The following is a list of memos by the **Child Health Consortium (CHC)**

TRENDS IN HEALTH INSURANCE COVERAGE

paper #1: Trends and Projections of Health Insurance Coverage for Children.

MANAGED CARE & MANAGED COMPETITION

paper #2a: What We Know About Managed Care for Children.
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UTILIZATION REVIEW

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ACCOUNTABILITY

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QUALITY

paper #8: Designing a Quality of Care System: The Child Health Perspective

SPECIAL POPULATIONS

paper #9: Foster Care, Medicaid, and Health Care Reform

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National Health Care Reform, Medicaid, and Children in Foster Care

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National Health Care Reform, Medicaid, and Children in Foster Care

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The unique health, legal, and social status of children in foster care* pose particular problems for the designers of any kind of health plan. Because many children in out-of-home care are highly mobile, move from family to family, and from one geographic locale to another, the context of their lives challenges the assumptions that health insurance is based upon. This article attempts to highlight current access to health care services for this group of children, how the President's proposed Health Security Act would affect the delivery of health services, and what special considerations are necessary to meet the needs of this particular group of children's needs. We have focused on the President's plan partially because it provides the greatest amount of detail, and because the President's plan has the greatest likelihood of doing the most to improve the availability of appropriate health services for children in general, and children in foster care in particular**. The analysis printed here is based upon the version of the Health Security Act that was introduced in Congress by members of the House and Senate on November 22, 1993. This most recent version of the Health Security Act has incorporated changes that greatly improve the extent of coverage and other considerations for children in foster care compared to earlier drafts of the plan.

Studies have documented that while children in foster care experience high rates of serious health problems, they also face significant obstacles in their access to essential health care services. Although professional organizations such as the American Academy of Pediatrics and the Child Welfare League of America have developed excellent standards for health care services for children in foster care, the actual delivery of health care services to this needy population falls far short of these standards. The reasons for this failure relate to both the *financing of services* and the *organization of care*. President Clinton's proposed American Health Security Act of 1993 (as introduced in Congress on November 22, 1993) would have a major impact on the accessibility of health care services for children in foster care. In a number of important respects, the proposed plan would improve access but in other critical areas it would limit essential care.

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* Generally "foster care" and "out-of-home care" are used in this article interchangeably to refer to children living in family foster homes, group homes, or residential treatment centers.

** While this article focuses on the strengths and weakness of the President's health care reform plan, most other plans that have been introduced by Congress, up to this point, have fallen even further short of addressing the health needs of vulnerable children.

Health Care Access for Children in Foster Care Under Current Law

Who are the children in foster care?

The population of children in foster care is growing rapidly. There were an estimated 460,00 children in foster care at the end of fiscal year 1993, with more than 659,000 served by the system that year. In the wake of escalating and persistent poverty, family violence, mental illness, and the drug epidemic, the number of children in foster care has been increasing nationwide since 1985. By 1995 , it is projected that 500,000 to 600,000 children will be in foster care. The vast majority of these children live in family foster homes (70%), and the remainder are in group homes, residential treatment centers, or institutional settings.

What are the health care needs of children in foster care?

Children in foster care have high rates of serious health problems. Several studies have documented that children in foster care have high rates of chronic medical problems that require ongoing treatment. Approximately 60% of children in foster care have moderate to severe mental health problems. Children in foster care also experience high rates (40%) of physical health problems (e.g. asthma, growth disorders, neurological abnormalities). The high frequency of health and mental health problems is a result of the children's poor health prior to placement, the effects of abuse and neglect, the effects of separation and frequent moves, and the lack of access to appropriate health and mental health services. A particular concern is the increasing number of infants entering care with multiple health and developmental needs due in large part to maternal drug use and prenatal exposure.

Children in foster care require a broad range of health care services. Given the high levels of need, children in foster care require access to a full range of developmental and mental health services, habilitative, and rehabilitative services. For many infants and toddlers, services are most appropriately delivered in the foster home. Short-term mental health interventions involving foster parents can help maintain children in foster homes, reduce foster parent turnover, and decrease the probability that a child will need costlier longer term psychotherapy, special education services, or even inpatient treatment. The availability of a comprehensive benefit package with a sufficient range of preventive services and community-based treatment services can potentially generate cross-system savings.

How are the health care needs of children in foster care met?

The process of delivering appropriate health care to children in foster care is complex. The complexity of delivering health care services to children in foster care includes: the gathering of health information from the birth parents, past health care providers, foster parents, social workers, and schools; assessing intertwining medical, emotional, and developmental needs; and providing case management and coordination of services among multiple providers.

Most children in foster care are currently eligible for Medicaid. The majority of children in foster care throughout the United States are covered by the Medicaid program. Nationally, about 50% of the children placed in foster care were previously AFDC eligible and, therefore, are eligible for federal foster care payments under Title IV-E of the Social Security Act. Their title IV-E eligibility automatically confers eligibility for Medicaid as well. Children with special needs who meet federal IV-E eligibility requirements and are adopted, retain their Medicaid eligibility after they leave the foster care system. Many states also have elected to cover under Medicaid other children in foster care, who are not IV-E eligible children, through the "Ribicoff" provision of the Medicaid statute (Section 1905a(i) of the Social Security Act). In reality, a number of states automatically provide Medicaid to all children in foster care just as they do for children who are federally IV-E eligible. However, Medicaid eligibility and coverage for children in foster care does vary from state to state.

Medicaid eligible children in foster care are entitled to EPSDT services. Children in foster care who are eligible for Medicaid are entitled to the full range of screening, diagnosis, and treatment services guaranteed under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. OBRA-89 amendments to EPSDT guarantee access to all federally reimbursed Medicaid coverable services, even if the service is not included in the state's Medicaid plan. Current systemic barriers however, have impeded the actual receipt of these comprehensive services by children who are eligible.

What are some of the current barriers to meeting foster children's health care needs?

Delays in establishing Medicaid eligibility. Long delays of several weeks or more can occur between the time that a child is removed from a parent's home and a petition is filed to make the child a dependent of the state. During this time the child may be ineligible for Medicaid, creating severe financial burdens for foster parents or depriving the children of access to health care entirely.

Low reimbursement rates in Medicaid. Many health care providers are discouraged by low Medicaid reimbursement rates from caring for children in foster care. This has created a crisis in availability and quality of services to this population.

A fragmented health and human service system. Even though children in out-of-home care need a comprehensive continuum of services to meet the wide range of their needs, the current service delivery system is fragmented with inadequate service capacity for many kinds of health services, particularly for mental health and developmental services. Basic organizational problems that result in fragmented delivery systems make it difficult for social workers, foster parents, and other caregivers to find providers, coordinate services, and make sure that children get the services and treatment they need.

What approaches have improved the delivery of health care to foster children?

Innovative models exist for providing appropriate health care to children in foster care. Several innovative health service delivery models have been developed in Connecticut, Oakland and Los Angeles, in California, and Syracuse and Rochester, in New York, to customize and more efficiently provide health services to foster children consistent with recommended standards of care. Los Angeles, for example, is planning and beginning to implement an integrated health and mental health system for the 50,000 children in protective custody in that county. The Los Angeles model uses regionalized multidisciplinary assessment and treatment centers specifically for children in foster care. These regionalized centers serve as hubs to provider networks of physicians, psychologists, and other therapeutic programs that surround each center and provide ongoing primary and specialty care to the children in the system. Public health nurses are stationed in the Department of Children's Services to serve as health care case managers and to provide a human link between the child welfare system and the health service delivery system. Once in place, this system should provide a comprehensive continuum of services and reduce child welfare costs caused by multiple placements due to deterioration of mental health and untreated behavioral problems.

Efforts to build effective systems for providing health care for children in foster care rely heavily on Medicaid reimbursement. California, Connecticut, New York, and other states have used Medicaid to help finance innovative programs to meet the needs of children in foster care and other vulnerable populations of children. These innovations have been possible through the state's use of Medicaid waivers, the expanded the use of standard Medicaid financing, particularly through the use of the rehabilitative services options under Medicaid, and the use of Medicaid to cover case management and additional administrative costs. Unlike demonstration programs and block grants, Medicaid has provided sources of funds that are ensured and continuous.

Health Care Access for Children in Foster Care Under the President's Plan

Positive Aspects of the President's Plan for Foster Children

All children in foster care would be entitled to the "comprehensive benefit package." All children (with the exception of undocumented immigrant children), including all children in foster care, would be entitled to the services in the comprehensive benefit package in the President's plan. Coverage for all foster children addresses some major gaps in the current system -- gaps which occur because of delays in establishing Medicaid eligibility, gaps which occur because certain children in state-subsidized foster care programs do not meet the income eligibility guidelines for Medicaid, and gaps in access to basic health and mental health services which occur because of low Medicaid reimbursement rates. Other groups of children for whom access to even basic health care has been a problem would also be eligible for the basic

comprehensive benefit package--some of these children are in and out of foster care. These include children with special needs who are receiving federal or state adoption assistance payments, as well as children in the care of juvenile justice agencies. For some of these children, and others in foster care, the services in the comprehensive benefit package alone would be adequate to meet their needs for preventive and treatment services; for others the comprehensive benefit package would be insufficient.

Some children in foster care also would be entitled to supplemental benefits to address their special needs. In addition to the comprehensive benefit package, the President's plan would establish a totally federally financed program to provide a range of supplemental services that are currently available to children under Medicaid. These include services provided under the expanded Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Currently, services available under Medicaid and EPSDT address a broad array of physical, mental, and developmental disabilities that frequently occur among many children in foster care. Children in the federal foster care program authorized under Title IV-E of the Social Security Act would continue to be eligible for these new supplemental services, as well as the proposed comprehensive benefit package, because they are defined for purposes of the plan as "AFDC recipients." Other children in state supported foster care who are not eligible for IV-E, many of whom are now eligible for Medicaid, would qualify for the supplemental services only if they meet certain family income eligibility standards.

Children in foster care could benefit from implementation of some of the activities supported by the Public Health Services Initiatives Fund. The President's plan establishes a Public Health Services Initiatives Fund that will support a range of activities to benefit underserved and hard-to-reach populations and special initiatives to promote the delivery of preventive services, mental health and substance abuse services, school-related health services, and health research. Children in foster care could benefit from these initiatives, although they are not specifically designated as a target population, nor are specialized delivery centers specifically designed for children in foster care targeted as essential providers. Moreover, it is not clear how funds for coordination activities, such as case management, and systems building and integration activities, could be supported through this funding mechanism. It is also important to understand that this is a discretionary fund, and does not ensure the security of an entitlement.

Limitations for Children in Foster Care in the President's Plan

1. Limits on Eligibility

The patchwork of eligibility for different services packages in the Health Security Act would limit access to expanded services for some children in foster care. The President's plan would provide all children, including those in foster care, with eligibility for the benefits included in the comprehensive benefit package. However, eligibility for expanded benefits through Medicaid or a new federal program for children with special needs would depend on the child's financial status or receipt of AFDC or SSI cash assistance. While children receiving foster care or

adoption assistance benefits under Title IV-E of the Social Security Act are included within the definition of "AFDC recipient," and would therefore be eligible for expanded benefits, some of the following groups may be ineligible:

- **Children in state-supervised foster care who are not IV-E eligible.** There are many children in state-supervised foster care who do not meet the eligibility requirements for the programs funded under Title IV-E of the Social Security Act, but may have the same needs for specialized services. These children generally receive state-funded foster care benefits and are included as Medicaid-eligible children in the state's Medicaid plan. Under the provisions of the President's plan, however, many of these children would not fit the definition of "AFDC recipient" or "SSI recipient" and might not qualify for supplemental benefits depending upon how their family income is determined.

- **Children receiving state adoption assistance payments.** Many children with special needs, who have been in foster care and are adopted, qualify for either federal or state adoption assistance payments. Eligibility for federal adoption assistance payments under Title IV-E of the Social Security Act currently allows a child to retain Medicaid eligibility after adoption. Under the President's plan, a child receiving IV-E adoption assistance would be considered an "AFDC recipient" for eligibility purposes and thus could receive expanded benefits either under Medicaid or under the new federal program. Children receiving-state funded adoption subsidies without IV-E assistance, although indistinguishable from the federally-eligible children in terms of needs, will not be eligible. The absence of access to supplemental benefits would likely serve as a deterrent to finding permanent adoptive homes for children with special needs.

- **Children in the juvenile justice system.** Under the President's plan, children in the juvenile justice system would be eligible for the comprehensive benefit package. However, these children, like children in foster care, often have a high incidence of serious physical and mental health problems, and may need specialized services as well. However, some of these children experience multiple placements in both the child welfare and juvenile justice systems, moving among detention facilities, correctional institutions, group homes, and foster homes. While in group homes or foster homes some might be eligible for IV-E benefits and thereby qualify for supplemental benefits as "AFDC recipients," some also may be financially eligible for the supplemental benefits. If they qualify for the supplemental benefits only while in foster homes and group homes, but not other placements, serious discontinuity in their health care could occur, potentially compromising their health status.

2. Limits on Benefits

Benefit levels would depend on financial criteria and health status. The specific scope of benefits to which children in foster care would have access under the President's plan would depend on both their financial circumstances and their health status. All children in foster

care, juvenile justice facilities, or state supported adoptive placements would be eligi comprehensive benefit package. Those children who meet financial eligibility criteria AFDC or SSI recipients would be eligible for supplemental benefits under Medicaid o federal program. Children with severe physical or mental disabilities would be eligible community-based long term care services under a new long term care benefit program.

Foster children who do not qualify for either supplemental benefits or long term care, hc would be able to receive only the services covered in the comprehensive benefit package. package contains some limitations on services that could adversely affect children in foste who currently are eligible for Medicaid. These limitations include:

- **Limits on the frequency of preventive visits.** The frequency of clinical preventive visi covered under the President's plan does not equal the frequency recommended by the American Academy of Pediatrics, nor ensure the content recommended by the federally sponsored Bright Futures Project. Children in foster care require comprehensive health assessments, including mental health and developmental assessments, at least as often, if no more often than other children. The greater risks faced by children in out-of-home care, ma of whom move frequently and cannot rely on their own parents or other permanent families t address their health and mental health needs, demand frequent monitoring of their health status.

- **Limits on mental health services.** Children in foster care, as a group, have more extensive needs for mental health services than many other groups of children. For example, a study in California in 1988 showed that although children in foster care represented approximately 4% of Medicaid enrollees, they consumed over 40% of the expenditures for mental health services for all enrollees less than 18 years of age. While some children in foster care with mental health needs will be eligible to receive a broad range of services under the supplemental benefit provisions for children with special needs, other who must rely on the mental health services in the "comprehensive benefit package" in the President's plan are less likely to have their needs met. Limits on the scope and duration of these mental health services, and trade-offs between inpatient and less restrictive benefits, that are imposed until 2001, will seriously restrict their usefulness in addressing the comprehensive needs of children with serious emotional disturbances. The cost sharing requirements are likely to further curtail access to these services. Without appropriate services, the needs of these children are likely to intensify and require more restrictive and costly services, thus resulting in increased costs for the child welfare, mental health, and health systems in the future.

- **Limits on home health care.** Some children need health services, in addition to mental health services, delivered in the home setting. Under the President's plan these services would be available to them only as an alternative to institutionalization after an illness or injury. Thus, children in foster care would only be eligible for such services once their condition had deteriorated to a point requiring institutionalization rather than as a means of preventing such

deterioration. For children with congenital or developmental problems, such s not be covered at all. Moreover, private duty nursing is excluded from covera even though is a critical component of home care for children with severe health

- **Limits on outpatient rehabilitative services.** The President's plan would cover rehabilitative services such as occupational, physical, and speech pathology servic cases of illness or injury. Such services are not covered to address problems that a congenital or developmental in origin, and this restriction would adversely affect m children in foster care with chronic physical, mental, or developmental conditions. I these rehabilitative services are limited to 60 days unless functioning continues to im For some children in foster care, however, these services are needed to enable them t maintain rather than improve their level of functioning. In addition to rehabilitative se regular habilitative services are essential for this group of children who are especially vulnerable to predictable disruptions due to planned or unplanned moves, or other stres events in their lives.

- **Limits on hearing services.** The President's plan would cover some hearing services for children. However, hearing aids would not be covered. Most foster parents would be una to pay for hearing aids for their foster children and are not legally obligated to do so. A chi in foster care would therefore be dependent on the willingness of the state to provide separa coverage for hearing aids. The lack of a hearing aid for a child in foster care who needed on could have severe adverse developmental, social, and education consequences.

3. Absence of Procedures and Safeguards

Disputes may take place regarding the financial responsibility for the cost of health care for children in foster care. Although all children in foster care would be eligible for coverage under the President's plan, it is not clear *who would be responsible for enrolling a foster child* in a health plan or for paying the premium--the child's biological parents, the foster parents, or the state or local child welfare agency. It is also unclear *whether children in foster care would be eligible for subsidies* for their premium costs and, if so, the extent of the subsidy. Also, when children are placed in foster care in locations other than where their parents live, it is not clear *which regional alliance will receive the premium and pay for the care*. As children move from foster home to foster home, back to the biological family or to an adoptive home, it is unclear *how immediate and continued coverage will be ensured*. Because children in foster care have, on the average, more extensive health care needs than other children, plans may be reluctant to serve this population unless the risk adjustment system takes these needs into account. It is also unclear *who would bear the burden of cost-sharing and copayments* for foster children.

Portability of coverage would not be assured. Under the President's plan, children in foster care who were moved to a placement outside of the jurisdiction of the health plan in which they were enrolled would be eligible only for urgent care. Registration with a new alliance or enrollment in a new plan is contemplated only for individuals who establish residence for a

minimum of three months. For children in foster care who move frequently this would disruption of coverage for non-urgent but nevertheless essential services.

Children in foster care often need service from multiple providers, many of will presumably be out-of-plan. Many children in out-of-home care, especially those i homes or other residential facilities, receive health and mental health services from multi providers, including providers employed by the group home, such as nurses and psycholo Placement, in fact, may be determined by the availability of such providers on site. It is no whether, and how, continued access to these and other specialty care service providers will available. While the President's plan requires health plans to offer the option of obtaining s from out-of-plan providers, in most instances a much higher co-insurance rate would apply these services.

4. Limits on Innovative Service Delivery Approaches

Funding would not be available to support case management services essential fo delivering appropriate health care to children in foster care. Because children in foster car have complex health care and other service needs, case management and other coordination services are essential for providing them with effective and efficient health care. Although case management is currently an optional Medicaid service, many states are using the targeted case management option to provide more appropriate care and to achieve cost savings through regionalization, coordination, and integration of services for children in foster care. Only children eligible for the expanded benefit package, long-term care, or specific mental health services would be eligible for case management services, and even then the scope of these services may be less extensive than what is currently available in some locales.

Model programs providing innovative and effective services to children in foster care would be threatened. Many of the innovative programs that have successfully customized health care services to more efficiently meet the special needs of children in foster care have done so by making creative use of funding under the Medicaid program. To the extent that children in foster care would no longer be eligible for Medicaid supplemental services, and the national guaranteed benefit package would not cover the full range of services that are currently covered under Medicaid (case management options, rehabilitative services, and clinic options, and administrative costs), these innovative programs would be undermined. Even if all children in foster care were eligible for expanded service benefits, it is not clear if sufficient funds will be available to support alterations to the service delivery system, such as regionalizing and integrating services within comprehensive centers.

5. Threats to Other Public Child-Serving Systems

The integrity of state and local child welfare programs could be threatened. State and local child welfare programs are mandated by federal law (Adoption Assistance and Child Welfare Act) as well as by state law to provide appropriate health care services for children in

foster care. A state's legal obligation to provide this care exists regardless of the coverage in a national benefit package, and the state is not relieved of this obligation simply because the guaranteed benefits are not sufficient. To the extent that the child welfare system has successfully met this obligation it has often done so by relying heavily on the Medicaid program to finance the cost of these services. Although the federalizing the supplemental benefit program for eligible children will help, there will be considerable numbers of children in foster care who do not qualify, and the cap on federal spending is likely to limit the scope of service available. If the current financing mechanisms for Medicaid services, are no longer as broadly available, the child welfare agencies may have to struggle to meet their legal obligations to children in out-of-home care and may suffer from severe increases in the costs of meeting those obligations. To the extent that costs currently shared between the state and federal government under Medicaid are shifted to the state and local governments, unacceptable burdens will be placed on a system that is already severely over stressed.

The ability of states and local school districts to comply with special education requirements would be threatened. States and school districts are currently obligated by state and federal law, specifically the federal Individuals with Disabilities in Education Act (IDEA) and its part H, Early Intervention Program (P.L.99-457), to provide children with disabilities a broad range of special educational and related health services. To the extent that these related services are covered by Medicaid, that is the source of funds that pays for them. To the extent that children in foster care requiring special education and related health services would no longer be eligible for Medicaid, a major financial burden would be transferred to the states and local school districts to pay for the required services. School districts can ill afford the increased burden.

Proposed Solutions

1. Eligibility

Ensure that all children in foster care are eligible for the same basic and supplemental benefits. Extensive documentation exists that children placed out-of-their homes are at increased risk for serious health problems. Their need for comprehensive health services does not depend on whether they are placed in foster care, juvenile justice facilities, or adoptive homes. It also does not depend on whether their placements are supported by federal or state funds. *Therefore, all children in out-of-home care should be eligible not only for the comprehensive benefit package, but also for expanded benefits available under Medicaid or a new supplemental federal program.* This could be achieved by ensuring eligibility for both the comprehensive and expanded benefits for at least three groups of children:

- all children in state-supervised foster care regardless of whether their placements are funded by federal (IV-E) funds or state funds;

- all special needs children placed for adoption regardless of whether their adoption subsidies are paid for by federal (IV-E) or state funds; and

- all children placed in the juvenile justice system, whether in detention or correctional facilities. (Although current law excludes these children from eligibility for Medicaid, under any health care reform plan they should be treated comparably to other children in out-home-placement.)

Ensure that children in foster care are eligible for premium subsidies and exempt from copayments. Under the President's plan, premium subsidies would be available to certain low-income children and reduced copayments would be available to AFDC and SSI recipients. While many children in foster care placements would qualify for this financial assistance, determinations of their eligibility would be made far more complex by virtue of their separation from their birth families and lack of clarity concerning whose income should serve as the basis of eligibility determination. The logistics about who would make copayments and how payment would be made, potentially creates other burdens and unnecessary barriers. This could involve significant delays and substantial administrative costs. *Therefore, any health care reform plan should specify that children in out-of-home care would be eligible for premium subsidies and exempt from copayments.*

2. Benefits

Ensure that children in foster care have access to a comprehensive set of services that is sufficient to meet their needs. Children in out-of-home placement must have access to a comprehensive set of benefits that is sufficient to meet their complex health and mental health care needs. Any health care reform plan should ensure that a broad range of benefits are available to these children. This could be achieved by doing the following:

- **Extend current EPSDT protections.** Any plan should specify that all children in out-of-home care would be eligible, at a minimum, for the services currently guaranteed to Medicaid eligible children under the EPSDT program. To the extent that these services are not covered under a national comprehensive benefit package they should be available to children in out-of-home placement either through an extension of Medicaid coverage or through a new expanded benefit program.

- **Clarify the definition of mental health services.** Any health care reform plan should make clear that the outpatient mental health services that are covered, include the home-based, foster home-based, and family-based therapies needed by children in foster care.

- **Eliminate the limits on mental health services, home health care, rehabilitative and habilitative services, institutional care, medical equipment and devices, and hearing aids.** Because of the special needs of children in foster care, certain services should be available to them without any limitation other than medical necessity as defined from a pediatric perspective (see Section 3, below). Any health care reform plan should provide access to any services not included in the comprehensive benefit package but currently available under Section1905 of the Social Security Act, that are identified as medically or psychologically necessary by a health care professional, or identified as necessary in a child's individual service plan under the IDEA, or in a child's case plan under the Adoption Assistance and Child Welfare Act.

3. Procedures and Safeguards

Ensure that the needs of children in foster care are addressed and protected at each level of government and administration. Any health care reform plan should ensure that the needs of these children are specifically addressed by each governmental and administrative entity with responsibility for implementation of health care reform. Specifically, under the President's plan, the needs of children in foster care must be addressed and protections adopted by:

- **the responsible federal agencies;**
- **the National Health Board;**
- **states;**
- **health alliances; and**
- **health plans.**

Ensure that standards and procedures are adopted which would address the special needs of children in foster care. At minimum, any health care reform plan should ensure that standards are in place that would address special issues of eligibility, scope of benefits, portability of coverage, procedural safeguards, and quality assessment procedures that are appropriate for children in foster care.

Ensure a child specific standard of medical necessity. Because "medical necessity" is a standard that is used to determine whether or not a benefit is provided, it plays a pivotal role in modifying those benefits which are actually provided, versus those that are potentially available. Over the past ten years the notion of medical necessity has been transformed in both practical application and legal enforcement from a physician determined criteria for inclusion of a particular service, to a health plan determined criteria for exclusion of services. If services are to be excluded at the discretion of a health plan, this exclusion must account for the special developmental vulnerability of children and their unique dependency status. For children in foster care who are even more vulnerable, the standard of medical necessity must account for their unique health, mental health, and developmental needs, and be determined by the primary physician responsible for their care.

Specify that states have ultimate responsibility for ensuring that children in foster care receive appropriate health care. Any health care reform plan should make clear that states have the ultimate responsibility to ensure that children in foster care receive appropriate health care and that child welfare agencies and health alliances work together to develop the necessary procedures and safeguards.

Require health alliances (or other financing entities) to ensure that health plans and providers meet the needs of children in foster care. Any health care reform plan should include provisions to ensure that the entities primarily responsible for financing and overseeing the delivery of health care participate in establishing appropriate procedures and safeguards to protect children in foster care. Specifically, under the President's plan, health alliances should be required to establish procedures in cooperation with state and local child welfare agencies to:

- *Ensure that health plan eligibility for children in foster care is established in a timely fashion and that portability of coverage is ensured.* These safeguards would specify that the child welfare agency is responsible for enrolling the child, that children are eligible for premium subsidies, and would also specify the ways that eligibility for premium subsidies would be administered to guarantee immediate, comprehensive, and continuous coverage when a child is moved out of the geographic area of a specific alliance.

- *Ensure that children in foster care receive the full scope of benefits to which they are entitled, including necessary linkages to out-of-plan services.* Health alliances must specify how additional services will be provided, how plans will ensure that appropriate linkages with out-of-plan providers are made without accompanying out-of-pocket expenses, and that coordination and continuity of care is ensured.

- *Ensure that adequate information is reported by the plans to the alliances and by the alliances to the child welfare agencies to facilitate accountability and determinations of the adequacy and quality of care received by children in foster care.* The National Health Board should set standards regarding eligibility, enrollment, coverage, portability, and data-reporting requirements. Alliances and child welfare agencies could be required, for example, to report when children came into custody, and when eligibility for coverage was established, and the nature of the services needed. These standards would be benchmarks of quality and permit measures for enforcement.

- *Ensure smooth relationships between alliances, child welfare agencies, and other agencies responsible for children in foster care.* A special health care-coordination ombudsman should be designated in each alliance to deal with the needs of children in out-of-home care.

- *Ensure that health plans have proper incentives to care for children in foster care.* A designated risk adjustment in their payments may be necessary.

- *Ensure that quality is guaranteed.* Require that a quality assessment system tracks key structure, process, and outcome measures specific to this population of children.

Continue to support innovative models of delivery that provide comprehensive and integrated services for children in foster care. Since a large proportion of children in foster care may have needs that are not effectively or efficiently encompassed by health plans, support of new service delivery models must continue. The development of models should become a priority of the Public Health Service. To support this, the national plan for health care reform should guarantee a source of funding that can be used to build the coordination and case management systems, extended service benefits, and alternative delivery mechanisms that are essential to comprehensive and integrated services. The plan could specify that children in foster care are one of the vulnerable populations intended to benefit from the Public Health Service Initiative Fund, or require that a portion of the Public Health Service Initiative funds are to benefit children in out-of-home care. The plan could also specify that special programs developed to provide health care services for children in foster care be designated as "essential community providers." A high priority should be placed on conceptual, financial, and physical integration of services.

Conclusion

Children in foster care have long been limited in their access to essential health care. Combined with their vulnerability in numerous other respects, this deprivation significantly increases their risk of growing up without the necessary health and functional capacity to participate normally as adults in society. Health care reform presents an excellent opportunity to increase the level of protection in the health care system for the special needs of this population and to increase the likelihood that they will receive the health care and related services they need. The President's plan, as introduced to Congress in November 1993, has made a strong beginning toward improving the health services available for children in foster care. Unless additional steps are taken to address the gaps in the plan, some children in foster care will continue to receive less that they need. The solutions proposed could address many of these potential short comings.

NATIONAL
ACADEMY
OF · SOCIAL
INSURANCE

February 11, 1994

Jennifer Klein
Special Assistant to the President for Domestic Policy
Second Floor, West Wing
White House
Washington, DC 20500

Dear Ms. Klein:

We have received confirmation that you will be attending the Senior Staff Working Seminar, *Pediatric Health Coverage in the Law: Options for Health Care Reform* sponsored by the National Academy of Social Insurance on **Thursday, February 17, 1994.** Attached is an article recently published by two of the presenters, Elizabeth Jameson and Elizabeth Wehr.

The seminar will be held at La Colline Restaurant, 400 North Capitol Street and will begin with a reception at 6:00 pm. Dinner will be served at 6:30 pm, and the program will begin promptly after dinner. There is free parking at the restaurant's garage after 5:00 pm. Please use the E Street entrance to the garage.

If you have any questions, please call Sara Okrend at the Academy, (202) 452-8097.

Sincerely,

Alison Evans
Research Analyst

Encl.

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- Drafting National Health Care Reform Legislation to Protect the Health Interests of Children