

REFORMING ACCESS TO MENTAL HEALTH FOR ALL FOSTER YOUTH

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EXECUTIVE SUMMARY

There are more than 400,000 children under the care of child welfare agencies, and over 80% of them have experienced a mental health crisis (Mental and Behavioral, 2021), compared to 18–22% of the general population (Mental Health, 2019). Mental and behavioral health needs are among the most consistently unmet needs for foster youth across the country, driven by insufficient access to providers, administrative burdens, and limited oversight of Medicaid-managed care systems (Mental and Behavioral, 2021). To ensure current and former foster youth receive the care they need, Congress should strengthen provider participation and retention, leverage Title IV-E funds to expand and recruit the behavioral health workforce, and establish national guidance requiring states to design dedicated managed care approaches that are explicitly responsive to the complex mental health needs of foster youth.

PERSONAL REFLECTION

During my time in foster care, I experienced significant barriers in accessing equitable and sustained mental health services. After an emergency removal from my home at 16, it took over three months before I was able to access mental health care, and even then, I only received a limited number of sessions that were insufficient to meet my needs. These services fell far short of what was necessary for meaningful stabilization, and once treatment ended, my mental health needs became even more acute. It took over a year of sustained advocacy from my foster mom and me before I was connected with a more appropriate therapist. After turning 18, access to a licensed and specialized counselor became even more limited, as the extended foster care program allowed only one youth referral every six months. I wrote letters requesting that my referral be renewed by social workers, the agency, and the court, and at one point was directed to Medicaid for California (Medi-Cal) and told to independently search for a therapist, yet I found very few accessible options, and even fewer providers with the specialized training modalities required to meet my needs.

THE PROBLEM & CURRENT LAW

Currently, in the United States, over 400,000 children are under the care of child welfare agencies, and more than 80 percent (approximately 320,000) experience a mental health crisis (Mental and Behavioral Health, 2021), far

THE PROBLEM & CURRENT LAW (CONTINUED)

exceeding rates among peers outside the system. Yet access to mental health care remains one of the most consistently unmet needs for foster youth nationwide (Mental and Behavioral Health, 2021). This gap is driven in part by a shortage of specialty-trained providers equipped to meet the complex needs of youth in or at risk of foster care, who experience trauma at rates including Post-Traumatic Stress Disorder (PTSD) two times higher than war veterans (Greeno et al., 2018). Despite Medicaid being the largest payer of mental health services in the United States (Counts, 2023), its payment structure, administrative complexity, and low reimbursement rates, with Medicaid paying on average 56 percent of private insurance rates (Dayaratna, 2012), contribute to persistent provider shortages and weak retention (Chatterjee, 2024).

Although federal law requires states to provide medically necessary care under Medicaid, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for youth under 21, these requirements do not specify enforceable standards for provider capacity, network adequacy, or workforce recruitment. As a result, enforcement is inconsistent and access remains limited. In practice, stakeholders report delays in behavioral health access driven by workforce shortages and insufficient provider supply (Reynolds, 2025). Provider scarcity is significant, with only 3.1 providers per 1,000 enrollees in many counties (Chatterjee, 2024), and over a quarter of providers reporting wait times of 30 days or more for new patients (Availability of Surveyed, 2025).



UP TO

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ACF/CB FY 2005 data

THE PROBLEM & CURRENT LAW (CONTINUED)

There is also no federal requirement for Medicaid agencies to coordinate directly with child welfare systems in designing care models for foster youth (Reynolds, 2025). Some states have developed targeted approaches such as Texas's STAR Health program, which provides foster youth specific Medicaid managed care with tailored behavioral health services (Thompson, 2021), and federal guidance now identifies foster focused managed care as a best practice aligned with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) compliance (Tsai, 2024). However, implementation remains uneven nationwide. Workforce focused initiatives, such as California's Medi-Cal Behavioral Health Student Loan Repayment Program, attempt to address shortages by incentivizing providers to serve Medicaid populations, but these efforts are not yet scaled nationally.

Other federal and state policies similarly fall short. While California requires coordination between its Department of Social Services and Department of Health Care Services, enforcement and implementation mechanisms remain unclear, limiting effectiveness. The Families First Prevention Services Act (FFPSA or "Family First") of 2018 allows Title IV-E funding for preventive behavioral health services but does not address the underlying shortage of qualified providers or how funding should be integrated with broader workforce strategies (New Law, 2018). As a result, states are left to identify and sustain provider networks independently, limiting the law's effectiveness in practice (Cohen, 2024). This gap is particularly consequential because parental mental health crises are a leading driver of child welfare involvement (Tiano & Anderson, 2026).

Taken together, these structural gaps demonstrate that despite multiple federal and state policy tools, there is no coordinated or enforceable system ensuring adequate provider capacity, workforce retention, or integrated care design for foster youth. The research is clear. Youth in foster care require timely access to specialized, trauma informed mental health services from trained providers (Mental and Behavioral Health, 2021). Strengthening access to these services is directly linked to improved permanency outcomes (Salazar et al., 2018) and more stable transitions to adulthood.

POLICY RECOMMENDATIONS

In order to ensure foster youth receive reputable and timely mental health services, Congress should:

- **Direct the federal and state governments to establish programs that can incentivize mental health providers to become enrolled as providers in Medicaid plans.**
 - Amend Title IV-E Act to reallocate funding for providers who choose to serve Medicaid-eligible individuals, specifically former and current foster youth populations. These providers must be required to complete modality training through programs such as the National Adoption Competency Mental Health Training Initiative (National Adoption, 2024).

POLICY RECOMMENDATIONS (CONTINUED)

- Create a federal guideline for states to follow, similar to California's Pilot Program, that tailors scholarships to mental health professionals who commit to serving child welfare communities in exchange for student loan repayment (Medi-Cal Behavioral, 2026)
- **Direct the US Department of Health and Human Services to establish a national guideline that requires states to create managed care plans** like Texas STAR Health program or Florida's Sunshine Health, that are designed to meet the unique needs of foster youth and have trained mental health providers. Practices should be aligned with streamlined application platforms to attract and retain providers and reduce administrative burden.
- **Amend the Family First Prevention Services Act (FFPSA or "Family First") to strengthen the mental health prevention workforce** by allowing states to use Family First funds for provider recruitment and retention strategies, including loan repayment, expanded eligibility for paraprofessional and telehealth providers, and incentives for service delivery in underserved communities, like higher reimbursement rates.