

# Health and Development Services for Children with Multiple Needs: The Child in Foster Care

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## I. THE CHANGING FACE OF CHILDHOOD

Over the past century, child morbidity and mortality has decreased for most children in Western societies due to improved living conditions and advances in health services.<sup>1</sup> Nevertheless, growing numbers of poor and disadvantaged children in the United States still do not enjoy even the most basic services like prenatal care and regular immunizations.<sup>2</sup> While many of the infectious diseases that threatened all children earlier in the century have been eliminated among middle and upper class Americans, such diseases continue to affect the poor and underserved.<sup>3</sup> Moreover, scholars and public health officials are now recognizing “new morbidities” such as developmental delays, school problems, emotional and behavioral problems, child abuse and neglect, intrauterine drug or alcohol exposure, and the effects of family disruption and violence.<sup>4</sup> Unlike the “old morbidities,” which have single biological origins amenable to

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1. See generally Hoekelman & Pless, *Decline in Mortality Among Young Americans During the 20th Century Prospects for Reaching National Mortality Reduction Goals for 1990*, 82 PEDIATRICS 582 (1988); Zill & Rogers, *Recent Trends in the Well-Being of Children in the United States and Their Implications for Public Policy*, in THE CHANGING AM. FAM. AND PUB. POL’Y 31 (A. Cherlin ed. 1988); STARFIELD, EFFECTIVENESS OF MEDICAL CARE: VALIDATING CLINICAL WISDOM (1985).

2. Newacheck & Halfon, *Preventive Care Use by School-Aged Children: Differences by Socioeconomic Status*, 82 PEDIATRICS 462 (1988); Newacheck & Halfon, *Access to Ambulatory Care Services for Economically Disadvantaged Children*, 78 PEDIATRICS 813 (1986); Singh, Torres & Forrest, *The Need for Prenatal Care in the United States: Evidence from the 1980 National Survey*, 17 FAM. PLAN. PERSP. 118 (1985).

3. See generally Zill & Rogers, *supra* note 1, at 55; Rosenthal, *Health Problems of Inner City Poor Reach Crisis Point*, N.Y. Times, Dec. 24, 1990, at 1, col. 6.

4. HAGGERTY, ROGHMANN & PLESS, CHILD HEALTH AND THE COMMUNITY 95-115 (1975); Halfon, Jameson, Brindis, Lee, Newacheck, Korenbrot, McCroskey & Isman, *Health*, in CONDITION OF CHILDREN IN CALIFORNIA 141 (1989) [hereinafter Halfon, et al.]; Newberger, *Family Transition, Stress, and Support: Impacts on Children*, 2 CURRENT OPINION IN PEDIATRICS 856 (1990). The concept of “new morbidities” describes actual changes in morbidity and mortality resulting from social and biomedical advances and is also a rhetorical device to redirect the attention of child health providers towards behavioral, learning, and family issues.

relatively simple interventions such as antibiotics, immunizations, and improved nutrition, the new morbidities result from multiple social and behavioral factors that demand complex responses.<sup>5</sup> Problems such as alcohol and drug abuse, school failure, and teenage pregnancy seldom have a single identifiable and treatable cause. Consequently, these problems require a combination of social, familial, behavioral, and educational interventions provided through infant development programs or family preservation programs designed to change the ecology of the child and family.<sup>6</sup>

Although the new morbidities are found throughout society, poverty greatly increases a child's risk of developing health and developmental problems.<sup>7</sup> For instance, poverty is associated with increased infant morbidity and mortality, perinatal AIDS, and high rates of injury resulting from fire, falls, motor vehicle accidents, and violence. The prevalence of acute medical problems such as meningitis or ear infections, chronic medical problems such as asthma and anemia, and functional problems such as hearing loss, poor vision, learning disabilities and developmental delays, is also greater among impoverished children. There are several reasons why poverty might increase a child's risk of suffering health and developmental problems. Children living in poor families are more likely to have parents who suffer from mental illness and alcohol and drug abuse.<sup>8</sup> The stress of poverty can also strain a child's relationship with her parents. Parents may fail to provide their children the support they need to develop.<sup>9</sup> The basic economic circumstances of poor families constrain their choice of neighborhoods, schools, recreation, and therapeutic options. Resources to meet the needs of poor families are inadequate, fragmented, and scattered in different agencies and institutions, each with its own restrictive eligibility criteria and benefits.<sup>10</sup> Unfortunately, child and family policies have historically been defined to address specific needs and have not

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5. Halfon, et al., *supra* note 4, at 144.

6. See generally Bronfenbrenner, *Ecology of the Family as a Context for Human Development: Research Perspectives*, 22 DEVELOPMENTAL PSYCHOLOGY 723 (1986).

7. Wise & Meyers, *Poverty and Child Health*, 35 PEDIATRIC CLINICS N. AM. 1169, 1180-1181 (1988). Parker, Greer & Zuckerman, *Double Jeopardy: The Impact of Poverty on Early Child Development*, 35 PEDIATRIC CLINICS N. AMER. 1227, 1231-34 (1988).

8. L. KLERMAN, *ALIVE AND WELL?: A RESEARCH AND POLICY REVIEW OF HEALTH PROGRAMS FOR POOR YOUNG CHILDREN 19-40* (National Center for Children in Poverty, 1991).

9. McLoyd, *The Impact of Economic Hardships on Black Families and Children: Psychological Distress, Parenting and Socioemotional Development*, 61 CHILD DEV. 311 (1990).

10. See generally Harvey, *Why We Need a National Child Health Policy*, 87 PEDIATRICS 1 (1991). The Aid for Families and Dependent Children Program Act of Aug. 14, 1935, ch. 531, 49 Stat. 627 (codified at 42 U.S.C. § 601 *et seq.* (1988)) (AFDC), reached only 56% of children in poverty in 1987 as opposed to 73% in 1975. Newberger, *supra* note 4, at 857. Until the recent augmentations in Medicaid eligibility in 1988 and 1989, the number of Medicaid eligible children had decreased from the mid-1970s because of the categorical link to AFDC.

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been conceived, legislated, or implemented to provide comprehensive, coordinated services.<sup>11</sup>

The new morbidities demand a new policy direction. Such new policies would serve children who have complex health needs (often exacerbated by poverty) that are not amenable to simple solutions, and who confront a fragmented and largely outmoded set of services and frustrated service providers.<sup>12</sup> To move in this new direction, policymakers must determine: (1) what services are needed and how they can be standardized, (2) how services can be more efficiently organized, (3) how services can be financed, and (4) what legal and legislative strategies can be employed to change these programs and make them more accountable.

This Article uses the health needs of children placed in foster care as a case study to address these questions. We chose children in foster care because they experience risks associated with multiple medical, developmental, emotional, and social problems. They are therefore representative of other children suffering from the new morbidities, such as drug-exposed infants living with their biological families, children born to teenage mothers, homeless children, and children with chronic illnesses living in impoverished families. Children in foster care come disproportionately from poor and minority families affected by unemployment, alcohol and drug abuse, mental illness, instability, teenage pregnancy, child abuse and neglect, and homelessness. They also often come from communities beset by poverty, drug abuse, and violence. Like other poor children, children in foster care are potentially eligible for a variety of publicly-funded services. We also chose children in foster care because it is easier to examine their experiences since they are already in the child welfare system. Being "in the system" might also mean that these children enjoy greater advocacy to resolve their problems and greater access to appropriate services than other children with complex health needs. Nevertheless, inadequacies and fragmentation in the child welfare service system often erase such advantages. Thus, while children in foster care may represent the extreme of need, they

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11. The two major federally supported programs that currently provide significant income maintenance and health assistance to poor families, AFDC and Medicaid, Pub. L. No. 89-97, 79 Stat. 291 (1965) (codified at 42 U.S.C. § 1396 *et seq.* (1988)), were neither designed nor originally intended to serve as major support programs for the poor. AFDC was added to the Social Security Act in 1935 to provide federal funds to state-initiated widows' pension plans. Medicaid was similarly appended to the Medicare program, Pub. L. No. 89-97, 79 Stat. 325 (1965) (codified at 42 U.S.C. § 1395 *et seq.* (1988)), in order to placate the American Medical Association, not as a major health insurance program for poor children. Both AFDC and Medicaid are thus state administered, income-based programs, added onto major national, universal entitlement programs for the elderly. See M. KATZ, *IN THE SHADOW OF THE POORHOUSE: A SOCIAL HISTORY OF WELFARE IN AMERICA* 237, 264 (1986). With the exception of Part H of the Education of the Handicapped Act Amendments of 1986, Pub. L. No. 99-457, 100 Stat. 1145 (codified in scattered sections of 20 U.S.C.), which specifies services and processes by which diverse agencies and disciplines can work together, most federal programs for children and families have been narrowly defined as fiscal transfers to states. Harvey, *supra* note 10, at 3.

12. Harvey, *supra* note 10, at 4-5; Rosenthal, *supra* note 3.

provide an effective lens through which to examine all children who experience the new morbidities associated with poverty and who confront a fragmented service system.

## II. FOSTER CARE

### A. Introduction to Foster Care in the United States

Since the early twentieth century, our public philosophy has supported and sustained the biological home and has urged that children should be removed from their homes only in the most extreme circumstances. Foster homes are intended to recreate the natural home environment as closely as possible because institutional placements are believed to inhibit a child's physical and emotional development.<sup>13</sup>

The Adoption Assistance and Child Welfare Act of 1980<sup>14</sup> codifies this public policy. The Act requires states to preserve families and prevent placement of children into foster care. When such placement cannot be avoided, states must make reasonable efforts to reunite children placed in foster care with their biological parents. The Act requires that the needs of children in foster care be addressed through a case plan reviewed every six months, and emphasizes maintaining biological families and permanent placement for children for whom family reunification has failed. Although this Act has served as the major organizing principle for restructuring child welfare services, its implementation has been poor. For instance, many states have not met compliance requirements ten years after the law was passed.<sup>15</sup> This failure has occurred despite a 125% increase in federal IV-E payments<sup>16</sup> to states between 1981 and 1987.<sup>17</sup> Furthermore, the Adoption Assistance and Child

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13. The 1909, 1919, and 1930 White House Conferences on the Care of Dependent Children set this policy. By 1933, 42% of dependent children were in foster family homes rather than institutions. See generally Bryant, *Special Foster Care: A History and Rationale*, 10 J. CLINICAL CHILD PSYCHOLOGY 8, 10-11 (1981); Cox & Cox, *The Foster Care System: An Introduction* in FOSTER CARE: CURRENT ISSUES, POLICIES, AND PRACTICES x (M. Cox & R. Cox eds. 1985); English, *Pediatrics and the Unwanted Child in History: Foundling Homes, Disease, and the Origins of Foster Care in New York City, 1860 to 1920*, 73 PEDIATRICS 699 (1984).

14. Pub. L. No. 96-272, 94 Stat. 500 (codified in scattered sections of 42 U.S.C.). For a discussion of the Act, see NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES, CHILD WELFARE LEAGUE OF AMERICA, YOUTH LAW CENTER & NATIONAL CENTER FOR YOUTH LAW, MAKING REASONABLE EFFORTS: STEPS FOR KEEPING FAMILIES TOGETHER (1985).

15. See generally WATAHARA & LOBDELL, THE CHILDREN NOBODY KNOWS: CALIFORNIA'S FOSTER CARE-DEPENDENCY SYSTEM (1990).

16. 42 U.S.C. § 670 *et seq.* (1988). Title IV-E payments are made to states by the federal government to provide services under the Adoption Assistance and Child Welfare Act of 1980 to foster children who have been removed from homes receiving AFDC.

17. The 125% increase in federal payments between 1981 and 1987 took place when the numbers of foster children increased by approximately 10 to 15%. SELECT COMM. ON CHILDREN, YOUTH, AND FAMILIES, 101ST CONG., 1ST SESS., NO PLACE TO CALL HOME: DISCARDED CHILDREN IN AMERICA 226 (1989) [hereinafter NO PLACE TO CALL HOME].

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Welfare Act of 1980 provides only the most general guidelines regarding the care of children and does not specifically address the complex medical, mental health, and developmental service needs of children in foster care.

The growing numbers of children in foster care in the United States have exacerbated the problem of adequately serving their complex needs. The number of children in foster care throughout the United States has increased from 303,500 in 1980 to 340,300 in 1988,<sup>18</sup> and is projected to surpass 500,000 by 1995.<sup>19</sup> There is, however, significant variation among states with respect to the total number and types of children in foster care.<sup>20</sup> Table 1, at the end of this Article, provides information, compiled by the House Select Committee on Children, Youth, and Families, on foster care trends in eleven large states. Although foster care populations in many states declined in the first part of the 1980s, this trend has reversed since 1985. In California, the number of children in foster care has grown at a greater rate than the rest of the nation, increasing by 126% from 27,534 in 1980 to 62,419 in 1988.<sup>21</sup> One explanation for the growing number of children in foster care (especially the growing number of younger children) is that the crack cocaine epidemic has forced many drug-exposed newborns into foster care.

While variability in data collection methods makes it difficult to determine the average time children spend in foster care, data from the Voluntary Child Welfare Information System (VCWIS) indicate that for a cohort of 106,000 children leaving foster care in 1985, the median time spent in foster care was eight months. In that same year 25% of children who were in foster care had been there for more than two years.<sup>22</sup>

Until early this century, children were placed outside of their homes largely because of parental death, incapacity, or economic misfortune. Recently, however, the majority of children in foster care has been placed there because

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18. *Id.* at 101.

19. National estimates on the number of children in foster care come from various surveys and a voluntary reporting system, the Child Welfare Voluntary Information System (VCWIS), which is maintained by the Office of Human Development Services in the Department of Health and Human Services. These numbers represent single day counts and do not reflect the dynamics of the flow of children in and out of the system. For example, in the last day in 1985, there were 276,000 children in foster care. During that year however, 453,000 children moved through the system. C. Gershenson, *Preparing for the Future Backwards: Characteristics of the Ecology for Children and Youth in Long-term Out-of-Home Care 11-12* (paper presented at Preparing for the Future: The Casey Family Program Symposium on Children and Youth in Long-Term Out-of-Home Care in Seattle, WA, May 31 - June 1, 1990).

20. State and local variations in the number of children who flow through the child welfare system reflect a complex set of interactions among the conditions of children and families and the structure and function of the state or community social service system. These interactions are also reflected in variations in placement rate in different states. For example, in 1985 there was a ten-fold difference between the placement rates of Texas (6 per 10,000) and Washington (85 per 10,000). Gershenson, *supra* note 19, at 3.

21. While 10% of children in the United States live in California, 20% of children in foster care live in California. *See generally* NO PLACE TO CALL HOME, *supra* note 17, at 101, 104.

22. Gershenson, *supra* note 19, at 12.

of abuse and neglect.<sup>23</sup> Many studies have found a relationship between poverty and abuse and neglect.<sup>24</sup> A 1986 national survey estimated the incidence of child maltreatment to be seven times higher among families with annual incomes below \$15,000 than among higher income families.<sup>25</sup> Other studies show that the number of children living in poverty has increased from 10.4 million in the mid-1970s to nearly 13 million in 1987, with 23% of children under six years of age now living in poverty. During the same period, the number of reports of child abuse and neglect increased nationally from 669,000 per year in 1976 to 2.4 million per year in 1988.<sup>26</sup> While these statistics suggest a relationship between poverty and abuse, the increasing reports of child maltreatment might also reflect increased awareness of child abuse, changes in reporting procedures, or both.<sup>27</sup> Some studies suggest that the degree of material deprivation is associated with severity of maltreatment.<sup>28</sup> While the stresses of poverty and the difficulties in obtaining appropriate services may contribute to child abuse and neglect, poor families may also be disproportionately represented in child abuse and neglect cases because they are already known to public agencies.

### *B. Health Needs of Children in Foster Care*

Many children in foster care have pre-existing health problems resulting from long-standing adversity or from the maltreatment that resulted in their placement. Often children develop additional problems while in foster care. As children move from place to place, their physical and mental health often deteriorates.<sup>29</sup>

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23. Schor, *The Foster Care System and Health Status of Foster Children*, 69 PEDIATRICS 521, 523 (1982).

24. See generally Hampton & Newberger, *Child Abuse Incidence and Reporting by Hospitals: Significance of Severity, Class and Race*, 75 AM. J. PUB. HEALTH 56 (1985); NATIONAL CENTER FOR CHILDREN IN POVERTY, FIVE MILLION CHILDREN: A STATISTICAL PROFILE OF OUR POOREST YOUNG CITIZENS 59-60 (1990) [hereinafter NATIONAL CENTER FOR CHILDREN IN POVERTY].

25. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, STUDY OF THE NATIONAL INCIDENCE AND PREVALENCE OF CHILD ABUSE AND NEGLECT 5-29 (1988). The Congressionally mandated National Incidence Study (NIS) of Child Abuse and Neglect estimated the national incidence of child maltreatment as increasing from 625,100 (9.8/1000) in 1980 to 931,000 (14.78/1000) in 1986, with lower family income demonstrating the most consistent relationship to all categories of abuse and neglect. Schools were sources of identification in more than half of reported cases. A. Sedlak, National Prevalence of Child Abuse and Neglect 6-7 (paper presented to the Conference on Child Welfare Reform Experiments, American Enterprise Institute, Washington, D.C., February 20-21, 1991).

26. Gershenson, *supra* note 19, at 11; KLERMAN, *supra* note 8, at 2-3; Wise & Meyers, *supra* note 7; NATIONAL CENTER FOR CHILDREN IN POVERTY, *supra* note 24, at 16-17.

27. WATAHARA & LOBDELL, *supra* note 15, at 35; Zill & Rogers, *supra* note 1, at 60.

28. Horowitz & Wolock, *Material Deprivation, Child Maltreatment, and Agency Interventions Among Poor Families*, in THE SOCIAL CONTEXT OF CHILD ABUSE AND NEGLECT 137, 153 (Pelton ed. 1981).

29. One study found a direct relationship between the number of placements a child experienced and the level of hostility she displayed at an intake interview for a foster care program. Fanshel, Finch & Grundy, *Foster Children in Life-Course Perspective: The Casey Family Program Experience*, 68 CHILD WELFARE 467, 470 (1989). Data from Florida indicate that children with higher levels of behavioral and

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Two examples illustrate the health problems a child in foster care might present. Consider first a prematurely born infant. This child might need to take several medicines to treat chronic respiratory problems. To prevent her breathing from stopping due to neurological immaturity, this child might also require ongoing cardio-respiratory monitoring. In addition, this child might require developmental rehabilitation and infant stimulation to address neurological problems resulting from cerebral hemorrhages common in premature infants. Since the child did not grow fully in the uterus, she might also need additional nutritional support to improve her growth. Finally, other more intensive monitoring and therapies may be needed to treat congenital infections like hepatitis or syphilis. The legacy of the prematurity may cause additional developmental and educational problems for the child into her school years and beyond. At the other end of the developmental spectrum, consider an adolescent girl who has been sexually abused in a home plagued by disruption, alcohol and drug abuse, and family violence. She might enter foster care with asthma and other allergies, a history of chronic urinary tract infections, two years delay in school, behavioral problems, or depression.

Several studies indicate that children in foster care are less healthy than other children and are more likely than other children to suffer both acute and chronic health problems.<sup>30</sup> Studies in New York City, Chicago, Baltimore, and Canada indicate that children in foster care have higher rates of chronic medical conditions such as asthma and higher rates of vision, hearing, growth, and dental problems.<sup>31</sup> Moreover, the incidence of emotional, behavioral, and developmental problems such as depression, conduct disorders, difficulties in school, and impaired social relationships among children in foster care is three to six times greater than the incidence among other children.<sup>32</sup> The long term

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emotional problems spend longer in foster care and find it difficult to return home or make the transition to adoption. OFFICE OF THE AUDITOR GENERAL, STATE OF FLORIDA, PERFORMANCE AUDIT OF THE FOSTER CARE PROGRAM 37 (1989) [hereinafter PERFORMANCE AUDIT].

30. Department of Pediatrics, Univ. of Maryland Medical School, *The Physical and Mental Health and Educational Status of Children Placed with Relatives—Final Report* (1990) (Dubowitz, project director) [hereinafter Dubowitz (1990)]; Hochstadt, Jaude, Zimo & Schachter, *The Medical and Psychological Needs of Children Entering Foster Care*, 11 CHILD ABUSE AND NEGLECT 53 (1987); KAVALER & SWIRE, FOSTER CHILD HEALTH CARE (1983); Schor, *supra* note 23.

31. Dubowitz (1990), *supra* note 30, at 23-25; Moffat, Peddie, Stulginskis, Pless & Steinmetz, *Health Care Delivery to Foster Children: A Study*, 10 HEALTH AND SOC. WORK 129, 131-32 (1985); Swire & Kavalier, *The Health Status of Foster Children*, 56 CHILD WELFARE 635, 643-44 (1977); White, Benedict & Jaffe, *Foster Child Health Care Supervision Policy*, 66 CHILD WELFARE 387, 389 (1987).

32. Dubowitz (1990), *supra* note 30, at 47-68; Simms, *The Foster Care Clinic: A Community Program to Identify Treatment Needs of Children in Foster Care*, 10 J. DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS 121 (1989); McIntyre & Keesler, *Psychological Disorders Among Foster Children*, 15 J. CLINICAL CHILD PSYCHOLOGY 297 (1986) [hereinafter McIntyre]; Runyan & Gould, *Foster Care for Child Maltreatment: Impact on Delinquent Behavior*, 75 PEDIATRICS 562 (1985); Runyan & Gould, *Foster Care for Child Maltreatment II: Impact on School Performance*, 76 PEDIATRICS 841 (1985); George & Main, *Social Interactions of Young Abused Children: Approach, Avoidance, and Aggression*, 50 CHILD DEV. 306 (1979); Klee & Halfon, *Mental Health Care for Foster Children in California*, 11 J. CHILD ABUSE AND NEGLECT 63 (1987).

consequences of this greater incidence of illness among children in foster care have not been adequately explored.<sup>33</sup>

### C. Barriers to Adequate Health Services

The limitations in available health services for children in foster care reflect structural problems in the child welfare system, which has evolved from one designed to remove children from danger to one increasingly expected to provide therapeutic interventions to support long term child health and development. During this evolution, however, the structure, organization, and resource base of the child welfare system has not changed. As a result, in many parts of the country case loads now exceed four times the recommended level.<sup>34</sup>

Children first enter foster care when authorities remove them from their families to investigate reports of suspected abuse, neglect, or abandonment.<sup>35</sup> Children may enter the system through several routes: schools, law enforcement agencies, health care facilities, or social service agencies. Typically, a child is placed in emergency foster placement while a dependency petition is filed, an investigation proceeds, and hearings are held to determine if the child should be returned home or become a dependent of the court. If the child is made a dependent, she may be returned home under the family maintenance program or be placed in foster care and the family reunification program. If the family has not been reunified after eighteen months, the child is referred for adoption, guardianship, or long term foster care.<sup>36</sup>

As a child moves through the foster care process, her health needs change. Initially, an intake health assessment is necessary to discover acute medical conditions that may place the child or her caretakers at risk. Later, more comprehensive developmental and mental health assessments to facilitate case planning are appropriate for the child who will remain in foster care or move from one foster home to another. In most locales, however, the delivery of health services is not integrated into the dependency and dispositional pro-

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A recent report indicates that the number of emotionally disturbed and developmentally disabled children in foster care in Florida has increased dramatically between 1982 and 1988. The data indicate that 54% of all children in foster care have behavioral problems and 16% have developmental disabilities. PERFORMANCE AUDIT, *supra* note 29, at 16-17.

33. Although adverse health and social consequences of foster care have not been fully documented longitudinally, it is known that prison inmates are more likely to report maltreatment as children. See generally Lewis, Mallouh & Webb, *Child Abuse, Delinquency, and Violent Criminality*, in CHILD MALTREATMENT: THEORY AND RESEARCH ON THE CAUSES AND CONSEQUENCES OF CHILD ABUSE AND NEGLECT 707, 709-21 (D. Cicchetti & V. Carlson eds. 1989).

34. NO PLACE TO CALL HOME, *supra* note 17, at 9; CHILD WELFARE LEAGUE OF AMERICA, STANDARDS FOR FOSTER FAMILY SERVICE (REVISED) 90-91 (1975).

35. Other reasons for removal include an absent or incapable caretaker, disability of the child, exploitation, and relinquishment.

36. WATAHARA & LOBDELL, *supra* note 15, at 4.



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cess.<sup>37</sup> The child welfare system is primarily designed to protect children from immediate danger and to adjudicate and provide placement services; it is not designed to serve children's long term medical, emotional, and developmental needs.<sup>38</sup> While some agencies contract with health care providers to deliver in-house services, the vast majority of agencies assign health care responsibilities to the foster parents.<sup>39</sup>

In many areas of the country, however, it is exceedingly difficult for a foster parent to find a physician, psychologist, or other health care professional who is willing to see a foster child. The reluctance of health care professionals to see foster children is due to the complexity and time consuming nature of these children's health problems, the poor reimbursement for services from Medicaid,<sup>40</sup> and geographic barriers created by the location of services.<sup>41</sup> Other essential services like therapeutic nurseries, family therapy, and transition counseling are even more rarely available to children in foster care. A 1987 California study found that pre-placement health assessments were inconsistently performed and that information available to social workers and foster parents was incomplete, thus impeding health care decisions. The study also found that county agencies were unable to monitor the health status and health service use by their wards, and that high quality comprehensive health assessments were rare.<sup>42</sup> Despite the fact that children in foster care do not have access to many needed health services, many states are not taking full advantage of programs under Medicaid, including the Early and Periodic Screening, Diagnosis, and Treatment Services program (EPSDT), which can be used to provide a range of needed services.<sup>43</sup>

### III. PROPOSED SOLUTIONS

Ten years after the passage of the Adoption Assistance and Child Welfare Act of 1980<sup>44</sup> more and more needy children are entering an overcrowded and overburdened child welfare system. Many of these children are not receiving appropriate health and developmental services, resulting in longer foster care placements, placement instability, and potential long term disabili-

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37. See generally E. SCHOR, R. APTEKAR & T. SCANNELL, *THE HEALTH CARE OF CHILDREN IN OUT-OF-HOME CARE: A WHITE PAPER* (1987) [hereinafter *WHITE PAPER*].

38. See generally Halfon & Klee, *Health Services for Foster Children in California: Current Practices and Policy Recommendations*, 80 *PEDIATRICS* 183 (1987).

39. Schor, *Foster Care*, 10 *PEDIATRICS REV.* 209 (1989).

40. 42 U.S.C. § 1396 *et seq.* (1988).

41. J. Hailey, *Tackling California's Demand for Foster Care* (Dec. 1990) (available from California Senate Office of Research); Halfon & Klee, *supra* note 38; *WHITE PAPER*, *supra* note 37.

42. Halfon & Klee, *supra* note 38.

43. See generally H. Fox & L. Wicks, *The Role of Medicaid and EPSDT in Financing Early Interventions and Preschool Special Education Services* (Apr. 1990) (available from Fox Health Policy Consultants, Inc., Washington, D.C.) [hereinafter *Fox*].

44. Pub. L. No. 96-272, 94 Stat. 500 (codified in scattered sections of 42 U.S.C.).

ties. Because the health needs of these children vary widely and have multiple origins, only a comprehensive and coordinated system can provide the services required.<sup>45</sup> Creating such a system demands policy changes at federal, state, and local levels, affecting many public agencies and providers. One problem in creating such a system is that there is currently no mechanism to ensure that foster children, who are under the authority of child welfare agencies, receive needed services from other public agencies and private providers. Policies are needed that more fully coordinate the intentions and efforts of multiple agencies. The next sections of this Article outline current efforts to clarify standards of care and obligations of states, to organize a continuum of services, and to formulate funding strategies to use current entitlement programs more effectively. These incremental, local efforts will be contrasted with a more universal, national reform that might better address the health needs of children in foster care.

#### *A. Public Interest Group Efforts to Determine Standards of Care*

Judicial clarification of state obligations under the Adoption Assistance and Child Welfare Act of 1980<sup>46</sup> began in the early 1980s. At the same time, professional organizations sought to establish standards of care for children in foster care. The most thorough national effort was initiated in 1986 by the Child Welfare League of America (CWLA) and the American Academy of Pediatrics and led to a widely noted policy paper on the standards of care and the provision of health services to children in the child welfare system.<sup>47</sup>

The Child Welfare League Standards for Health Care Services for Children in Out-of-Home Care (Standards) are directed toward children living in emergency shelters, foster family homes, group homes, residential centers, independent living programs, and other public facilities. The Standards address three general areas: (1) assessment of health needs, (2) provision of health services, and (3) organization and administration of health services.<sup>48</sup> The Standards present a recipe for providing individual services but also extend beyond the rights of the individual child. The Standards call for service and

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45. See generally WHITE PAPER, *supra* note 37; Halfon & Klee, *supra* note 38. Family preservation services are also an important strategy to prevent foster care placement but our comments are limited to children who are already in foster care.

46. Pub. L. No. 96-272, 94 Stat. 500 (codified in scattered sections of 42 U.S.C.).

47. CHILD WELFARE LEAGUE OF AMERICA, STANDARDS FOR HEALTH CARE SERVICES FOR CHILDREN IN OUT-OF-HOME CARE (1988) [hereinafter STANDARDS]; See generally WHITE PAPER, *supra* note 37.

48. The STANDARDS provide specific details for each major area of recommendations. STANDARDS, *supra* note 47. See generally WHITE PAPER, *supra* note 37. The impact of the STANDARDS is just beginning to be felt. The State of Maryland has clearly relied on the STANDARDS in mandating changes in the Department of Human Resources Social Services Administration. See generally *L.J. v. Massinga*, 699 F. Supp. 508 (D. Md. 1988); 17 Md. Reg. 1871.

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administrative upgrades, new and needed expertise, interagency and intra-agency coordinating procedures, and the development of new models of care.

In the area of assessment, the Standards recommend collection of specified health history information, initial health evaluations within twenty-four hours of placement, comprehensive health and mental health assessments within thirty days of placement, and the establishment of an individual case plan based upon these assessments.

With respect to health services, the Standards recommend that children have access to an ongoing system of preventive health measures, health maintenance services, mental health services, emergency medical care, acute and chronic health care, and care for special health problems. The Standards recommend use (with some additional recommendations) of the guidelines of Health Supervision of Children and Adolescents published by the American Academy of Pediatrics. The Standards also suggest procedures child welfare agencies could adopt to ensure access to necessary and qualified health and mental health services.

Finally, in the area of organization of health services organization, the Standards recommend that state, local, and county governments create Health Services Management Units to provide direct support to case workers and health care providers. The role of case workers with respect to the health care of children is discussed in detail, as are criteria for selection of health care providers. The Standards recommend procedures for standardized data collection and health care information retrieval, including central use of an abbreviated health record or "medical passport." In addition, the Standards suggest ways to train case workers and health care providers in child development and behavior, and in pediatric medical and emotional problems. The Standards also offer specific recommendations for coordination among local, county, and state agencies.

The recommended organizational goals enumerated in the Standards provide a strategy for reform without fundamentally restructuring the child welfare system. Professional standards of care, such as the Child Welfare League of America Standards for Health Care Services for Children in Out-of-Home Care, are important not only for defining service content, quality, duration, and procedures, but also for role clarification, organizational reform, and cross-disciplinary education.<sup>49</sup>

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49. Advocacy and consensus building regarding state standards of care can be facilitated by convening multiagency consensus conferences to discuss standards and develop specific legislation. *See generally* Klee, Soman & Halfon, *Implementing Critical Health Services for Children in Foster Care: Recommendations of the California Conference on Health Care for Children in Foster Care*, CHILD WELFARE (forthcoming, 1991).

*B. Legal Efforts to Define State Obligations and Standards of Care*

Although the Adoption Assistance and Child Welfare Act of 1980<sup>50</sup> includes general guidelines regarding the obligation of states to dependent children, courts have only recently begun to clarify these guidelines. Under the Act, states may not receive federal funds unless they implement and operate a "case review system . . . for each child receiving foster care under the supervision of the State."<sup>51</sup> States must establish "a service program designed to help children, where appropriate, return to families from which they have been removed or be placed for adoption or legal guardianship."<sup>52</sup> In addition, states must "provide for the development of the case plan . . . for each child receiving foster care."<sup>53</sup>

Child welfare advocates have long debated whether open legal definitions or more defined statutory authority better serve the needs of children. Some argue that open definitions allow decision makers to respond to contextual, local, and emergent features of a situation. Others argue that narrow legal definitions prevent decisions from being made on an ad-hoc, biased, and unsupported basis. This debate has focused especially on definitions of neglect as a basis for placing children in foster care.<sup>54</sup> Narrow definitions might be more appropriate in health care provisions because decisions to intervene on behalf of a child's health needs should be based upon professional standards of care, rather than on the personal values of judges, social workers, and foster parents whose expertise in the health area might be limited.

Several suits filed in the 1980s attacked failures by states to serve the needs of children placed in foster care. These suits began to clarify standards of care under the Adoption Assistance and Child Welfare Act of 1980, including standards of health care.<sup>55</sup> In addition to developing standards under the Act,

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50. Pub. L. No. 96-272, 94 Stat. 500 (codified in scattered sections of 42 U.S.C.).

51. 42 U.S.C. § 627(a)(2)(B) (1988).

52. 42 U.S.C. § 627(a)(2)(C) (1988).

53. 42 U.S.C. § 671(a)(16) (1988).

54. See generally Wald, *State Intervention on Behalf of "Neglected" Children: A Search for Realistic Standards*, 27 STAN. L. REV. 985 (1975); Johnson, *The Changing Concept of Child Abuse*, in THE AMERICAN FAMILY AND THE STATE 257 (Peden & Glahe eds. 1986).

55. *L.J. v. Massinga*, 838 F.2d 118 (4th Cir. 1988), *cert. denied*, 488 U.S. 1018 (1989) (affirmed lower court injunction to redress deficiencies in the administration of the foster care program in Baltimore following presentation of evidence of physical and sexual abuse and medical neglect of children while in foster care); *G.L. v. Zumwalt*, 564 F. Supp. 1030 (W.D. Mo. 1983) (approving a consent decree that established procedures for licensing of foster homes, prohibited use of improper punishment, eliminated overcrowding, and required adequate medical, dental, and mental health care); *G.L. v. Zumwalt*, 731 F. Supp. 365 (W.D. Mo. 1990) (later proceeding where plaintiff failed to establish defendant in contempt of earlier consent decree); Connecticut Department of Children and Youth Services, Consent Decree (D. Conn. 1991) (to be filed in the case of *Juan F. v. O'Neil*, CIV. NO. H-89-859 (D. Conn. filed Jan. 7, 1991)); *R.C. v. Hornsby*, No. 88-D-1170-N (M.D. Ala. filed Apr. 19, 1989) (summary judgement motion denied in action alleging failure by Alabama to provide appropriate care and psychiatric treatment for its dependent children); Plaintiffs' Memorandum in Response to Defendants' Coler and Farie Motion to Dismiss Plaintiffs' Amended Complaint, *M.E. v. Martinez*, No. 90-1008-CIV-KEHOE (S.D. Fla. filed Aug. 17,

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*G.L. v. Zumwalt* and *L.J. v. Massinga* illustrate both the gains that litigation can provide and the systemic barriers to implementing judicial decisions. The 1983 consent decree issued in *Zumwalt* required that the Jackson County Department of Family Services (DFS) in Missouri institute several changes in the care received by foster children. The health care provisions mandated by the consent decree stated in part that:

A. Defendants shall establish an adequate medical care system to ensure that foster children's medical, dental and mental health needs are adequately met . . . .

B. Beginning on or about July 1, 1983, DFS shall enroll each foster child in either a health maintenance organization or a prepaid health plan which shall provide a full range of medical services for each child . . . .<sup>56</sup>

Along with other specific responsibilities, the decree also required that the DFS establish a medical care coordinator position and ensure that all children receive a complete medical examination within twenty-four hours and dental, hearing, and eye exams within one month of coming under state custody.<sup>57</sup>

The Jackson County DFS did not submit a written proposal on how it would provide medical care until September 1988, more than five years after the consent decree was issued. The agency's proposal contained a procedure to establish a prepaid health plan by obtaining a Medicaid waiver<sup>58</sup> but the procedure was subsequently abandoned because of expense and time pressures. In June 1990, after numerous other delays and a failed attempt by the plaintiff to demonstrate that the agency was in contempt by not complying with the original consent decree, the DFS proposed to use a system of case management to organize and coordinate health services. Ongoing monitoring of compliance with the consent decree indicates that the DFS has been able to meet some requirements, such as providing a medical exam within twenty-four hours, but that it has been unable to successfully meet many of the other health-related requirements of the decree. For example, only 38% of children in custody have a medical treatment plan on file.<sup>59</sup>

The 1989 consent decree issued in *Massinga* was similar to the consent decree issued in *Zumwalt*, although it mandated more substantive changes. The *Massinga* consent decree required the Baltimore Department of Human Re-

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1990) (alleging failure by the Florida Department of Health and Rehabilitative Services to provide children in state custody with necessary therapeutic services).

The recently enacted Omnibus Budget Reconciliation Act of 1989 (OBRA), Pub. L. No. 101-239, 103 Stat. 2106, 2258-73 (codified at 42 U.S.C.A. § 1396 (West Supp. 1990)), which requires that appropriate services be provided for any medical, mental health, or developmental defect identified by the EPSDT screening, provides an additional basis from which to scrutinize the delivery of care to foster children.

56. 564 F. Supp. at 1037.

57. 564 F. Supp. at 1035, 1037.

58. 42 U.S.C. § 1396 *et seq.* (1988).

59. Foster Care Consent Decree Report of Compliance at 99, *G.L. v. Zumwalt*, 564 F. Supp. 1030 (W.D. Mo. 1983) (filed Aug. 27, 1990) [hereinafter Consent Decree].

sources make substantive changes in the structure, organization, and provision of services. These changes included a new supervisory process, a quality assurance unit, and a specialized unit with expertise in mental health, special education, developmental disabilities, and drug and alcohol abuse.<sup>60</sup> The design of this decree has incorporated many of the recommendations of the Child Welfare League Standards.<sup>61</sup> In many respects, the agency has complied with the consent decree. It has restructured the agency, provided comprehensive health assessments, created a medical information management system, and provided additional case planning and review. Nonetheless, the compliance reports and review indicate that provision of appropriate referrals has been hampered by the fragmentation of children's services and barriers to health services, such as the lack of providers willing to see children placed in foster care.<sup>62</sup>

Both *Zumwalt* and *Massinga* relied upon the Child Welfare League Standards, although in different ways. In *Zumwalt* the Standards served as guidelines during the protracted implementation of the consent decree requirements. In *Massinga* the Standards were used to design the consent decree requirements and to modify state law. Both cases illustrate the usefulness of litigation to clarify and enforce state obligations. However, the cases also demonstrate that judicially mandated modifications in agency procedures are insufficient by themselves to ensure that children receive needed services. In both *Zumwalt* and *Massinga*, a fragmented health service system and a lack of providers and services proved to be critical impediments to providing foster children adequate health care. Fundamental system barriers cannot be easily addressed through litigation based solely the Adoption Assistance and Child Welfare Act of 1980. Other changes in federal and state laws affecting health care agencies and providers and new models of service organization and delivery are necessary.<sup>63</sup> In addition, although litigation under the Adoption Assistance and

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60. 699 F. Supp. 508, 518-26 (D. Md. 1988), *aff'd*, 838 F.2d 118 (4th Cir. 1988).

61. STANDARDS, *supra* note 47.

62. See generally Plaintiffs' Initial Response to Defendants' First Six Months Compliance Report, L.J. v. Massinga, 699 F. Supp. 508 (D. Md. 1988) (No. JH-84-4409); Plaintiffs' Response to Defendants' Second Six Months Compliance Report, L.J. v. Massinga, 699 F. Supp. 508 (D. Md. 1988) (No. JH-84-4409); Plaintiffs' Response to Defendants' Third Six Months Compliance Report, L.J. v. Massinga, 699 F. Supp. 508 (D. Md. 1988) (No. JH-84-4409); Plaintiffs' Response to Defendants' Fourth Six Months Compliance Report, L.J. v. Massinga, 699 F. Supp. 508 (D. Md. 1988) (No. JH-84-4409).

63. A more recent suit, *M.E. v. Martinez*, filed in Florida on behalf of children not receiving appropriate mental health and developmental services, has broadened the basis of challenge. Plaintiffs alleged not only a violation of the provisions of the Adoption Assistance and Child Welfare Act of 1980 but also violations of section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1988), and provisions of the Omnibus Budget Reconciliation Act of 1989 (OBRA), Pub. L. No. 101-239, 101 Stat. 2106, 2256-70 (codified at 42 U.S.C.A. § 1396 (West Supp. 1990)), mandating Medicaid coverage. By broadening the basis of the suit to include the financing functions in Medicaid and EPSDT, mandated standards under the Adoption Assistance and Child Welfare Act may be more effectively linked to the fiscal ability to provide services and monitor outcomes under OBRA. Plaintiffs' Memorandum in Response to Defendants' Coler and Farie Motion to Dismiss Plaintiffs' Amended Complaint, *M.E. v. Martinez*, No. 90-1008-CIV-KEHOE (S.D. Fla. filed Aug. 17, 1990).

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Child Welfare Act of 1980 has made some inroads in specific locales, the impact has been limited geographically. After all, a decree issued in one jurisdiction does not apply nationwide.

### *C. New Models of Care*

Implementing the Child Welfare League Standards<sup>64</sup> nationwide depends on new models of care that can overcome barriers to services. These new models of care require changes in federal, state, and local policies to facilitate planning and coordination among different agencies and programs. Changes in federal, state, and local policies are also necessary to encourage coordinated use of national and state funding provisions and to clarify the jurisdictional authority of different agencies.<sup>65</sup>

Services must be organized to respond to children's individual needs. A typical child in foster care may have asthma requiring ongoing medications, allergy shots, and environmental modifications to prevent attacks; anemia requiring iron supplements and ongoing monitoring; speech and language impediments requiring speech therapy; educational delays demanding additional remedial work; and depression or problems adapting to the new foster home that demand individual, group, and family therapy. A system of care is needed to guarantee that these children receive thorough assessments of their physical, developmental, emotional, and social needs and that appropriate preventive, treatment, and rehabilitative services are identified and provided through a care plan that is communicated effectively to the foster parents and child welfare workers. In addition, service delivery must be coordinated with other competing demands on the child and foster family. There is mounting evidence that individuals with multiple health needs, such as children in foster care, are best served by organized health care systems that provide a continuum of services.<sup>66</sup> The complex health care needs of foster children demand a system organized to maximize coordination, comprehensiveness, and continuity, and to minimize fragmentation, duplication, and gaps.

There are two general models of how services should be presented to children with multiple health needs. The centralized model of care envisions an integration of services in one physical location. Under the centralized coordination model, a single resource center provides a variety of health and

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64. STANDARDS, *supra* note 47.

65. The fragmentation and inflexibility in child service programs reflect an historic piecemeal approach to policy making. The federal government has more than 100 programs for children and each program has been added to pre-existing programs with little attempt at integration. State programs are similarly uncoordinated, thereby multiplying the problem. See Harvey, *supra* note 10, at 3; Smrekar, *State Policy Making for Children*, in *CONDITION OF CHILDREN IN CALIFORNIA* 323 (1989).

66. See generally Benjamin, *Long-Term Care and AIDS: Perspectives from Experience with the Elderly*, 66 *MILBANK Q.* 415 (1988).

psychosocial services. These services include health assessments, primary medical care, health care case management, early intervention services for young children, mental health services, family support services, and foster placement transition services. Resource centers can be located in children's hospitals, public clinics, or community centers and can be under contract to provide complete primary care services to all foster children. The medical centers in Oakland, California, the University of Maryland in Baltimore, and Waterbury, Connecticut are examples of centralized health service centers.<sup>67</sup> In contrast, the decentralized model of care envisions procedural mechanisms, such as case management, that coordinate various health and welfare services.

In practice, service delivery systems are often hybrids of these two approaches, with certain key services centralized and other services coordinated through case management.<sup>68</sup> For example, a health care case manager, such as a public health nurse or designated child welfare worker, can organize health care for children within an agency.<sup>69</sup> Agencies can also create special interagency teams to coordinate and provide care for high risk, multiple problem children who may be receiving services from several county agencies.<sup>70</sup>

A variation on the centralized service model is the health maintenance organization (HMO) which provides a set of health services for a predetermined price. In 1976, Baltimore established an HMO for children in foster care that provided high quality, comprehensive health services to approximately one-third of the city's foster children. Reimbursement was provided through Medicaid<sup>71</sup> at a lower cost than the Medicaid fee-for-service system.<sup>72</sup> The HMO was initiated by a group of health care providers with cooperation from the social services agency in Baltimore, and required effort by both parties to

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67. See generally Dubowitz (1990), *supra* note 30; Simms, *supra* note 32.

68. Case management is a service organizing technique designed to improve assessment of complex psychosocial problems and overcome some of the barriers that hinder the provision of comprehensive, community-based primary care. The basic elements of case management are: outreach, assessment, care plan development, service referrals, linkage and brokering of services, advocacy, monitoring, and evaluation. See generally Lamb, *Therapist Case Managers: More than Brokers of Services*, 31 HOSP COMM. PSYCHIATRY 762 (1980).

69. This approach was taken by the Department of Family Services of Jackson County, Missouri to fulfill the terms of the consent decree issued in *G.L. v. Zumwalt*, 564 F. Supp. 1030, 1037 (W.D. Mo. 1983); Consent Decree, *supra* note 59. Additionally, demonstration projects in San Diego and Santa Cruz, California use a public health nurse as a centralized case manager to organize care through a network of community-based pediatricians and other health care providers.

70. California Assembly Bill 2268 mandates such interagency coordination in California for medically fragile children entitled to services from different agencies. A.B. 2268, Reg. Sess., (1989). Maryland uses a "Section 2176" home and community-based waiver to provide comprehensive care through a multiagency team to all technology dependant children in Maryland's foster care system. See generally M. DeWoody, Options and Strategies for Child Welfare Agencies: Medicaid Supplemental Security Income (SSI) (Feb. 5, 1991) (unpublished manuscript available from the Child Welfare League of America).

71. 42 U.S.C. § 1396 *et seq.* (1988).

72. Schor, Neoff & LaAsmar, *The Chesapeake Health Plan: An HMO Model for Foster Children*, 63 CHILD WELFARE 431 (1984).



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sustain. A similar effort to establish an HMO for children in foster care was attempted by the Department of Family Services in Jackson County, Missouri but failed. One reason the Baltimore HMO succeeded and the Missouri HMO did not is that the Baltimore HMO was initiated and sustained by health care providers and social service agencies while the Missouri HMO was initiated to satisfy the requirements of a consent decree. Baltimore's experience with the foster care HMO indicates that it can be a cost effective model of care when service providers are willing participants.<sup>73</sup>

The HMO model can be further extended by including non-medical social services in a community-based resource center to create a "social HMO." Social HMOs have already been successfully used to provide both health and social services for multiple problem populations such as the frail elderly. A social HMO providing prevention and early intervention services may also be an effective way to serve the health needs of children placed in foster care.

### D. Health Care Financing

The creation of coordinated systems of child health care requires innovative financing so that providers can coordinate funding streams from an array of federal programs.<sup>74</sup> Recent changes in federal Medicaid regulations have made it possible to expand the provision of needed services such as case management, routine psychological and developmental assessments, individual family therapy, and preventive and rehabilitative services. Since the majority of children in foster care is eligible for Medicaid, this program can help states fund a full continuum of health and developmental services.

*1. Provision of health services through Medicaid.* Medicaid was created in 1965 through Title XIX of the Social Security Act.<sup>75</sup> It is an optional, federally supported, state administered program designed to provide health services to the poor. As an income-based, state administered program it differs from Medicare, which was created in 1965 under Title XVIII of the Social Security Act<sup>76</sup> as a federally administered universal entitlement program for all persons over 65 years of age. States choosing to offer a Medicaid program must provide certain mandated services and may provide up to thirty-one optional services.<sup>77</sup> Currently Medicaid coverage and eligibility varies widely among

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73. The consent decree was issued in *L.J. v. Massinga*, 838 F.2d 118 (4th Cir. 1988), *cert. denied*, 488 U.S. 1018 (1989).

74. Brewer, McPherson, Magrab & Hutchins, *Family Controlled, Community Based Coordinated Care for Children with Special Health Care Needs*, 83 PEDIATRICS 1055 (1989) [hereinafter Brewer].

75. Pub. L. No. 89-97, 79 Stat. 343 (codified at 42 U.S.C. § 1396 *et seq.* (1988)).

76. Pub. L. No. 89-97, 79 Stat. 325 (codified at 42 U.S.C. § 1395 *et seq.* (1988)).

77. Mandated services include inpatient hospital care, outpatient hospital services, rural health services, laboratory and X-ray services, skilled nursing facility services, services under the Early and Periodic Screening, Diagnosis, and Treatment Services program (EPSDT), family planning, physician services, home

the states. The following section discusses ways in which the states use the authority granted them under Medicaid to develop new service delivery systems, and how these systems and other programs might be coordinated to provide a continuum of services for children.

An organized system of care based on Medicaid funding requires that children in foster care be universally eligible for Medicaid, a goal that has not yet been achieved.<sup>78</sup> States have wide latitude in determining both Medicaid eligibility and benefits. While states are required to make some foster children eligible for Medicaid and reimburse certain core services, they have wide discretion over whether to extend eligibility and service provisions to other foster children. In all states foster children qualify for Medicaid benefits if they are IV-E eligible.<sup>79</sup> They may also qualify for Medicaid benefits through the Supplemental Security Income (SSI) program<sup>80</sup> for disabled children<sup>81</sup> or through other programs established at the state's option under Medicaid.<sup>82</sup> With recent expansions in Medicaid eligibility due to the Omnibus Budget Reconciliation Act (OBRA), eligibility for children in foster care will also expand.<sup>83</sup>

Although case management is an optional service under Medicaid, it is essential to coordinating services for children with multiple health care needs.<sup>84</sup> A 1986 addition to the Social Security Act gives states the option of providing case management to "assist individuals eligible under the state plan in gaining access to needed medical, social, educational, and other services."<sup>85</sup> Both Alabama and West Virginia have developed special programs to

health services, and nurse midwife services. Section 1905(a) of the Social Security Act also lists optional services that may be covered by Medicaid at a state's discretion. 42 U.S.C. § 1396d (1988).

78. The exact number of children in foster care who are eligible for Medicaid is unavailable. Eligibility for Medicaid is complex and states vary widely in the procedures they use to determine AFDC status, and IV-E status, *supra* note 16. Currently, Medicaid must cover AFDC eligible children, Title IV-E eligible foster children, and pregnant women and children under the age of six from households with incomes lower than 133% of the poverty level.

79. 42 U.S.C. § 1396(a)(10)(A)(i)(I) (1988). For a brief discussion of Title IV-E payments *see supra* note 16.

80. 42 U.S.C. § 1396(a)(10)(A)(i)(II) (1988).

81. Children's eligibility for Medicaid coverage under the SSI program has recently expanded. Under *Zebley v. Sullivan*, 110 S. Ct. 885 (1990), the eligibility criteria must be more sensitive to children's disabilities.

82. Optional programs a state might establish include the medically needy and medically indigent programs under Medicaid. 42 U.S.C. § 1396a(a)(10)(A)(ii) (1988). Another program a state can establish is a program for "Ribicoff children." Named for former U.S. Senator Abraham Ribicoff, who sponsored this legislation, the program extends categorically needy coverage, at a state's discretion, to children under age seven who would be eligible for AFDC if they met the definition of a dependent child. 42 U.S.C.A. § 1396d(n)(2) (West Supp. 1990). States can optionally extend coverage to children under age 21, and may include children who live in privately subsidized foster care or those who live in certain institutional settings. 42 U.S.C.A. § 1396a(10)(ii) (West Supp. 1990). *See CONGRESSIONAL RESEARCH SERVICE, 100TH CONG., 2D SESS., MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS 59* (Comm. Print 1988).

83. Under OBRA, 42 U.S.C.A. § 1396(a)(l) (West Supp. 1990), all children under age 19 living below 100% of the poverty level will be covered by Medicaid by the year 2002.

84. *See generally* Brewer, *supra* note 74.

85. 42 U.S.C. § 1396n(g)(2) (1988).

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provide this optional service to needy children. In Alabama, foster children and children at risk for placement have been designated to receive a range of case management services such as assessment, information management, brokering, and health service coordination. Through an arrangement with the Regional Health Care Financing Administration, Alabama's Department of Human Services allocated 75% of the time of social workers to Medicaid eligible individuals.<sup>86</sup> Similarly, West Virginia has targeted two groups of Medicaid eligible individuals for case management services. The two groups targeted are those with DSM-III-R diagnoses of chronic mental retardation, developmental disabilities, or substance abuse and children aged sixty-one days to two years identified by a physician to be at high risk for developing poor health. Case management services for both groups are performed by health care providers or a designated case management agency.<sup>87</sup>

Another Medicaid option that allows states to provide targeted services to needy children is the rehabilitative services option available under section 1905(a)(13) of the Social Security Act.<sup>88</sup> Under this optional program, services can be targeted to rehabilitate children at risk for developing permanent disabilities. Rehabilitative services are services rendered by a physician, or other licensed practitioner of the healing arts, to reduce physical and mental disability and restore a recipient to her best possible functioning level.<sup>89</sup> The Medicaid rehabilitative category services option offers significant opportunities for financing non-traditional medical and mental health services such as preschool special education services. States currently use this option to provide Individual Education Plan (IEP) rehabilitative services under Part H of the Education of the Handicapped Act Amendments of 1986,<sup>90</sup> mental health rehabilitation services, and physical health rehabilitation services.<sup>91</sup> For example, North Dakota has used the rehabilitative service option to institute a program designed to provide rehabilitative services, such as family therapy, group therapy, and in-home service care, to foster children and families of children at risk of being removed from the biological home.<sup>92</sup>

In addition to mandated services and optional services, states may elect to offer other services through special waiver programs created by Congress to

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86. See DeWoody, *supra* note 70, at 31.

87. See DeWoody, *supra* note 70, at 32-33. As of April 1990, 26 states had amended their state plans to provide reimbursement for case management. Two states, Alabama and Utah, provide targeted case management reimbursement for children in foster care. Seventeen states provide targeted case management reimbursement for high risk children. See Fox, *supra* note 43, at 81.

88. 42 U.S.C. § 1396d (1988).

89. 42 C.F.R. § 440.130(d) (1989).

90. Pub. L. No. 99-457, 100 Stat. 1145 (codified in scattered sections of 20 U.S.C.). In 1990 the Education of the Handicapped Act was amended and renamed the Individuals with Disabilities Act (IDEA), Pub. L. No. 101-476, 104 Stat. 1141, 1142 (codified at 20 U.S.C.A. § 1400(a) (West Supp. 1990)).

91. See Fox, *supra* note 43, at 75-78.

92. See DeWoody, *supra* note 70, at 26-29.

meet the needs of very specific populations. Under Section 1915(c) of the Social Security Act,<sup>93</sup> states may apply for a waiver to provide special services to institutionalized children and children at risk of institutionalization who can be cared for in a community setting. These waivers are known as "2176 home and community-based waivers." The waiver provides for benefits, such as respite care, psychosocial services, and case management, not otherwise authorized under Medicaid.<sup>94</sup> New Mexico and Maryland have instituted programs for medically fragile children under this waiver.<sup>95</sup> In addition, under section 1915(e) of the Social Security Act<sup>96</sup> states can apply for "boarder baby waivers" to provide services to children infected with the HIV virus or who have been drug exposed *in utero*. Under this waiver children under age five who receive or expect to receive federal IV-E services may receive a range of services including nursing care, respite care, supplies, transportation, and physician services.<sup>97</sup>

2. *Provision of health care through Medicaid's Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)*. One of the required services that all states participating in Medicaid must provide is the Early and Periodic Screening, Diagnostic, and Treatment Services program (EPSDT). Although EPSDT is a core Medicaid service, it is functionally distinct in that it targets children and provides guidelines and reimbursement for preventive, as well as diagnostic and treatment, services. The EPSDT program provides three basic services: (1) identifying and informing eligible children and their parents of the benefits and assistance available, (2) assessing a child's health needs through initial and periodic evaluations of physical health and development, and (3) assuring that detected health problems are diagnosed and fully treated in a timely manner.<sup>98</sup> States must also provide outreach and case management services under EPSDT. Unlike other Medicaid services, EPSDT services do not have to be uniformly available to all eligibles. States can target and augment EPSDT services for particular high risk populations.<sup>99</sup>

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93. 42 U.S.C. § 1396n(c) (1988).

94. 42 C.F.R. §§ 440.180 (1989). Unlike the EPSDT provisions of Medicaid, these "2176 waivers" are only available to states that demonstrate that the per capita cost of providing the services does not exceed the cost Medicaid would have incurred if the services were not provided, i.e., budget neutrality. 42 C.F.R. §§ 441.300-.310 (1989). With the expansion of EPSDT benefits under OBRA in 1989, these "2176 waivers" may become less important to states.

95. See DeWoody, *supra* note 70, at 38-41.

96. 42 U.S.C. § 1396n(e) (1988).

97. Similar to the "2176 waivers", states wishing to use the "boarder baby waivers" must guarantee budget neutrality. However, contrary to the "2176 waivers", "boarder baby waivers" are not granted at the federal government's discretion. Nonetheless, the federal government has not yet issued any boarder baby waivers.

98. 42 C.F.R. § 441.56 (1990).

99. See generally DeWoody, *supra* note 70.

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The Child Welfare League Standards<sup>100</sup> recommend that children receive initial intake assessments and periodic comprehensive health assessments that include medical, developmental, and emotional evaluations. The Standards also recommend treatment for identified problems, preventive services for emerging conditions, and case management. The new provisions of the 1989 Omnibus Budget Reconciliation Act (OBRA) potentially allow the EPSDT Program to provide most of these recommended services.<sup>101</sup> Because OBRA mandates the provision of EPSDT services, regardless of whether the services are otherwise included in the state Medicaid plan, therapeutic services for emotional, behavioral, and developmental problems that have traditionally been difficult for health care providers and child welfare agencies to provide because of inadequate funding will be available. Such services might include therapeutic infant parent psychotherapy, therapeutic nursery services, foster family support and transition services, day treatment, and the case management necessary to develop and administer these therapeutic interventions.<sup>102</sup>

Alaska currently uses EPSDT provisions to provide mental health services to Medicaid eligible children. All children entering Alaska's child welfare system receive a full EPSDT screen and may receive an additional partial screen to more clearly identify emotional problems. The majority of children with simple mental health service needs receive traditional, limited interventions, such as the therapy<sup>103</sup> and medication, through the Children's Mental Health System (CMHS). Other children with more complex service needs receive services through the Comprehensive Children's Mental Health System (CCMHS). The CCMHS uses an interagency team to develop individual and family care plans that may include day treatment, crisis management, home-based treatment, and inpatient services. These services in the child's plan are reimbursable as medically necessary treatment services under EPSDT.<sup>104</sup>

As the previous discussion illustrates, states can use the Medicaid provisions to provide a full range of services<sup>105</sup> to children in the welfare system.<sup>106</sup> Many states, however, face significant impediments to fully ex-

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100. STANDARDS, *supra* note 47.

101. The Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-329, § 6403(a), 103 Stat. 2106, 2262-64 (codified at 42 U.S.C.A. § 1396d (West Supp. 1990)).

102. Since states determine what services are medically necessary, as well as the scope and duration of services offered, they will still have considerable latitude in structuring access to services. *See generally* Fox, *supra* note 43.

103. These children might receive individual, group, or family therapy.

104. *See* DeWoody, *supra* note 70, at 22.

105. The preceding discussion focused on the provision of mental health, developmental services, and in-home preventive, rehabilitation, and case management services because these have traditionally been the most difficult to reimburse.

106. In addition to Medicaid, other federal and state programs can be used to provide additional elements in the needed continuum of services. Through the Head Start program, Head Start, Economic Opportunity, and Community Partnership Act of 1974, Pub. L. No. 93-644, 88 Stat. 2291 (codified in scattered sections of 42 U.S.C.), children three to five years of age can receive developmentally appropriate preschool services. Through OBRA amendments to Title V of the Social Security Act, 42 U.S.C.A. §

ploiting the Medicaid provisions. For example, while the promise of matching federal funds is an incentive to states to expand Medicaid services, many states do not have the necessary revenue base for Medicaid expansion. Furthermore, constructing a system of care based on optional Medicaid services is difficult because optional programs are usually provided only if they are politically attractive and inexpensive to implement, conditions that might not apply to health services for children in foster care. Optional programs are also the most vulnerable to cuts when state budget deficits arise.

In addition, longstanding disincentives to provider participation in Medicaid and EPSDT exist.<sup>107</sup> Pediatrician participation in the Medicaid program has decreased because of poor reimbursement levels, inefficient payment mechanisms, and frustrating bureaucratic paperwork.<sup>108</sup> The foster child is often a demanding patient to the health care provider, presenting with little information about her past history and multiple health problems. To guarantee that there are providers willing to provide appropriate treatment, reimbursement rates must be made commensurate with market rates.<sup>109</sup>

### *E. Local Versus National Strategies of Reform*

This Article has presented steps that have been taken and should be taken to meet the multiple health needs of children in foster care. These steps include establishing and implementing professional standards of care, clarifying governmental obligations to those standards, enforcing those standards through litigation, developing service models that improve coordination among individuals and agencies responsible for providing care, and developing a funding base through use of existing finance mechanisms.

Nevertheless, continued incremental tinkering with a system that is so dysfunctional will yield only limited results for limited numbers of children.

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701(a)(1)(D) (West Supp. 1990), children in foster care with chronic illnesses eligible for programs for children with special health care needs may receive comprehensive, community-based, coordinated care.

107. Numerous studies have documented that Medicaid reimburses health care providers at a rate far below that of other third-party payers. See generally Perloff, Kletke & Neckerman, *Physicians' Decisions to Limit Medicaid Participation: Determinants and Policy Implications*, 12 J. HEALTH POL. POL'Y AND L. 221 (1987) [hereinafter Perloff]; Yudkowsky, Cartland & Flint, *Pediatrician Participation in Medicaid: 1978-89*, 85 PEDIATRICS 567 (1990).

108. See generally Hadley, *Physician Participation in Medicaid: Evidence from California*, 14 HEALTH SERVICES RES. 266 (1979); Mitchell & Shurman, *Access to Private Obstetrics/Gynecology Services Under Medicaid*, 22 MED. CARE 1026 (1984); Davidson, *Physician Participation in Medicaid: Background and Issues*, 6 J. HEALTH POL. POL'Y AND L. 703 (1982); Sloan, Mitchell & Cromwell, *Physician Participation in State Medicaid Programs*, 13 J. HUM. RES. 211 (1978); Perloff, *supra* note 107.

109. The Physician Payment Review Commission that drafted recently enacted changes in Medicare reimbursement is currently exploring several strategies to improve the reimbursement of services under Medicaid. In addition, OBRA requires that federally licensed community health centers be reimbursed at full cost and that reimbursement rates under Medicaid be set at levels that do not impede access to care. Pub. L. No. 101-239, §§ 6402, 6404, 103 Stat. 2106, 2260-65 (codified at 42 U.S.C.A. § 1396 (West Supp. 1990)).

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In isolation, each of the steps outlined is necessary but not sufficient to leverage the change needed. While health care providers, social workers, and educators must discuss the implementation of professional standards at the state and local levels, such discussions alone will not clear away the legal, organizational, and funding problems that exist. New models of care can blossom in specific geographic locales under the tutelage of interested health and social service providers, but policy leadership and financial support from the federal Department of Health and Human Services and national foundations are needed for these new models to flourish nationally. In addition, litigation might create change in specific locales that affects national policy but reform through litigation would require many cases and legal advocacy that would be difficult to mount and sustain.

A national strategy would not attempt to correct the inadequacies of the Adoption Assistance and Child Welfare Act of 1980<sup>110</sup> on a state-by-state basis. Rather, it would provide states with a federal mechanism to implement necessary comprehensive systems reforms. Federal legislation specifying the standards of care that children in foster care must receive should be drafted. This legislation should mandate uniform Medicaid eligibility requirements and require states to provide certain services that are currently optional under Medicaid.<sup>111</sup> The new law should also provide the funding to make implementation possible and should provide for coordination of services with other programs such as Part H programs under the Education of the Handicapped Amendments of 1986,<sup>112</sup> programs under the Education of the Handicapped Children Act of 1975,<sup>113</sup> Title V programs,<sup>114</sup> Child Nutrition Act of 1966 (WIC) programs,<sup>115</sup> and Head Start programs.<sup>116</sup> Finally, under the new law each foster child and her foster and biological family should receive a timely, comprehensive, multidisciplinary assessment to identify their unique needs. Regulations to the new legislation should specify the appropriate location and scope of developmentally appropriate services. This means that infants and toddlers could receive home-based developmental services, therapeutic nursery services, and appropriate entry into Head Start, while adolescents could receive counseling, career guidance, vocational training, and independent learning skills training. Similar to the recently amended Education of the Handicapped Act, this new legislation should require an individualized child and family service plan and specify its content and administration. In

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110. Pub. L. No. 96-272, 94 Stat. 500 (codified in scattered sections of 42 U.S.C.).

111. 42 U.S.C. § 1396 *et seq.* (1988).

112. Pub. L. No. 99-457, 100 Stat. 1145 (codified in scattered sections of 20 U.S.C.).

113. Pub. L. No. 94-142, 89 Stat. 773 (codified in scattered sections of 42 U.S.C.).

114. 42 U.S.C. § 701 *et seq.* (1988).

115. 42 U.S.C.A. § 1786 (West Supp. 1990).

116. Head Start, Economic Opportunity, and Community Partnership Act of 1974, Pub. L. No. 93-644, 88 Stat. 2291 (codified in scattered sections of 42 U.S.C.).

addition, the law should define case management, provide procedural protections for both child and family, and provide a mechanism to promote inter-agency planning and coordination.<sup>117</sup> The Child Welfare League Standards<sup>118</sup> could be used to construct the components of this new federal law. This type of federal mandate might overcome barriers that have traditionally kept state agencies from developing common service agendas and more effective working relationships. A more universal mandate would spare children in foster care the fate of waiting as each state and locale figures out how to develop a system of care and fund it through Medicaid.

The Education of the Handicapped Act Amendments of 1986, which added Part H to the Education of the Handicapped Act, provide an example of a federal effort to deliver comprehensive early intervention and treatment services to children with multiple health problems. Using this Act as a model, a new federal law could assist states in: (1) developing statewide, comprehensive, coordinated interagency programs of early intervention, treatment, and rehabilitation services for foster children, (2) coordinating payment for these services from federal, state, local, and private sources, and (3) providing quality prevention and early intervention services. Although the success of the Education of the Handicapped Act Amendments of 1986 has not yet been determined, it can serve as a model for similar legislation aimed at children in foster care. Such legislation should mandate many of the same services and coordinating mechanisms, but should also go further by requiring universal Medicaid eligibility and access to all currently optional Medicaid benefits.

Some might argue that such a hybrid program combining the service provisions and coordination functions of the Education of the Handicapped Act Amendments of 1986 and the fiscal functions of an expanded Medicaid program falls short of real universal reform that a national health insurance program might provide. However, even if the United States instituted a reasonably comprehensive national health insurance program, the complexity and magnitude of the service needs of many children in foster care would demand a range of individual services that might not be routinely offered.

#### IV. CONCLUSION

This Article has used children placed in foster care to illustrate how children with complex health needs are inadequately served by existing health care programs. Current programs are characterized by unclear standards of care, restrictive eligibility requirements, outmoded service delivery models, and

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117. The interagency coordination model used by Alaska to provide EPSDT-funded mental health and developmental services is a good example. DeWoody, *supra* note 70.

118. STANDARDS, *supra* note 47.



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inadequate funding.<sup>119</sup> This Article has presented several strategies that should be pursued to address the complex health needs of multiple problem children. In summary, our recommendations are: (1) establishment of professional standards of care, (2) clarification of state obligations to implement those standards, (3) enforcement of those obligations through suitable litigation, (4) national agreement regarding an appropriate continuum of services to meet the health needs of these children and their families, (5) improved coordination among individuals and agencies who provide services, and (6) more creative use of existing funding mechanisms to finance needed care. We urge a coordinated national approach so that children and families who live in poverty in the United States do not remain inadequately served by fragmented, underfunded, bureaucratic structures.

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119. See generally Harvey, *supra* note 10.

**Table 1**  
**FOSTER CARE TRENDS IN SELECTED LARGE STATES**  
**1980 - 1988\***

State	1980	1985	1988	Trend 80-85	Trend 85-88	Minorities 1985 (%)	% Less Age 6
California	27,534	43,344	62,419	57%	44%	51%	37%
Florida	9,922	6,766	7,725	-32%	14%	31%	40%
Illinois	14,302	14,643	17,425	2%	19%	50%	45%
Michigan	8,686	8,455	11,302	-3%	34%	53%	28%
Missouri	7,492	6,303	6,376	-16%	1%	n/a	n/a
New Jersey	10,275	8,983	8,542	-13%	-5%	65%	37%
New York	40,762	26,022	33,645	-36%	29%	72%	38%
North Carolina	8,531	6,575	6,126	-23%	-7%	n/a	35%
Ohio	17,663	12,990	13,100	-26%	1%	35%	34%
Pennsylvania	14,652	12,901	14,797	-12%	15%	n/a	21%
Texas	6,818	4,851	5,449	-29%	12%	52%	45%
11 State Total	166,637	151,833	186,906	-9%	23%		
U.S. TOTAL	303,500	276,300	340,300	-9%	23%		

\* Adapted from SELECT COMM. ON CHILDREN, YOUTH, AND FAMILIES, 101ST CONG., 1ST SESS., NO PLACE TO CALL HOME: DISCARDED CHILDREN IN AMERICA 226 (1989).