and youth are when compared to their non-foster care counterparts. Moreover, there

are other serious factors that are unique to the foster care population that will need to be taken into consideration when setting the capitation rate for this population of children and youth as they enter the managed care arena with the hope of receiving the full range of benefits to which they are entitled. The patterns of utilization related to the time in care also provide a unique challenge in setting an appropriate capitation rate.

There is an extraordinary need for more primary and preventive health and dental care as well as a network of behavioral health providers that offer timely and consistent access to mental health treatment. Developing the networks of trauma-informed providers for these children

There is an extraordinary need for more primary and preventive health and dental care as well as a network of behavioral health providers that offer timely and consistent access to mental health treatment.

and youth require significant attention to assure appropriate treatment and reduce unnecessary inpatient hospitalization. Revamping care so that it is appropriate to meeting the needs of these children will create the opportunity to reduce unnecessary or preventable hospital admissions and ER visits, both of which are major cost drivers.

COST COMPONENTS

When looking at different cost components (e.g., Pharmacy, inpatient, dental, physician/professional, and outpatient/ER), the situation varies. The dataset available for this project includes claims data that provides a look at the FFS costs for certain categories of service for children and youth not enrolled in managed care plans. An analysis of this data leads to some interesting observations.

Pharmacy Costs

- Pharmacy costs for children who have exited the foster care system tend to be less than they had been prior to their entry. In NYC, children and youth (all ages) had average pmpm pharmacy costs of $89 one month prior to entry and $29 one month after exit, ultimately rising to $59 one to two years post-exit.
- Children and youth in the rest of the state had higher pmpm pharmacy costs than their counterparts in New York City.
- Fee-for-Service retail pharmacy costs remain constant for the period of time before, during, and after stays in foster care.
- Some pharmacy costs are paid with the per diem, so that when the FFS pharmacy component of the per diem is added to the pharmacy cost for children while in foster care, the pharmacy

expenditures appear to increase by approximately 20 percent when compared to pharmacy expenditures before and after stays in care (using 2011 as a sample year).

Inpatient Costs

In both NYC and ROS pmpm inpatient hospital costs were much higher prior to entry into foster care than during or after exiting the system. For example, in NYC three months prior to entry into the system average pmpm costs for all age groups[14] were $1,861, as compared to $202 three months into care and $167 three months following discharge. The numbers are somewhat different ROS, but the pattern is similar.

When the pharmacy component of the per diem is added to the FFS pharmacy cost for children while in foster care, the pharmacy expenditures appear to increase by approximately 20 percent when compared to pharmacy expenditures before and after stays in care (using 2011 as a sample year).

Professional/Physician Specialist Costs

Disturbingly, physician specialist pmpm costs decline significantly from their levels pre-foster care to post-foster care,[15] raising further questions about the adequacy of medical care for these children and youth. Three months prior to foster care, pmpm physician costs for all age groups in NYC[16] were $34 as compared to $8 after exiting the system and then declining further to $4 one to two years post-exit.

Facility Outpatient/ER

In the month prior to entry into foster care, the average pmpm cost for this category of service across all ages in NYC[17] was $573. Costs decline significantly while they are in foster care, declining to $155 three months following entry (note that these types of services are NOT covered under the agency per diem but under the regular fee-for-service Medicaid program, so the decline is not due to the per diem reimbursement structure). After exiting the foster care system, facility outpatient and ER costs remain low compared to pre-foster care (but still high relative to other non-foster care pediatric populations) at $135 three months post-exit.

[14] These pmpm IP costs apply to FFS only and exclude children and youth enrolled in MCOs.

[15] During the period of time children and youth were in foster care, physician cost data is incomplete due to the per diem reimbursement methodology, which does not permit us to identify physician costs covered by the per diem for any individual – only the FFS claims that were paid through the regular Medicaid claims system.

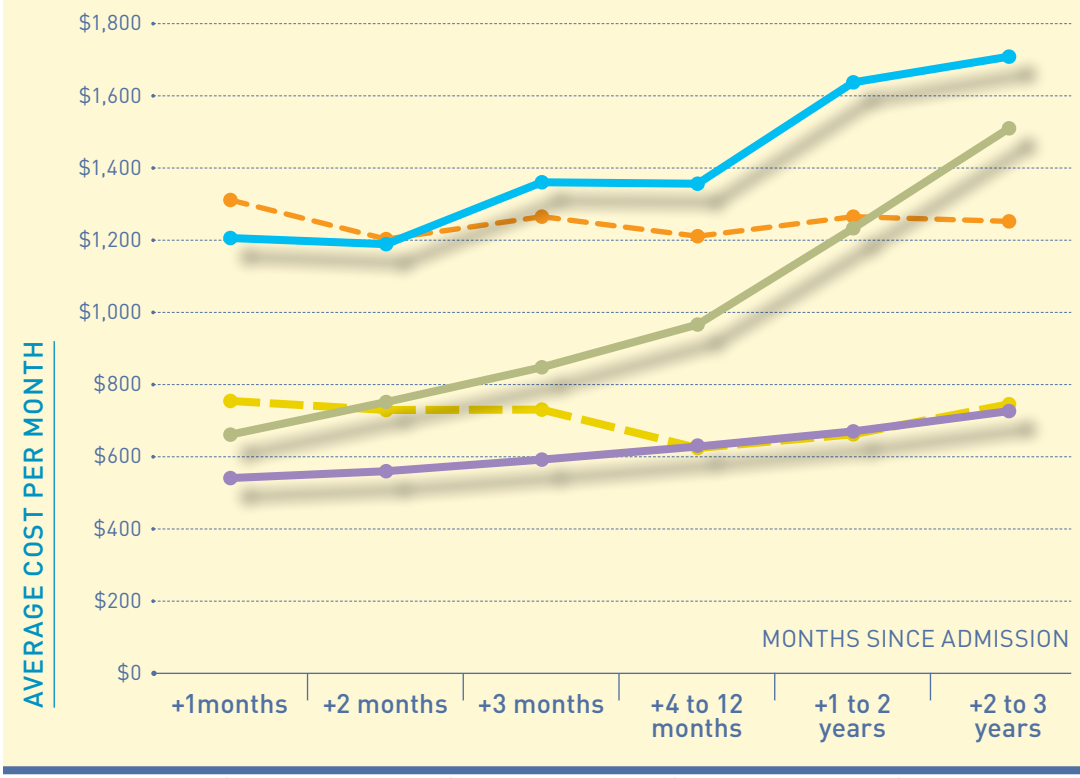
[16] These pmpm professional/physician costs apply to FFS only and exclude children and youth enrolled in MCOs.

[17] Ibid.

SPENDING OVER TIME IN CARE

Because health care spending on behalf of foster children is inextricably linked to length of stay in foster care, it is important to understand exactly how health care spending is correlated with placement duration. The data in the chart below illustrates the salience of this point. The graph displays the average costs per month by age at admission and placement month (i.e., the number of months that have passed since admission). The average cost calculation includes only those children and youth who are in foster care on the first day of the month.

AVERAGE COST PER MONTH BY AGE AT ADMISSION AND PLACEMENT DURATION



From these data there are three noteworthy findings:

- First, average monthly costs differ by age at admission. Younger children (under the age of 11 at admission) incur lower average costs per month, especially in the early months of foster care.

- Second, the average cost per month generally increases, which means that the children who remain in care cost more than on average. This is probably because high-needs children are the more likely to stay in care longer.
- Finally, the most striking increases are among children between the ages of 6 and 14 at the time of their admission, followed by 1 to 5 year olds.

Per Diem Payments

What follows is a sample of the per diem payments paid to 67 foster care agencies for the year 2011. This information was taken from the cost reporting submitted by the foster care agencies. The total number of children and youth represented in this year's sample is 15,506, for a total number of 5.6 million care days.

It is interesting to note that the overall expenditures paid by the foster care agencies are greater than the income the agencies receive through the per diem by a net of approximately 6.3 percent, requiring the agencies to find the financial resources to fill the gap.

The overall member months in the data set is 186,068, with Medicaid paying an average of $689.17 pmpm through the per diem. There is wide variation in the placement categories, with significant profit and loss differences depending on the specialized foster care placement category.

The expenditures paid by the foster care agencies are greater than the income the agencies receive through the per diem by a net of approximately 6.3 percent.

The foster care Medicaid per diems have been in place since the 1970s. The per diem also enables foster care agencies to hire medical and mental health staff and to support foster parents in accessing community-based health care (whenever possible to access care from the same providers the foster family utilizes for their own children).

Additional advantages of the per diem include:

- Enabling agencies to engage clinical professionals in a manner that meets the unique needs of the foster care children and within the parameters governed by rules and regulations of the foster care system.
- Devoting time to engaging resistant and hostile children and youth when necessary
- Consulting with caseworkers and providing expert support for case planning and family court hearings.

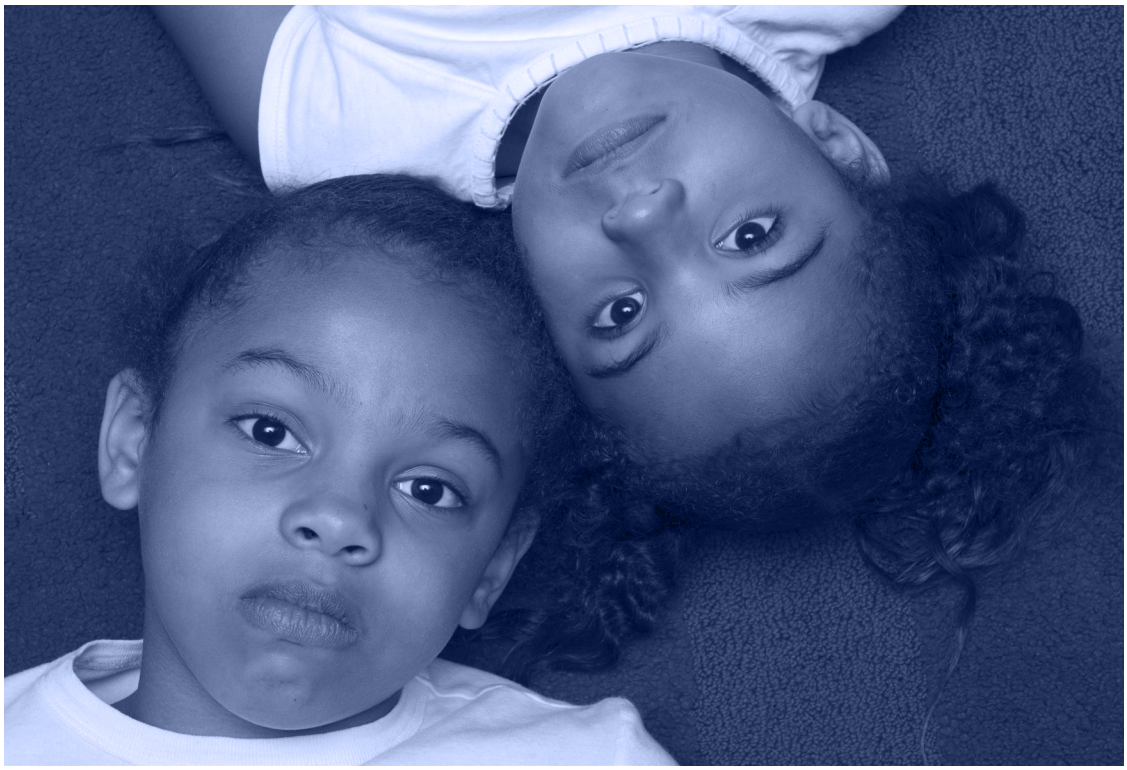
- Enabling nursing and other designated agency staff to perform vital care coordination functions.
- Enabling residential programs to operate in a therapeutic fashion with clinical staff providing support, guidance, and training to para-professional child care staff.

The per diem rates include a portion of the administrative overhead and property costs of the agencies.

- Allowing for nursing capacity, including on-campus well child care, "sick call" routine interventions, and medication administration.

In accordance with standard cost allocation rules, the per diem rates include a portion of the administrative overhead and property costs of the agencies. Changes in payment methodology will need to address this cost center to prevent the loss of federal dollars.

Significant problems with the per diem system also exist. Since per diem rates are based on past (two years prior) spending (with caps on various components) the spending varies greatly



over time and across agencies based on numerous factors, including whether an agency has access to cash to spend 'in a year with a low rate." If the agency does not have the funds to support new/necessary spending, future rates will continue to be low. Interviews with agency medical staff suggest that the per diem rate system results in some instances in care being rationed (dental was cited as an example). Finally, even when there have been cost-of-

Nursing services comprise the largest percentage of the total expenditures per diem.

living increases included in the rates, they have not kept pace with rapid increases in health care costs, notably in the cost of pharmaceuticals. As rates are based on a retrospective look at expenditures, they never catch up to actual costs.

Critically, the fact that per diem reimbursement levels vary widely across foster care agencies for both family-based care and residential care means that the care provided on-site as well as outside services secured for foster children varies across agencies. The lack of system-wide consistency is extremely problematic.

The analysis that follows provides expenditures by service category as reported to the SDOH by the private, non-profit foster care agencies. Noteworthy highlights include:

- Nursing services comprise the largest percentage of the total per diem expenditures
- Dental services are the lowest percentage of the total.
- Pharmacy and psychological services tie for the next largest percentage of expenditures.

Service Utilization Patterns and Expenditures *(continued)*

SUMMARY OF 2011 NY FOSTER CARE COST REPORTS
(Salaried & Purchased Medical Services)

CATEGORY	GENERAL FOSTER CARE	SPECIALIZED FOSTER CARE PLACEMENT CATEGORIES							TOTAL FOSTER CARE
		AIDS	BB	MAT	HTP	TBH	DIAG	OTHER	
# of Homes Serving	58	3	1	6	22	19	9	2	67
Total Days	4,449,825	12,650	53,896	53,273	486,150	528,062	55,987	19,731	5,659,574
Avg Annual # in care	12,191	35	148	146	1,332	1,447	153	54	15,506
Total Income	$62,539,142	$399,023	$2,959,968	$1,832,503	$34,312,951	$20,017,475	$4,325,202	$1,846,108	$128,232,372
Total Expenditures	$70,385,274	$268,150	$3,558,979	$2,106,588	$35,423,202	$18,052,992	$4,957,607	$1,606,966	$136,359,758
$ NET GAIN/(LOSS)	$(7,846,132)	$130,873	$(599,011)	$(274,085)	$(1,110,251)	$1,964,483	$(632,405)	$239,142	$(8,127,386)
% NET GAIN/(LOSS)	-12.5%	32.8%	-20.2%	-15.0%	-3.2%	9.8%	-14.6%	13.0%	-6.3%
Member Months	146,296	416	1,772	1,751	15,983	17,361	1,841	649	186,068
PMPM Income	$427.48	$959.44	$1,670.48	$1,046.28	$2,146.84	$1,153.02	$2,349.80	$2,845.90	$689.17
PMPM Expenditures	$481.12	$644.76	$2,008.54	$1,202.77	$2,216.30	$1,039.86	$2,693.37	$2,477.25	$732.85
$ NET GAIN/(LOSS)	$(53.63)	$314.68	$(338.06)	$(156.49)	$(69.46)	$113.16	$(343.57)	$368.65	$(43.68)

EXPENDITURES SERVICE CATEGORY (PMPMS)

SERVICE CATEGORY	GENERAL FOSTER CARE	SPECIALIZED FOSTER CARE PLACEMENT CATEGORIES							TOTAL FOSTER CARE
		AIDS	BB	MAT	HTP	TBH	DIAG	OTHER	
Physicians	$29.99	$24.54	$-	$-	$82.95	$55.58	$149.27	$153.43	$37.96
Psychiatrist	$39.49	$13.45	$111.31	$50.75	$289.83	$112.52	$245.45	$37.43	$70.57
Psych Services	$50.98	$15.49	$64.07	$140.42	$322.66	$139.14	$132.61	$201.94	$84.77
Social Workers	$23.12	$2.11	$11.19	$160.04	$161.69	$131.76	$209.58	$356.94	$49.30
Dental	$15.78	$4.25	$81.83	$55.85	$36.25	$24.71	$31.54	$67.81	$19.69
Specialists	$20.69	$0.31	$9.44	$24.22	$49.21	$22.72	$30.64	$75.28	$23.50
Nursing Services	$116.26	$298.43	$111.95	$7.91	$493.49	$171.65	$884.62	$171.06	$160.97
Medical Admin	$30.10	$63.52	$763.25	$390.44	$92.23	$69.81	$50.41	$376.02	$51.00
Rx & Supplies	$59.97	$102.73	$282.28	$59.62	$248.32	$92.97	$224.03	$61.55	$83.07
Medical Trans	$5.76	$3.10	$305.47	$87.29	$24.79	$13.37	$19.40	$19.52	$11.90
Central Admin	$36.96	$39.91	$94.05	$5.85	$155.45	$87.35	$241.09	$298.09	$55.03
Admin Overhead	$23.79	$28.63	$98.86	$62.05	$134.56	$54.91	$208.68	$61.24	$39.25
Property	$23.30	$48.30	$21.43	$82.60	$95.19	$53.06	$204.25	$596.93	$36.64
Hospital/Clinical	$4.92	$-	$53.41	$75.64	$29.69	$10.30	$61.81	$-	$9.22
TOTALS	$481.12	$644.76	$2,008.54	$1,202.68	$2,216.30	$1,039.86	$2,693.37	$2,477.25	$732.85

CHAPTER

4

Discussion of Findings

Discussion of Findings

Between 2005 and 2012, 73,000 children entered New York State's foster care system, receiving 38 million days of care and $2.6 billion dollars of Medicaid services during this period (slightly more than one quarter of these children remain in care). And while we can quantify what that money purchased in terms of ER visits, hospitalizations, and other services, we know little about the overall return on investment as it relates to outcomes or impact on physical and behavioral health status, school performance, personal relationships, and other important indicators.

In order for the child welfare system to be held accountable, payment for services needs to be linked to performance and outcomes as well as volume. This is true for the healthcare system in general, but it is particularly critical for vulnerable populations with complex needs. Government and private sector agencies should be expected to demonstrate that the monies they spend are directed at value-based purchasing strategies and not solely on the acquisition of services.

In too many instances there is little or no quantifiable data relating to the array of services individual children are receiving, the quality of care being delivered, or physical and behavioral health outcomes.

Based on our analysis of service utilization patterns coupled with input from clinicians, government officials, advocates, and voluntary child welfare agency leaders and staff, in too many instances there is little or no quantifiable information that is available relating to the array of services individual children are receiving, the quality of care being delivered, or physical and behavioral health outcomes. This is not to ignore the pockets of high quality that exist across the system, but from a global perspective there is insufficient insight into what New York received for the $2.6 billion spent on behalf of 73,000 of its most vulnerable children and youth. It is important to note that SDOH and OCFS collect an extraordinary quantity of yet-to-be-analyzed data that would provide enormous insight into the types and quantity of services these children have received. The most significant remaining blind spot relates to quality and outcomes. That said, if properly analyzed our understanding of this population of children would improve markedly and inform future policy making, particularly as we make the transition to managed care.

PATTERNS OF UTILIZATION AND COSTS

In general, children and youth in the foster care system are much more costly to the Medicaid program than children who are not in out-of-home placement. In many ways that is to be expected given the unique health and mental health needs of foster children. For example, the per member per month (PMPM) capitation rate for children and youth in New York's Medicaid Managed Care program is roughly $200 while the average cost for those in foster care is nearly five times higher, with costs rising dramatically during the three-month period prior to entry

into the system and remaining high while in care. Even after exiting the system, PMPM costs for former foster care children remain 2.5 to 3 times higher than the average Medicaid capitation rate for non-disabled children.

The healthcare expenditures analyzed cover a span of nine years (2003 to 2012) and include claims prior to entering foster care, during time in care, and after exiting the system. All of the children in this data set were eligible for Medicaid as a matter of categorical eligibility during the time they were in foster care. The analysis reveals many concerning facts, including:

- Higher than normal levels of emergency room utilization and inpatient hospital care
- Lower than normal levels of primary and preventive care (e.g., well child visits and dental visits)
- Low levels of expenditures for physician and professional services prior to and after exiting the child welfare system

The reasons for these patterns are multi-faceted and tied to an array of factors, including:

- Parental neglect and abuse
- Poor access to primary and preventive health care
- Inadequate treatment and follow-up for childhood illnesses and conditions
- A paucity of comprehensive outpatient behavioral health programs and services and inconsistent access to therapists and psychologists

Given the high level of spending, these deficiencies in accessing needed services seem glaring, contributing to poor health outcomes and the need for even more costly interventions going forward. These deficiencies in care also impact children's ability to function well in school and to participate in activities that can promote emotional development and social adjustment. The impact of stress and trauma alone can have a significant effect on a child's physical and behavioral health, and a failure to recognize and treat the causes and effect of childhood trauma and stress often has a significant impact not only on the children and their families, but on the fiscal components of the child welfare system, the juvenile justice system, and the health care system—especially Medicaid.

To successfully transition the foster care system to managed care, New York must focus on addressing the deficiencies in the current system and improving the delivery of primary and preventive health care, identifying and addressing behavioral health needs, and designing interventions that can avert crises or ensure quick and comprehensive responses to critical incidents, such as the use of mobile crisis intervention and increasing the availability of

comprehensive ambulatory behavioral health services. There must also be a particular emphasis placed on caring for infants and toddlers, with this analysis showing that in NYC only 1/3 of children (with six months or more Medicaid coverage) ages 1 – 12 months of age had at least one well-child visit in the 12 months prior to entering foster care. Given the large number of infants and young children taken into custody, there is clearly a need to ensure they receive appropriate primary and preventive care. Strategies such as home visits by nurses have proven effective for promoting the care and well-being of infants and should be evaluated as a managed care program service for infants in foster care as well as infants recently discharged from care.

THE TRANSITION TO MANAGED CARE

To achieve its goals, the transition of children and youth in foster care into managed care must encompass a robust effort to address the underlying problems that currently drive high utilization and costs and poor health and mental health outcomes. Merely enrolling these children and youth into a managed care plan will not, in and of itself, generate the results that the State and its policymakers seek. Without question, New York's Medicaid managed care program has generated significant improvements in beneficiary health outcomes, but the managed care plans are not structured to deal with the myriad of circumstances that impact

the physical and mental health of children and youth in foster care (e.g., parental neglect, mistreatment, abuse, and the impact of trauma and severe stress, among others).

Not unlike any other group of individuals who are experiencing or have experienced trauma, long term treatment and comprehensive interventions are often needed and ideally are provided by skilled professionals who can deliver appropriate evidence-based services. Children and families must also be engaged in treatment, either voluntarily or through court orders. And while MCOs can enhance access to care and encourage families to avail themselves of the care and services that will benefit both the child and the parent(s), they cannot compel participation.

MCO capitation rates must be adequate to enable MCOs to offer this level of care and to ensure that each child receives significant care coordination services from agencies and providers with expertise in child welfare and trauma-informed care.

A number of specific recommendations include (please see chapter 5 for a more detailed discussion):

- **Continuity of Care and Services:** The analysis uncovers disturbing patterns in service utilization before, during, and after exit from foster care, including low levels of primary and preventive care before entry and after exit, suggesting that gains made during foster care[18] are not sustained and previous patterns of inadequate care resurface. Continuity of care and the continuation of therapies and treatment that were underway while in foster care should be a priority; when relationships with therapists and other providers are disrupted, treatment is often set back. To address this, MCO networks need to include an array of practitioners and physicians with expertise and experience in serving these children before, during, and after they are in foster care so that continuity of care can be preserved.

MCO networks need to include an array of practitioners and physicians with expertise and experience in serving these children before, during, and after they are in foster care

- **Moving from Intuition to Evidence-Based Interventions:** The importance of trauma-informed care is paramount. Evidence-based interventions coupled with a robust system for monitoring and improving the quality of care should be standard practice within MCOs. New York needs to educate and train more physicians and practitioners in dealing with the specialized needs of children and youth with traumatic exposure.

[18] Gains made by children and youth during foster care are not fully quantified due to the nature of the per diem payment system.

- **Reimbursement Structure:** For the past 35 years, health services for children and youth in foster care have been delivered and financed through a mix of Medicaid fee-for-service reimbursement coupled with per diem payments to private, non-profit foster care agencies. Specifically, the Medicaid fee-for-service system reimburses providers for services such as inpatient hospital care, certain clinic services, a limited set of specialty services, and some medications while other, more routine forms of care and virtually all outpatient mental health services and primary health care services are financed through the per diem rates (see Appendix A). Under the State's plan, the current per diem reimbursement system for the agencies will be replaced. Recommendations for the financing of health care services and care coordination provided by traditional foster care providers and child welfare agencies are discussed in detail in Chapter 5.

ISSUES RELATING TO ENROLLMENT IN MANAGED CARE

Under New York's current mandatory managed care system for TANF, Safety Net, SSI recipients, and those in related Medicaid eligibility categories, virtually all children eligible for and enrolled in Medicaid or CHIP are required to join a managed care plan. Accordingly, a majority of children and youth entering the foster care system today are already receiving Medicaid services through an MCO.

As noted earlier, under the current system the vast majority of children and youth entering the foster care system are immediately disenrolled from managed care and placed in the Medicaid FFS/per diem arrangement with private, non-profit foster care agencies, and then following exit from foster care they are required to re-enroll (the exception being children in direct care outside of New York City). For obvious reasons, some observers ask "why not keep these children in their managed care plan while they are in foster care?" The reasons behind the "why not" are varied and must be addressed if New York's current managed care program is to work effectively for these children and youth. Challenges that need to be addressed include:

- **Relocation of Children beyond Their MCO's Service Area:** Children and youth in foster are often relocated to a foster boarding home or group home that lies outside of their current MCO's service area, which could require a transition to a new MCO. This may happen multiple times during the child's time in foster care. Possible solutions include:
  - Having children remain with their current MCO and require the MCO to reimburse out-of-network providers at Medicaid FFS rates for care the child receives.
  - Have children transition to a new MCO, with both the exiting MCO and the new MCO required to coordinate a seamless transition for the child under a formal transition plan.

- **Requiring Services beyond What MCOs Typically Pay For (e.g., "body checks", court-ordered drug screenings):** Some services that must be provided to foster children and youth may not be deemed "medically necessary" by MCOs, but are nonetheless required by State, County, and City child welfare agencies as safety/protection issues or are ordered by the courts without regard to medical necessity or MCO network constraints. Either MCOs or the State will need to pay for these services even though they are not normally provided to similarly situated children who are not in foster care. Our recommendations include requiring MCOs to cover these services.

- **Time Consuming Prior Authorization Requirements:** The foster care system must be able to respond to the immediate needs of children and youth in its custody, including any urgent need for medical, dental, or behavioral services. Prior approval or network adequacy issues that might impede a child's ability to access essential services within the timeframes deemed necessary by the child welfare agencies must be eliminated. One of the recommendations made by the project workgroups and endorsed by the Steering Committee is that each MCO be required to employ a foster care "liaison" with sufficient expertise and authority to approve services within very short timeframes. This issue is discussed in more detail in Chapter 5.

- **Administrative Requirements for Voluntary Foster Care Agencies:** There are numerous and complex statutory and regulatory requirements imposed upon voluntary foster care agencies. To meet these requirements, these agencies employ nurses, psychologists, social workers, and other professionals to evaluate children, identify their needs, formulate care plans, and deliver or arrange for the delivery of needed medical, dental, and behavioral health services. These requirements are not expected to be lifted when enrollment in managed care begins. A mechanism for ensuring coordination between voluntary foster care agencies and MCOs must be developed and funding mechanisms devised to ensure that agencies continue to have sufficient financial resources to meet statutory and regulatory requirements.

- **Consent to Treatment Issues:** Unlike most children enrolled in managed care, obtaining consent for the treatment of children and youth in the foster care system is complex. In general, foster parents are legally prohibited from providing consent and the child's birth parents (or the court if the birth parents are unable or unwilling) must be engaged in making decisions for all but the most basic types of care. Prior to enrolling foster care children in managed care, MCOs and their network providers will require education and training on consent to treat issues and extensive coordination will be required between the voluntary foster care agencies and MCOs.

- **Establishing Capitation Rates:** A number of advocates and voluntary foster care agency leaders have expressed concern that the current per diem system does not adequately fund all the services provided by voluntary foster care agencies, including medical and behavioral health services. This underfunding of services, to the extent that it exists, will garner prominent attention as the State begins the process of establishing actuarially sound MCO capitation rates that reflect the historical expenditures for this population, including fee-for-service as well as per diem expenditures.

  The MCO rates must be adequate to enable the MCOs to provide all necessary care and services in a cost-efficient and clinically appropriate manner. Needless to say, fundraising and other related activities that have historically been used by the voluntary foster care

agencies to supplement the rates paid by the State are not a normal business practice for managed care plans.

There will also be an ongoing need for the care coordination services currently provided by the foster care agencies. Accordingly, the Medicaid capitation rates must include funds that can be passed to these agencies so that they may continue these services as required by law. Again, recommendations for how to make these financial arrangements work are included in Chapter 5.

CHAPTER

5

Recommendations

Recommendations

The Steering Committee endorsed recommendations in the following nine key areas:

1. PHASE-IN OF MANDATORY MANAGED CARE
2. MCO-SPECIFIC REQUIREMENTS
3. ELIGIBILITY, ENROLLMENT, AND TRANSITIONS
4. SERVICE DELIVERY
5. CARE COORDINATION AND CASE MANAGEMENT
6. BENEFIT PACKAGE
7. QUALITY OF CARE METRICS AND MONITORING
8. ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION EXCHANGE
9. FOSTER CARE AGENCY SERVICES AND FINANCING UNDER MANAGED CARE

1 PHASE-IN OF MANDATORY MANAGED CARE

The enrollment of children and youth in foster care into managed care should take place in three distinct phases (recognizing the children and youth in direct care were required to enroll effective April 2013):

- **The initial phase** would include the enrollment of all children and youth in foster family boarding homes in the New York City metropolitan area (i.e., the five boroughs of NYC, Nassau, Suffolk, and Westchester Counties). Noteworthy exceptions would be children and youth who are medically fragile, intellectually and developmentally disabled (IDD), and those with HIV/AIDS. These groups will be addressed in phase II.

- **Phase two** would bring in medically fragile children, those with IDD and those with HIV/AIDS, as well as those residing in congregate settings in the New York City metropolitan area, including those in group homes and RTCs.
- **The third phase** would bring in all other children and youth in foster care in the rest of the state, including children in residential placements.

Many Commissioners outside of NYC have direct custody of foster care children in their respective counties. These Commissioners have had the option of enrolling children in the Medicaid managed care program for almost 15 years; however, nearly half of these children remained in the FFS system until April 2013 when enrollment of these children in managed care became a State requirement. The children in the direct custody of County Commissioners are considered 'pre-phase 1' for the purposes of this report.

First, it was decided to begin the phase-in process in the New York City metropolitan area with the children and youth placed in foster family boarding homes.

Second, it was concluded that the challenging nature of providing health care services to the medically fragile group warranted delaying enrollment until the managed care plans

have first gained some experience in serving the population of foster children and youth that are not medically fragile and are placed in family foster boarding homes as opposed to congregate settings. Many of the children in care in the counties outside of the NYC Metropolitan area are in residential settings, including group homes and campus settings, and there are a number of issues to be worked through before the system is ready to enroll the children on residential campuses. It was therefore agreed that more input is needed from these Commissioners, the voluntary agencies involved, and the managed care plans in the rest of the State prior to initiating enrollment of children in residential settings.

And finally, given the limited experience around the country of enrolling foster care children and youth into general managed care plans (i.e., those serving other Medicaid populations such as TANF, CHIP, and related groups), the consensus opinion was that New York should take a measured and careful approach to the inclusion of this population for reasons that are made all-too-apparent in this report.

The proposed approach for phasing-in managed care would result in 72 per cent of foster care children and youth enrolled in managed care by the end of Phase 1 (as 15 per cent are in direct care and their enrollment began in April 2013), an additional 8 percent during Phase 2, and the remaining 20 percent in the final phase. In terms of actual numbers, the enrollment schedule would be as follows:

PHASE	# OF ENROLLEES	CUMULATIVE ENROLLMENT
PHASE 1	12,200	15,600*
PHASE 2	1,650	17,250
PHASE 3	4,350	21,600

* includes 3400 Direct Care Children and Youth enrolled in 2013

2 MCO-SPECIFIC REQUIREMENTS

Participation of all Medicaid Managed Care Plans

All managed care plans currently under contract to the New York State Department of Health (SDOH) serving the Medicaid population will be required to participate in the foster care mandatory enrollment program. New York has no precedent for granting managed care plans an option not to enroll certain sub-populations of non-dually eligible[19] Medicaid beneficiaries, and all plans are currently required to enroll the physically disabled, chronically ill, and other eligible populations with medically challenging conditions.

[19] Dually eligible recipients have both Medicare and Medicaid coverage and Medicare is the primary payer for most acute care services. Accordingly, the duals do not participate in the general Medicaid managed care program but instead are enrolled in Managed Long-Term Care partial cap plans (if they are eligible for long-term care services) or Medicaid Advantage Plus plans (soon to be Fully Integrated Duals Advantage or "FIDA" Plans).

Foster Care Liaison

Each MCO must be required to employ an experienced foster care liaison to serve as the "Single Point of Contact" (SPOC) between the MCO, the foster care agencies, and applicable State and City agencies and departments (i.e., SDOH, the Office of Children and Family Services [OCFS], the NYC Administration for Children's Services [ACS], and local Departments of Social Services (LDSSs)).

At a minimum, the foster care liaisons must have experience and expertise in New York's foster care system and be knowledgeable about its requirements, regulations, and policies, including consent requirements. They must also be licensed clinicians (e.g., RN, MSW, psychologist) and possess the authority to authorize vitally needed services so that avoidable delays in care and treatment are minimized. The liaisons also need to have expertise in childhood trauma and be very familiar with primary care pediatrics, pediatric subspecialty care, and how to navigate the health care system in general. The liaisons (or their designees) must be available on a 24/7 basis to respond to any urgent needs these children and youth may have as well as to coordinate with the foster care agencies with whom they are placed. The liaisons should also be available to address any concerns or issues raised by State, City, and County authorities.

And finally, the MCO foster care liaisons should be required to meet on a regular basis with leadership from State, City and County agencies as well as with representatives from the voluntary foster care agencies. It is anticipated that this type of collaborative working relationship between the MCOs and the agencies will improve care coordination and service delivery and enhance outcomes for this population.

Health Home Model

It is recommended that the MCOs be required to utilize a Health Home model for the foster care population, and Health Homes approved by New York State should be required to contract with the foster care agencies to provide certain health home services for the children and youth in their care.

Under this approach, Health Home payment rates would be established by SDOH and paid to the MCOs, which would in turn pay the Health Home agencies as a "pass-through" form of reimbursement. Consistent with Health Home criteria established by SDOH and in consultation with OCFS, there must be appropriate criteria in place for agencies seeking certification as a Health Home. Some foster care agencies may even function as Health Homes, depending on the parameters established by SDOH. Those foster care agencies that do not have the capacity to serve as a Health Home may be qualified to serve as the "downstream" providers to the qualified Health Home entities.

3 ELIGIBILITY, ENROLLMENT, AND TRANSITIONS

To ensure a successful transition to a managed model of care, OCFS, ACS, and the LDSSs need to develop a process that will allow them to quickly determine whether or not children and youth entering foster care are:

- Enrolled in Medicaid
- Enrolled in managed care
- Enrolled in a specific MCO (i.e., name of plan)

This will permit the ACS/LDSS to notify the foster care agency of the name and contact information for the MCO in which the child is enrolled within 24 hours of the child's entrance into foster care. Foster care agencies (and in the case of children in direct care, the LDSS) must in turn be required to notify the child's MCO within 48 hours that he or she has been taken into custody and is in their care. This will permit the MCO to coordinate with the agency in obtaining needed medical information about the child (e.g., the child's PCP and contact information, medication list, current health conditions, etc.). If the child is already on Medicaid and enrolled in an MCO, he or she will remain in that MCO unless a change is necessary due to a re-location of the child. If the child is on Medicaid but not enrolled in an MCO, either the birth parent, ACS/LDSS, or the foster care agency (if delegated) will select a managed care plan for the child and he or she will be enrolled.

If a child is not enrolled in Medicaid, he or she will immediately become enrolled and an MCO will be selected either by the birth parent (if available and willing), ACS/LDSS, or the foster care agency (if ACS/LDSS has delegated this responsibility).

During the child's time in foster care, if no health or behavioral health care is provided for a 90-consecutive day period, there will be a reciprocal notification (MCO to Agency or Agency to MCO) as a means of guarding against any unidentified or unintentional gaps in care.

Discharge

Children and youth will remain in the foster care system and enrolled in their managed care plan until their discharge is finalized. Upon final discharge from foster care, children and youth will continue to receive care coordination services and follow-up for a transition period to be determined by the State. There must be a mechanism to assure the State's ongoing obligation to pay for these services through the managed care capitation.

Pursuant to the Affordable Care Act and beginning January 1, 2014, young adults who were in foster care and enrolled in Medicaid at the age of 18 can continue to receive Medicaid coverage until they turn 26, regardless of income. Consistent with these recommendations, continued

coverage by the young adult's MCO is essential. State, City, and County agencies will need to work with all relevant parties to assure the continuation of coverage facilitates the continuation of needed services.

4 SERVICE DELIVERY

The State should require MCOs to offer provider contracts to all qualified foster care providers and practitioners (qualified standards will be determined by the SDOH and OCFS) in addition to:

- Article 28 clinics (including those operated by foster care agencies)
- Article 31 clinics (including those operated by foster care agencies)
- FQHCs (and FQHC look-alikes)
- Private practice physicians, dentists, nurse practitioners, and behavioral health practitioners
- Physicians, dentists, and clinicians employed by or contracted to foster care agencies

It is further recommended that the State consider the following requirements when determining what constitutes a "qualified" primary care provider (PCP) for children and youth in foster care:

- Meet MCO credentialing requirements as pediatricians, family medicine physicians, or pediatric or family medicine nurse practitioners. In addition, PCPs should have at least two years experience in delivering care to children and youth in foster care
- Require children and youth in foster care to constitute at least 10 percent of their active patients (where their panel of patients does not exceed 1,500)
- Require trauma-informed training of the clinicians
- Require co-located behavioral health services or a formal written linkage agreement with behavioral health providers experienced in foster care
- Are recognized as a Level 2 or 3 Patient-Centered Medical Home (PCMH), or working toward such status
- Have hospital admitting privileges
- Meet cultural competency standards for a PCMH and have written policies in place
- Have 24/7 availability for emergency calls
- Have the capacity to provide reproductive health services on-site, including prenatal assessment and appropriate referral, birth control, basic GYN care, STI assessment and treatment

5 ASSESSMENT, CARE COORDINATION, AND CASE MANAGEMENT

It is recommended that foster care agencies able to meet the State's criteria be allowed to serve as Health Homes for children and youth in foster care, provide all required care coordination activities, and be paid an administrative fee by the MCOs for these services at rates established by the State.

These agencies will be responsible for conducting or arranging all required assessments and screenings, using the child's MCO network providers to the greatest extent possible. The MCOs would reimburse the agencies for these assessments and screenings at rates established by the State.

Because there does not appear to be sufficient data regarding the children's strengths and needs, a comprehensive medical and behavioral assessment should be completed immediately upon entry into care, whether or not the child remains in care for a day, a week, or longer. This placement with an agency should be viewed as a sentinel event triggering Medicaid enrollment, enrollment in managed care (if appropriate), and assessment of strengths and needs.

Foster care agencies should be required to:

- Develop and maintain a database of assessment information on children and youth in their care (information to be shared as needed and appropriate)
- Move toward using a standardized set of assessment and screening tools and instruments
- Assist with obtaining needed parental consent for the care and treatment of children and youth in their custody
- Work collaboratively with MCO foster care liaisons on all aspects of the provision of health care
- Arrange case conferences to ensure an interdisciplinary approach to identifying and treating children with physical and/or behavioral health needs and, to the extent possible and appropriate, engage both the birth and foster parents in these conferences
- Assist with scheduling and arranging transportation to appointments, with MCOs responsible for reimbursing the agencies for these costs (if transportation is a covered health plan benefit)

SDOH should issue a model contract that MCOs and Health Homes are required to use when contracting with the foster care agencies for health home services; in addition, MCO provider contracts should require providers who treat foster care children and youth to comply with all foster care agency reporting requirements, including the submission of consulting reports on a timely basis.

6 BENEFIT PACKAGE EXPANSION

The managed care benefit package for children and youth in foster care should be expanded as follows:

- No limits on eyeglasses, DME, or medical supplies[21]
- Replacement policy for lost or missing medications[22]
- Reimbursement for "blister" packaging and limited quantity dispensing when requested for children going home for short-term visits with birth parents
- HIV counseling and screening at prescribed intervals
- Family planning counseling and services at prescribed intervals

MCOs should not be permitted to impose restrictions on required health services such as "body checks"[23] or physical examinations that foster care agencies are legally required to perform. Forensic exams should be performed by qualified (SAFE) providers. If qualified SAFE providers are not available within the plan network at the time and place of a required exam, foster care agencies should be permitted to arrange for these exams from non-network providers and MCOs should be required to reimburse these providers at Medicaid rates.

Services to the foster care population are often viewed as services to the child, yet services to the parent or adoptive parent also assist the child in achieving permanency. Often these children need comprehensive mental health services that may involve the parent, foster parent, or adoptive parent. In those instances when the parent, foster parent, or adoptive parent is a member of the managed care plan, the plan will be required to coordinate services to the child and parent. In those situations where parents, foster parents, or adoptive parents adoptive parents are not plan members, accommodation/payment must be considered if family treatment is considered medically necessary including evidence-based mental health treatment.

In addition, there are a number of behavioral health services that have heretofore been paid through Medicaid waivers (B2H services, OMH children's waiver). As the capitation rate is computed by the NYSDOH, these services will be necessarily included in the managed care plan capitation rate. A transition strategy for these services will need to be jointly developed by SDOH/OCFS/OMH.

[21] Suspected fraud should be documented and reported to authorities.

[22] Ibid.

[23] A "body check" or unclothed examination of the child is designed to detect potential instances of abuse by checking for signs of unusual bruising, burns, scars, etc.

Finally, with regard to the benefit package expansion:

- MCO capitation rates should reflect the cost of the expanded benefit package as well as the historic utilization and expenditure patterns of the foster care population.
- New and emerging therapies and treatment modalities should be covered by MCOs based on recommendations by a committee of clinical experts charged with determining when these should be covered as medically necessary and clinically therapeutic.

7 QUALITY OF CARE METRICS AND MONITORING

It is recommended that SDOH require MCOs to collect and report on current QARR data coupled with additional quality metrics specific to the foster care population. This requirement should be implemented in a manner that allows stakeholders to separate performance metrics for the cohort of children and youth in foster care from the general pediatric managed care population. To this end, SDOH, with the assistance of OCFS/LDSSs (as needed), should:

- Identify the domains to be assessed
- Identify measures that are quantifiable
- Develop an incremental process for enhancing outcomes, including a pathway for improvement
- Establish financial incentives for delivery system improvements

It is further recommended that SDOH establish any additional quality and performance metrics deemed appropriate for the care and services provided to children and youth in foster care.

It is recommended that OCFS identify foster care outcome metrics (e.g., length of stay, stability) which should be used to monitor whether enrollment in managed care contributes positively or negatively to child welfare outcomes. And finally, OCFS/ACS/LDSS should continue to monitor and audit foster care agencies for the provision of Health Home services (e.g., care coordination) and the well-being of the children and youth in their care (defined to include safety and permanency).

8 ELECTRONIC HEALTH RECORDS (EHRS) AND HEALTH INFORMATION EXCHANGE

It is recommended that foster care agencies pursue the implementation of EHRs and/or Care Management Systems. Their participation in the Regional Health Information Organizations (RHIOs) would also be beneficial, and perhaps might best be achieved by negotiating as a consortium with these entities. The State should allocate new funding for improvements in Information Technology (IT) for children's services, particularly for foster care children and youth, as this would permit immediate access to historical health care information, including providers, diagnoses, medications, previous surgeries, etc. The instability of this population of children and youth underscores the importance of timely, accessible records that can facilitate essential information exchange.

An enhanced IT capability among foster care agencies would also allow for:

- The prompt notification of stakeholders about a sudden health care event such as an ER visit, and the prompt receipt of referral reports.
- The ability to communicate care plans and contact information with others in the community.
- An enhanced ability to coordinate care between foster care agencies, MCO liaisons, community providers, and other stakeholders involved in the child's care.

Despite this promising potential for improvement over the current system, there are also difficult challenges that must be addressed, including access to capital, implementation barriers, privacy protections, and consent requirements.

9 FOSTER CARE AGENCY SERVICES AND FINANCING UNDER MANAGED CARE

Foster Care Agencies are currently paid a per diem allowance for each child in their care. The amount of the per diem varies by the type of placement (e.g., regular foster family, medically fragile, group home, etc.) and is intended to cover the cost of providing certain Medicaid-covered health care services to children in their custody. In turn, the foster care agencies employ or contract with health care providers (by salary or a contract payment agreement) to provide the medical, behavioral health, and dental care the children and youth in their care need

and reimburse these providers out of the health care per diem they receive from the state. This includes nursing coverage that is often required 24/7 or 2 shifts a day, particularly for residential settings, and includes the administering of needed medications. A recently published analysis suggests that the current funding for the foster care agencies is inadequate to meet existing costs of the complex needs of the children and youth in their care.[24] Over 6% of agency spending was not covered by the existing per diem rates. To supplement the state per diem reimbursement, a number of agencies have drawn on private donations and funding.

Under the proposed transition to managed care, the current per diem reimbursement methodology has to be changed. As to how it should be changed, it is recommended that the existing Medicaid per diem funding stream be replaced with three distinct potential revenue sources for the foster care agencies depending on the services the agency provides:

- Direct reimbursement by MCOs for Medicaid-covered services
- Clinical administrative reimbursement by the State
- Care Coordination fees paid by the MCOs as a pass-through to agencies serving as Health Homes or downstream providers to Health Homes.

Each of these funding methodologies is briefly described below.

Direct Reimbursement for Medicaid-covered Services

When employed or contracted health care providers affiliated with foster care agencies deliver direct services to children enrolled in managed care, the agency would be reimbursed on a fee-for-service basis by the MCO for these services. Payment rates, unless otherwise negotiated, would be at prevailing Medicaid rates and MCOs will be required to contract with these providers as a part of their overall pediatric and adolescent provider network. Providers (e.g., physicians, psychologists, nurse practitioners) employed by or under contract with the agencies would be required to meet MCO credentialing standards as applicable. Article 28 or 31 clinics affiliated with the foster care agencies would bill the MCO directly for services provided to an enrollee who is under the care of that particular agency.

Clinical Administrative Reimbursement by the State

Foster care agencies that provide clinical services (other than services provided directly to an individual child) that are approved as clinical administrative costs[25] would be reimbursed by the State. The workgroup anticipates that these reimbursement levels would initially need to

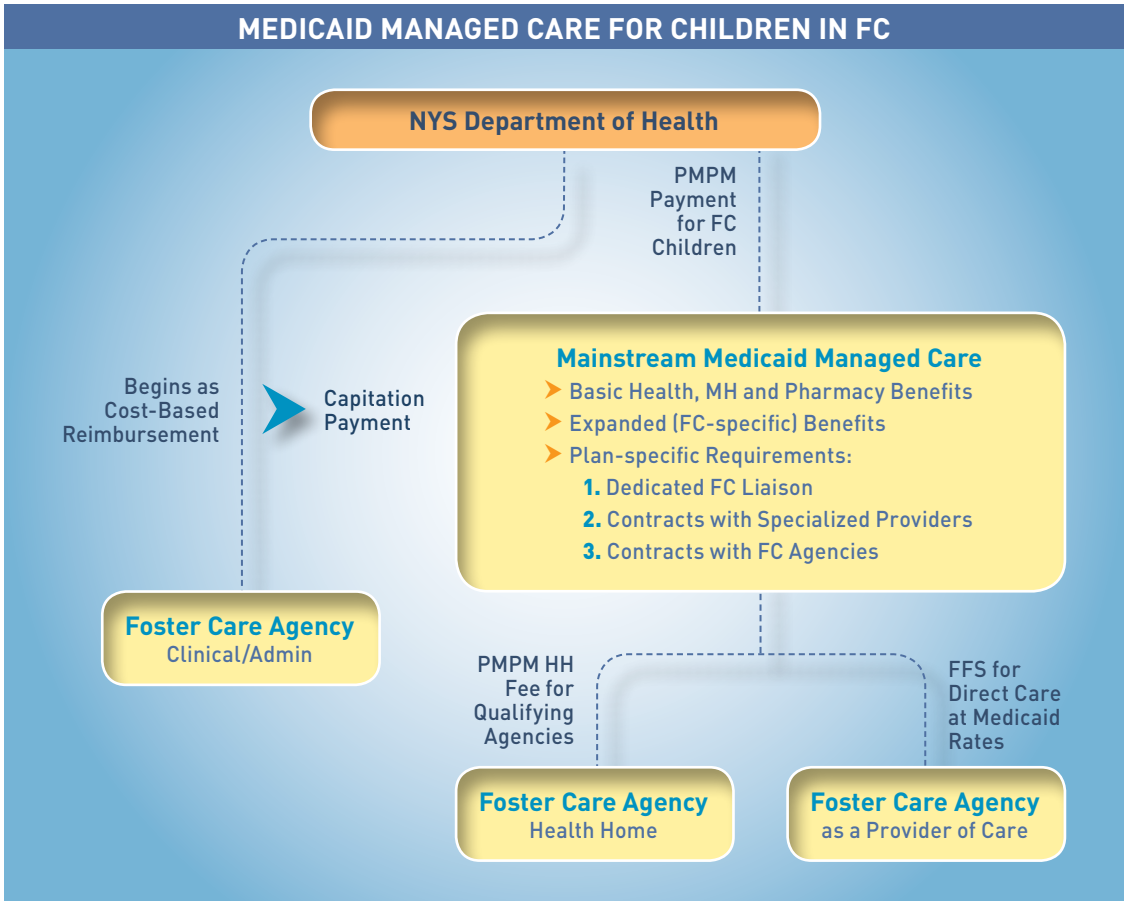
[24] Nicole P. Marwell, Thad Calabrese, and James Krauskopf, "The Financial Health of New York's Child Welfare Nonprofits," Center for Nonprofit Strategy and Management, Baruch College of Public Affairs (October 2012).

[25] Examples of clinical administrative costs include the activities of clinical staff (e.g., physicians and psychologists) such as quality improvement, medical direction and oversight, training of non-clinical staff in areas such as care management and treatment modalities, facilitation of case conferences and multi-disciplinary team intervention, and consultation and court appearances.

be cost-based owing to the scope and cost variation among the foster care agencies for these types of clinical administrative services. However, the long-term goal would be to transition to a series of fixed rates for clinical administrative costs based on the number and type of children and adolescents the agencies serve.

Health Home Fees Paid by the MCOs as a Pass-Through to Agencies Serving as Health Homes and Downstream Health Home Providers

As discussed above, it is recommended that foster care agencies be eligible to serve as Health Homes if they meet the State's criteria. For those agencies that achieve designation as Health Homes, the MCOs would be required to pay them an administrative fee at rates established by SDOH for this program. For those agencies that are not designated as Health Homes, they should receive the care coordination 'pass through' capitation from the Health Home in order to be the designated downstream provider for the children and youth in their custody. It is recommended that all foster children be considered 'Health Home eligible'; however, if not, it is recommended that a care coordination rate would would be paid through the MCO capitation rate.



FOSTER CARE

A, B, C

Appendices

Appendix A

PER DIEM SERVICES	MEDICAID FEE-FOR-SERVICE
Administrative Services	Article 28 Outpatient Dept. (Hospital-based)
Nurse	Emergency Room
Physician Specialist	School-based Health Clinic
Physician	Family Planning Clinic
Article 28 Clinic	OMH Partial Hospitalization
Psychiatrist	OMH Day Treatment
Psychologist	OMH State-Operated Clinic
Certified Social Worker (LMSW/LCSW)	OASAS Licensed Clinic
OMH Licensed Voluntary Clinic	General Inpatient Hospitals and Nursing Facilities
OMRDD Licensed Voluntary Clinic	OMH Inpatient
Dentist	OMRDD Inpatient
Dental Free Standing Clinic	OASAS Inpatient
Prescription Drugs (Not of SDOH Exclusion List)	Dental Outpatient Departments (OPD)
Non-Prescription Drugs	Orthodontist
Medical Supplies	Prescription Drugs (On SDOH Exclusion List)
Durable Medical Equipment	Early Intervention
Home Health Care	Preschool and School Supportive Health Services Programs
Laboratory	Comprehensive Medical Case Management
X-Ray/Radiology	
Medical Transportation	
Eye Care	
Physical Therapy	
Occupational Therapy	
Speech and Audiology	

Appendix B

Detailed Tables that profile Children in Care

TABLE 2.1: Age Distribution and Location For First Entry into Foster Care, 2005-12

AGE AT FIRST FOSTER CARE ENTRANCE	TOTAL UNIQUE FOSTER CARE CHILDREN & YOUTH IN DATASET (2005-12)				DISTRIBUTION BY REGION	
	ROS	NYC	STATEWIDE	PCT. IN NYC	ROS	NYC
Newborns (<1 month)	2,451	3,670	6,121	60%	7.3%	9.3%
1-12 months	3,259	4,213	7,472	56%	9.8%	10.7%
1-5 years	7,545	10,271	17,816	58%	22.6%	26.1%
6-11 Male	2,961	4,294	7,255	59%	8.9%	10.9%
6-11 Female	2,525	3,772	6,297	60%	7.6%	9.6%
12-14 Male	3,718	2,762	6,480	43%	11.1%	7.0%
12-14 Female	2,639	2,877	5,516	52%	7.9%	7.3%
15-16 Male	4,367	3,198	7,565	42%	13.1%	8.1%
15-16 Female	2,942	3,036	5,978	51%	8.8%	7.7%
17+ Male	476	536	1,012	53%	1.4%	1.4%
17+ Female	508	793	1,301	61%	1.5%	2.0%
Totals	33,391	39,422	72,813	54%	100%	100%
TOTAL STATEWIDE: 72,813					54% IN NYC	

Note: Only analyzed those with at least one day of Medicaid eligibility after discharge from foster care; this eliminated 1.45 percent of members.

TABLE 2.2: Pct. of Children and Youth with Only One Span in Foster Care for children who first entered Foster care in 2006

AGE AT FIRST ENTRANCE INTO FC	PCT. OF CHILDREN AND YOUTH WITH ONLY 1 SPAN IN FOSTER CARE (ENTERED FC IN 2006)	
	REST OF STATE	NYC
Infants (<1 mo.)	76%	52%
1-12 mos.	73%	50%
1-5 years	67%	50%
6-11 Male	53%	53%
6-11 Female	58%	52%
12-14 Male	52%	53%
12-14 Female	42%	51%
15-16 Male	72%	51%
15-16 Female	60%	44%
17+ Male	76%	52%
17+ Female	72%	44%
TOTAL	62%	51%

TABLE 2.3: Rest of State Placement by Age, for new entrants, 2005–12

REST OF STATE DISTRIBUTION BY PLACEMENT CATEGORY					
AGE AT FIRST FC ENTRANCE	FOSTER CARE	KINSHIP CARE	INSTITUTION	GROUP HOME OR RESIDENCE	ALL OTHER
Infants (<1 mo.)	93%	5%	1%	0%	0%
1-12 mos.	90%	8%	2%	0%	0%
1-5 years	85%	10%	3%	1%	0%
6-11 Male	69%	8%	14%	7%	2%
6-11 Female	76%	10%	8%	5%	1%
12-14 Male	23%	2%	56%	15%	4%
12-14 Female	38%	3%	39%	15%	4%
15-16 Male	14%	1%	63%	17%	5%
15-16 Female	30%	1%	43%	21%	6%
17+ Male	23%	2%	41%	24%	9%
17+ Female	36%	4%	28%	23%	10%
TOTAL	58%	6%	25%	9%	2%

TABLE 2.4: NYC Placement by Age, for new entrants, 2005–12

NYC DISTRIBUTION BY PLACEMENT CATEGORY					
AGE AT FIRST FC ENTRANCE	FOSTER CARE	KINSHIP CARE	INSTITUTION	GROUP HOME OR RESIDENCE	ALL OTHER
Infants (<1 mo.)	69%	31%	0%	0%	0%
1-12 mos.	65%	34%	0%	0%	0%
1-5 years	62%	37%	0%	0%	0%
6-11 Male	58%	36%	4%	1%	1%
6-11 Female	60%	37%	2%	0%	1%
12-14 Male	28%	19%	40%	11%	1%
12-14 Female	44%	23%	19%	11%	2%
15-16 Male	14%	8%	60%	15%	3%
15-16 Female	37%	16%	23%	20%	4%
17+ Male	17%	14%	27%	35%	7%
17+ Female	41%	16%	12%	24%	7%
TOTAL	52%	29%	12%	6%	1%

TABLE 2.5: Reasons for Exit from Foster Care in Other than NYC, for new entrants, 2005–12

AGE AT FIRST FC ENTRANCE	REST OF STATE: REASON FOR EXIT FROM FOSTER CARE				
	ADOPTED	REUNITED W/ FAMILY	AGE OUT	RUNAWAY	OTHER
Infants (<1 mo.)	54%	43%	0%	0%	3%
1-12 mos.	30%	66%	0%	0%	4%
1-5 years	21%	75%	0%	0%	4%
6-11 Male	14%	80%	0%	0%	5%
6-11 Female	13%	81%	0%	0%	5%
12-14 Male	2%	79%	3%	2%	14%
12-14 Female	3%	79%	6%	4%	9%
15-16 Male	0%	76%	7%	3%	14%
15-16 Female	1%	75%	13%	4%	8%
17+ Male	0%	60%	28%	2%	11%
17+ Female	0%	60%	28%	2%	11%
TOTAL	14%	73%	4%	2%	7%

TABLE 2.6: Reasons for Exit from Foster Care in NYC, for new entrants, 2005–12

AGE AT FIRST FC ENTRANCE	NYC: REASON FOR EXIT FROM FOSTER CARE				
	ADOPTED	REUNITED W/ FAMILY	AGE OUT	RUNAWAY	OTHER
Infants (<1 mo.)	48%	49%	0%	0%	3%
1-12 mos.	25%	72%	0%	0%	4%
1-5 years	12%	84%	0%	0%	4%
6-11 Male	7%	86%	0%	1%	6%
6-11 Female	8%	86%	0%	1%	5%
12-14 Male	2%	68%	3%	7%	20%
12-14 Female	3%	67%	7%	12%	11%
15-16 Male	0%	63%	8%	8%	21%
15-16 Female	0%	56%	20%	13%	10%
17+ Male	0%	46%	29%	12%	12%
17+ Female	0%	42%	40%	9%	9%
TOTAL	11%	72%	5%	4%	8%

TABLE 2.7: Age Distribution of Medicaid Coverage Prior to First Entry into Foster Care, by Location, for new entrants, 2005–12

AGE AT FIRST ENTRANCE INTO FOSTER CARE	PCT. WITHOUT MEDICAID 1 MONTH PRIOR TO ENTRY INTO FOSTER CARE		AMONG THOSE WITH MEDICAID, PCT. IN MANAGED CARE 1 MONTH PRIOR TO ENTRY INTO FC	
	ROS	NYC	ROS	NYC
Newborns (<1 mo.)	47.2%	70.7%	23.8%	3.6%
1-12 Months	8.7%	36.1%	51.2%	46.4%
1-5 Years	15.3%	37.1%	68.9%	75.7%
6-11 Male	18.8%	39.0%	63.5%	78.1%
6-11 Female	20.9%	39.4%	66.3%	78.6%
12-14 Male	29.2%	41.2%	52.7%	72.7%
12-14 Female	28.7%	43.5%	54.8%	77.5%
15-16 Male	37.8%	49.0%	47.4%	73.1%
15-16 Female	35.5%	46.0%	49.7%	74.4%
17+ Male	50.2%	50.6%	35.0%	59.2%
17+ Female	37.8%	44.4%	44.9%	69.4%
TOTAL	25.9%	43.3%	56.4%	68.6%

TABLE 2.8: Pct. Enrollment in Medicaid Managed Care One Month into Foster Care and One Month after Foster Care, by Age and Location, for new entrants, 2005–12

AGE AT FIRST ENTRANCE INTO FOSTER CARE	PCT. ENROLLED IN MEDICAID MANAGED CARE ONE MONTH INTO FOSTER CARE		PCT. ENROLLED IN MEDICAID MANAGED CARE ONE MONTH AFTER FOSTER CARE	
	ROS	NYC	ROS	NYC
Newborns (<1 mo.)	19.1%	2.3%	38.9%	26.2%
1-12 Months	29.7%	7.1%	50.0%	38.1%
1-5 Years	30.7%	10.9%	54.7%	44.0%
6-11 Male	21.9%	13.6%	45.7%	42.9%
6-11 Female	26.0%	12.1%	51.2%	44.5%
12-14 Male	7.0%	10.0%	29.1%	28.5%
12-14 Female	10.2%	13.0%	37.0%	35.3%
15-16 Male	4.5%	8.2%	21.1%	21.5%
15-16 Female	7.5%	13.4%	33.3%	34.2%
17+ Male	4.4%	7.8%	20.2%	22.1%
17+ Female	9.6%	11.3%	34.4%	38.8%
TOTAL	18.2%	10.1%	40.1%	36.7%

Appendix C

Detailed Tables of Expenditure Patterns

TABLE 3.1: Total Medicaid Claim Dollars Before, During, and After FC by Category of Expenditure

CATEGORY OF SERVICE	EXPENDITURES BEFORE FOSTER CARE	DURING FC	AFTER FOSTER CARE	TOTAL: BEFORE, DURING, AND AFTER FC
MCO Capitation	$138,397,503	$36,276,870	$168,663,766	$343,338,139
Agency Per Diems	$5,317,940	$386,196,552	$46,088,977	$437,603,469
Community-Related	$156,926,576	$170,072,342	$229,714,917	$556,713,835
Dental	$5,940,324	$9,517,858	$6,800,631	$22,258,813
Inpatient Facility	$331,163,457	$239,165,104	$193,850,887	$764,179,448
Outpatient Facility	$40,659,308	$85,067,458	$84,428,156	$210,154,922
Other Facility	$898,988	$1,489,645	$1,219,014	$3,607,647
Behavioral Health Services	$66,481	$167,808	$132,521	$366,810
Bridges to Health	$524,519	$28,345,666	$57,061,325	$85,931,510
Physician Services	$10,000,077	$11,680,585	$8,479,705	$30,160,367
Vision Services	$119,838	$342,113	$232,391	$694,343
Speech Therapy		$1,717	$12,719	$14,436
Transportation	$401,384	$335,405	$962,905	$1,699,694
Other Professional Services	$2,783,916	$5,701,980	$4,097,620	$12,583,516
Retail Pharmacy	$58,742,832	$59,199,796	$56,100,716	$174,043,344
GRAND TOTAL	$751,943,143	$1,033,560,897	$857,846,250	$2,643,350,290

TABLE 3.2: Pct. of ER Visits among Medicaid-eligible Children and Youth Before, During, and After FC for new entrants between 2005–2012

AGE COHORT	PCT. OF PRE-FC COHORT WITH AT LEAST 1 ER VISIT IN THE 12 MOS. PRECEDING FC*		PCT. OF FC COHORT WITH AT LEAST 1 ER VISIT DURING THE FIRST 12 MONTHS FOLLOWING ENTRY INTO FC**		PCT. OF POST-FC COHORT WITH AT LEAST 1 ER VISIT IN THE FIRST 12 MONTHS FOLLOWING FINAL EXIT FROM FC***	
	ROS	NYC	ROS	NYC	ROS	NYC
0 Months	3.4%	6.4%	35.4%	49.2%	26.0%	27.3%
1-12 Months	50.0%	58.1%	41.1%	49.7%	34.4%	27.7%
1-5 Years	47.3%	51.0%	29.8%	39.9%	24.1%	22.2%
6-11 Male	37.3%	41.8%	27.3%	34.5%	23.3%	19.4%
6-11 Female	30.9%	37.8%	23.1%	31.9%	23.3%	17.9%
12-14 Male	42.0%	42.3%	28.6%	29.8%	24.1%	15.6%
12-14 Female	46.3%	43.7%	36.2%	38.3%	36.4%	26.0%
15-16 Male	40.3%	37.1%	25.1%	29.8%	23.8%	15.9%
15-16 Female	52.6%	49.3%	33.8%	44.3%	38.2%	29.4%
17+ Male	33.3%	33.5%	22.9%	33.1%	24.7%	17.8%
17+ Female	46.8%	53.5%	36.6%	47.0%	44.2%	32.4%
TOTAL	40.4%	42.8%	30.9%	38.8%	27.6%	22.3%

*Includes children and youth with 6 or more months of Medicaid eligibility prior to 1st FC entry.
**Includes FC with 6 or more mos. of Medicaid eligibility during the 1st 12 mos. following entry.
***Includes post-FC children and youth with 6 or more mos. of Medicaid eligibility following exit.

TABLE 3.3A: ER Visits within 12 Months Prior to First Entry into FC among Medicaid-Eligible Children and Youth for new entrants between 2005–2012

REST OF STATE COUNTIES							
AGE/GENDER COHORT	ANNUAL ER VISITS PER 1,000	1ST HIGHEST DX GROUP		2ND HIGHEST DX GROUP		3RD HIGHEST DX GROUP	
		FREQ.	DX GROUP	FREQ.	DX GROUP	FREQ.	DX GROUP
0 Months	129.9	29.8%	Childbirth/ Pregnancy	17.5%	Injury	14.0%	Other Screening
1-12 Months	1,451.8	23.5%	Respiratory	14.1%	Malaise / Nausea/ Fever	13.7%	Injury
1-5 Years	1,109.1	21.9%	Injury	19.0%	Respiratory	13.3%	Low-Cost Nerv. Sys.
6-11 Male	709.0	28.1%	Injury	25.0%	Mental Illness	10.0%	Respiratory
6-11 Female	613.4	26.9%	Injury	14.5%	Mental Illness	13.2%	Respiratory
12-14 Male	931.2	34.0%	Injury	33.2%	Mental Illness	6.5%	Respiratory
12-14 Female	1,151.4	34.5%	Mental Illness	25.4%	Injury	7.7%	Respiratory
15-16 Male	1,008.0	38.8%	Injury	24.2%	Mental Illness	7.3%	Respiratory
15-16 Female	1,231.8	29.5%	Mental Illness	21.3%	Injury	8.1%	Respiratory
17+ Male	761.7	35.1%	Injury	27.8%	Mental Illness	6.0%	Respiratory
17+ Female	1,271.0	22.4%	Mental Illness	17.5%	Injury	10.3%	Respiratory
NEW YORK CITY							
AGE/GENDER COHORT	ANNUAL ER VISITS PER 1,000	1ST HIGHEST DX GROUP		2ND HIGHEST DX GROUP		3RD HIGHEST DX GROUP	
0 Months	250.6	40.0%	Childbirth/ Pregnancy	16.4%	Unclassified	7.3%	Respiratory
1-12 Months	1,770.3	28.6%	Respiratory	12.8%	Malaise/ Nausea/ Fever	9.9%	Injury
1-5 Years	1,312.9	21.7%	Respiratory	15.8%	Injury	10.9%	Infections
6-11 Male	910.7	21.9%	Injury	14.9%	Mental Illness	11.6%	Respiratory
6-11 Female	800.1	19.5%	Injury	17.2%	Respiratory	9.2%	Infections
12-14 Male	937.5	30.8%	Mental Illness	28.1%	Injury	5.8%	Chronic Asthma
12-14 Female	1,038.5	32.2%	Mental Illness	20.6%	Injury	8.6%	Respiratory
15-16 Male	1,143.1	31.1%	Injury	28.1%	Mental Illness	6.6%	Respiratory
15-16 Female	728.5	21.3%	Mental Illness	17.9%	Injury	9.3%	Childbirth/ Pregnancy
17+ Male	686.9	27.4%	Injury	26.2%	Mental Illness	6.5%	Asthma
17+ Female	1,480.4	16.4%	Childbirth/ Pregnancy	16.3%	Mental Illness	15.8%	Injury

TABLE 3.3B: ER Visits within First 12 Months after 1st Entry into FC among Medicaid-Eligible Children and Youth for new entrants between 2005–2012

REST OF STATE COUNTIES							
AGE/GENDER COHORT	ANNUAL ER VISITS PER 1,000	1ST HIGHEST DX GROUP		2ND HIGHEST DX GROUP		3RD HIGHEST DX GROUP	
		FREQ.	DX GROUP	FREQ.	DX GROUP	FREQ.	DX GROUP
0 Months	664.7	29.3%	Respiratory	14.8%	Malaise /Nausea/ Fever	9.1%	Low-Cost Nerv. Sys
1-12 Months	938.3	24.3%	Respiratory	14.5%	Injury	13.3%	Malaise /Nausea/ Fever
1-5 Years	571.1	27.4%	Injury	13.9%	Respiratory	12.1%	Low-Cost Nerv. Sys.
6-11 M	535.3	32.9%	Injury	25.5%	Mental Illness	5.9%	Respiratory
6-11 F	431.6	26.6%	Injury	20.2%	Mental Illness	12.0%	Respiratory
12-14 M	577.4	46.9%	Injury	20.6%	Mental Illness	3.6%	Respiratory
12-14 F	876.2	32.5%	Mental Illness	27.5%	Injury	6.6%	Abdominal Pain
15-16 M	521.0	50.5%	Injury	16.5%	Mental Illness	3.7%	Respiratory
15-16 F	791.1	27.4%	Injury	20.3%	Mental Illness	6.6%	Abdominal Pain
17+ M	501.7	47.9%	Injury	11.8%	Mental Illness	7.6%	Respiratory
17+ F	944.2	20.7%	Injury	18.5%	Mental Illness	8.7%	Childbirth/ Pregnancy
NEW YORK CITY							
AGE/GENDER COHORT	ANNUAL ER VISITS PER 1,000	1ST HIGHEST DX GROUP		2ND HIGHEST DX GROUP		3RD HIGHEST DX GROUP	
0 Months	1,097.9	33.3%	Respiratory	13.5%	Malaise/ Nausea/ Fever	9.8%	Infections
1-12 Months	1,220.8	27.9%	Respiratory	12.5%	Malaise/ Nausea/ Fever	10.6%	Infections
1-5 Years	836.8	19.3%	Respiratory	18.7%	Injury	9.3%	Infections
6-11 M	696.1	22.3%	Injury	21.4%	Mental Illness	10.8%	Respiratory
6-11 F	646.4	17.3%	Injury	16.6%	Mental Illness	12.7%	Respiratory
12-14 M	610.1	40.1%	Injury	17.5%	Mental Illness	5.8%	Other Screening
12-14 F	1,046.1	22.2%	Mental Illness	22.0%	Injury	7.2%	Other Screening
15-16 M	1,160.8	49.4%	Injury	9.8%	Mental Illness	9.5%	Other Screening
15-16 F	740.8	14.3%	Injury	12.6%	Childbirth/ Pregnancy	11.8%	Mental Illness
17+ M	756.6	36.3%	Injury	11.6%	Other Screening	10.4%	Mental Illness
17+ F	1,407.4	17.9%	Childbirth/ Pregnancy	11.3%	Injury	11.0%	Other Screening

TABLE 3.3C: ER Visits within 12 Months after Last Exit from Foster Care among Medicaid-Eligible Children and Youth for new entrants between 2005–2012

REST OF STATE COUNTIES							
AGE/GENDER COHORT	ANNUAL ER VISITS PER 1,000	1ST HIGHEST DX GROUP		2ND HIGHEST DX GROUP		3RD HIGHEST DX GROUP	
		FREQ.	DX GROUP	FREQ.	DX GROUP	FREQ.	DX GROUP
0 Months	708.6	23.2%	Respiratory	16.3%	Malaise /Nausea/ Fever	14.3%	Low-Cost Nerv. Sys
1-12 Mos.	840.8	23.0%	Respiratory	16.4%	Injury	13.7%	Malaise /Nausea/ Fever
1-5 Years	541.8	25.6%	Injury	18.3%	Respiratory	12.3%	Low-Cost Nerv. Sys.
6-11 M	482.2	31.3%	Injury	16.6%	Mental Illness	11.0%	Respiratory
6-11 F	467.2	28.3%	Injury	15.0%	Respiratory	14.5%	Mental Illness
12-14 M	558.5	37.4%	Injury	17.0%	Mental Illness	8.6%	Respiratory
12-14 F	1,011.5	21.6%	Injury	14.9%	Mental Illness	9.0%	Respiratory
15-16 M	521.0	50.5%	Injury	16.5%	Mental Illness	3.7%	Respiratory
15-16 F	739.5	17.2%	Injury	11.5%	Childbirth/ Pregnancy	9.9%	Mental Illness
17+ M	678.0	25.7%	Injury	17.7%	Mental Illness	12.4%	Respiratory
17+ F	1,558.2	15.8%	Injury	15.3%	Childbirth/ Pregnancy	9.5%	Mental Illness
NEW YORK CITY							
AGE/GENDER COHORT	ANNUAL ER VISITS PER 1,000	1ST HIGHEST DX GROUP		2ND HIGHEST DX GROUP		3RD HIGHEST DX GROUP	
0 Months	880.3	24.4%	Respiratory	12.5%	Injury	12.5%	Infections
1-12 Mos.	936.8	24.0%	Respiratory	13.0%	Injury	12.3%	Infections
1-5 Years	646.7	19.0%	Respiratory	17.7%	Injury	11.0%	Low-Cost Nerv Sys
6-11 M	491.7	22.8%	Injury	16.2%	Mental Illness	12.0%	Respiratory
6-11 F	458.7	20.9%	Injury	13.5%	Respiratory	12.9%	Mental Illness
12-14 M	357.6	29.9%	Injury	19.7%	Mental Illness	8.5%	Respiratory
12-14 F	743.2	13.4%	Injury	13.2%	Childbirth/ Pregnancy	12.2%	Mental Illness
15-16 M	884.7	31.4%	Injury	12.1%	Mental Illness	8.5%	Respiratory
15-16 F	374.8	20.6%	Childbirth/ Pregnancy	10.6%	Injury	8.3%	Mental Illness
17+ M	440.6	17.7%	Injury	15.2%	Mental Illness	7.9%	Respiratory
17+ F	1,128.9	27.2%	Childbirth/ Pregnancy	11.6%	Injury	7.4%	Respiratory

TABLE 3.4: Pct. with at Least One Medicaid FFS Well-Child (WC) Visit Before, During, and After Entry into Foster Care (note: excludes per diem services provided during FC) for new entrants between 2005–2012

AGE COHORT	REST OF STATE			NEW YORK CITY		
	% WITH AT LEAST 1 WC VISIT IN THE 12 MOS. BEFORE ENTRY*	% WITH AT LEAST 1 WC VISIT IN THE 1ST 12 MOS. AFTER 1ST FC ENTRY**	% WITH AT LEAST 1 WC VISIT IN THE 1ST 12 MOS. AFTER FINAL EXIT***	% WITH AT LEAST 1 WC VISIT IN THE 12 MOS. BEFORE ENTRY*	% WITH AT LEAST 1 WC VISIT IN THE 1ST 12 MOS. AFTER 1ST FC ENTRY**	% WITH AT LEAST 1 WC VISIT IN THE 1ST 12 MOS. AFTER FINAL EXIT***
0 Mos.	75.3%	4.9%	57.3%	42.7%	1.3%	21.2%
1-12 Mos.	63.9%	67.4%	54.5%	33.8%	34.2%	22.7%
1-5 Years	46.2%	60.1%	38.5%	23.0%	36.8%	17.7%
6-11 M	34.6%	34.5%	27.1%	15.6%	24.4%	13.9%
6-11 F	36.9%	33.9%	28.6%	17.1%	24.4%	13.5%
12-14 M	19.4%	24.0%	14.8%	11.5%	19.0%	8.5%
12-14 F	28.2%	26.7%	23.3%	13.2%	21.5%	9.4%
15-16 M	14.4%	18.3%	10.3%	7.3%	15.7%	4.8%
15-16 F	25.4%	24.9%	19.2%	12.8%	18.4%	8.5%
17+ M	9.0%	8.3%	7.0%	6.0%	12.1%	4.1%
17+ F	21.9%	21.8%	16.1%	12.5%	16.7%	6.3%
TOTAL	31.9%	36.5%	25.4%	15.7%	25.2%	11.9%

*Pct. of children and youth with 6 or more months of Medicaid eligibility prior to 1st FC Entry (i.e., pre-FC cohort)
**Pct. of children and youth with 6 or more months of Medicaid eligibility in the first 12 months following their first FC entry (i.e., FC cohort).
***Pct. of children and youth with 6 or more months of Medicaid eligibility following their final FC exit (i.e., post-FC cohort).

TABLE 3.5: Pct. with at Least One Medicaid FFS Dental Visit Before, During, and After Entry into Foster Care (note: excludes per diem services provided during FC) for new entrants between 2005–2012

AGE COHORT	REST OF STATE			NEW YORK CITY		
	% WITH AT LEAST 1 DENTAL VISIT IN THE 12 MOS. BEFORE ENTRY*	% WITH AT LEAST 1 DENTAL VISIT IN THE 1ST 12 MOS. AFTER 1ST FC ENTRY**	% WITH AT LEAST 1 DENTAL VISIT IN THE 1ST 12 MOS. AFTER FINAL EXIT***	% WITH AT LEAST 1 DENTAL VISIT IN THE 12 MOS. BEFORE ENTRY*	% WITH AT LEAST 1 DENTAL VISIT IN THE 1ST 12 MOS. AFTER 1ST FC ENTRY**	% WITH AT LEAST 1 DENTAL VISIT IN THE 1ST 12 MOS. AFTER FINAL EXIT***
1-5 Years	10.6%	29.7%	23.4%	4.2%	17.5%	10.9%
6-11 M	19.2%	38.7%	26.0%	10.0%	22.6%	12.3%
6-11 F	19.8%	43.4%	28.2%	10.0%	24.1%	13.0%
12-14 M	17.7%	21.3%	11.6%	12.0%	34.7%	9.8%
12-14 F	21.3%	29.4%	18.7%	15.8%	30.9%	12.7%
15-16 M	16.3%	18.6%	9.3%	10.9%	30.2%	6.7%
15-16 F	20.8%	25.7%	15.3%	14.1%	28.9%	13.4%
17+ M	14.4%	18.8%	10.7%	11.7%	27.5%	8.8%
17+ F	16.9%	24.5%	13.6%	12.0%	25.8%	11.1%
TOTAL	16.4%	29.2%	19.4%	9.6%	25.1%	11.0%

*Pct. of children and youth with 6 or more months of Medicaid eligibility prior to 1st FC Entry (i.e., pre-FC cohort)
**Pct. of children and youth with 6 or more months of Medicaid eligibility in the first 12 months following their first FC entry (i.e., FC cohort).
***Pct. of children and youth with 6 or more months of Medicaid eligibility following their final FC exit (i.e., post-FC cohort).

TABLE 3.6A: Inpatient Admissions within 12 Months Prior to First Entry into Foster Care among Medicaid-eligible Children and Youth for new entrants between 2005–2012

AGE/GENDER COHORT	REST OF STATE		NEW YORK CITY	
	ANNUAL ADMITS PER 1,000	HIGHEST DX GROUP (FREQ.)	ANNUAL ADMITS PER 1,000	HIGHEST DX GROUP (FREQ.)
1-5 Years	133.2	Injury (18.4%)	162.6	Asthma (15.7%)
6-11 M	203.1	Mental Illness (79.9%)	150.2	Mental Illness (57.8%)
6-11 F	106.8	Mental Illness (63.3%)	87.9	Mental Illness (35.1%)
12-14 M	313.4	Mental Illness (82.1%)	318.0	Mental Illness (79.6%)
12-14 F	386.0	Mental Illness (81.9%)	330.0	Mental Illness (77.2%)
15-16 M	288.5	Mental Illness (63.2%)	240.4	Mental Illness (66.2%)
15-16 F	523.3	Mental Illness (69.3%)	419.3	Mental Illness (55.2%)
17+ M	443.9	Mental Illness (71.6%)	220.8	Mental Illness (61.1%)
17+ F	599.0	Mental Illness (64.7%)	484.4	Mental Illness (40.0%)

TABLE 3.6B: Inpatient Admissions within 12 Months after First Entry into Foster Care for new entrants between 2005–2012

AGE/GENDER COHORT	REST OF STATE		NEW YORK CITY	
	ANNUAL ADMITS PER 1,000	HIGHEST DX GROUP (FREQ.)	ANNUAL ADMITS PER 1,000	HIGHEST DX GROUP (FREQ.)
1-5 Years	75.5	Injury (19.3%)	96.9	Asthma (19.0%)
6-11 M	141.6	Mental Illness (83.6%)	160.7	Mental Illness (78.6%)
6-11 F	109.9	Mental Illness (72.0%)	104.2	Mental Illness (68.1%)
12-14 M	127.8	Mental Illness (72.6%)	180.1	Mental Illness (80.3%)
12-14 F	273.8	Mental Illness (82.1%)	325.5	Mental Illness (76.8%)
15-16 M	98.7	Mental Illness (60.0%)	111.1	Mental Illness (64.4%)
15-16 F	237.3	Mental Illness (55.4%)	334.2	Mental Illness (50.0%)
17+ M	90.6	Mental Illness (61.5%)	162.8	Mental Illness (63.0%)
17+ F	240.3	Mental Illness (51.4%)	311.0	Childbirth/Preg. (50.6%)

TABLE 3.6C: Inpatient Admissions within 12 Months Following Final Exit from Foster Care for new entrants between 2005–2012

AGE/GENDER COHORT	REST OF STATE		NEW YORK CITY	
	ANNUAL ADMITS PER 1,000	HIGHEST DX GROUP (FREQ.)	ANNUAL ADMITS PER 1,000	HIGHEST DX GROUP (FREQ.)
1-5 Years	51.0	Mental Illness (23.2%)	64.8	Mental Illness (26.7%)
6-11 M	92.3	Mental Illness (74.0%)	89.5	Mental Illness (63.2%)
6-11 F	69.2	Mental Illness (59.1%)	76.6	Mental Illness (59.8%)
12-14 M	73.7	Mental Illness (53.2%)	105.4	Mental Illness (56.5%)
12-14 F	207.1	Mental Illness (52.3%)	222.8	Mental Illness (51.0%)
15-16 M	93.1	Mental Illness (44.8%)	81.7	Mental Illness (43.4%)
15-16 F	224.1	Childbirth/Preg. (41.3%)	260.9	Childbirth/Preg. (43.8%)
17+ M	135.0	Mental Illness (44.4%)	128.9	Mental Illness (35.4%)
17+ F	322.2	Childbirth/Preg (37.5%)	210.8	Childbirth/Preg. (60.3%)

TABLE 3.7: Average Inpatient Lengths of Stay (ALOS) Before, During, and After Foster Care, by Age and Location for new entrants between 2005–2012

REST OF STATE COUNTIES

AGE/GENDER COHORT	PRE-FC ALOS			DURING FC ALOS			POST-FC ALOS		
	TOTAL	PHYS. HEALTH	MENTAL HEALTH	TOTAL	PHYS. HEALTH	MENTAL HEALTH	TOTAL	PHYS. HEALTH	MENTAL HEALTH
0 Mos.	5.7	5.7	data not credible	3.3	3.3	data not credible	3.8	3.8	data not credible
1-12 Mos.	8.8	8.8	data not credible	5.8	5.8	data not credible	4.3	4.3	data not credible
1-5 Years	5.6	5.5	8.2	5.7	5.3	11.5	4.6	3.4	8.5
6-11 Male	11.2	9.7	11.6	12.1	7.3	13.1	10.2	5.3	11.9
6-11 Female	8.3	3.2	11.3	8.7	5.0	10.2	11.4	6.1	15.0
12-14 Male	9.8	4.2	11.1	8.4	5.7	9.5	7.7	5.3	9.7
12-14 Female	8.6	4.6	9.5	8.8	4.0	9.8	6.4	3.7	8.8
15-16 Male	8.7	6.8	9.8	8.6	6.5	9.9	7.4	5.1	10.2
15-16 Female	8.0	5.2	9.3	7.8	4.9	10.2	5.5	3.8	9.0
17+ Male	13.4	8.1	15.5	7.1	3.2	9.6	7.8	5.7	10.5
17+ Female	7.7	4.4	9.5	8.9	4.5	13.0	6.5	4.0	11.5

NEW YORK CITY

AGE/GENDER COHORT	PRE-FC ALOS			DURING FC ALOS			POST-FC ALOS		
	TOTAL	PHYS. HEALTH	MENTAL HEALTH	TOTAL	PHYS. HEALTH	MENTAL HEALTH	TOTAL	PHYS. HEALTH	MENTAL HEALTH
0 Mos.	8.7	8.7	data not credible	3.7	3.7	data not credible	4.2	4.2	data not credible
1-12 Mos.	9.0	9.0	data not credible	5.6	5.6	data not credible	4.9	4.9	data not credible
1-5 Years	5.0	4.9	7.1	6.3	5.1	14.7	5.7	3.9	10.8
6-11 Male	8.2	4.0	11.3	8.9	4.4	10.2	10.1	10.6	9.9
6-11 Female	7.1	4.8	11.3	8.5	4.2	10.6	10.6	8.3	12.2
12-14 Male	7.7	2.5	9.1	8.3	6.1	8.8	7.7	4.0	10.6
12-14 Female	6.2	3.0	7.1	8.5	5.9	9.2	6.7	4.1	9.2
15-16 Male	8.4	5.6	9.8	6.2	5.0	6.9	7.4	5.4	10.1
15-16 Female	7.2	3.2	10.4	6.1	4.2	8.1	5.8	4.0	10.9
17+ Male	7.8	3.2	10.8	5.8	6.7	5.3	6.1	5.8	6.6
17+ Female	6.1	4.2	9.1	5.5	3.5	10.3	4.5	3.3	10.5

TABLE 3.8: Total Medicaid PMPM Costs Before, During, and After Foster Care (PMPM numerator includes all Medicaid paid claims in database including MCO capitation, community-related services, and per diem payments; PMPM denominator includes children and youth with Medicaid Eligibility) for new entrants between 2005–2012

REST OF STATE COUNTIES

AGE/ GENDER COHORT	PRE-FOSTER CARE			DURING FOSTER CARE			AFTER FOSTER CARE		
	1-2 YEARS PRIOR	3 MONTHS PRIOR	1 MONTH PRIOR	1 MONTH DURING	3 MONTHS DURING	1-2 YEARS DURING	1 MONTH AFTER	3 MONTHS AFTER	1-2 YEARS AFTER
0 Months	data not credible	data not credible	$5,021	$543	$376	$412	$273	$286	$236
1-12 Mos.	data not credible	$2,924	$1,310	$686	$663	$633	$438	$418	$443
1-5 Years	$421	$330	$421	$359	$424	$542	$332	$429	$313
6-11 M	$518	$1,124	$955	$844	$1,139	$1,568	$668	$1,019	$999
6-11 F	$331	$593	$600	$544	$718	$1,000	$504	$708	$480
12-14 M	$760	$1,451	$1,083	$1,241	$1,274	$1,374	$485	$619	$626
12-14 F	$547	$1,103	$919	$1,151	$1,245	$1,587	$668	$887	$720
14-16 M	$629	$1,025	$824	$1,231	$1,129	$1,070	$471	$548	$617
14-16 F	$665	$1,143	$1,203	$1,296	$1,290	$1,251	$537	$675	$637
17+ M	$885	$1,560	$1,449	$1,097	$856	$733	$212	$381	$504
17+ F	$994	$1,452	$1,106	$1,318	$1,093	$723	$721	$982	$888
Total	$535	$1,058	$1,066	$844	$895	$955	$465	$604	$551

NEW YORK CITY

AGE/ GENDER COHORT	PRE-FOSTER CARE			DURING FOSTER CARE			AFTER FOSTER CARE		
	1-2 YEARS PRIOR	3 MONTHS PRIOR	1 MONTH PRIOR	1 MONTH DURING	3 MONTHS DURING	1-2 YEARS DURING	1 MONTH AFTER	3 MONTHS AFTER	1-2 YEARS AFTER
0 Months	data not credible	data not credible	$8.603	$963	$907	$709	$363	$369	$265
1-12 Mos.	$54	$4,494	$1,385	$826	$975	$893	$454	$529	$378
1-5 Years	$513	$423	$417	$536	$539	$686	$384	$480	$397
6-11 M	$376	$682	$630	$720	$917	$1,354	$830	$832	$653
6-11 F	$213	$383	$344	$536	$614	$1,002	$572	$610	$589
12-14 M	$559	$1,140	$945	$1,316	$1,432	$1,795	$477	$565	$501
12-14 F	$396	$720	$599	$1,110	$1,482	$1,781	$672	$783	$858
15-16 M	$543	$809	$698	$1,450	$1,281	$1,470	$364	$446	$594
15-16 F	$426	$726	$815	$1,260	$1,352	$1,260	$548	$573	$678
17+ M	$507	$851	$1,134	$1,335	$1,112	$1,242	$280	$234	$611
17+ F	$591	$610	$1,131	$1,252	$1,046	$1,042	$381	$508	$574
Total	$443	$1,011	$1,068	$878	$939	$1,025	$493	$559	$534
Diff. from Upstate	-17%	-4%	0%	+4%	+5%	+7%	+6%	-7%	-3%

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