FINANCING THE SPECIAL HEALTH CARE NEEDS OF CHILDREN AND YOUTH IN FOSTER CARE: A PRIMER

By Sheila Phicil, MPH

The following is an overview of the topics covered in this primer.

CATALYST CENTER
IMPROVING FINANCING OF CARE for Children & Youth WITH SPECIAL HEALTH CARE NEEDS

"There can be no keener revelation of a society's soul than the way in which it treats its children."

– Nelson Mandela

About This Primer

At the Catalyst Center we are dedicated to improving coverage and financing of care for children and youth with special health care needs (CYSHCN) in partnership with other stakeholders. In this primer, we turn our attention to an often overlooked population of CYSHCN: children and youth in foster care. State Title V Maternal and Child Health (MCH) and CYSHCN programs can play a significant role in improving the system of coverage and care for this group of vulnerable children. Some of the ways in which Title V programs are currently doing so include leading or participating in initiatives related to medical home, benefits counseling, child abuse and neglect prevention, service quality monitoring and measurement, and transition.

With the information provided in this primer, we hope to spark interest in and facilitate a deeper understanding of the health care coverage and financing needs of children in foster care. We also want to offer Title V program staff some useful models to consider in creating and sustaining collaborative partnerships with others who are concerned with children and youth in foster care.

Executive Summary

Children in foster care are children with special health care needs.

Currently, approximately 700,000 children in the U.S. receive foster care services over the course of a year, and an estimated 400,540 children were reported to be in foster care on September 30, 2011.[1] A high percentage of children enter foster care after having experienced extreme poverty, parental substance abuse, homelessness, neglect, and sexual and/or physical abuse.[2,3] Children in foster care are vulnerable in many ways and should be considered important members of the population of CYSHCN because of their increased risk for and prevalence of poor physical, developmental and mental health status and outcomes.[4] Compared with children from similar socioeconomic backgrounds, children in foster care are in poorer overall health, and have higher rates of serious emotional and behavioral problems, chronic medical conditions, and developmental delays.[3] Children in foster care also have a higher level of diagnosed disability than the general population of children do.[22]

Children in foster care face challenges in the coverage and financing of their health care.

The child welfare system is a complex arrangement of federal, state, and private partnerships with multiple stakeholders. Only a small percentage of children who enter the child welfare system are placed in some form of out-of-home care.[5] There are a variety of different types of foster care settings, and where children end up is based on their level of need and the resources available to meet that need. Different foster care settings have varying implications for coverage and financing of health care for children. For example, children in formal kinship care placement are five times more likely to lack health insurance than children in non-relative foster care and are also less likely to receive mental health services.[6]

Children in foster care face challenges in access to quality care.

Although over time there has been increased recognition of the vulnerabilities of children in foster care, their basic health needs frequently go unmet.[7] A federal review of state child welfare agencies found that 30% of children sampled never received a health care assessment or treatment.[8] Even if children in foster care are enrolled in a public insurance program, they face significant barriers in accessing health care. In some cases, they face the same challenges as anyone who uses public insurance, such as a lack of providers who are able and willing to serve Medicaid recipients.[8] Removal from the care of biological parents often makes tracking children's health history difficult, and while in foster care, they may move to several foster homes or treatment settings and encounter a number of different providers.[8] All of these factors complicate efforts to document health care histories and ensure children receive the health care services they need.

Children in foster care should have access to a comprehensive system of care.

To support a comprehensive system of care, states must ensure that needed services are properly financed and accessible. The Child Welfare League of America (CWLA) and the American Academy of Pediatrics (AAP) have identified the following four components of health care services that are necessary when caring for children in foster care:

- Initial health assessment
- Comprehensive medical/dental assessment
- Developmental and mental health evaluation
- Ongoing care and monitoring of health status[3]

At the state level, child welfare agencies are largely responsible for the health needs of children in foster care; however, they operate within a large, fragmented system that includes other stakeholder agencies and providers such as Title V, Medicaid, mental health, and children's health. To make significant strides in improving health care for children in foster care, all of these agencies will have to play a part.[7]

Health care coverage and financing is fundamental to meeting the health care needs of children in foster care.

Title IV-E is the largest source of funding for child welfare services, but states cannot use these funds for the purpose of providing direct health care services. States can finance health care services for children in foster care using Medicaid, CHIP or Supplemental Security Income (SSI). Most health care that children in foster care receive is financed through Medicaid. Children who are receiving Title IV-E foster care maintenance payments are categorically eligible for Medicaid.[9] Children in foster care who do not qualify for Medicaid coverage or whose placements are supported by child-only TANF payments may be eligible for health insurance under the state CHIP program.[10] SSI cash payments along with the associated entitlement in most states to Medicaid for SSI enrollees are particularly helpful in covering children's health care needs after permanent placement or reunification with their biological families.[11]

As both public and private agencies have released reports on the health conditions of children in foster care, federal and state lawmakers have taken steps to improve the system of care for this population. Several major federal efforts have sought to reform foster care and improve access to health care services. These federal laws have important implications for coverage and financing of care for children in foster care. Most recently, the Patient Protection and Affordable Care Act (ACA) of 2010 (PL 111-148) extends Medicaid coverage for former foster youth up until age 26 and facilitates enhanced care coordination and supports through health homes. States have taken additional steps to improve the quality of services for children in foster care by:

- Enforcing Medicaid entitlement services by requiring all children to be provided medically necessary care under the Early and Periodic Screening, Diagnostic and Treatment program (EPSDT)
- Expanding Medicaid/CHIP programs
- Adopting a managed care model as a method of obtaining comprehensive care for children in foster care[3,12]

Title V can work with states and other stakeholders to improve the system of care for children in foster care.

In several states across the U.S., Title V programs are working to improve the system of care for children in foster care through initiatives which include:

- Provision of quality health care and coordination
- Interagency collaboration
- Child abuse and neglect prevention
- Quality monitoring and measurement

Read on to learn more about financing the special health care needs of children in foster care. The primer also includes three examples of innovative program models of health care delivery for children in foster care.

Foster Care: Then and Now

Before we begin the discussion of coverage and financing issues related to children in foster care, let us offer some background. The origins of foster care in the United States can be traced back to the mid-1800s when children who were homeless in New York were transported on "Orphan Trains" to western states where they were taken in by families to work on farms.[13] Since then, there has been much effort to call attention to the country's responsibility to protect the safety and well-being of children. The first White House Conference on Children and Families was held in 1909 and established the principles of foster care with the recognition that children fared better when raised in a family setting rather than an institutional one such as an orphanage.[14]

Foster care is defined as "all out-of-home placements for children who cannot remain with their birth parents."[15] It can also be referred to as out-of-home placement or out-of-home care. Currently, approximately 700,000 children in the U.S. receive foster care services over the course of a year, and an estimated 400,540 children were reported to be in foster care on September 30, 2011.[1] (See Table 1 for demographics.) From 1982 to 1999, the number of children in foster care more than doubled from 262,000 to 567,000 children.[16,17] Contributing to this increase was a rise in several significant social problems in the mid-1980s that impact the ability of parents to care for their children effectively: the crack epidemic, homelessness, parental incarceration, and HIV/AIDS infection.[15]

Since 1999 there have been modest declines in the number of children in foster care, in part as a result of increased efforts by child welfare agencies to reunite children with their biological parents or recruit extended family members to care for them, along with a simultaneous increase in the rate of

Table 1: Demographics of Children in Foster Care

Demographics of Children in Foster Care on Sept 30, 2011		
Age		
0 - 3 years	108,664	27.2%
4 - 7 years	78,211	19.5%
8 - 11 years	59,951	15.0%
12 - 14 years	52,071	13.0%
15 - 17 years	84,585	21.1%
18 - 20 years	16,654	4.2%
Gender		
Male	209,532	52.3%
Female	190,932	47.7%
Race/Ethnicity		
American Indian/ Alaskan Native	8,020	2.0%
Asian	2,296	0.6%
Black or African American	109,775	27.5%
Native Hawaiian/ Other Pacific Islander	752	0.2%
Hispanic (of any race)	83,810	21.0%
White	164,406	41.1%
Unknown/Unable to Determine	8,703	2.2%
Two or more races	21,837	5.5%
Total	400,540	

Source: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2012). The AFCARS Report: Preliminary FY2011 estimates as of July 2012. Retrieved August 7, 2012 from http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report19.pdf

adoption out of foster care.[3,14] Another important factor is the decreasing number of children who are eligible for federal foster care payments.[18] Eligibility for Title IV-E foster care payments is linked to 1996 income levels; as the cost of living has increased, the number of children whose families are eligible has gradually declined.[5]

A high percentage of children enter foster care after having experienced extreme poverty, parental substance abuse, homelessness, neglect, and sexual and/or physical abuse.[2,3] Approximately 50% of children in foster care are reported to have been the victim of maltreatment.[1,2] Infants and young children are the fastest growing population in need of foster care.[2,3] Children of some racial and ethnic groups make up the majority of the foster care population with a disproportionate representation of African-American and Native American children.[19]

Title V Spotlight: Child Abuse and Neglect Prevention (CAN)

Hawaii

Within the Department of Health, the Title V Maternal & Child Health Branch (MCHB) is the state lead for primary and secondary CAN prevention. MCHB administers family strengthening contracts for respite services; a telephone warm-line for parents, caregivers, and service providers; and parenting and child development services to homeless families. MCHB also administers the federal Community-based Child Abuse Prevention (CBCAP) grant.

For more information on Hawaii's MCHB, go to http://hawaii.gov/health/family-child-health/mchb/index.html

Adapted from the state's Title V Block Grant Report/Application 2010/2012 at https://mchdata.hrsa.gov/TVISReports

Special Health Care Needs of Children in Foster Care

The federal Maternal and Child Health Bureau (MCHB) defines children and youth with special health care needs (CYSHCN) as those "who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."[20] Children in foster care are vulnerable in many ways and should be considered important members of the population of CYSHCN because of their increased risk for and prevalence of poor physical, developmental and mental health status and outcomes.[4]

This population is at higher risk of developing social and behavioral difficulties in part due to the lasting effects of complex childhood trauma and the stress of being removed from familiar caregivers.[7] Compared with children from similar socioeconomic backgrounds, children in foster care are in poorer overall health, and have higher rates of serious emotional and behavioral problems, chronic medical conditions, and developmental delays.[3]

The Government Accountability Office (GAO) estimates that 80% of children in foster care have significant health care needs.[8] However, identification of both routine and special health care needs is not always coupled with intervention. Although over time there has been increased recognition of the vulnerabilities of children in foster care, their basic health needs frequently go unmet.[7] A federal review of state child welfare agencies found that 30% of children sampled never received a health care assessment or treatment.[8]

Among the foster care population there is a subgroup of children who have disabilities. The Americans with Disabilities Act Amendments of 1990 (ADA) defines a disability as "a physical or mental impairment that substantially limits one or more

major life activities."[21] The National Child Abuse and Neglect Data System (NCANDS) reported that in 2010 28.0% of children in foster care had a diagnosed disability, compared to 4.0% of the total noninstitutionalized child population.[22] More specifically, 2.0% were diagnosed with an intellectual disability, 2.8% experienced a visual or hearing impairment, 1.3% experienced a physical disability, 16.3% were diagnosed with an emotional disturbance and 14.2% experienced other diagnosed disabling conditions.[22]

The high proportion of children with disabilities in foster care is of particular concern because studies have shown that children with disabilities are more likely to experience maltreatment than children without disabilities.[23] Moreover, the health status of children in foster care with a diagnosed disability is at risk of deteriorating if their placements do not meet their specific needs.[7] In 2007, states reported lower levels of success in achieving permanent placement for children exiting foster care who had a diagnosed disability (median = 77.0%) compared to all children (median = 86.9%).[24]

Foster Care Placement

It is generally agreed in the child welfare community that removing children from their home should be considered a measure of last resort in order to promote their safety, permanency and overall well-being.[3] However, for children who suffer severe neglect and abuse, placement in foster care can be an important opportunity to provide abuse prevention and rehabilitation services.[7] There are a variety of different types of foster care, with varying implications for coverage and financing of health care for children. In this section we describe the various ways children enter foster care. We also explain the types of placements they may experience and how these have historically impacted their health status.

Involuntary Placement

Children are placed in foster care when their original parents or guardians are either unwilling or unable to care for them or they are considered "persons (or children) in need of supervision" (PINS or CHINS)."[14] Some children are placed into foster care at birth when their biological parents are deemed unable to care for them.[15] Other children enter the foster care system when a concerned citizen or mandated reporter reports maltreatment to child protective services.[15]

Custody Relinquishment

In an attempt to obtain help for their children, some parents choose to relinquish custody to either the juvenile justice or child welfare system in order for their children to qualify for public benefits because they cannot get either coverage or services for their children otherwise.[12] Parents who face custody relinquishment may have lost private insurance, have adopted children with special health care needs, or may be unable to get treatment for their children despite having health care coverage.[12] In these cases, families may decide to voluntarily relinquish their children to state custody.

A study in 2000 showed that over half of the fifty states have reported incidents where families seeking mental health care for their children chose between "getting the mental health treatment their child needs or retaining legal custody of the child."[12] In 2010, 1.3% (8,147) of children in foster care were placed in the child welfare system due to custody relinquishment.[22] Currently, many child welfare agencies do not differentiate between children who are in state custody because of abuse and neglect from those who are placed for access to mental health services.[12] Parents who are forced to relinquish custody to obtain care for their children may face helplessness and humiliation and are often treated as neglectful and abusive parents.[12]

Types of Out-of-Home Placements

When children are removed from their homes of origin, they can be placed in a number of different of settings. Where children end up depends on their level of need and the resources available to meet that need. In 2011 the average length of stay for children in foster care was 21.1 months.[1] Children who have been in foster care for a longer period of time are more likely to face placement instability.[15]

Non-relative Foster Care

In 2011, 47.0% of children in foster care were placed with a non-relative foster family.[1] Foster parenting is a voluntary service that is a very demanding responsibility and requires the foster parents to provide a home; coordinate with welfare agencies, schools, and other providers to meet the needs of the children in their care; and help the children maintain relationships with their birth parents.[1] Foster parents are required to be certified and undergo training.[14] The training foster parents receive is focused primarily on interactions with the child welfare agency and the birth family but also involves topics such as managing child development, dealing with behavior problems, providing discipline, ensuring safety, and understanding the impact of abuse and neglect.[14] Although foster parents do receive payment for their work, on average, foster parents subsidize about 33% of the cost of caring for children in foster care.[14]

Kinship Foster Care

Kinship foster care involves "relatives who have become certified foster parents and relatives and friends who care for children placed with them by the court as a result of child protection investigation."[14] In 2011, 27.0% of children in foster care were placed in kinship foster care.[1] Kinship care can be either formal or informal. Formal kinship care is the result of a court ruling that children be removed from their home of origin and placed in the custody of a relative to provide full-time care. Informal kinship care is when biological families retain legal custody of their children but arrangements are made to have the children live with relatives.[26] This process may involve a social worker but does not require relatives to be licensed or supervised by the state.

Kinship care has gradually become more commonplace in foster care as it has been formally acknowledged as a legitimate placement for children.[15] Children in kinship care have also been found to experience lower risks of behavioral and social issues and are more likely to receive well-child care.[6,27] On the other hand, children in formal kinship care placement are five times more likely to lack health insurance than children in non-relative foster care and are also less likely to receive mental health services.[6]

A national study of children in kinship care versus non-relative foster care found that children in kinship care are more likely to live in households with low socioeconomic status.[27] As a result, children in formal kinship care are likely to be eligible for public coverage based on household income.[28] However, their caregivers may not have access to the same financial and social supports that foster caregivers receive. Like other parents and caregivers of uninsured children, they may face significant barriers to enrollment and retention in public coverage such as a lack of knowledge about eligibility and how to apply for coverage, burdensome or complicated paperwork requirements, stigma and the perception of poor quality care.[29]

Treatment Foster Care

Treatment foster care (TFC), also known as therapeutic, specialized, intensive or enhanced foster care, has been practiced since the 1950s and has be-

come a viable alternative to residential and hospital care.[30] In these settings, foster families (or adoptive families and biological families when appropriate) receive intensive training, education, and supportive services in care for CYSHCN.[14] States may have more rigorous standards for training and licensing procedures for treatment foster care providers. Children in TFC often have severe emotional, behavioral, and medical health care needs. TFC is a growing practice in addressing the special needs of children in foster care because it is tailored to the needs of the individual child and provides a more stable setting for children who have had multiple failed placements.[30]

Group Home or Residential Programs

Although it is preferred that children remain in a family setting, some children have special needs that require a more structured environment than can be provided in a private home. In 2011, approximately 14.6% of children in foster care were placed in a group home or institutional setting.[1] There are numerous models of group home care.

Interjurisdictional Placement

In some cases the best available placement for children may be in a county or state outside of their own community or jurisdiction, commonly known as interjurisdictional placement. Approximately 5.5% of all children in foster care reside in a state other than the state that is responsible for their care.[31] This commonly occurs in two situations: if children have relatives who can care for them in another state or if children have special needs that cannot be met with the treatment resources available within the state.[32]

Interjurisdictional placement takes longer than in-state placements and often legal, administrative, and resource constraints will delay the process.[33] The leading cause of delays is resolving financial responsibility for medical and educational expenses between the sending state and the receiving state.[31] Coverage for health care services is particularly difficult for children who are not Title IV-E eligible because they must meet the receiving state's eligibility requirements for public coverage, which in many cases includes residency status.[33]

Other Types of Placement

Other forms of placement include emergency care and shared family care. In emergency care children are removed from birth parents and placed in a shelter or group facility for the children's safety.[34] In shared family care, parents and children are placed together with a host family who provides mentorship and support in developing the skills parents need to care for their children independently.[34]

Child Welfare System

The child welfare system is a complex arrangement of federal, state and private partnerships with multiple stakeholders. The primary goals of the child welfare system are ensuring children's safety, securing permanency, and supporting the well-being of children and families.[7]

Safety is defined as first and foremost protecting children from abuse and neglect and, whenever possible and appropriate, safely maintaining children in their home of origin.[35] Permanency is defined as securing permanent and stable living situations for children and ensuring the continuity of family relationships and connections.[35] Well-being is a broader concept and is defined as "healthy social and emotional functioning that ensures families can create safe, secure, and responsive environments and allows children to be successful during childhood and into adulthood."[36]

The child welfare system falls under the leadership of the U.S. Department of Health and Human Services' (HHS) Administration for Children and Families (ACF), whose mission is to "plan, manage and coordinate the nationwide administration of comprehensive and support programs for vulnerable children and families."[37] In its oversight of the child welfare system, the ACF aims to improve the economic and social well-being of individuals, children, families, and communities. Its activities include administering programs that offer necessary services and productive partnerships with states, tribes and communities; monitoring operations and review of programs; providing training and technical assistance; and supporting research and evaluation of program outcomes.[37]

Foster care is not synonymous with the child welfare system. Only a small percentage of children who enter the child welfare system are placed in some form of out-of-home care.[5] Foster care falls under the umbrella of programs that are offered by the child welfare system and was designed to be a temporary service with the primary goals of placing children in the least restrictive setting that supports their health and well-being. In addition to these objectives, foster care helps prepare older children and youth in out-of-home placement for self-sufficient adulthood. Of the 245,260 children discharged from foster care in 2011, an estimated 10.7% were emancipated or "aged out" of the system.[1] For these young people, the foster care programs work to provide resources to promote independent living.

The structure of the child welfare system has important implications as to how the health care needs of children in foster care are addressed. In this section we will discuss the central elements of the child welfare system including funding for child welfare services, federal legislation, models for organizing state child welfare systems, and key players in the child welfare system.

Funding for Child Welfare Services

Federal funding for child welfare services is authorized under Title IV of the Social Security Act. These funds are administered through the ACF as an open-ended entitlement to states and federally recognized tribes to provide out-of-home care and placement for children who enter the child welfare system. Title IV-E, funded at $6.75 billion in 2011, is the largest source of funding for child welfare services.[38] Title IV-E allows states to receive reimbursement for expenses related to providing child welfare services such as administrative activities, short- and long-term training, adoption assistance, and foster care maintenance payments.[39] The amount of funding a state receives reflects the number of children in placements who meet the following Title IV-E federal eligibility criteria:

- U.S. citizenship or qualified immigrant status[40]
- Under the age of 18 (or up to age 21 for extended foster care)[40]
- Entered care through voluntary placement or a judicial determination after reasonable efforts to prevent removal were made[41]
- Currently in a licensed or approved foster care setting[41]
- Removed from a home that meets income/asset tests and family structure rules of the former Aid to Families with Dependent Children (AFDC) program[41]

For children who are not Title IV-E eligible, the state is responsible for covering the entire cost of their care. Today about 50% of children in foster care are Title IV-E eligible, whereas about 70% were eligible in the mid-1980s.[18,42] Much of this decrease is attributable to the Title IV-E definition of poverty which is linked to 1996 income levels; as the cost of living has increased, the number of children whose families are eligible has gradually decreased.[5] Consequently, today Title IV-E foster care payments are only provided to families with the greatest level of financial need.[18]

For children who are not Title IV-E eligible, other sources of federal funding are available, such as Title IV-B. Funded at $709 million in 2011, Title IV-B provides funding for children in foster care and supports families to prevent their children from entering foster care.[38] Although there is no income eligibility limit for Title IV-B as there is for Title IV-E, these funds are very limited. In order to receive Title IV-E and IV-B funding, state child welfare agencies must agree to meet certain federal requirements such as the submission of a case plan containing children's health information.

Through the case plan, information such as immunization records and a list of medications can be shared with foster families. Child welfare agencies are also required to have standards in place to protect the safety and health of children. However, because these standards have not been defined, states have great flexibility in setting safety and health standards.[8]

In addition to Title IV-E and IV-B, there are three federal funding programs that are not specifically targeted to children in the child welfare system but are available to help meet the needs of the children and families they serve: Medicaid, Temporary Assistance to Needy Families (TANF), and the Social Services Block Grant (SSBG).

Medicaid

Medicaid is a public health insurance program under Title XIX of the Social Security Act and works as an entitlement program. The program is jointly financed by both state and federal funds. States receive a federal match for each dollar that is spent on providing Medicaid services. This is an important funding source for states because nearly all children in foster care are Medicaid eligible and states can receive reimbursement for medical services, counseling, and therapy.

Temporary Assistance to Needy Families

Temporary Assistance to Needy Families (TANF) is a federally mandated block grant program that is allocated to states to assist families with no income or low income. TANF was created under the Personal Responsibility and Work Opportunity Act (PRWORA) in 1996, replacing its predecessor AFDC and gave states increased flexibility in welfare related policies.[5] States use TANF funds to provide cash and other forms of assistance to help families in financial need.[43] Additionally, states can use TANF funds in child-only cases to support child welfare services such as family preservation, foster care, kinship care support, and employment programs for foster youths.[44] The availability of TANF funding is not guaranteed and is subject to competing budget priorities at the federal, state, and local levels.[43]

Title V Spotlight: Interagency Collaboration

New York

New York State Title V staff work with the Office of Children and Family Services (OCFS) on health care of children in foster care and on issues related to the health and safety of infants and children in childcare. The Early Intervention Program collaborated with OCFS in the development of a guidance document entitled, "Protocols for Children in Foster Care Who Participate in the Early Intervention Program."

An electronic copy of the protocol can be found at: http://www.health.ny.gov/community/infants_children/early_intervention/memoranda/docs/foster_care_protocol.pdf

Adapted from the state's Title V Block Grant Report/Application 2010/2012 at https://mchdata.hrsa.gov/TVISReports

Social Services Block Grant

Social Services Block Grant (SSBG) is a mandatory, capped entitlement program whose purpose is to help states achieve five social policy goals: "(1) to prevent, reduce, or eliminate dependency; (2) to achieve or maintain self-sufficiency; (3) to prevent neglect, abuse, or exploitation of children and adults; (4) to prevent or reduce inappropriate institutional care; and (5) to secure admission or referral for institutional care when other forms of care are not appropriate."[45] States can use this funding for a variety of purposes including supporting foster care for children. Although Native American tribes are not eligible to receive SSBG funds directly from the federal government for their foster care programs, they can access these funds by submitting a competitive application to the state.[43] As is the case with TANF funding, the availability of SSBG funding is not guaranteed and is subject to competing budget priorities at the federal, state and local levels.[43]

States also play an important role in funding child welfare services either by matching the federal dollars or using state and local dollars to pay for services that are not covered or insufficiently covered by federal dollars. States use funding from both local sources such as schools contributing $1 per student and private sources such as grants from the Annie E. Casey Foundation.[46,47] How states uses non-federal funding on child welfare services varies considerably from state to state and is influenced by a number of factors including:

- Structure of the child welfare system;
- Statutory requirements that control how funds are spent;
- Lawsuits or court orders that direct how states and localities can use funds for child welfare services;
- Changes in the level of need among children and families.[43]

Federal Legislation

Over the past few decades, changes in the quality and administration of child welfare services at the state level have been largely influenced by lawsuits that often have resulted from highly publicized failures of the system to protect children.[7] Since the initial White House Conference on Children and Families in 1909, several major federal efforts have sought to reform foster care and improve access to health care services. In addition to the Adoption Assistance and Child Welfare Act (AACWA) of 1980 (PL 96-272) and the Adoption and Safe Families Act (ASFA) of 1997 (PL 105-89), the following federal laws have important implications for coverage and financing of care for children in foster care:

Foster Care Independence Act of 1999 (PL 106-169)

The purpose of this act was to expand and reform the Independent Living (IL) programs that were offered to youth aging out of foster care. Federal funds for the program were doubled and made available to states to assist youths in reaching self-sufficiency by offering educational opportunities, employment training, connections with dedicated adults, and prevention services.[48] States were given more flexibility in designing their IL programs, including having the option to extend Medicaid coverage to youth up to age 21 (defined as those between ages 18 and 20) who have been emancipated from foster care.[49] This is known as the Chafee option. Table 2 provides a list of states that offer extended Medicaid.

Fostering Connections to Success and Increasing Adoptions Act of 2008 (PL 110-351)

This law is the most recent effort to improve the child welfare system. It was intended to encourage and assist kinship care and improve the outcomes of

Table 2: States that Have Adopted the Medicaid Option to Cover Youth Aging Out of Foster Care Up to Age 21 (As of January 1, 2011)

State	Youth in Foster Care Up to Age 21
Alabama	N
Alaska	N
Arizona	Y
Arkansas	N
California	Y
Colorado	Y
Connecticut	Y
D.C.	N
Delaware	N
Florida	Y
Georgia	Y
Hawaii	N
Idaho	N
Illinois	N
Indiana	Y
Iowa	Y
Kansas	Y
Kentucky	N
Louisiana	Y
Maine	N
Maryland	Y
Massachusetts	Y
Michigan	Y
Minnesota	N
Mississippi	Y
Missouri	Y

State	Youth in Foster Care Up to Age 21
Montana	N
Nebraska	Y
Nevada	Y
New Hampshire	N
New Jersey	Y
New Mexico	Y
New York	Y
North Carolina	Y
North Dakota	N
Ohio	Y
Oklahoma	Y
Oregon	Y
Pennsylvania	N
Rhode Island	Y
South Carolina	Y
South Dakota	Y
Tennessee	N
Texas	Y
Utah	Y
Vermont	N
Virginia	N
Washington	Y
West Virginia	Y
Wisconsin	Y
Wyoming	Y
Total	33

Source: Heberlein, M., Brooks, T., Guyer, J., Artiga, S. & Stephens, J. (2011). Holding steady, looking ahead: Annual findings of a 50-State survey of eligibility rules, enrollment and renewal procedures, and cost sharing practices in Medicaid and CHIP, 2010-2011. Retrieved July 20, 2012 from Kaiser Family Foundation website: http://www.kff.org/medicaid/8130fm

children in foster care. The law extended Medicaid eligibility to children receiving kinship guardianship assistance payments and requires that states to work with pediatricians to develop a plan for oversight and coordination of health care services for children in foster care.[14] This could include providing access to a medical home. The law also permitted states to continue Title IV-E maintenance payments for youth in extended foster care up to age 21.[14]

Patient Protection and Affordable Care Act (ACA) of 2010 (PL 111-148)

The federal health care reform law contains several provisions to improve health care coverage and health care services for underserved populations, particularly those served by the child welfare system.

Extended Medicaid coverage for former foster youth up until age 26

In an effort to lower the rate of uninsurance among young adults, the ACA includes a provision that allows them to remain on a parent's employer-based insurance up until the age of 26.[50] Since youth in foster care typically do not have this option, starting on January 1, 2014, the ACA will allow former youth in foster care to maintain their existing Medicaid coverage until the age of 26, regardless of their income.[51] For these young adults, states will receive the standard federal Medicaid match at the cost of their health care services.[51] To qualify for this extension of Medicaid coverage, former youth in foster care must be:

- In the care of the state's foster care program when they reached the age of 18 or older according to the state's child welfare plan (See Table 3 for the maximum age in each state.)
- Enrolled in Medicaid or other waiver program while in foster care[51]

Expanded funding for Maternal, Infant, and Early Childhood Home Visiting Programs

In an effort to improve the economic and well-being outcomes for children and families, the ACA includes a provision to support the expansion of early childhood home visitation programs for families that are at-risk, including those who are involved in the child welfare system. This provision makes available $1.5 billion in funding to states over a five-year period for programs that have the potential to prevent placement of children in foster care. Families with a history of child abuse or neglect have been identified as a priority group for these programs.[51]

Increased options for home and community-based services

As part of a strategy to increase the number of states that adopt Medicaid home and community-based services (HCBS) programs, the ACA includes a provision which gives states increased flexibility in providing these services to specific populations, particularly children and youth in foster care. This provision amends section 1915(i) of the Social Security Act (SSA) and allows states to "extend HCBS programs to individuals with higher incomes, provide additional services, target services to specific populations, and provide different services to targeted populations than to other Medicaid beneficiaries for the first five years of the program operation (or longer with federal approval)."[51]

This amendment does not require individuals to need an institutional level of care, and those with mental health and substance abuse disorders can receive services under this provision. If more states elect to utilize this option, then children and youth in foster care may greatly benefit from coordinated systems of care for their medical and mental health care needs.

Table 3: Maximum Age for State-Funded Foster Care Beyond 18

State	Maximum Age in Foster Care	State	Maximum Age in Foster Care
Alabama	21	Montana	21
Alaska	20	Nebraska	19
Arizona	21	Nevada	21
Arkansas	21	New Hampshire	20
California	18	New Jersey	21
Colorado	21	New Mexico	21
Connecticut	23	New York	21
D.C.	21	North Carolina	21
Delaware	21	North Dakota	21
Florida	18	Ohio	21
Georgia	21	Oklahoma	21
Hawaii	N/A	Oregon	21
Idaho	21	Pennsylvania	21
Illinois	21	Rhode Island	18
Indiana	21	South Carolina	21
Iowa	20	South Dakota	21
Kansas	21	Tennessee	N/A
Kentucky	21	Texas	22
Louisiana	18	Utah	19
Maine	21	Vermont	19
Maryland	21	Virginia	21
Massachusetts	22	Washington	21
Michigan	21	West Virginia	21
Minnesota	21	Wisconsin	19
Mississippi	N/A	Wyoming	21
Missouri	21		

Source: University of Oklahoma, National Resource Center for Youth Services, National Resource Center for Youth Development. (2010). State Pages. Retrieved August 7, 2012 from http://www.nrcyd.ou.edu/state-pages

Enhanced care coordination and supports through Health Homes

Under Section 2703 of the ACA, states have the option to create primary care "health homes" for children and adults with chronic illnesses who are Medicaid beneficiaries. Significant financial incentives for providers who are recognized as health homes are included in the provision.[51] Services under Section 2703 include:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care/follow-up;
- Patient and family support; and,
- Referral to community and social support services.[51]

In order to be eligible for health home services, an individual must have:

- At least two chronic conditions (includes asthma, diabetes, heart disease, obesity, a mental condition or substance abuse disorder);
- One chronic condition and be at risk for another;
- One serious and persistent mental health condition.[51]

Health care proxy designation

The ACA recognizes the importance of transition planning for youth in foster care. It includes a provision that requires a transition plan for youth aging out of foster care to include information about health insurance options and identification of a health care proxy.[50] This provision encourages youth to identify a person who can make health care decisions on their behalf if they are unable to participate in such decisions and do not have or do not want relatives involved in such decisions.[51]

Models for Organizing State Child Welfare Systems

States have great flexibility and control in how they structure and implement their child welfare system.[8] The organizational models that states adopt directly impact how health care services for children in foster care are delivered and paid for. The organization of the child welfare system is determined by whether the program is administered at the state or county level. State-administered programs are more likely to have a consistent approach for matters such as foster parent licensing requirements and training of caseworkers. Child welfare programs that are administered at the county level are more decentralized and practices will vary widely across the state.[4]

Organizational models can be further classified by the type of agency responsible for the care of children in foster care. Agencies that provide services for children in foster care are serving in either a direct or indirect capacity. In the case of direct care, the state or county administering the program is responsible for the management and delivery of services. In the case of indirect care, a county or state government contracts with a lead agency, either nonprofit or for-profit, to coordinate and provide services.

In a direct model, states maintain the traditional service-delivery structure and may work with other public agencies to finance health care. States may choose to implement managed care contracting practices in paying providers. In an indirect care model, child welfare administrators may implement a variety of payment methods to cover the health care costs of children in foster care. For example, states or counties may choose to provide the lead agency a medical per diem or a single payment that covers all services.[4,46] These payments are financed

by the state, Medicaid, or a mixture of both and may vary depending on the level of care that a child needs.[4] The level of care children receive is determined in part by the placement setting. In some settings, such as residential treatment facilities, health care services may be required to be provided on site.

Key Players in the Child Welfare System

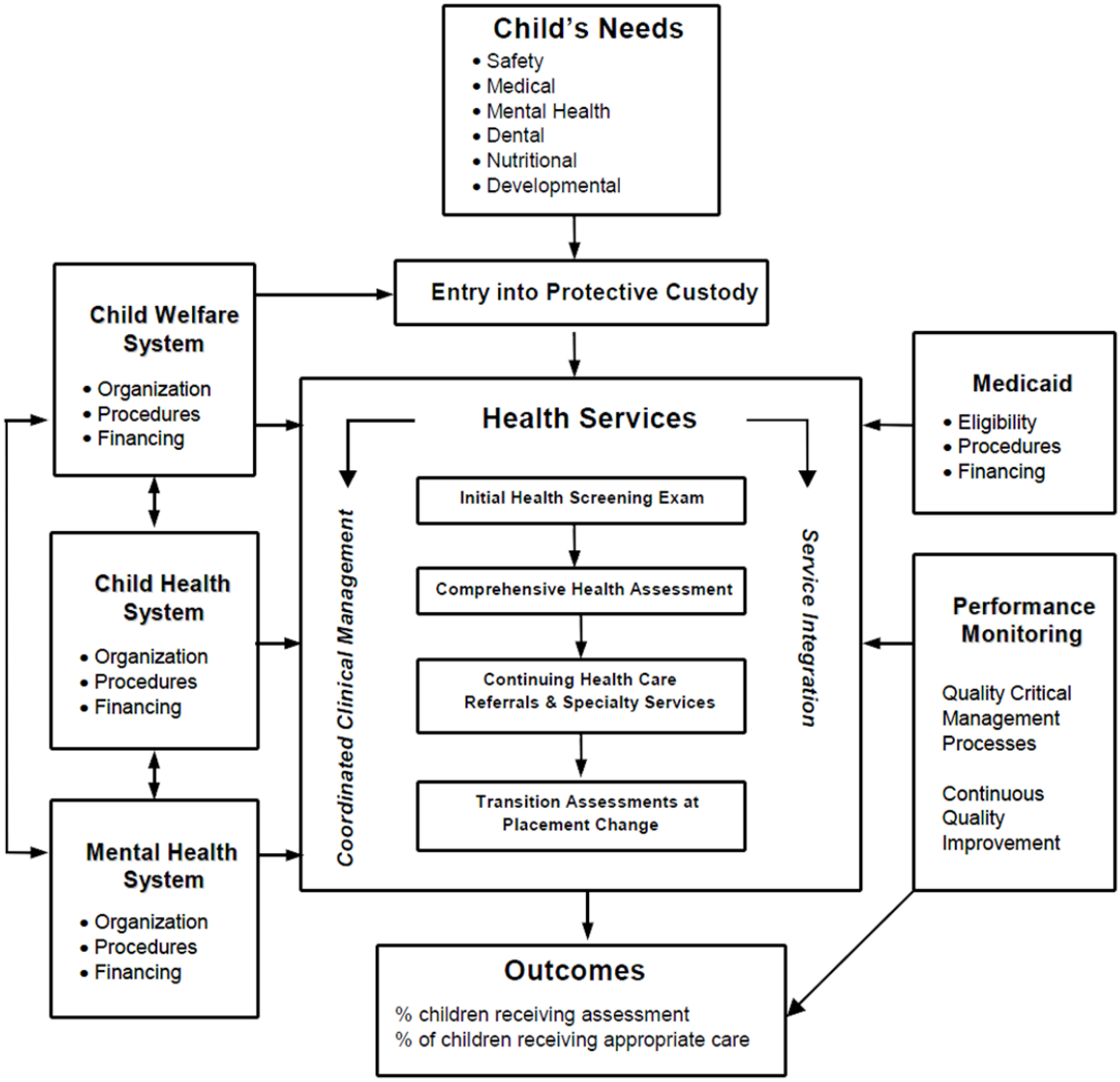
Children in foster care are in a state of transition, and they interact with multiple individuals, institutions and systems that are involved in their care, including "foster parents, biological parents, case workers, child welfare agency, providers, lawyers, child advocates and judges."[7] In this section we identify the key players in the child welfare system and what role they play in addressing the health care needs of children in foster care. This will help readers gain a better insight into the complexities of the child welfare system and make it clear why coordination and communication among stakeholders is important.

At the federal level, HHS plays a role in sustaining and improving the health of children in foster care. Their efforts include providing direct service funds, offering technical assistance, and supporting research. Agencies such as MCHB and the Substance Abuse and Mental Health Services Administration's (SAMHSA) Child and Adolescent Service System Program (CASSP) have made efforts to organize systems of care for CYSHCN and provide solutions that child welfare agencies could implement to improve the access to and quality of health care for children in foster care.[7] An example of this is SAMHSA's Multidimensional Treatment Foster Care (MTFC) community-based intervention which sought to facilitate positive reunification of families by targeting adolescents with chronic delinquency and substance abuse problems and temporarily placing them in a specialized foster home.[52] The Agency for Healthcare Research and Quality, although not directly serving children in foster care, works to improve the quality, affordability, and access to care for children and youth through its research initiatives.

There are several organizations that work at the national level to support the child welfare system. As part of the Training and Technical Assistance (T&TA) Network, ACF has funded 10 National Child Welfare Resource Centers who work to build the capacity of child welfare agencies on an array of topics including organizational improvement, judicial issues, youth development, data and technology, etc. More information about the T&TA Network can be found on the ACF website at http://www.acf.hhs.gov/programs/cb/tta/. Also working on the national level is the Association of Administrators of the Interstate Compact on the Placement of Children (AAICPC). Authorized under the Interstate Compact on the Placement of Children (ICPC), the AAICPC is responsible for facilitating foster care and adoptive placements by providing the legal and administrative framework to ensure the safety and well-being of children placed across state lines.[31]

At the state level, child welfare agencies are largely responsible for the health needs of children in foster care; however, they operate within a large, fragmented system that includes other stakeholder agencies and providers such as Title V, Medicaid, mental health, and children's health. To make significant strides in improving health care for children in foster care, all of these agencies will have to play a part.[7] Figure 1 provides a model of health care delivery for children in foster care. In light of the flexibility that states are given in designing and implementing their child welfare system, program administrators have opportunities to learn from each other and share best practices through the National Child Welfare Resource Centers as well as collaborative efforts led by national advocacy organizations.

Figure 1: Health Care Delivery Model for Children in Foster Care



Source: Halfon, N., Inkelas, M., Flint, R., Shoaf, K., Zepeda, A., & Franke, T. (2002). Assessment of factors influencing the adequacy of health care services to children in foster care. Retrieved July 6, 2011 from UCLA Center for Healthier Children, Families and Communities website: http://www.healthychild.ucla.edu/AssessmentFactors.asp

Health care providers, such as pediatricians and nurse practitioners, play an important role in helping families and children who interact with the child welfare system to minimize trauma and improve health status. During well-child visits providers conduct evaluations of physical, psychosocial and developmental needs; however, a well-child visit for children in foster care requires more time than average for other children.[3] This is because providers face the challenge of caring for and treating children with complex conditions, often without prior medical history, and this requires a comprehensive physical examination of all body systems along with tests for infections, chronic illnesses, and communicable diseases.[4] In addition, providers must communicate care instructions and coordinate additional treatment with foster parents and caseworkers.[3]

The courts play a critical role in the placement of children in foster care. They determine if children are to be removed from their home of origin, approve the permanency plan, and make children available for adoption through termination of parental rights.[15] Foster families and birth families tend to perceive the court system as distant and uncaring.[15] This sense of feeling left out of the process can be attributed to the large number of cases and lack of capacity, which make courts unable to respond in a timely fashion or facilitate relationship building with the children and families involved.[15]

The courts' restrictions in increasing capacity are due to limited budgets, which derive almost exclusively from state and local funds.[15] Under the Family Preservation and Support Services Program Act of 1993, Congress set aside targeted funding for the Court Improvement Program (CIP), which aims to improve court performance in handling child welfare cases and allows states to set up programs that address capacity constraints.[15,53] One strategy states are implementing to improve continuity is the "one-judge, one-family" initiative that allows the same judge to preside over the entire case from removal to permanent placement.[15]

Caseworkers play a significant role in continuity of care. They serve as the representative of the child welfare agency to children and families and are involved in every decision. The child welfare field faces chronic shortages of caseworkers.[15] They carry large caseloads from 10 to over a 100, often with minimal training or supervision.[15] Caseworkers face further challenges due to condensed timelines and an emphasis on accurate data and accountability requirements.[15] For these reasons, fewer than 15% of state child welfare agencies require either a bachelors or masters degree for their caseworkers.[15]

Foster parents play the most important role, as they are the primary caregivers to children in foster care. They are often the first to identify any developmental, physical, or mental health needs of the children placed in their care and are responsible for accessing the appropriate services. Foster parents are also required to communicate and coordinate with case workers and other providers to ensure that children are receiving adequate services. Although states provide training and resources, most parents of children in foster care rely on connections within their community or their previous experience of raising biological or other children in foster care.[54]

Comprehensive Health Care for Children in Foster Care

Child welfare agencies are responsible for addressing the health care needs of children in foster care. Although federal guidelines exist for the administration of public insurance programs, states take different approaches in how they utilize available resources. To support a comprehensive system of care, states must ensure that needed services are properly financed and accessible. In this section we will cover what constitutes comprehensive care, models that states use to finance care, and issues that children in foster care face in accessing care.

Table 4: CWLA/AAP Standards for Health Services to Children in Foster Care

Assessing Health Needs
Initiating health services
Initial pre-placement health evaluation
Components of the initial pre-placement evaluation
Health and mental health history
Releases for health and educational information
Comprehensive health assessment
Comprehensive mental health assessment
Establish health plan
Health Services
Preventive health and health maintenance services
Routine health care
Psychiatric and psychological services
Emergency care
Specialized health consultation
Physical access to health services
Organization and Administration of Health Services
Responsibility for health and mental health services
Direct provision or contracting for services
Coordination of health services
Health program management (policies and procedures)
Caseworker roles in health care coordination
Contracts include protocols for frequency and content
Criteria for selecting health providers
Coordination of State and Local Agencies
Cooperative relationships between agencies, providers

Data Collection and Retrieval
Responsibioity for health data
Sequencing and flow of health information
Sharing of information
Standardized system for collecting and conveying data
Use of abbreviated health record
Accessibility of health records to caseworker
Data maintained for evaluation purposes
Data maintained to profile population's health status
Quality Assurance
Quality assurance program components
Medical provider contract monitoring
Reporting requirements for HMOs
Training for Caregivers and Caseworkers
Training curriculum for caseworkers on health needs
Pre-service training for caregivers on health needs
Information on child development, to caregivers
Information on child emotional response, to caregivers
Information on child health problems, to caregivers
Pre-service training for caseworkers
Ongoing training for caseworkers
Caseworker resources on child development
Caseworker resources to address emotional response
Caseworker understanding of population's health needs
Caseworker training on obtaining/recording health data
Caseworker understanding of PCP/health system roles
Caseworker awareness of agency policies on data and assurance roles and responsibilities

Source: Halfon, N., Inkelas, M., Flint, R., Shoaf, K., Zepeda, A., & Franke, T. (2002). Assessment of factors influencing the adequacy of health care services to children in foster care. Retrieved July 6, 2011 from UCLA Center for Healthier Children, Families and Communities website: http://www.healthychild.ucla.edu/AssessmentFactors.asp

Comprehensive Health Care

The Child Welfare League of America (CWLA) and the American Academy of Pediatrics (AAP) have completed assessments of the gaps in health care for children in foster care and have created standards for providing health care to children in foster care. The four components of health care services that have been recommended include an initial health assessment, comprehensive medical/dental assessment, developmental and mental health evaluation, and ongoing care and monitoring of health status.[3]

Table 4 provides a summary of these guidelines as well as what constitutes comprehensive care for children in foster care.

Financing Health Care

States cannot use Title IV-E or IV-B funds for the purpose of providing direct health care services. However, they can use local dollars as well as federal funding streams not dedicated to child welfare services to cover the cost for health care for children who are in foster care.

Medicaid

Most health care that children in foster care receive is financed through Medicaid. Children who are receiving Title IV-E foster care maintenance payments are categorically eligible for Medicaid.[1] Children in foster care who are funded by the state can become eligible for Medicaid if they meet the financial and/or disability requirements under other existing optional or mandatory coverage groups.[9,10] Data from 2001 indicate that although children in foster care make up a small percentage of the Medicaid population (3.7%), they represent a disproportionate amount of Medicaid expenditures (12.3%) due to the higher prevalence of psychiatric conditions and greater utilization of specialist services.[5,7,55]

Children's Health Insurance Program (CHIP)

Similar to Medicaid, CHIP is administered by states and is jointly funded by states and the federal government to provide health coverage for children in families whose income is too high to qualify for Medicaid but do not have access to health care coverage. Children in foster care who do not qualify for Medicaid coverage or whose placements are supported by child-only TANF payments may be eligible for health insurance under the state CHIP program.[10] States have reported using CHIP funds to cover a variety of health care services for children in foster care including initial health screening exam, comprehensive health assessment, mental health assessment, developmental assessment, ongoing developmental intervention, and ongoing mental health treatment or intervention.[7]

Supplemental Security Income (SSI)

Administered by the Social Security Administration (SSA), SSI provides monthly cash assistance to individuals with low income who have a disability, experience blindness, or are over the age of 65. Children in foster care are eligible for SSI if they have a medically determinable physical or mental impairment which results in marked or severe functional limitation and has lasted or is expected to last for a continuous period of at least 12 months.[57]

In 2010 5.7% of children in foster care received SSI or other Social Security benefits.[22] In a national sample of 1,179 children who had come into contact with child welfare agencies and had been placed in out-of-home settings, approximately 20.4% were estimated to be eligible for SSI.[11] This suggests that many more children in foster care could be receiving SSI benefits.[11] The complex interaction between SSI and Title IV-E payments may offset some of the advantages offered by these individual funding sources during children's experience in foster care, but SSI cash payments along with the associated entitlement in most states to Medicaid for SSI enrollees are particularly helpful in covering children's health care needs after permanent placement or reunification with their biological families.[11]

Title V Spotlight: Quality Monitoring/ Measurement

Iowa

Under Title V, the Child Health Specialty Clinics (CHSC) work with the Iowa Department of Human Services to assure quality care for children and youth with special health care needs who are enrolled in the state's Medicaid and CHIP programs and foster care.

To learn more about CHSC, visit http://www.chsciowa.org/

Adapted from the state's Title V Block Grant Report/Application 2010/2012 at https://mchdata.hrsa.gov/TVISReports

Covered Services

States are required to provide Medicaid-enrolled children, including those in foster care, with a comprehensive array of services under the Early and Periodic Screening, Diagnostic and Treatment program (EPSDT). Services under EPSDT include screening, diagnosis, and treatment to prevent, ameliorate, or treat conditions and to promote healthy development. States have some flexibility in determining how often children (including those in foster care) receive EPSDT screenings, and payment is limited by rules which require that all services be medically necessary and delivered by qualified providers.

In addition to EPSDT, states can choose to offer other services for children, including those in foster care, such as those allowed under the Medicaid Rehabilitation Services option or targeted case management (TCM). As of 2010, all 50 states and D.C. extend both rehabilitative and TCM services to children in foster care who are Title IV-E eligible, except for Delaware which only provides rehabilitative services.[58] States that take up the Medicaid Rehabilitation Services option can provide reimbursement for diagnostic, screening, preventative, and rehabilitative services, including any medication or remedial services provided in a facility, home, or other setting.[59] States can use this option to address specific physical and/or mental health needs of children in foster care in a community-based setting. TCM is defined as case management services that assist eligible individuals to gain access to needed medical, social, educational, and other services.[18]

For TCM to be used by child welfare agencies, the State Medicaid Plan must identify children in foster care as an eligible population and describe the services.[18] Available data suggest that children who receive TCM are more likely to access critical medical and social services compared to those who do not receive TCM.[60] The specific rehabilitative or TCM services vary from state to state, but typically include:

- Assessing children's needs;
- Developing a service plan;
- Assisting children and families in obtaining needed services;
- Monitoring children's progress by following up on referral services and consulting with providers and families;
- Arranging crisis intervention services.[61]

Children who are enrolled in Medicaid are entitled to mental health assessments and the necessary treatments to address their health needs. However, there continues to be a gap between being enrolled in Medicaid and actually receiving services.[12] An estimated 70% of children in foster care never receive comprehensive examinations for developmental or psychological issues.[15,62] In addition, Medicaid programs typically do not facilitate access to the full range of developmental and mental health care services that children in foster care need due to inadequate reimbursement rates for pediatric specialists such as child psychiatrists and poorly funded therapies such as substance abuse treatment.[3,4,63]

States can utilize Medicaid waivers to introduce system flexibility or pay for services that traditionally would not be provided through Medicaid. There are three primary types of waivers. Section 1115 Research and Demonstration Projects waiver allows states the flexibility to use Medicaid funding to test new or existing strategies in delivering services. Section 1915(b) Managed Care waivers allow states to use Medicaid funds in providing managed care services to specific populations. Section 1915(c) HCBS waivers allow states to provide long-term care services in a home or other community setting for individuals who would otherwise receive services in an institutional setting. Many states have opted to use the waiver option to pro-

vided targeted services for children in foster care. An example of this is New York's Bridges to Health Program (B2H) which is a HCBS waiver program for "children in foster care who have significant mental health, developmental disabilities, or health care needs to help them live in a home or community-based setting."[64] The B2H program covers services such as accessibility modifications, crisis respite, day habilitation, health care integration, skill building, and more.[64]

Payment Methods

States can use different payment methods for Medicaid services to children in foster care, including Medicaid managed care (MMC) plans or fee-for-service (FFS) providers. The method of payment a state uses may impact the ability of children in foster care to access needed services, particularly mental health services, the need for which are highly prevalent among this population.[7] State agencies are increasingly using MMC as an approach to manage costs and deliver higher quality services.[65] As of 2010, 36 states included children in foster care as an eligibility group for MMC in at least one program or geographic area and 11 states and the District of Columbia explicitly exclude this population from enrollment in an MMC.[65] Table 5 provides a list of which states include or exclude children in foster care from MMC enrollment eligibility.

The advantage of MMC is that it can offer improved access to primary care services, which may result in a focus on prevention, care coordination, increased access to ambulatory services, a decrease in emergency room use, and other improvements in the quality of care. However, a considerable portion of children in the child welfare system have a high need for mental health services and the per-member-per-month (PMPM), capitated payments offered by managed care plans create incentives for providers to control the use of mental health services.[4,66] In fee-for-service (FFS), the lower reimbursement rates to providers contribute to other documented consequences that result in effectively limiting access such as "shortages of health professionals, racial and ethnic disparities in treatment among children in foster care, medication management issues, overuse of psychotropic medication, and avoidable inpatient stays."[4,67]

Access to Care

Even if children in foster care are enrolled in a public insurance program, they face significant barriers in accessing health care. In some cases, they face the same challenges as anyone who uses public insurance, such as a lack of providers who are able and willing to serve Medicaid recipients.[8] Other challenges that states, providers, foster parents, and social workers face in addressing the health care needs of children in foster care include:

- High rate of individual children coming in and out of foster care placement;[14]
- Difficulty in identifying health care needs;[8]
- Inability to contact biological parents to review health history;[3]
- Lack of understanding of the type of services a child should receive;[3]
- Lack of resources to ensure delivery of appropriate health services;[8]
- Lack of documentation and monitoring of health care;[8]
- High turnover of case workers and support professionals.[4]

Removal from the care of biological parents often makes tracking children's health history difficult, and while in foster care, children may move among several foster homes or treatment settings and encounter a number of different providers.[8] In addition, children in foster care experience increasingly complicated physical and mental health conditions.[3] All of these factors complicate efforts to document health care histories and ensure children receive the health care services they need.

Table 5: Medicaid Managed Care Enrollment Eligibility for Children in Foster Care

State	MMC Eligibility	State	MMC Eligibility
Alabama	No, Excludes	Montana	No, Excludes
Alaska	N/A	Nebraska	Yes, Includes
Arizona	Yes, Includes	Nevada	No, Excludes
Arkansas	Yes, Includes	New Hampshire	N/A
California	Yes, Includes	New Jersey	Yes, Includes
Colorado	Yes, Includes	New Mexico	Yes, Includes
Connecticut	Yes, Includes	New York	No, Excludes
D.C.	No, Excludes	North Carolina	Yes, Includes
Delaware	Yes, Includes	North Dakota	No, Excludes
Florida	Yes, Includes	Ohio	Yes, Includes
Georgia	Yes, Includes	Oklahoma	No, Excludes
Hawaii	Yes, Includes	Oregon	Yes, Includes
Idaho	Yes, Includes	Pennsylvania	Yes, Includes
Illinois	No, Excludes	Rhode Island	Yes, Includes
Indiana	Yes, Includes	South Carolina	Yes, Includes
Iowa	Yes, Includes	South Dakota	No, Excludes
Kansas	Yes, Includes	Tennessee	Yes, Includes
Kentucky	Yes, Includes	Texas	Yes, Includes
Louisiana	No, Excludes	Utah	Yes, Includes
Maine	Yes, Includes	Vermont	Yes, Includes
Maryland	Yes, Includes	Virginia	No, Excludes
Massachusetts	Yes, Includes	Washington	Yes, Includes
Michigan	Yes, Includes	West Virginia	No, Excludes
Minnesota	Yes, Includes	Wisconsin	Yes, Includes
Mississippi	Yes, Includes	Wyoming	N/A
Missouri	Yes, Includes		

Source: Gifford, K. & Paradise, J. (2011). A profile of Medicaid managed care programs in 2010: Findings from a 50-state survey. Retrieved on May 2, 2012 from Kaiser Family Foundation website: http://www.kff.org/medicaid/8220.cfm

Title V Spotlight: Access to Quality Health Care and Care Coordination

California

The Health Care Program for Children in Foster Care (HCPCFC) provides public health nurse expertise in meeting the medical, dental, mental and developmental needs of children and youth in foster care. It is a collaboration between the Department of Social Services and Children's Medical Services (the state Title V CSHCN program) to improve oversight of health care for children in foster care.

For more information of HCPCFC, visit http://www.dhcs.ca.gov/services/HCPCFC/Pages/ProgramOverview.aspx

Adapted from the state's Title V Block Grant Report/Application 2010/2012 at https://mchdata.hrsa.gov/TVISReports

Federal and State Efforts to Improve the System of Health Care

As both public and private agencies have released reports on the health conditions of children in foster care, federal and state lawmakers have taken steps to improve the system of care for this population. In October 2008, Congress amended Title IV-B to require states to "develop plans for the ongoing oversight and coordination of health care services for children in foster care."[8] This requirement applies to all children in foster care whether or not they meet the federal Title IV-E eligibility criteria. In addition, ACF has a network of 30 technical assistance centers designed to help state child welfare agencies improve their ability to meet the needs, including health needs, of children in foster care.[68] These technical assistance centers can help states work more collaboratively with other public and nonprofit agencies, including those that provide health care services. Two of these centers, the National Technical Assistance Center for Children's Mental Health[i] and Technical Assistance Partnership for Child and Family Mental Health[ii], focus exclusively on the mental health needs of children and families.

Furthermore, HHS has also taken several steps to expand mental health services and prevent custody relinquishment through an official document produced by the ACF that clarifies that while a state child welfare agency is responsible for the placement and care of children in out-of-home care, it is not required that the state obtain custody of the child.[40] States have also implemented important measures to prevent custody relinquishment by:

- Amending policies that require state custody in order for children to have access to mental health services;
- Allowing child welfare agencies to set up voluntary agreements with parents for out-of-home placement without custody relinquishment;
- Giving juvenile courts jurisdiction to order mental health treatment for children in out-of-home placement.[12]

i National Technical Assistance Center for Children's Mental Health (TA Center) provides assistance to States, Tribes, territories, and communities to build systems of care that enhance access to quality care and improve outcomes for children, youth and families with, or at-risk of, emotional disorders. The center provides information, technical assistance, and training on systems of care and to cross system audiences. More information available at http://gucchdtacenter.georgetown.edu.

ii Technical Assistance Partnership for Child and Family Mental Health (TA Partnership) provides technical assistance to system of care (SOC) communities funded by the Comprehensive Community Mental Health Services for Children and Their Families program. The TA Partnership helps communities transform the way services are delivered to children and families by emphasizing the SOC philosophy of delivering services that are community-based, family-driven, youth-guided, and culturally competent. More information available at http://www.tapartnership.org.

Additional steps states have taken include enforcing Medicaid entitlement services by requiring all children to be provided medically necessary care under EPSDT, expanding Medicaid/CHIP programs, or adopting a managed care model as a method of obtaining comprehensive care for children in foster care.[3,12] With regard to physical, developmental and mental health assessments, several states have reported using designated providers to perform the initial and comprehensive evaluations with some evidence that this has increased the consistency and thoroughness with which health care needs are being identified.[8]

Furthermore, states can request Title IV-E child welfare waiver demonstrations from HHS. The waivers allow states more flexibility in the use of Title IV-E funding to support innovation in the delivery of child welfare services.[43] As of March 2012, six states had active waivers authorized by HHS.[69] Under this waiver, states have been able to provide a range of programs and services including "intensive preventive services, substance abuse services for parents, subsidized guardianships, and post adoption services."[43] More specifically, states have used this waiver to address the mental health needs of children in the child welfare system or those who are at risk of entering into state care.[43]

Title V Spotlight: Access to Quality Health Care and Care Coordination

Illinois

The Illinois Department of Children and Family Services and the Department of Human Services' Bureau of Maternal and Infant Health collaborate on the operation of HealthWorks of Illinois, which has developed regional networks of primary and specialty care to ensure that children in foster care receive the health care services they require.

HealthWorks of Illinois has six key features to assist in accomplishing this goal:

- An Initial Health Screening must be completed within 24 hours of a child entering custody and before placement into substitute care;
- A Comprehensive Health Evaluation is conducted within 21 days of custody, which includes an Early and Periodic Screening, Diagnostic and Treatment program (EPSDT) examination and a vision, hearing, and dental screening when appropriate. Mental health, developmental, and alcohol and substance abuse screenings are performed when appropriate. Referrals for specialized services are made as needed;
- A Primary Care Physician is selected for the child by the substitute caregiver. Participating physicians are required to complete a residency that includes pediatric training, offer 24-hour availability, and have hospital admitting privileges;
- Specialty and subspecialty care is made available including dental care, optometry services, and other pediatric subspecialty care;
- Medical case managers promote strategies directed at improving access to services identified in the individualized care plan created for each child;
- A Health Passport containing information about the child's diagnosis, services provided, immunization records and diagnostic studies serves as a "portable" medical record and follows the child. In addition, physicians use standardized age-specific medical forms.

To learn more about Healthworks of Illinois, go to http://www.dhs.state.il.us/page.aspx?item=31899

Adapted from the state's Title V Block Grant Report/Application 2010/2012 at https://mchdata.hrsa.gov/TVISReports and the Healthworks of Illinois website (see above).

Innovative Models of Health Care Delivery in Foster Care

After decades of targeted research and widespread dissemination of best practices in health care delivery for children in foster care, several states and counties have worked with local providers to implement these ideas. Below are examples of three programs that have established innovative models that help integrate foster care with the health care system.

The Special Kids♥Special Care Program, Massachusetts

Who is eligible?

Children and youth from newborn to age 22 who have complex and/or unstable medical conditions and are in the Department of Children and Families' (DCF) custody or foster care program (and some group homes) are eligible for the *Special Kids♥Special Care Program*. Once enrolled, children can remain in the program as long as they continue to have complex medical needs and an open case with DCF, even if they are returned to the care of their biological family, adopted or guardianed. Children must require complex medical management, skilled nursing, assessment, or monitoring for an unstable medical condition on a regular basis. DCF staffs from the Health and Medical Services Team and DCF Social workers are the primary referral sources to the program, but anyone may make a referral.

Medical conditions of children in the program include but are not limited to premature babies, children with medical conditions such as brain damage and severe physical disabilities from nonaccidental trauma, conditions that require medical technology such as tracheotomies and ventilators, children with chronic medical conditions such as cerebral palsy, cystic fibrosis, HIV, seizure disorders, congenital anomalies, complex cardiac defects, renal failure, lupus, multiple sclerosis (MS) and adolescents with uncontrolled diabetes. There are 143 children enrolled in the program as of July 2012.

What is provided?

Children in foster care enrolled in the *Special Kids♥Special Care Program* receive intensive medical case management from the pediatric nurse practitioners (PNPs) who are employed by Neighborhood Health Plan (NHP). The PNP works with DCF staff, the foster family, primary and specialty physicians, home health providers and social workers to manage and coordinate children's care, assess ongoing health care needs, obtain health records and develop detailed individualized health care plans that are updated quarterly and given to DCF, the caretaker and the child's primary care physician.

The PNP assesses each child medically, orders necessary services and medications on an ongoing basis, participates in certain medical appointments, evaluates the ability of substitute caretakers and biological parents to provide the necessary care and provides information and education regarding the child's condition and care needs for the child's caretakers and DCF staff. In addition to an individualized and ongoing assessment of health care needs, the caregiver for the child has access to a PNP 24 hours a day, 7 days a week.

How is the program funded?

The *Special Kids♥Special Care Program* began in 1999 as a collaboration between DCF and MassHealth, the state Medicaid program. MassHealth has an agreement with NHP to administer the program. NHP is a managed care organization and is funded by MassHealth which pays a monthly fee per member.

Key Clinic of Penobscot Pediatrics, Maine

Who is eligible?

Children who are in custody of the child welfare system and live in Penobscot or Piscataquis counties are eligible for the program. The practice also serves those in kinship care and voluntary out-of-home placement. Some common diagnoses include developmental delay, behavior disorder, attachment disorder, anger issues, obesity, delayed immunizations, neonatal abstinence syndrome and anemia. As of March 2012, 124 patients were enrolled.

What is provided?

The Key Clinic is housed within the pediatric division of Penobscot Community Health Care (PCHC) and serves as a medical home for children in foster care. The clinic's staff provide a medical assessment for children in foster care, ideally within 72 hours of entering custody, to update medications, address immediate medical needs, and begin the often arduous process of piecing together a child's medical records. After the first visit, a social worker and primary care physician work with the foster family to provide health-related resources. Children and foster care families are also provided with a comprehensive evaluation that focuses on catch-up immunizations, developmental and cognitive issues, necessary laboratory, vision and hearing screenings, and appropriate referrals as well as a thorough physical examination by a Board Certified Pediatrician. The office can also serve as a medical home for children in foster care who are in need of a Primary Care Provider.

How is the program funded?

Key Clinic received initial seed funding from an American Academy of Pediatrics Community Access to Child Health (CATCH) grant in 2008. All children at the Key Clinic are enrolled in Maine's Medicaid program, MaineCare. The nurse care manager is funded through a Patient Centered Medical Home grant at PCHC.

Thomas H. Pinkstaff Medical Home Clinic, Kentucky

Who is eligible?

The Thomas H. Pinkstaff Medical Home Clinic was created by the Commission for Children with Special Health Care Needs, which is the Commonwealth's Title V CSHCN program, in collaboration with the University of Kentucky. The clinic only accepts children with Medicaid and focuses on children in out-of-home care, but does see some children in the care of their families. Children are required to have a physical evaluation within 24 – 48 hours of being removed from their home. The program has provided 3,899 patient visits since its inception in December 2007. Please note that this number may seem larger than other programs because it counts the number of patient visits and not the number of children enrolled.

What is provided?

Two pediatricians at the Thomas H. Pinkstaff Medical Home Clinic provides primary medical care for foster children such as well-child visits, sick visits, immunizations, developmental assessment, and referrals for specialized care. An Advanced Practice Registered Nurse (APRN) also assists with providing direct patient care, seeking patients for initial evaluations, maintaining follow-up and overseeing intake process. In addition to doctors and nurses, the clinic also has licensed social workers for support with behavioral issues, and a part-time therapist visits with clients weekly to provide mental health services. Staff members collaborate with caseworkers to minimize the number of visits a child has to make to the clinic and maintain up-to-date medical records.

How is the program funded?

The clinic was established and continues to receive support from a grant through the Kentucky Commission for Children with Special Health Care Needs. The services provided at the clinic are billed to Medicaid.

Closing Thoughts

Foster care in the U.S. is based upon a large and fragmented system comprised of many key players. The nature of foster care in moving children from homes where they are at risk to a permanent safe placement highlights the need for high quality, coordinated health care while simultaneously creating challenges in accessing it. Evidence shows that the medical and mental health needs of children in foster care are often overlooked.[8] Through an increased focus on the health care needs of children in foster care, efforts to increase their access to both coverage and high quality health care and greater coordination among the many different stakeholders responsible for and invested in their health and well-being, we can ensure that they will be able to grow, learn and reach their full potential.

As for any child, health care coverage for children in foster care must be universal and continuous, adequate and affordable. Therefore, well-organized and comprehensive systems of both coverage and care are vital to promoting the health and well-being of children in foster care. As we explore the health care issues that children in foster care face, we hope that you will share your thoughts and work with us to highlight innovations that improve the system of care for children and youth who interact with the child welfare community.

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Medical Director
Key Clinic, Penobscot Pediatrics, Penobscot Community Health Care, Bangor, ME

Lynda Honberg
Division of Children with Special Health Needs, Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services

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Mary Lutz
Director of Medical Services
Commonwealth of Massachusetts, Department of Children and Families

Mary Anne MacKusick
Commonwealth of Massachusetts, Department of Children and Families

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Boston University School of Public Health

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