



## Principles & Recommendations for Health Reform

CWLA is committed to the goal of accessible, affordable, and comprehensive health coverage for all children and families. Changes to the existing health structure offer important opportunities to not only fill shortages, but to expand health coverage to all or at least a significant portion of the millions of children and youth in America who are uninsured. As the new Administration and Congress consider health reform, it is essential that vulnerable populations such as children and youth in our nation's child welfare and foster care systems are not left behind.

Children who come into contact with the child welfare system receiving placement and in-home services typically demonstrate more intensive health needs that warrant attention in this debate. These children have a higher rate of physical and mental health issues, stemming either from abuse and/or neglect or from preexisting health conditions and unmet long-term service needs. Before they walk through the service delivery door, many of these children have been exposed to multiple traumas, including domestic violence, physical and emotional abuse, neglect, community violence, and exposure to other risk factors such as parental mental health problems, substance abuse, and poverty. For infants and toddlers who are at a critical developmental stage, exposure to such trauma puts them at particular risk of developing hard-to-overcome emotional difficulties and developmental delays.

For the child who cannot remain with his/her family, options include foster care, kinship care, and adoption. Regardless of the child's placement—whether it be in temporary care, or a permanent placement with kin or an adoptive family—programs such as Medicaid and the Children's Health Insurance Program are vital supports when tackling health needs that tend to linger. Fifty-four percent of kinship caregivers, for instance, live under 200% of the federal poverty level, making low-income health insurance programs a lifeline to needed services. If a child remains in foster care, he or she will continue to travel through the system until a set, statutory age at which point federal funds are cut off. Few, if any, of the 20,000-25,000 youth who "age out" of foster care each year have adequate financial resources, a place to live, and sufficient support from family, friends, and the community. Their uphill battle is often made steeper because many times, their health needs linger into adulthood and can result in post-traumatic stress disorder and major depression, issues compounded by the fact that by some estimates, over a third of foster care alumni entirely lack health insurance.

### *Some statistics:*

- An estimated 54%–80% of children in out-of-home care meet clinical criteria for behavioral problems or psychiatric diagnosis.<sup>1</sup>

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- When compared to the general population, children younger than 6 in out-of-home care have higher rates of respiratory illness (27%), skin problems (21%), anemia (10%), and poor vision (9%).<sup>2</sup>
- Substance abuse is estimated to be a factor in one to two-thirds of cases of children with substantiated reports of abuse and neglect, and in two-thirds of cases of children in foster care.<sup>3</sup> Children from families with substance abuse problems tend to come to the attention of child welfare agencies younger than other children, are more likely than other children to be placed in out-of-home care, and are likely to remain there longer.<sup>4</sup>
- By age 19, nearly half of surveyed females in foster care have ever been pregnant, compared with 20% of their counterparts not in foster care.<sup>5</sup>
- Foster care alumni experience higher rates of general mental health problems (54.4% versus 22.1%), post-traumatic stress disorder (25.2% versus 4%), and major depression (20.2% versus 10.2%).<sup>6</sup>

Child welfare agencies are responsible for meeting the health and mental health needs of all children in state custody. Virtually all children in foster care and many in other permanent settings such as kinship care are eligible for and obtain health care services for both acute and long-term conditions through Medicaid. The Children's Health Insurance Program (CHIP, formerly SCHIP) is also unquestionably vital, as it has successfully broadened health coverage for low-income children and families, especially families that are at-risk and children transitioning out of foster care. These programs provide essential coverage, but serious gaps remain. Over eight million children remain uninsured<sup>7</sup> and even many of those with health insurance face various obstacles and do not receive the services they need. Children in our nation's child welfare and foster care systems are particularly disadvantaged and improvements to their situations and to their physical and mental wellbeing should be taken as part of health reform.

### **CWLA Principles and Recommendations:**

CWLA standards recognize that health care services and supports must be child focused, family centered, coordinated through strong collaboration, culturally competent, strengths based and provided through timely, effective, evidence-based and outcome driven methods. In this context, all children and their families should have meaningful access to affordable, comprehensive, culturally competent, quality health coverage. Specific recommendations:

- Preserve and strengthen Medicaid by:
  - Simplifying enrollment and renewal procedures;
  - Increasing payments to qualified providers accepting Medicaid beneficiaries and to the extent possible, ensure that Medicaid providers are properly trained to handle the unique physical and mental health needs of children in foster care in a culturally appropriate manner;
  - Ensuring that an adequate number of Medicaid providers exist in traditionally underserved geographic areas, such as rural America;
  - Establishing therapeutic foster care as a Medicaid reimbursable service;
  - Extending Medicaid or other comprehensive health coverage to all youth formerly in foster care until at least age 21;

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- Protecting the Medicaid Rehabilitative Services and Targeted Case Management options, which are highly effective in treating and making sure children in foster care get the services they need;
  - Automatically, temporarily increasing the federal match for Medicaid programs in times of economic difficulty;
  - Ensure that the families of children placed in out-of-home care receive Medicaid coverage for treatment services to address their needs in order to facilitate the child's timely and safe return home;
  - Ensure that children receiving inpatient psychiatric hospital services receive both physical and mental health services guaranteed to them under EPSDT; and
  - Create a Medicaid waiver (across Title IV-E) that would allow states to demonstrate long term savings by wrapping-around health care services so that a child might receive care before and/or after a child is removed from their family.
- Require comprehensive and culturally competent health screenings (including mental and dental health) for all children entering out-of-home care, within 30 days of the child's entry.
  - Enhance service delivery to transition age youth;
  - Significantly reduce or eliminate racial and ethnic disparities in coverage, access, quality, and workforce;
  - Provide more funding for substance abuse treatment, particularly comprehensive family-based treatment through legislation that would provide grants to state child welfare and substance abuse agencies or expand the current substance abuse grants provided through the Title IV-B PSSF program to target family-based treatment programs for all forms of substance abuse.
  - Ensure that youth in and aging out of foster care have access to pregnancy prevention programs and receive comprehensive reproductive health and family planning services, through Medicaid and increased funding for Title X.

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<sup>1</sup> Halfon et al., Mental health services for children in foster care; dosReis, S., Magno Zito, J., Safer, D.J., & Soeken, K.L. (2001). Mental health services for youths in foster care and disabled youths. *American Journal of Public Health, 91*(7), 1094-1099.

<sup>2</sup> Takayama, J.I., Wolfe, E., & Coulter, S. (1998). Relationship between reason for placement and medical findings among children in foster care. *Pediatrics, 101*, 201-207.

<sup>3</sup> HHS. (1999). *Blending Perspectives and Building Common Ground*. Washington, DC: Author.

<sup>4</sup> Semidei, J.; Radel, L.F.; & Nolan, C. (2001). Substance abuse and child welfare: Clear linkages and promising responses. *Child Welfare, 80* (2), 109-128.

<sup>5</sup> Bilaver, L.A., & Courtney, M.E. (2006). *Science Says: Foster Care*. Washington, DC: National Campaign to Prevent Teen Pregnancy. Online at [www.teenpregnancy.org/works/pdf/ScienceSays27\\_FosterCare.pdf](http://www.teenpregnancy.org/works/pdf/ScienceSays27_FosterCare.pdf).

<sup>6</sup> Pecora, P., Kessler, R., Williams, J., O'Brien, K., Downs, A.C., English, D., White, J., Hiripi, E., White, C.R., Wiggins, T., & Holmes, K. (2005) *Improving family foster care: Findings from the Northwest Foster Care Alumni Study*.

<sup>7</sup> DeNavas-Walt, C., Proctor, B.D., & Smith, J.C. U.S. Census Bureau, Current Population Reports, P6-235, *Income, Poverty, and Health Insurance Coverage in the United States: 2007*. Washington, DC: Government Printing Office.

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