



Medicaid and Children in Foster Care

Kamala D. Allen, MHS
Taylor Hendricks, MS
Center for Health Care Strategies

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Introduction

The health care needs of children in foster care are vast and often compounded by their circumstances. These children face myriad challenges – from placement instability, to emotional, behavioral, and educational difficulties, to juvenile justice involvement – that threaten their health and well-being. Because they are often at the intersection of multiple public systems including behavioral health, child welfare, education, juvenile justice, and primary care, it is critical for these systems to work collaboratively to meet their health needs.

Much national attention is currently being directed toward this population, particularly around the issue of psychotropic medication use, which has shed a spotlight on the behavioral health challenges faced by these children. Most children in foster care are insured through Medicaid, which makes state Medicaid agencies one of the major players in developing solutions to address the issues of this population.

This brief details the health care needs of children in foster care and the role of Medicaid in providing health coverage for this population. It also highlights existing policy levers that may help to address some of the ongoing health and well-being issues faced by children in foster care.

Health Care Needs of Children in Foster Care

It is well-documented that children in foster care have significant health care needs, including physical, dental, and especially behavioral health needs.^{1,2,3} Nearly 90 percent of young children entering the foster care system have physical health problems, and 55 percent have two or more chronic conditions.⁴ Almost a quarter of children entering foster care have three or more chronic conditions. The most common physical health issues among this population include skin conditions, asthma, anemia, malnutrition, and manifestations of abuse.^{5,6}

Healthy Foster Care America, an initiative of the American Academy of Pediatrics (AAP), notes that approximately 35 percent of children and teens enter foster care with significant dental and oral health problems.⁷ The AAP recommends that children entering foster care receive a dental evaluation within 30 days of placement. While as of 2010, 38 states had policies that align with that recommendation, ensuring access to preventive oral health care and treatment remains challenging for this population of children, among whom other issues may overshadow the need for dental care, and preventive dental care in particular.⁸

Despite higher levels of physical and oral health issues among children in foster care, chief among their health-related needs are behavioral health issues. In 2011, out of 676,569 children for whom abuse or neglect was substantiated, approximately 60 percent (400,540) entered foster care.⁹ The trauma associated with abuse and/or neglect, as well as removal from the home, has the potential to create a set of circumstances that may lead to challenging behaviors. Further, there is a subset of children who ultimately come to the attention of the child welfare system because their mental health needs outstrip the capacity of their families to manage. For these children, comprehensive and coordinated behavioral health care is critical to their health, well-being, and long-term outcomes, which are poorer than those of youth who have not had foster care experience.¹⁰

Children in foster care represent only 3 percent of children in Medicaid, but 15 percent of children in Medicaid using behavioral health services.¹¹ Further, these children represent 13 percent of those in Medicaid receiving psychotropic medications, and are four times more likely to receive these medications than children in Medicaid overall. Across three Medicaid eligibility categories – children receiving Temporary Assistance for Needy Families (TANF) benefits, children receiving Supplemental Security Income (SSI), and children in foster care – only children with SSI status exceed those in foster care in the rate at which they receive psychotropic medications, at 27 and 23 percent respectively. Children in foster care are also more likely to use restrictive/expensive service types, including residential treatment/group care, inpatient psychiatric treatment, and emergency room services.¹² These findings suggest a high level of need for physical and behavioral health services among children in foster care. Moreover, they reveal trends in service use that allude to the

prevalence of serious physical and behavioral health needs, and the potential challenges to accessing certain services.

As far back as 30 years ago, the AAP Committee on Adoption reported that children in foster care were unlikely to receive routine health care, immunizations, dental care, and hearing or vision screening. A seminal General Accounting Office report published in 1995 found that, specifically for young children in foster care, child welfare systems were unable to ensure appropriate health screenings in a timely manner, and states had difficulty monitoring the extent to which identified needs were addressed across the range of foster care placements.¹³ More recently, a review of state child welfare systems by the Department of Health and Human Services revealed that half of the states failed to provide adequate physical and mental health services to children in almost one-third of cases reviewed.¹⁴ The health care needs of this population remain complex and today, access to and coverage of comprehensive, timely, and appropriate health care services remain key issues for children in foster care.

The federal government has passed legislation establishing guidelines and requirements for state child welfare agencies related to the health and well-being of children in foster care, including the provision of grants and technical assistance to enable states to meet these needs and make explicit connections with state Medicaid.¹⁵ In addition, many states have aggressively sought to ensure that the well-being of the children in their custody is better addressed by tying their screening requirements to those for the Medicaid program in their states.¹⁶

Children in foster care are considered by many, including the AAP, to be a population of children with special health care needs.¹⁷ Some states have created special health-related programs to better address and coordinate the complex physical, behavioral, and social needs of these children. A number of state child welfare agencies including those in Illinois, New Jersey, Vermont, and Utah, have created in-house programs ranging from a few designated staff to full health units, or have contracted for medical expertise, to better manage the health care needs of the children in their custody. Additionally, as of 2010, a total of 35 states were enrolling their foster care populations in Medicaid managed care programs, a trend that provides opportunity to better manage care for this population if appropriate customization is built into the managed care system

There are a number of issues unique to involvement in foster care that make providing access to needed services, and coordination among services when they are received, more difficult for this population, including:

- Frequent changes in placement and caregivers;
- Trauma experienced by the child, both prior to and as a result of removal from the home;
- Significant behavioral health needs that may not be appropriately addressed due to failure to incorporate customized screening and assessment and/or evidence based interventions into delivery systems;
- Over-reliance on psychotropic medication to address behavioral issues;
- Lack of specialty child behavioral health care providers trained to diagnose and treat childhood trauma;
- Multi-system involvement of children in foster care, which may be characterized by poor cross-agency coordination, and lack of access to relevant data;
- Fragmentation across Medicaid, child welfare, and behavioral health financing streams; and
- Lack of knowledge among case workers about other agencies' benefit programs, for which children in foster care are eligible.

The Medicaid program, which can cover a comprehensive set of health care benefits for foster children, provides a solid foundation for addressing their health needs. Recent federal legislation presents stakeholders with opportunities to build upon this foundation and improve care for these children. The following section outlines the array of services allowable under Medicaid for children enrolled in the program.

Medicaid Coverage for Children in Foster Care

Medicaid is a joint state and federal program that provides health care coverage to eligible beneficiaries. It is administered individually by each state and financed jointly by states and the federal government.¹⁸ Among the broad rules established by the federal government are the income limits, covered services, and categories of individuals who must be covered by the Medicaid program. The latter are referred to as mandatory populations (states have the flexibility to extend coverage beyond those groups to optional populations, or to include optional benefits) and largely consist of low-income individuals and those with disabilities. With full implementation of the Affordable Care Act in 2014, however, categorical eligibility for the Medicaid program will be eliminated and only income will be considered.

Virtually all children in foster care are categorically eligible for Medicaid, which covers a specific set of benefits for children called Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) services (see Figure 1).¹⁹ These core benefits for children include screening, preventive, and early intervention services, as

well as diagnostic services and treatment for acute and chronic physical and mental health conditions. Dental and vision care are also covered, as are services for children with disabilities, such as durable medical equipment and various forms of therapy.

The AAP recommends the following four domains of health care be provided to every child in foster care: initial health screening, comprehensive medical and dental assessment, developmental and mental health evaluation, and ongoing primary care and monitoring of health status.²⁰ While each of these domains is an area of health care that is covered by the Medicaid program, there are certain services and aspects of care that may be particularly beneficial to children in foster care that are not currently reimbursable under Medicaid. For example, tutors, room and board costs for treatments like therapeutic foster care, and services to parents or family members. In addition, there are other important services for this population, including intensive care coordination, treatment planning, family training, recreational therapies, peer support, intensive in-home services, and mobile response and stabilization that are reimbursable under Medicaid through waivers or State Plan Amendments, but are not automatically included in a state's Medicaid program. This results in gaps in coverage. Some states, like Arizona and Massachusetts, have worked to expand their Medicaid benefit to include more of these supportive and evidence-based services for children. Additionally, in some states, Medicaid and child welfare agencies have worked together, combining resources to ensure that all needed services are covered.²¹

Figure 1. Core EPSDT Elements

Health Care Benefits

- Periodic assessments of children's growth and development in accordance with accepted pediatric assessment standards, including:
 - Unclothed physical exam including a nutritional assessment;
 - An assessment to determine a child's overall physical, mental, and developmental health (the developmental assessment);
 - Health history;
 - Laboratory services as needed, including assessment of blood lead levels;
 - Immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices; and
 - Anticipatory guidance.
- Interperiodic (as needed) assessments.
- Comprehensive vision, dental and hearing services in accordance with reasonable professional standards.
- All medically necessary diagnostic and treatment items and services that fall within the definition of medical assistance.
- A preventive standard of medical necessity that specifies "early" coverage to "correct or ameliorate" physical and mental conditions in children.
- Coordination with related programs.

State Administrative Support Services

- Information about EPSDT and the value of preventive health care.
- Provision of scheduling and transportation to families who request services in order to ensure the timely provision of care.
- Provision of reports to the United States Department of Health and Human Services regarding the number of children receiving screening and dental services, the number of children referred for corrective treatment, and the state's results in attaining federally set participation goals.

Coordination of Cross-System Funding for Children in Foster Care

In recent years, the federal Centers for Medicare & Medicaid Services have undertaken efforts to clarify the appropriate use of Medicaid funds for services that are of particular benefit to children in foster care. For example, targeted case management, some evidence-based treatments (must be delivered by qualified Medicaid providers), and substance abuse treatment services for youth are reimbursable under Medicaid. However, not all services needed by children and youth in foster care are covered by Medicaid. For example, tutors or the room and board costs of certain treatment programs like therapeutic foster care are not covered.

It is therefore critically important that states encourage the coordination of financing for this population. This may be accomplished by undertaking a cross-agency mapping of funding streams to services to understand which services may be covered by which funding streams. This exercise may allow a state to free-up more flexible dollars to cover services that are not eligible for reimbursement under more restrictive funding streams. For example, there are health-related services that a state might choose to cover with Medicaid to free-up child welfare or behavioral health block grant dollars to cover more non-traditional, but still essential, community based services.

Policy Opportunities

As the dominant health insurer for children in foster care, Medicaid covers a range of critical health care services. However, certain states may not cover the full array of needed services and supports in their state Medicaid plans. As is evident in examining the prevalence of physical, behavioral, and oral health needs, trends in service utilization, and Medicaid expenditures for children in foster care, states must explore ways to expand access to and improve the quality and cost-effectiveness of health care for children in foster care. Further, the child welfare goals of safety, permanency, and well-being²² should be reflected in policies governing the financing and delivery of health care for children in foster care. In recent years, several important pieces of legislation have emerged that encourage states to invest in new and effective methods for improving health care quality for children in foster care through enhanced care coordination, family engagement, and continuity of care.

The Fostering Connections to Success and Increasing Adoptions Act of 2008, the Affordable Care Act (ACA) of 2010, and the Child and Family Services Improvement and Innovation Act of 2011 present states with opportunities for quality improvement in health care for children in foster care by promoting collaboration among Medicaid, child welfare, behavioral health, and other systems. These laws also support expanded access, oversight mechanisms, and delivery system innovations that have the potential to significantly improve health outcomes for children in foster care.

Policy Opportunity: Interagency Collaboration for Better Care Coordination

Care coordination is paramount to ensuring that children in the foster care system receive needed services and supports, and that these services are clinically appropriate and cost-effective. The Fostering Connections to Success and Increasing Adoptions Act of 2008 (Fostering Connections) acknowledges the need for better

health care coordination among the key agencies serving the foster care population. It requires states to develop plans to better monitor and coordinate health services provided to children in foster care, as well as to expand access to medical homes for children with child welfare involvement who may experience multiple placement changes.²³ Since Medicaid covers nearly all children in foster care, implementation of Fostering Connections' health care provisions has largely been, and continues to be, a collaborative process between state Medicaid and child welfare agencies.

For example, Tennessee's Department of Child Services (DCS) collaborates with TennCare, the state Medicaid agency, through an interagency agreement to coordinate the enrollment and ongoing provision of health services for all children in state custody. As soon as a child enters state custody, DCS notifies TennCare *Select*, the state's Medicaid managed care company serving children in foster care, and the child is assigned immediate eligibility and a primary care practitioner (PCP) who serves as their medical home. The PCP is responsible for providing basic primary care as well as coordinating all physical and behavioral health services for these children. These PCPs are members of TennCare *Select*'s Best Practice Network of physicians, dentists, and behavioral health care providers who have agreed to serve the health care needs of this unique population and fulfill the roles and responsibilities associated with management of children in state custody.²⁴

TennCare *Select* also provides customer service tailored to the needs of DCS family service workers and resource parents through a toll-free phone line staffed by personnel familiar with DCS processes. Both agencies work together around issues of psychotropic medication use, informed consent, and meeting the physical and behavioral health needs of children in foster care. TennCare *Select* and DCS meet regularly to develop and implement strategies to improve care for children in state custody, including transition of children aging out of the system, management reporting to DCS, and coordination of inpatient psychiatric hospitalizations.²⁵

Policy Opportunity: Monitoring Psychotropic Medication Use

The use of psychotropic medications among children in foster care has gained national attention as rates of use among this population have steadily increased over the past decade. The Child and Family Services Improvement and Innovation Act of 2011 requires state child welfare plans to include protocols governing the appropriate use and monitoring of psychotropic medications. States must also outline in their plans how they will address the trauma associated with abuse and neglect faced by children in child welfare, which can often lead to behavioral issues. Many states are already working to enhance oversight and monitoring mechanisms that can help reduce inappropriate use of psychotropic medications. Through its *Psychotropic Medication Quality Improvement Collaborative* (PMQIC), the Center for Health Care Strategies is bringing together

leaders in Medicaid, child welfare, and behavioral health from six states to develop new approaches for monitoring psychotropic medication use among children in foster care.²⁶

For example, Illinois, one of the states participating in the PMQIC, is taking on several efforts to improve oversight of psychotropic medication use among children in foster care. The state has established a data-sharing agreement between Medicaid and child welfare in order to better monitor the prescription of psychotropic medications, and is in the process of enacting a “hard stop” where the pharmacy will not be reimbursed by Medicaid for psychotropic medications dispensed to foster children whose medications have not been reviewed and approved by the clinical consultant to the child welfare agency. Further, the state is implementing a requirement that all children in foster care have up-to-date consent forms for all psychotropic medication prescriptions. Given the association between use of psychotropic medication and metabolic diseases such as diabetes, Illinois is also requiring that all children on second-generation antipsychotics be screened for metabolic disturbances. These efforts, among many others being developed by states participating in the PMQIC, are creating more effective mechanisms for monitoring the use of psychotropic medications among children in foster care.

Policy Opportunity: Extension of Medicaid Coverage to Age 26 for Former Foster Youth

The ACA contains many provisions that may impact the health and well-being of children in foster care. One foster care issue addressed in the ACA is the loss of coverage upon “aging out” of the child welfare system. Formerly, when a child in the foster care system turned age 19, he or she was reclassified as an adult and was no longer categorically eligible for Medicaid. Beginning January 1, 2014, the ACA extends Medicaid coverage to former foster youth up until the age of 26, regardless of their income.

A Chapin Hall study pointed to the potential impact of this policy change, with data indicating that youth who age out of foster care under current policy are less likely to report having health insurance or having seen a health or dental care provider in the past year.²⁷ Given what we know about the prevalence of physical, and especially behavioral, health needs among this population, this provision is critical to ensuring that foster youth entering adulthood continue to receive needed services and supports. An additional ACA provision requires that transition plans for youth aging out of foster care and independent living programs include information on designating a medical power of attorney.

Policy Opportunity: Increased Access to Home- and Community-Based Services for Children in Foster Care

Medicaid-eligible children in foster care often receive some portion of their treatment in residential or institutional facilities.²⁸ Recognizing that these services tend to be expensive and may further isolate children

from family and community supports, the ACA has granted states increased flexibility to provide home- and community-based services (HCBS) to certain populations, including children in foster care.

The 2005 Deficit Reduction Act authorized grants to nine states to take part in the Community Alternatives to Psychiatric Residential Treatment Facilities (PRTF) Demonstration Program. The goal of the program was to provide HCBS to children as an alternative to placement in residential treatment facilities, in order to test the health outcomes and cost-effectiveness of these services. An independent evaluation of the state PRTF Demonstration Program, released in May 2012, showed that it succeeded in maintaining or improving children's functional outcomes in juvenile justice, school functioning, substance abuse, and involvement with child protective services. Further, the treatment costs associated with the demonstrations were on average far lower than institutional alternatives, with an average per capita savings of \$20,000 to \$40,000.²⁹ Many states are now using 1915(c) waivers and considering use of 1915(i) state plan options under the Social Security Act to develop and expand HCBS for this population of children.

While 1915(c) waivers remain the primary tool used by states to expand HCBS for their Medicaid populations, states now have increased flexibility through the ACA to use the 1915(i) state plan option for this purpose.³⁰ Prior to the ACA, the 1915(i) plan option was available to provide HCBS only to individuals with incomes up to 150 percent of the federal poverty level, and could not be targeted to particular populations. States now have the option to expand eligibility for HCBS under 1915(i) up to 300 percent of the Supplemental Security Income federal benefit rate, and these services can be directed to a specific population such as children with serious emotional disturbance. In addition, unlike 1915(c) waivers, recipients of home- or community-based care under a 1915(i) option do not need to qualify for institutional-level care. Services offered under a 1915(i) state plan option must be offered statewide and cannot have waiting lists.³¹ Previously, very few states had elected the 1915(i) option, but the hope is that with the expanded flexibility under the ACA, more states will take advantage of this option and perhaps choose to design service packages specifically for children in foster care.

Policy Opportunity: Expansion of Maternal, Infant, and Child Home Visiting Programs

Building on the emphasis toward home- and community-based care, the ACA allocates additional federal funds, amounting to \$1.5 billion over five years, for states to test or expand evidence-based maternal and child home visiting programs for at-risk families. These programs may include a range of services provided by nurses, social workers, psychologists, or other professionals that address the health, early education, child protection, and social needs of families. Regular home visits may consist of a discussion of self-care during pregnancy, a play activity designed to promote intellectual development and parent involvement, or a developmental screening assessment, among many other activities. Several federally approved evidence-based

models that are authorized for expansion under the ACA include the Nurse Family Partnership, Early Head Start, and Healthy Families America.³²

The Maternal, Infant, and Early Childhood Home Visiting program, established through the ACA and jointly administered by the Administration for Children and Families and the Health Resources Services Administration, has awarded grants to all 50 states and the District of Columbia to test and/or expand home visiting programs for mothers and children. These programs are currently financed in most states through a combination of private, state, and federal funds including Medicaid. However, Medicaid often covers only certain services provided through home visiting programs, and only 15 states report Medicaid as a funding source for these initiatives.³³

As ACA-funded home visiting programs develop and produce improved health outcomes, including demonstrating the prevention of child abuse and neglect, states may want to explore ways of using Medicaid funds to strengthen, expand, and sustain these programs. Several Medicaid funding mechanisms, including EPSDT, 1915(b) waivers, and HCBS waivers, among others, may represent viable ways of pursuing this option.³⁴ The development of ACA-approved evidence-based home visiting programs has the potential to reduce the incidence of child abuse and neglect,³⁵ and may therefore stem the need for foster care placement. Home visiting programs may also aid in the reunification of children in foster care with their biological families or may help pregnant or parenting youth in care break the cycle of abuse and neglect.

Policy Opportunity: Health Homes for Children in Foster Care with Chronic Conditions

The ACA provides a financial incentive through temporary enhanced federal reimbursement for state Medicaid agencies to establish health homes for individuals with chronic health conditions, including children with serious emotional disturbance. This provision may be of particular importance to children in foster care who have high rates of behavioral, as well as chronic physical health, issues. Placement instability and lack of connectivity between child welfare, behavioral health, primary care, and other child-serving systems also contribute to poorer health among children in foster care. The health home model has the potential to overcome some of these barriers to access, coordination, and continuity of care and improve outcomes for children in foster care with chronic physical or behavioral health needs.

Health homes are required to provide care coordination and management services as well as access to preventive, mental health, and substance abuse services; chronic disease management; and individual, family, and social supports; among others.³⁶ Additionally, states that elect the health home option are required by the Centers for Medicare & Medicaid Services to consult with the Substance Abuse and Mental Health Services Administration.³⁷ The intent of this requirement is to ensure that health home models adopted by states make

provisions for coordination with mental health care, which is of particular importance to children in foster care.

Conclusion

The health care needs of children in foster care are significant and complex. Many of these children enter care eligible for Medicaid and consequently their prospects for access to care are better than those without health insurance. However, several key factors impact their receipt of appropriate and timely health-related services including coverage, which under the ACA will be extended to age 26; the range of services covered under state Medicaid plans; child welfare case worker/supervisor knowledge of the health benefits available to these children; and state, local, and administrative policies that support the coordination of care delivery and financing among key agencies.

EPSDT will likely remain the centerpiece of Medicaid coverage for children, including those in foster care. As such, mandatory screenings and necessary assessments for children in foster care will continue to be covered benefits, as will diagnosis and treatment of various acute and chronic health and behavioral health conditions. However, as noted previously, Medicaid is unable to reimburse for all services and supports needed by children in foster care and their families or caregivers. It is therefore essential for systems serving children in foster care to coordinate financing of services to ensure that these children and families have access to the full range of services and supports they need.

Emerging policy opportunities that promote care coordination, home, and community-based services, family engagement, and continuity of care align child welfare and health reform goals and provide a pathway to better health outcomes for the foster care population. Together, the recent changes in legislation and increased state and federal recognition of the needs of these children have resulted in further efforts to improve the well-being of children in foster care, and ultimately improve their outcomes and prospects beyond their tenures in care. Stakeholders understand that in order for these children to receive the highest-quality care and improve their long-term outcomes, the systems that serve them must work together. Moving forward, continued collaboration among child welfare, Medicaid, and behavioral health agencies at a system and individual child level will be necessary to achieve the promise of well-being and good health outcomes for children in foster care. Stakeholders should continue to take full advantage of the emerging opportunities embedded in Fostering Connections, the ACA, and the Child and Family Services Act to improve health care for this population.

Quick Resource Guide

For more information on:

Fostering Connections Act, including provisions, state implementation, and additional resources, visit: www.fosteringconnections.org.

Appropriate use and oversight of psychotropic medications, visit www.childwelfare.gov/systemwide/mentalhealth/effectiveness/psychotropic.cfm.

Your state's Medicaid program, including eligibility, benefits, state-specific waivers, State Plan Amendments, and links to state Medicaid websites, visit: www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html.

Medicaid-related provisions of the ACA, including a timeline for implementation, visit: www.medicaid.gov/AffordableCareAct/Affordable-Care-Act.html.

Medicaid health homes provision of the ACA, visit: www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html.

Developing health homes for children with behavioral health needs, read: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261488#UUr92BdQE30.

Maternal, Infant and Early Childhood Home Visiting program, grants, grantees, models, and technical assistance resources, visit: <http://mchb.hrsa.gov/programs/homevisiting/index.html>.



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Contact the Authors

Kamala Allen

Director of Child Health Quality
Center for Health Care Strategies, Inc.
kallen@chcs.org
609.528.8400

Taylor Hendricks

Communications Associate
Center for Health Care Strategies, Inc.
thendricks@chcs.org
609.528.8400

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³⁶ Center for Health Care Strategies. “Health Homes: Opportunities for Medicaid.” March 2011. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261238.

³⁷ Centers for Medicare and Medicaid Services State Medicaid Director Letter #10-024: Health Homes for Enrollees with Chronic Conditions. November 16, 2010. Accessed December 19, 2012, <https://www.cms.gov/smdl/downloads/SMD10024.pdf>.