

# Protecting Children in Foster Care: Why Proposed Medicaid Cuts Harm Our Nation's Most Vulnerable Youth



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Casey Family Programs' mission is to provide and improve—and ultimately to prevent the need for—foster care.

Established by United Postal Service founder Jim Casey, the Seattle-based national operating foundation has served children, youth, and families in the child welfare system since 1966.

The foundation operates in two ways. It provides direct services, and it promotes advances in child welfare practice and policy.

Casey collaborates with foster, kinship, and adoptive parents to provide safe, loving homes for youth in its direct care.

The foundation also collaborates with counties, states, and American Indian and Alaskan Native tribes to improve services and outcomes for more than 500,000 young people in out-of-home care across the United States.

Drawing on four decades of front-line work with families and alumni of foster care, Casey Family Programs develops tools, practices, and policies to nurture all youth in care and to help parents strengthen families at risk of needing foster care.

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## AUTHORS

### **David Rubin, MD, MSCE**

Assistant Professor of Pediatrics

University of Pennsylvania School of Medicine

Director of Research & Policy

Safe Place: Center for Child Protection & Health  
at The Children's Hospital of Philadelphia

### **Neal Halfon, MD, MPH**

Professor of Pediatrics,  
Public Health and Public Policy

UCLA Schools of Medicine, Public Health,  
and Public Affairs

Director

UCLA Center for Healthier Children,  
Families & Communities

### **Ramesh Raghavan, MD, PhD**

Assistant Research Scientist,  
Department of Psychiatry  
and Biobehavioral Sciences

University of California, Los Angeles

### **Sara Rosenbaum, JD**

Hirsh Professor and Chair,  
Department of Health Policy

The George Washington University  
School of Public Health and Health Services

## Executive Summary

The Bush Administration, the Medicaid Commission, the National Governors Association (NGA), and the National Conference of State Legislatures (NCSL) recently offered short-term Medicaid reform proposals, only some of which are designed to achieve Medicaid savings. Many would make broad but as yet untested changes in basic Medicaid policies affecting children in foster care, whose medical, developmental, and mental health needs far surpass those of other children. Children and adolescents in foster care depend on Medicaid to fund health care, and many of the most promising innovations in child welfare depend on the survival of a shared mission with Medicaid.

Specific proposals have the potential for serious consequences, including service reductions, limitations in the availability of extended coverage to youths departing foster care, loss of service integration, reductions in child welfare system capacity, and greater cost shifting to states:

- The NGA and NCSL: These proposals to roll back Medicaid's Early and Periodic Screening, Detection, and Treatment (EPSDT) benefits could eliminate many prevention, treatment, and health maintenance options for children in foster care, especially those who are the sickest and most in need of services. They may also endanger the likelihood that states will exercise the Chafee Medicaid option to extend coverage to adolescents departing foster care until age 21, thereby threatening the continuity of treatment plans developed while in foster care.
- The NGA, NCSL, and Medicaid Commission: These proposals fail to exempt children receiving foster care and child welfare services and could decrease access to, and utilization of services, especially preventive care.
- The Administration: Proposals to eliminate Medicaid coverage for case management and rehabilitation services in the case of programs with

“shared missions,” such as Medicaid and child welfare, could fundamentally affect the child welfare system, reduce benefits, and undermine efforts to develop partnerships between child welfare and health care systems within states.

Rather than reducing coverage for children and the capacity of states to develop strong systems of foster care and child welfare services, Congress should:

- Preserve and protect EPSDT
- Protect the shared mission of Medicaid and child welfare services by adequately funding case management and rehabilitative services
- Reject cost-sharing proposals affecting children in foster care

In addition, Congress should demonstrate its commitment to the health and well-being of all children by:

- Supporting proposals that strengthen the delivery of preventive services to children in foster care;
- Building on current law to guarantee continued Medicaid coverage for adolescents leaving foster care in order to ensure access to continuing and comprehensive treatment;
- Enacting Medicaid payment reforms aimed at encouraging the establishment of collaborative and integrated systems of care for children and families in the child welfare system, and
- Raising the quality of care received by children in foster care by clarifying the full range of allowable collaborative activities between Medicaid and child welfare agencies.

## Introduction

This report examines Medicaid's role in providing health care to children in foster care. It also assesses the implications for foster children and child welfare systems of various Medicaid reform proposals now pending in Congress. Hurricane Katrina has delayed consideration of these proposals, but Congress is expected to act by year's end. When enacted, this Medicaid reform legislation will implement the provisions of the FY 2006 Budget Resolution, which calls for \$10 billion in Medicaid spending reductions over five years.

This report begins with a background and overview describing the health and health care needs of children and adolescents in foster care, as well as the relationship between Medicaid and state foster care and child welfare programs. The report then examines key provisions contained in four separate Medicaid reform proposals offered by the Bush Administration, the Medicaid Commission, the National Governors Association (NGA), and the National Conference of State Legislatures (NCSL). None of the Medicaid reform proposals specifically addresses services to children or adolescents in foster care; at the same time, however, each proposal contains elements that carry important implications for their well-being and for the operation of child welfare systems. The report concludes with several near-term recommendations and identifies issues that should be considered as part of a longer-term Medicaid reform effort.

## Key Facts: Who is in foster care?

- An estimated 4.5% of all children (3,000,000 children) are involved each year in allegations of abuse or neglect. Of these, 1 in 20 will enter foster care.<sup>1</sup>
- Children in foster care experience an average length of stay of 22 months.
- One out of every 2 children entering a new episode of foster care will remain in foster care for more than 18 months; many will remain for years.<sup>2, 3</sup>
- Although less than 1% of all children under 18 lives in foster care at any single point in time, an estimated 3–7% of all children will spend some time in foster care during their youth.
- Nearly a quarter of all children who enter foster care will remain in foster care until adolescence, at which time they will “age out” to planned independent living. Worse yet, some may exit care by running away, becoming incarcerated, or entering a psychiatric inpatient facility.<sup>4</sup>
- Of those children who return home, 1 in 3 children will return to foster care within 2 years,<sup>7</sup> often with a deterioration in their health status.

## Background and Overview

### The Current State of Children Living in Foster Care

As of 2004, approximately 523,000 children and adolescents were living in foster care, a subgroup of an estimated several million children who receive child welfare services annually.<sup>1, 2</sup> Many children and adolescents receiving child welfare services transition in and out of foster care; they experience stays of varying duration and may move frequently among placement settings.

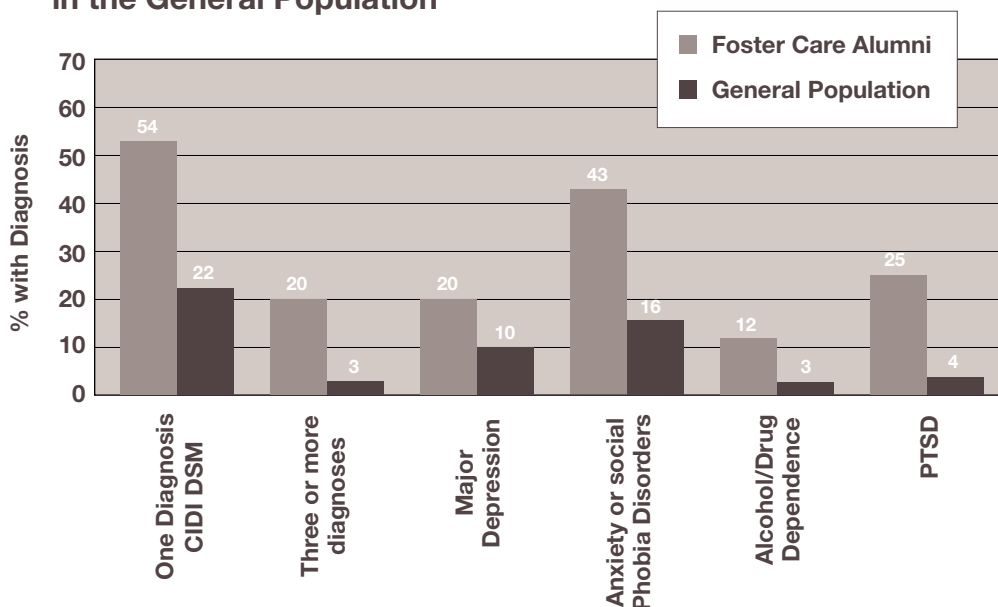
Evidence drawn from decades of research has demonstrated that children living in foster care experience a very high rate of chronic physical, mental, developmental, and behavioral conditions that impair functioning and fundamentally threaten proper growth and development. Children who experience the longest stays in foster care and drift from placement to placement are also at risk for the most serious medical,<sup>13, 14</sup> developmental,<sup>16</sup> and mental health problems,<sup>11, 24-32</sup> with rates rising considerably among older children and adolescents, who are more likely to spend time in residential treatment facilities

and inpatient psychiatric hospitals. At the same time, this research also reveals that those in foster care rarely receive health services appropriate to their level of medical need.<sup>9, 11, 12, 37-40</sup> As a result, children and adolescents with the greatest health needs are also the most likely to lack quality and consistent health care, given the often-fragmented state of their lives.

### Key Facts: What we know about the medical needs of children in foster care

- An estimated 1 in every 2 children in foster care has chronic medical problems unrelated to behavioral concerns.<sup>9-12</sup> Evidence suggests that these chronic conditions increase the likelihood of serious emotional problems.<sup>15</sup>
- Studies suggest that of the 40%–80% of children and adolescents in foster care who exhibit a serious behavioral or mental health problem requiring intervention,<sup>11, 18-23</sup> only a quarter to two-thirds will receive any services.<sup>5, 9, 15, 17, 33, 34</sup>
- With their needs often unmet, older children and adolescents in foster care rely increasingly on emergency departments for their usual source of care, most often in periods around placement changes, for injuries and mental health concerns.<sup>35</sup>
- One out of every 2 adults who were placed in foster care as children have serious mental health problems well into adulthood, and 1 in 4 suffer from post-traumatic stress disorder (PTSD).<sup>36</sup>

**Figure 1: The Proportion of Adult Alumni from Foster Care with Psychiatric Problems, Compared to Other Young Adults in the General Population**



Source: Pecora, P.J. et al. (2005). *Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study*. Seattle, WA: Casey Family Programs.

## The Congressional Response to the Needs of Children and Adolescents in Foster Care

In 1997, recognizing the unique and unmet needs of children in foster care and their continuing risk for receiving substandard treatment, Congress enacted the Adoption and Safe Families Act (ASFA, P.L. 105–89). Among the Act’s purposes were to strengthen federal oversight of state systems, to promote greater system safety and permanency, and to improve the quality of foster care in order to ensure children’s health and well-being. In 2000, the Administration for Children and Families (ACF) initiated a program of Child and Family Service Reviews (CFSRs) to assess the extent to which states were adopting programs that promoted optimal health, mental health, and development of the children in their care. These CFSRs include specific assessments of whether the health care children receive is adequate to meet their physical and mental health needs.

Consonant with meeting these performance goals, Medicaid has played a critical role in the improvement of services for children in foster care. Medicaid coverage is mandatory for children in federally assisted foster care and special needs adoption placements.<sup>41</sup> Medicaid is an essential service for the great majority of children who enter foster care; 70 percent of children entering foster care had Medicaid before placement.<sup>42</sup> Both prior to and during foster care, Medicaid’s relationship to the child welfare system is enormous. In addition to providing health insurance coverage to children who otherwise would have none, Medicaid is critical to children, both young and old, who receive child welfare services.

For younger and older children alike, because of its particularly broad benefits known as Early and Periodic Screening Diagnostic and Treatment (EPSDT) services,<sup>43</sup> the EPSDT benefit covers comprehensive periodic and as-needed health exams,<sup>44</sup> complete vision, dental, and hearing care,<sup>45</sup> and

diagnosis and treatment for physical and mental conditions disclosed during periodic or as-needed exams.<sup>46</sup> Services and benefits that are considered optional for adults are required for children; under EPSDT, state programs must cover all medically necessary services and benefits that are part of the definition of “medical assistance,” even if the benefits are not covered for adults or are covered only with limits. In this regard, case management services, an optional medical assistance benefit for adults, is mandatory for children.<sup>47</sup> In the context of EPSDT, services that assist children to secure access to needed medical, health, educational, and social services are an essential part of child health care financing.

Moreover, the concept of “medical necessity” in EPSDT—a concept that is basic to all forms of health insurance, public or private—is grounded in early detection and prevention, ensuring access to diagnosis and treatment coverage at the earliest possible time.<sup>48</sup> Unlike traditional health insurance or Medicaid coverage for adults, Medicaid EPSDT benefits are designed to provide coverage as soon as potentially serious physical or mental health conditions are identified through a periodic or “as needed” assessment, such as the assessments that are conducted upon entry into foster care.

Medicaid, as it is currently structured, has also been an important and responsive partner to the child welfare system in providing additional coverage options to allow states to fashion appropriate mental health coverage to children and adolescents under their care. Given their high level of serious mental health problems that may have long-standing impact, states have used therapeutic, rehabilitative, and case management options in the Medicaid program to create appropriate service delivery packages specifically for these children. Florida, for example, has made use of Medicaid’s therapeutic and rehabilitative services to provide bio-psychosocial evaluations and comprehensive behavioral assessments, to develop individualized treatment plans, to provide intensive therapeutic service inside a child’s home, and to develop

rehabilitative and therapeutic day-treatment targeting foster care youth. Nevada, as another example, has created intensive community-based treatment programs—inclusive of assessments, family therapy, collateral intervention with schools and other systems affecting the child, and assistance in self, household, and family management—that are designed to provide the necessary treatment to a child and family (substitute or natural) to allow that family to remain intact, thus preventing the need for long-term residential or hospital psychiatric care on the part of the child. Nevada also provides rehabilitative skills training to children who need periodic intervention into their living environment to achieve stable, successful long-term outcomes. These programs, responsive to the needs of children and adolescents in foster care, would not be possible without the rehabilitative and case management funding through the Medicaid program.<sup>58</sup>

Another important example of how Medicaid has been used to respond to the particular needs of this population of children is exemplified through the creation of the Chafee Medicaid option in 1999. The Foster Care Independence Act of 1999, in addition to funding the expansion of independent living programs for older adolescents in foster care (Chafee Independence Program), also allowed states—in much the same way that parents are given a similar option for their own children—to act in a responsible way to extend Medicaid coverage to adolescents who were transitioning from foster care until age 21 so that their treatment plans could remain in place. With nearly a third to a half of all children exiting foster care losing their Medicaid coverage,<sup>42</sup> the failure to provide this extended coverage can have serious consequences for a population that has a high likelihood of homelessness, incarceration, and serious mental health problems into adulthood.

Beyond aiding children and adolescents at the individual level, Medicaid is also essential to the very structure and operation of child welfare programs.

Federal funding for child welfare services covers a broad range of social and support interventions; at the same time, the child welfare laws assume that Medicaid will bear the cost of health care for lower income children in the child welfare system. When necessary, these costs include the highly specialized medical and rehabilitation services for children in foster care and out-of-home residential placements that were noted above. Indeed, an issue underlying federal expansion of the EPSDT program in 1989, which broadened the range of required diagnostic and treatment services, was the need to ensure proper health care access for children receiving child welfare services, including children in foster care.

Through its comprehensive coverage of complete medical care and supportive case management, EPSDT aids state child welfare systems in carrying out their responsibilities for children and adolescents in their care. Federal child welfare laws do not finance the provision of medical and medical support services; this crucial part of the child welfare scheme is found, in fact, in Medicaid. As such, EPSDT enables states to finance a level of health care that meets the national professional guidelines for children and adolescents in foster care. These guidelines, developed by the American Academy of Pediatrics (AAP), the Child Welfare League of America (CWLA), and the American Academy of Child & Adolescent Psychiatry (AACAP),<sup>50-52</sup> guide the activities of state and local child welfare agencies. The guidelines emphasize a comprehensive array of services, more intensive case management, and a more coordinated delivery system for children and adolescents in foster care to accommodate their complex physical, developmental, and mental health conditions. Medicaid's broad coverage standards for children encompass preventive, clinical, and medical case management services, as well as assistance with scheduling and transportation. These standards guide state child welfare agencies in the development of systems of care that promote access to high quality health services.

## State and Local Response to the Needs of Children and Adolescents in Foster Care

In most states, child welfare and state Medicaid agencies are closely linked not only operationally but also financially through a special system known as intergovernmental transfers (IGTs). The IGT system permits public child welfare agencies to certify covered health expenditures, made on behalf of Medicaid-enrolled children and adolescents, as state medical and administrative expenditures for Medicaid federal financial participation purposes. IGT arrangements ensure that investment by states and localities in therapeutic services for Medicaid-enrolled children and adolescents receiving foster care and other child welfare services qualify for allowable levels of federal financial support. Without this type of coordination between child welfare spending and federal Medicaid financing, state child welfare budgets would experience a precipitous decline, and their ability to meet children's disproportionate therapeutic needs would be significantly compromised.

These fiscal arrangements also exist largely because child welfare systems work primarily with children and adolescents whose complex needs create enormous challenges for professionals charged with overseeing and assuring the provision and coordination of a multitude of critically needed services.<sup>35, 53</sup> Faced with these challenges, the child welfare system—utilizing these fiscal arrangements—has responded with an increasing number of “joint ventures” and cross-sector partnerships among health agencies, child welfare agencies, and state Medicaid programs, demonstrating that, with appropriate Medicaid support, it is possible to improve the quality and coordination of health and child welfare services. Indeed, in good measure, it is Medicaid's broad coverage rules, coupled with the IGT process for capturing and reporting public investments in health care for children in the child welfare system, which have made many of these cross-system collaborations possible. There are currently no other sources of federal funding for health and

therapeutic services that could sufficiently fund such cross-system collaboration in the absence of Medicaid funds.

For many systems, these collaborations have resulted in strengthened and more coordinated involvement with local health care providers, whose care has become specialized for children in foster care. In some of these arrangements, the child welfare system has ensured the referral of all children entering out-of-home care to a single, point-of-entry specialty clinic where their physical, developmental, and mental health needs can be properly assessed. These specialty programs have likewise depended heavily on Medicaid financing to support their comprehensive screening, diagnosis, and case management services. This type of comprehensive and specialized clinical intervention has also been shown to improve recognition of underlying problems and improve access to developmental and behavioral services.<sup>54</sup>

Other child welfare systems have gone one step further, increasing access to mental health services through the availability of on-site health professionals (psychologists, public health nurses) within their child welfare units. Supported principally through Medicaid funding, these professionals are responsible for achieving universal screening at the point of entry into out-of-home care. They also coordinate the care and referral of children and adolescents for services as they traverse the public child welfare, health, and mental health systems. County child welfare systems that have invested in efforts to link child welfare and child health care services through well trained and on-site professionals appear to show significant improvements in the quality of care. The evidence suggests that such agencies are more likely to be able to identify children in greatest need of services. Moreover, compared to those with less developed linkage systems, higher investment counties are more likely to obtain services for those foster children in greatest need.<sup>34</sup>

## Illustrative Examples of Integration Between Child Welfare and Health Care Sectors

- **Behavior and Wellness Program, Philadelphia, Pennsylvania**—Collaborate efforts among three entities—the Philadelphia Department of Human Services (DHS), Behavioral Health System, and Family Court—have led to multiple strategies to assist children and families in the child welfare system to access appropriate behavioral health services. Special units created at DHS work closely with the city-operated managed behavioral health organization (Community Behavioral Health) to integrate behavioral health and child welfare operations and services.
- **Special Kids/Special Care, Massachusetts**—Special Kids/Special Care (SK/SC) is an approach to medical care coordination for children and adolescents in foster care who have special health care needs being pilot-tested by MassHealth in collaboration with the MA Department of Social Services and Neighborhood Health Plan (NHP), a nonprofit managed care organization that contracts with MassHealth. A community-based nurse practitioner, working in collaboration with a child's primary care provider, manages each child's care while serving as a direct care provider for the primary care team. The program incorporates a monthly capitated payment rate for each enrolled child.
- **Assessment and Consultation Team, Riverside County, California**—The Assessment and Consultation Team (ACT) was created through an interagency agreement between two Riverside County departments—Department of Mental Health (the county-operated managed mental health plan) and Department of Public Social Services. ACT places 13 mental health clinicians in DPSS offices throughout the county to ensure access, through the county's managed care plan, to community-based mental health services for children and adolescents in the child welfare system.
- **Office of Child Behavioral Health Services, Office of Children Services in the Department of Human Services, New Jersey**—This system of care initiative is a statewide behavioral health carve-out, serving children (to age 21) with serious behavioral and mental health problems and their families who depend on public systems of care (including child welfare, among others). The initiative creates a single statewide, integrated system of behavioral health care to replace the previously fragmented system in which each child-serving system provided its own set of behavioral health services. The NJ Department of Human Services is the state purchaser, pooling resources from mental health, child welfare, juvenile justice, Medicaid, and other state funds. The initiative uses statewide administrative services organizations and locally based care management organizations to coordinate care.

**Source:** McCarthy, J. (2002). *Meeting the health care needs of children in the foster care system*. Washington, D.C.: Georgetown University.

Thus, it is the children and adolescents most in need who benefit the most from Medicaid's comprehensive coverage rules and its ability to operate flexibly in coordination with child welfare systems. The coverage that Medicaid offers, coupled with its ability to coordinate its special child health mission with the fundamental mission of the child welfare system, means that Medicaid is able to operate in partnership with the child welfare system. The beneficiaries are those Medicaid-enrolled children and adolescents with the most compromised health.

### **The Reliance of Foster Care Children on the Medicaid Program: The Evidence**

#### **Key Facts:**

- **Children in foster care represent 2–4% of all Medicaid enrollees in most states, but account for a disproportionate share of Medicaid expenditures because of their special health care needs.**
- **Despite representing only 2–4% of all Medicaid enrollees, children and adolescents in foster care account for 25–41% of all Medicaid-funded mental health expenditures in most state Medicaid programs.<sup>5, 6</sup>**
- **Per capita Medicaid expenditures on foster care children were more than triple those of nondisabled children in the Medicaid program in 2001 (\$4,336 vs. \$1,315), demonstrating the critical demand for health care services by these children.<sup>8</sup>**
- **As an indicator of how important certain benefits are for children in foster care, recent state-level data demonstrate that these children account for 15% of all targeted case management (TCM) funds allocated by the Medicaid program, divided across 38 states.<sup>8</sup>**
- **Children and adolescents receiving TCM services in Medicaid services are more than 50% more likely to use multiple health care services, including physician services, prescription drugs, medical and psychiatric inpatient services, and rehabilitative services, demonstrating the unique need for care coordination in this population.<sup>8</sup>**
- **The magnitude of mental health service use by children and adolescents in foster care is 8–11 times greater than other low-income, and generally higher risk, children in the Medicaid program.<sup>5, 17</sup>**

## **A Comparison of Key Provisions of Medicaid Reform Proposals Pending Before Congress**

Table 1, found in the Appendix to this report, sets forth the four principal proposals for Medicaid reform. Each proposal contains recommendations that carry significant implications for children in foster care and state child welfare programs. In no cases do children in foster care or child welfare systems appear to be exempted from the impact of the more serious proposals.

### **The Bush Administration**

An important thrust of the Bush Administration's proposals is to limit federal exposure to state health care costs. The Administration seeks to accomplish this in the following ways.

First, the Administration proposes to narrow the meaning of case management and rehabilitation services, two key health care services covered under EPSDT and for which federal Medicaid funding is available. This proposal aims to exclude payment for either service if provision of the service is "an intrinsic element of another program." Under Medicaid the purpose of case management is to enhance access to needed medical, educational, social, and health services. Access enhancement is, of course, intrinsic to the duties of child welfare agencies, as is rehabilitation of children receiving child welfare services or living in foster care. In addition, this new "shared mission exclusion" would appear to cover every aspect of rehabilitation services, from assessment and therapeutic applications through other permissible applications.

Were the Administration's proposals to be enacted, they could result in the total elimination of all medical assistance payments for children receiving Titles IV B and IV E services, regardless of whether these children are under the care of either public or private health care providers. These definitional proposals would prevent the program from coordinating its mission, in the case of children, with that of the child welfare system.

Second, the Administration proposes to make it more difficult for states to generate the qualified expenditures they must make in order to claim federal Medicaid funding. This narrowing of state powers to generate “expenditures” would be achieved both by tightening IGT rules and by limiting states’ ability to raise tax revenues (via broad-based provider taxes) to support Medicaid expenditures. Agencies such as child welfare programs, which undertake Medicaid expenditures that are then captured through the IGT process, would no longer have their expenditures counted as IGTs, unless they retained all resulting federal matching expenditures. At first blush this might result in an enhancement of child welfare service budgets, but the proposal leaves unclear the question of whether agencies credited with the federal payments would also have the flexibility to reinvest earned revenue in ways that would further that particular agency’s mission. For example, a child welfare agency that receives federal payments for the provision of targeted case management services resulting in an IGT might wish to dedicate the revenues toward respite care for families. Whether the Administration’s proposal would allow the agency to retain this type of flexibility is unclear.

Child welfare agencies ultimately would be affected, as well, by the limits proposed by the Administration on states’ ability to generate the revenues they need through broad-based provider taxes. As states’ taxing capacity is restrained, states’ ability to maintain necessary Medicaid spending levels also is implicated.

The Administration also proposes to limit federal accountability for medical care costs by capping payments to states for their administrative costs, including administrative costs related to services performed on behalf of Medicaid agencies by child welfare agencies under memoranda of understanding. Such memoranda are common across state governments. For example, state child welfare agencies conduct eligibility determinations and re-determinations, locate health care providers and arrange for health

services, and may provide EPSDT outreach to birth and foster families. A cap on Medicaid administration financing would jeopardize such arrangements, particularly since the cap would coincide with expanded state Medicaid administration responsibilities related to the implementation of the new Medicare prescription drug benefit. In other words, these activities, although legitimate expenses associated with administering the Medicaid and EPSDT programs, would likely not be reimbursed because federal funds would be reserved for traditional eligibility determination processes.

In addition, the Administration proposes to reduce federal contributions for medical assistance case management from the current rates paid to states to 50 percent across the board. For those beneficiary populations for whom the most sustained form of case management is needed, such as children and adolescents in foster care and residential placements, the financial implications undoubtedly would be the most substantial.

Finally, the Administration proposes several reforms as part of its New Freedom demonstration initiative, at least two of which hold promising implications for children receiving child welfare services, and for children in foster care and residential placements. The first proposal is to extend additional respite care services, and home and community-based services to children in out-of-home and foster care placements. The second proposal is to allow presumptive eligibility for persons with disabilities who receive home and community-based services, so that care may begin immediately.

The first set of recommendations by the Administration would, in effect, create a specific home and community program for children in foster care, clarifying the already broad reach of Medicaid's existing home and community care program. The second set of recommendations would permit more rapid service in the case of children not yet enrolled in Medicaid but with significant disabilities.

## Medicaid Commission

Unlike the Bush Administration, the Medicaid Commission does not propose the realignment of federal/state payment arrangements. Instead, it endorses a series of financial reforms in payment for services, as well as greater flexibility with respect to beneficiary cost sharing in the case of prescription drugs, with waivers of cost-sharing requirements only in the case of “true hardship” or where “failure to take a preferred drug might create serious adverse health effect.” The Commission makes no recommendation for children receiving child welfare services or for those in foster care or residential placements; indeed, the Commission does not discuss the relationship of its proposal to the current cost-sharing exemption for children under 18 years of age. Neither does the Commission discuss the obligation of pharmacies, if any, to dispense prescriptions, in the event that a beneficiary is unable to pay a co-payment.

Cost sharing has been shown to have a significant and negative impact on access to prescription drugs.<sup>55</sup> Where a child is under the care of the state, the state would have an obligation to remove any barrier to necessary health care access, including tiered prescription coverage arrangements that create inappropriate barriers to recommended treatment, as well as cost-sharing tiers that deter utilization of prescription drugs.

## NGA and NCSL

Both the NGA and NCSL focus heavily on gaining greater flexibility to reduce coverage and shift more financial exposure onto beneficiaries. NCSL also recommends the addition of coverage options to extend Medicaid to low-income persons generally, as well as changes in Medicaid financing to counteract Medicaid’s countercyclical nature.

It is the program flexibility and cost-shifting measures that merit the closest attention. Both organizations recommend cost-sharing flexibility. As with

the Medicaid Commission, neither organization proposes to exempt children receiving child welfare services or in foster care and residential placements from the reach of their cost-sharing recommendations, although NGA recommends an exemption for mandatory coverage groups, and NCSL recommends exempting “higher income groups.”

Even more significantly, both groups recommend a rollback in EPSDT coverage for diagnosis and treatment. In the case of NCSL, the recommendation would eliminate all treatment obligations other than “dental issues” for all children. No exemptions are drawn for mandatory coverage groups of children, including children receiving federally assisted foster care or adoption services. NGA’s EPSDT diagnosis and treatment rollback recommendations are confined to optional coverage categories, which include several million near-poor children, including children who may move in and out of the child welfare system. Indeed, it is for those children transitioning to and from foster care—and for adolescents departing the system—that these recommendations may have a particularly strong impact; a rollback of available services may severely impact the continuation of treatment plans developed while in foster care and may increase the likelihood of return to the system at a later date. (The NGA document also seeks to eliminate the existing waiver process, in order to allow states to more rapidly pursue federal waivers of those basic coverage rules for which they do not recommend outright repeal, such as EPSDT protections for the poorest children, as well as mandatory groups, such as children in federally assisted foster care and adoption placements.) The most extended treatment for the sickest children will be vulnerable under the EPSDT rollback recommendations made by NGA and NCSL.

Figure 2 indicates that, in fiscal year 2004, children and adolescents cost Medicaid about \$1,700 on average, approximately 13 percent of the amount spent on persons with disabilities and the elderly. So little is spent, in fact, that state savings would be negligible at best. According to the Congressional

Budget Office (CBO), reducing EPSDT coverage achieves no scorable savings because cost estimators cannot gauge state response. In other words, there appears to be no budget-related reason for making changes in coverage design with such far-reaching implications.

Because so little is spent on children and adolescents, the NGA and NCSL recommendations may carry their biggest implications for costly treatments for select subgroups, such as children receiving child welfare services but not yet in a foster care placement or under direct state control. It was the general underservice of children in the child welfare system that spurred the 1989 EPSDT amendments, and it is not out of the realm of possibility that this group would be negatively affected once again.

**Figure 2: Per Capita Medicaid Expenditures by Beneficiary Group, FY 2004**

	Children	Adults	Elderly	Blind and Disabled
<b>UNITED STATES</b>	<b>\$1,700</b>	<b>\$1,900</b>	<b>\$12,300</b>	<b>\$12,800</b>

Source: Henry J. Kaiser Family Foundation, Medicare and Medicaid Statistics, available at <http://www.kff.org/medicaid/upload/Key%20Medicare%20and%20Medicaid%20Statistics.pdf>

## Recommendations

The evidence presented in this analysis underscores the special vulnerabilities of children and adolescents in foster care and the child welfare system, as well as the potential to show real improvements in the quality of health care for these children through strong collaboration between Medicaid and child welfare systems. The Medicaid proposals discussed here would reduce Medicaid’s coverage strength for children and adolescents, potentially endanger the availability of extended coverage to adolescents departing foster care, and limit Medicaid’s flexibility to act as a full partner in building quality systems of care for the nation’s most vulnerable children.

If adopted, the cost-sharing and EPSDT proposals put forth by the Medicaid Commission, the National Governors Association, and the National Conference of State Legislatures promise diminished Medicaid coverage for low income children, and in the case of the NCSL proposal, for the very poorest children. The children and adolescents who stand to lose the most are those with chronic and long-term physical, mental, and behavioral conditions requiring intensive therapy—the very children and adolescents who are disproportionately represented in the child welfare system, with frequent entries and exits and long lengths of stay. Indeed, for those adolescents departing foster care in participating states where coverage is extended to age 21, service reductions and cost sharing will greatly imperil the continuity of mental health treatment plans developed while in foster care.

The Bush Administration's proposals are even more far-reaching. By calling for the elimination of Medicaid payments for “duplicative” case management and rehabilitation services, and by failing to exempt the services of child welfare agencies from this recommendation, the Administration's recommendation would erode efforts to build basic links between Medicaid and child welfare so that Medicaid can perform as a true partner where the welfare of the most vulnerable children is concerned. Indeed, the very feature of Medicaid that the Administration views as duplicative—its ability to pay for health care for children in the care of child welfare agencies—gives Medicaid the capacity to act as a partner in the care of children. Far from being duplicative, Medicaid coverage of health care for children under the care of the child welfare system reflects a conscious decision by Congress to use Medicaid—not child welfare programs—to finance health care for children and adolescents in foster care. The Administration offers no alternative to this decades-old arrangement. Child welfare agencies already are seriously underfunded at all levels of government; the Administration's proposal, if adopted for child welfare systems, would further cripple their efforts.

Reducing federal Medicaid outlays will provide short-term budgetary relief by either decreasing federal expenditures or allowing funds to be used for other federal programs. That short-term budgetary relief, however, comes at the cost of reduced health care access for the most vulnerable youth. Reducing coverage for the heightened health needs of vulnerable youth will not make the problem go away, but may exacerbate it and result in higher costs to society in the long run.

### **Short-Run Medicaid Reforms**

As the 109th Congress considers budget reconciliation proposals to reduce federal Medicaid outlays, it is important to reject proposals that would either impair coverage, diminish the likelihood that states will extend continued coverage to adolescents transitioning from foster care, or threaten the long-term working relationships among state and local public agencies that undergird service systems for the most vulnerable Americans. Even more fundamentally, it is important to reject changes that lack a careful assessment regarding the need for reform or a carefully structured set of recommendations aimed at avoiding harm to essential services and missions. Neither the EPSDT or cost-sharing recommendations, nor the proposal to restructure the relationship between Medicaid and child welfare systems, meet this test. Indeed, the recommendations that would permit states to curb EPSDT funding for comprehensive mental and behavioral health services for children with chronic conditions carry another danger. Such recommendations, if enacted, could serve to further exacerbate an already troubling trend, documented through government reports and studies, of the voluntary relinquishment of seriously ill children and adolescents to the child welfare system by low-income families who cannot find an alternative pathway to appropriate care. State and local governments already face enormous difficulties finding adequate sources of care for children and adolescents with serious mental

illness. Withdrawing the only means of financing such health care—which lies beyond the furthest limits of commercial insurance plans—can only worsen matters.

## **Long-Term Proposals**

There is much that can be done in the long run to strengthen the relationship between Medicaid and child welfare systems and to make Medicaid a more effective partner in supporting preventive services that avert entry into foster care and improve the health care prospects for children who must spend time in out-of-home arrangements. We believe that four options should be assessed in greater depth over the next year so that comprehensive proposals can be brought forward. In addition, we propose immediate steps that the Administration can take to stimulate relationships, in our view, between Medicaid and child welfare programs.

1. Strengthening Preventive Collaboration Between Medicaid and Child Welfare

Under current law, Medicaid is mandatory only for children in foster care or federally funded adoption placements. Uniform eligibility should be extended to children living in low-income families as soon as they enter the child welfare system, so that agencies are able to arrange essential health services that could improve health and help avert voluntary or mandatory relinquishment. In cases in which the services needed to avert relinquishment include health care for uninsured or underinsured parents, child welfare–based Medicaid eligibility also should trigger coverage for the parent. Getting health care to parents in such cases may in fact be one of the most essential acts of family preservation.

## 2. Assuring Comprehensive Treatment for Adolescents in Foster Care and Out-of-Home Placements, and for Those Transitioning from Foster Care

Current law, through the Medicaid Chafee option, gives states the option of extending Medicaid coverage up to age 21 in the case of children residing in foster care on their 18<sup>th</sup> birthdays.<sup>56</sup> However, to date, only 11 states have made use of this option for adolescents exiting from foster care. Significant spending reductions in the Medicaid program will certainly diminish the likelihood that this option will reach adolescents in additional states, and may imperil the availability of this option in the states already using it. Recent evidence from the Casey Family Programs' Northwest Alumni Study—which found that the majority of adult graduates from foster care had at least one mental health problem, while one in four had post-traumatic stress disorder,<sup>36</sup> would suggest that the Congress consider changing this option to a requirement that coverage for adolescents departing foster care be mandated, in order to ensure appropriate time and resources to address their heightened health needs and to continue their treatment plans. In addition, just as many parents can continue dependent coverage up to the age of 26 for adult children who continue in education and training, states should have a similar option to extend coverage for young adults with an extensive history of foster care residence, who elect to continue their own education and training.

## 3. Developing Comprehensive Systems of Care

Medicaid should be revised to provide federal funding at the enhanced rate available under the State Children's Health Insurance Program to support the development and operation by Medicaid and child welfare agencies of collaborative and integrated systems of care for children and families in the child welfare system. Existing Medicaid authority allows for the use of such systems—Section 1915 (b) and (c) of the Social Security Act allows states to develop specialty care systems that can be targeted at subpopulations—and the

Bush Administration recommends stimulating their development through a time-limited grants program. What is also needed, however, are reforms ensuring that, once developed, these systems can be sustained through on-going Medicaid coverage and payments. A preferred federal rate for their design and operation is a sensible step given the ability of such specialty care programs to improve family health and functioning and avert entry into foster care. The use of Medicaid to avert long-term health and social consequences is consistent with efforts by federal and state officials in recent years to develop specialty care systems for individuals with serious health conditions such as diabetes, mental illness, and cardiovascular disease. This trend, known as disease management, has been strongly encouraged by CMS,<sup>57</sup> and its financing elements should be transferable to preventive services for children and families at risk.

4. Diffusing Innovative and High Quality Services Through More Extensive Federal Guidance Regarding Options for Improving the Quality of Care for Children in Foster Care and the Child Welfare System

Much attention is paid in health care policy to the concept of diffusing innovations in health care and health technology. This theme runs through efforts to advance the use of health information technology. This concept of innovation diffusion is hardly unique to medical care technology. It applies to the diffusion of innovations aimed at the improvement of existing programs and services. In this regard, the Centers for Medicare and Medicaid Services and the Administration for Children and Families could collaborate on extensive joint guidance that addresses options for improving the relationship between Medicaid agencies and child welfare programs under current law, in the context of both preventive services and services for children in foster care and out-of-home placements. It is evident that emerging models promise higher quality care and better outcomes. These models can be and have been evaluated for their program and financing design features. From these evaluations,

the federal government can prepare and disseminate guidance to states that illustrates how Medicaid can be used to advance their replication. As with other health innovations, this type of systematic evaluation and dissemination of findings is critical to the diffusion of advances in health care.

## **Conclusions**

A number of the Budget Reconciliation proposals now pending before Congress carry serious implications for the accessibility and quality of health care for children and adolescents in foster care as well as those receiving child welfare services. As Congress considers Medicaid proposals, particularly those linked to federal payments, cost sharing, and EPSDT restructuring, the potential impact of reforms on foster children—and children in the child welfare system more generally—should be a key consideration. Indeed, an unintended effect may be to increase the rolls of the child welfare system should these proposals be enacted, even if children in foster care are exempted in the process. Children and adolescents in the child welfare system are among the nation's most vulnerable. The child welfare system can become a necessity for any family in the United States. Low-income children and adolescents should not have to wait until they are under the system's protection to be assured of adequate and affordable health care, no matter how sick they might be.

This is a time when Congress should seek innovation in child welfare, especially through the wider availability of comprehensive coverage to children in foster care and those exiting the system, and through the use of integrated reforms representing the culmination of decades-long work to improve the health and well-being of children and adolescents in foster care. Driven first by the American Academy of Pediatrics, the Child Welfare League of America, and the American Academy of Child & Adolescent Psychiatry, the

Congress took up this issue in 1997 in order to promote not only safety and permanency for children and adolescents in foster care, but their health and well-being as well. Medicaid has been a chief partner in supporting these reforms, and advancing the well-being of children and adolescents should be a cornerstone of its short- and long-term reform.

## Appendix A: Key Medicaid Reform Proposals Affecting Children in Foster Care and Child Welfare Programs

Proposal	Elements	Implications
<b>BUSH ADMINISTRATION</b>	<p>Clarify definition of rehabilitation and case management services to prohibit payment for either service if provision of the service is “an intrinsic element of another program.”</p> <p>Reduce FMAP for general and targeted case management services to 50%.</p> <p>Cap federal payments to states for costs related to administration of state Medicaid programs.</p> <p>Limit state capacity to generate revenues for state expenditures through the use of broad based taxes.</p> <p>Disallow state Medicaid payments not retained by governmental entities.</p> <p>Establish “New Freedom” 10-year demonstrations authorizing: (a) expanded respite care to certain Medicaid-enrolled children with substantial disabilities, who require continuous care in order to remain in their homes and communities, and (b) home and community-based alternatives to residential treatment in psychiatric facilities.</p> <p>Presumptive eligibility for persons with disabilities to allow provision of home and community-based services while Medicaid eligibility is being determined.</p>	<p>Potentially affects all Medicaid payments to health care professionals and providers furnishing case management or rehabilitation services to children in foster care or receiving any other service through the child welfare system, since case management and restoration of health and functional capacity may be considered intrinsic to the mission of child welfare programs.</p> <p>Could result in loss of federal contributions to the cost of case management services furnished by child welfare agencies and their contracting health professionals and providers, with resulting payment cuts possible.</p> <p>Implicates the availability of funds for state Medicaid administration, including administration activities carried out on behalf of states by child welfare agencies. Recommendation coincides with assumption of major new administration duties by states as a result of the Medicare prescription drug program.</p> <p>Would limit states’ overall ability to generate revenues to operate all aspects of their Medicaid programs.</p> <p>Would permit child welfare agencies to retain all Medicaid payments received.</p> <p>Capped grants program that would help support the development of alternatives to out-of-home care in states that qualify for assistance.</p> <p>Would permit immediate assistance in home and community to children with disabilities while their eligibility is being determined.</p>
<b>MEDICAID COMMISSION</b>	<p>Broaden state authority to impose tiered co-payment obligations on beneficiaries, with waivers possible only in cases of “true hardship” or “where failure to take a preferred drug might create serious adverse health effects.”</p>	<p>Provides no exemption for children as under existing law, including children in foster care or special needs adoption placements or children receiving preventive and supportive services through the child welfare system.</p>

Proposal	Elements	Implications
<p><b>NATIONAL GOVERNORS ASSOCIATION</b></p> <p>(Short-Run Medicaid Reform)</p>	<p>Allow states the option of closed prescription drug formularies that exclude drugs not listed in the formulary.</p> <p>Tiered cost sharing including tiered cost sharing for prescription drugs, with exemption for persons with incomes at or below 100% FPL except in the case of drug co-payments. No discussion of existing exemption for children.</p> <p>“Increased flexibility to tailor benefits to beneficiary health care needs” by permitting states to use SCHIP “benchmark” premium support approach for certain populations, with exemptions for mandatory child and family beneficiaries and SSI recipients.</p> <p>Ease waiver process to allow states to pursue waivers of benefit requirements (e.g., EPSDT, statewide coverage, comparability, amount duration and scope, nondiscrimination) and other aspects of federal Medicaid program in the same manner that state plan amendments are adopted.</p> <p>Limit authority of the federal judiciary to enforce Medicaid law with respect to “optional Medicaid categories.”</p>	<p>Provides no exemption for children in foster care or special needs adoption placements or children receiving preventive and supportive services through the child welfare system.</p> <p>Provides no exemption for children as under existing law, including children in foster care, special needs adoptions, or receiving services through child welfare agencies.</p> <p>Near-poor children in optional coverage groups receiving foster care or adoption services or preventive and support services through child welfare agencies could experience service reductions.</p> <p>Would ease state capacity to waive EPSDT and other benefit protections for some or all children, including children in foster care and special needs adoptions and children receiving preventive or supportive services under child welfare programs.</p> <p>Could affect rights of children in foster care or receiving services through child welfare agencies whose eligibility is optional.</p>
<p><b>NATIONAL CONFERENCE OF STATE LEGISLATURES</b></p>	<p>Provide “countercyclical assistance” to state Medicaid programs.</p> <p>Ease waiver process (similar to NGA).</p> <p>Allow states to cover persons based solely on income.</p> <p>Increased flexibility in benefit design as requested by NGA, but without stated exemptions for mandatory populations as in the NGA proposal. Includes increased EPSDT flexibility through elimination of diagnosis and treatment requirements, other than “dental issues.”</p> <p>Broader premium, deductible, and cost-sharing flexibility, including prescription drug cost-sharing. Higher cost-sharing for “higher income” persons; no exemption for children.</p>	<p>Increases aid to states during periods of economic downturn, thereby increasing state capacity to respond to needs of Medicaid population, including children in foster care and special needs adoptions as well as children receiving child welfare preventive and support services.</p> <p>Similar to NGA.</p> <p>Potential assistance to families who need medical care and whose children are receiving child welfare services.</p> <p>Would eliminate comprehensive treatment requirements for all children including children in foster care and special needs adoptions, as well as children receiving preventive and supportive services through child welfare agencies.</p> <p>Implications for children in “higher income” families receiving assistance through child welfare agencies.</p>

**Sources:** *Bush Administration:* available through Families USA, Washington D.C. *NGA:* available at <http://www.nga.org/Files/pdf/0508MEDICAIDREFORM.PDF> *Medicaid Commission:* available at <http://www.cms.hhs.gov/faca/mc/090105rpt.pdf> *NCSL:* available at <http://www.ncsl.org/statefed/health/MArefPrinc.htm>.

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