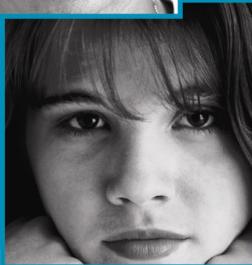
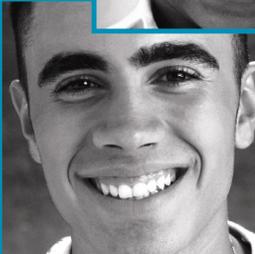
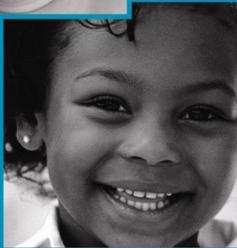


CONNECTICUT
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Careening Toward Crisis:

State and Federal Funding of Child Welfare Services in Connecticut

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Executive Summary

The State of Connecticut has a legal and moral responsibility to ensure the health, safety, education, and sound development of all children and youth placed into its care and custody because of parental abuse or neglect. When the Department of Children and Families (DCF) fails in this duty, it compounds the harm already done to these children.

This report, the first in a two-part series, examines how state and federal funding is used *now* in DCF's budget to meet that responsibility, and how that funding has changed over time. The report finds that perverse federal funding incentives, coupled with some imprudent past state budget choices, is causing DCF and the children and families it is to serve to careen toward crisis in two significant ways:

- Connecticut's budget now invests far too little in the home and community-based services that can prevent child abuse and neglect in the first instance, and then avert out-of-home placements if a child is referred to DCF. Instead, families are helped primarily after crises erupt, children are harmed, and the problems have become more difficult and costly to address.
- Once children are in DCF's care, Connecticut's spending remains skewed, with a diminishing share of all funding allocated for the programs and services that could maintain children in family-like settings, and an increasing share of funds being spent on more costly and restrictive institutional out-of-home care.

This report concludes that past state budget choices, coupled with illogical restrictions placed on the use of federal child welfare funding under Title IV-E of the Social Security Act, actually have undermined the development of a system of child welfare services that meets all requirements of federal and state law and serves the best interests of children.

While there have been some recent, and very important, efforts to reverse some of these funding patterns (e.g., the development of KidCare, increased funding for Nurturing Families), concurrent state budget choices have actually accelerated the trends (e.g., increased reliance on TANF funds in DCF's budget). As a result, there remains a very serious mismatch between the goals of a well-functioning child welfare system (as specified in state and federal law) and current state and federal financing of that system. It will take a fundamental re-structuring of how state and federal child welfare-related funds are used to prevent continuing increases in DCF's caseload and budget.

Key Findings

1. Growth in DCF's Budget Has Far Exceeded Growth in DCF's Caseload

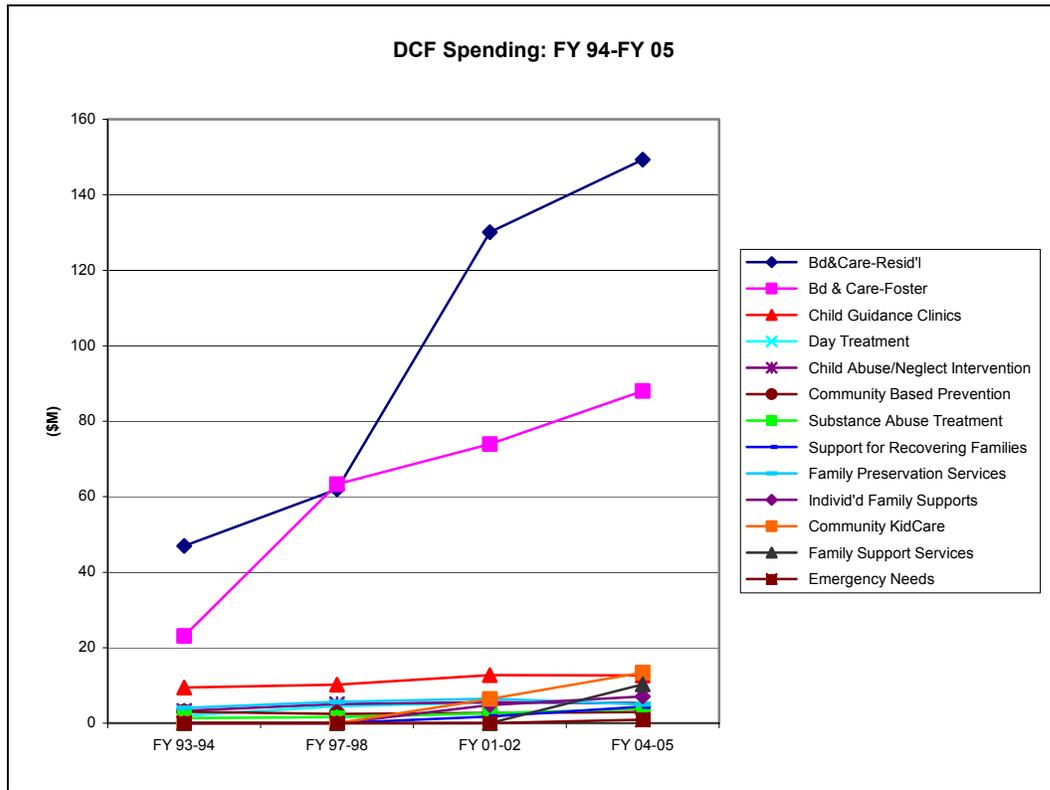
In the last decade, the number of children served by DCF increased from 7,500 children at the end of FY 94 to 12,247 children at the end of FY 04 (a 63% increase). DCF's General Fund budget grew faster -- from \$227.6 million in FY 94 to \$604.1 million in FY 04 (a 165% increase). With DCF's revised SFY 05 General Fund budget at \$642.6 million, there has been a 182% nominal increase since FY 94.

While some of this growth can be attributed to the more complex clinical needs of children now in care and to long overdue investments to improve the quality of DCF's care for these children, much growth also is due to skewed spending choices that skimp on funding for services that could reduce child welfare involvement while, at the same time, increasing spending for expensive "back end" placements and services.

2. DCF's Spending on Out-of-Home Placements Has Far Exceeded Growth in Its Spending on the Programs and Services That Could Help Avert Such Placements

Out-of-home care. As Chart 1, below, chart illustrates, over the past decade DCF's investments in the home and community-based services that could help prevent child abuse and neglect and avert out-of-home placements have been anemic, while spending on expensive out-of-home care has soared.

Residential treatment. In addition, as Chart 1 further illustrates, DCF's growth in spending on expensive residential treatment has far outstripped growth in spending for less expensive and more family-like foster care and therapeutic foster care placements. Moreover, the growth in DCF's spending for residential treatment (a 218% increase between FY 94 and FY 04) is nine times greater than the growth in the number of children and youth placed in residential treatment (a 24% increase over this period).



In-patient psychiatric hospitalizations. Spending growth also has been rapid for in-patient psychiatric hospitalizations. A significant portion of this growth can be attributed to

“gridlock” in Connecticut’s children’s mental health system. Connecticut’s failure to invest adequately in a robust continuum of home and community-based services has resulted in children in DCF care and custody languishing in costly psychiatric hospital settings past the time for discharge. Connecticut’s “reinsurance” program is the cause of much of this acceleration in spending.

Specifically, soon after children in the care of DCF were enrolled in the Medicaid managed care program, issues arose concerning discharge of children from psychiatric hospitals. The Medicaid managed care organizations often determined that a child was no longer in need of inpatient treatment, but DCF had no appropriate placement to which the child could be moved. Since September 1998, this discharge issue has been addressed through reinsurance. The Connecticut Department of Social Services (DSS) reimburses the managed care plans for in-patient psychiatric hospital care after a certain length of stay. Under the current contract between the health plans and DSS, the health plans are fully responsible for the first fifteen days of care at both the acute and sub-acute levels. However, from day 16 to day 45, the state assumes 75% of the cost of care; from day 46 to day 60, the state pays 90%; and after 60 days, the state is fully responsible for paying for the care that is provided to the child.

This reinsurance program has become extremely costly. In 2002, DSS made over \$23 million in reinsurance payments to the managed care organizations (*nearly half* – 46% -- of the health plans’ total behavioral health spending). Importantly, these payments were *in addition to* the monthly capitation payments DSS already had paid the health plans to provide *all* needed behavioral health care to enrolled children. During just the first six months of 2003, reinsurance payments to the health plans totaled over \$12 million (the same amount that had been projected for *all* of 2000).

3. Multiple State Factors Contribute to Increased “Back End” Funding at DCF

A number of factors -- *other than* the clinical needs of the children and youth in DCF care –contribute to Connecticut’s increased spending at the “back end” – for in-patient psychiatric care, residential treatment, and foster care. They include:

- *Lack of a comprehensive continuum of home and community-based services, resulting in DCF relying more than may be clinically-necessary on more restrictive out-of-home placements that also are far more costly.* As illustrated in the following chart, the annual cost for a child to stay in an in-patient facility or a residential treatment program far exceeds the annual cost of the comprehensive home and community-based services that can prevent child abuse or neglect or, if such maltreatment occurs, might allow a child either to remain at home or be placed in a less restrictive, more family-like placement. For example, for the average cost of maintaining a child at DCF’s Riverview Hospital for a year (\$492,000/child), DCF could provide in-home therapy services to 65 children for a year (\$7,500/child).

A Sampling of Costs of State-Funded Programs and Services	
	Cost Per Year, Per Bed/Child
DCF-Riverview Hospital	\$492,020
DCF-High Meadows	\$456,615
DCF-CT Children's Place	\$339,450
DCF-CT Juvenile Training School	\$325,215
DCF-Funded Private Residential Treatment	
High: Wellspring	\$123,560
Stonington Institute	\$112,610
Low: APT Foundation/Alpha House	\$40,898
New Hope Manor	\$38,504
After-School Extended Day Treatment	\$32,000
Special Needs Day Care	\$31,200
Head Start with Parent Partnering	\$10,630
Intensive Case Management	\$9,600
Intensive In-Home Child & Family Therapy	\$7,500
Multi-Systemic Therapy	\$6,800
Home Visiting for At-Risk Children (by nurses)	\$6,200
Medication and Monitoring	\$6,000
Home Visiting for At-Risk Children (by trained paraprofessionals)	\$3,200
Supportive Case Management	\$3,200
Average Cash Assistance Grant under Temporary Family Assistance	\$6,500/yr for a family of 3 (2004)
Sources: <i>Letter from Office of the State Comptroller to Commissioner of Department of Administrative Services</i> (July 17, 2003)[DCF facility per capita costs, as of July, 2003]; Office of the Child Advocate & Attorney General of Connecticut, <i>The Cost of Failure</i> (2003), pp. 18-21 [other cost data].	

Importantly, Connecticut squandered an important opportunity in the late 1990s to build a comprehensive continuum of home and community-based services using General Fund surplus funds.¹ Had Connecticut built “front-end” capacity in these years, it would now be far easier to keep children and youth with their families, and out of more restrictive and expensive settings.

¹ Like the time when the polio vaccine was developed and governments found themselves briefly paying both for the costs of the vaccine to prevent future cases and also the costs of care for those who had polio, some period of “double” funding is necessary to build capacity among providers of home and community-based services before Connecticut children can be moved out of residential and in-patient care into less restrictive placements. Connecticut elected *not* to make this “double” investment when the state had large budget surpluses, preferring to reduce taxes. A notable exception was the Community Mental Health Strategic Investment Fund that used state surplus funds to seed innovative pilot initiatives to reduce gridlock and improve services in Connecticut’s adult and children’s mental health systems.

○ *Differences in state funding formulas.* State law guarantees Connecticut's private residential treatment facilities a cost-based rate of reimbursement; DCF's rate of reimbursement to the facilities increases as their costs of operation increase. By comparison, there is no cost-based reimbursement for home- and community-based services (such as child guidance clinics, family preservation services, and family support programs). Indeed, these programs have not consistently received cost of living increases.

○ *Connecticut's costly reinsurance program undermines efforts to provide appropriate community-based services to children and reduces access to in-patient hospitalization for DCF children in psychiatric crisis.* The fact that Connecticut is now spending tens of millions of dollars on reinsurance – i.e., essentially paying managed care plans *twice* for behavioral health care – means there is less funding available for the home and community-based services that would address the underlying problem of gridlock in the system. With substantial state funding going toward this clinically-unnecessary care, funding to develop more appropriate placements and services is lacking.

In addition, while the current reinsurance system absolves the managed care organizations and the mental health care providers of having to pay for care at a level of acuity that is no longer needed, it also removes any incentives that the health plans and hospitals previously had to find community-based placements for children no longer in need of in-patient hospitalization. Instead, children linger in the hospital longer than is clinically necessary, occupying beds that then are not available to other children who urgently need in-patient psychiatric hospitalization.

4. Connecticut's Current Use of Federal Funds Contributes to DCF's Increasing Caseload and Soaring Budget. Over the past 70 years, the federal government's involvement in child welfare has expanded primarily through enactment of various funding initiatives. Congress would appropriate funds for specific child welfare-related purposes and condition states' receipt of these funds on compliance with the specified requirements set out in the federal enabling legislation.

As discussed in detail in this report, DCF's projected \$658 million budget for FFY 05 includes federal funds² from a variety of sources: a) Title IV-B of the Social Security Act (\$5.1 million); b) the Child Abuse Prevention and Treatment Act (\$0.3 million); c) the Chafee Foster Care Independence Program (\$2 million); and d) various other smaller federal grant programs (\$3 million). It also includes \$118 million in funds from the TANF block grant, as well as \$174.4 million in funds appropriated and claimed under Title IV-E of the Social Security Act and \$21.9 million appropriated and claimed under Medicaid. In addition to these child welfare-related federal funds, Connecticut receives

² The manner in which Connecticut presents its budget fails to reflect, on its face, this full federal contribution. Connecticut *gross* budgets, i.e., it appropriates both state and also anticipated federal reimbursements through its General Fund budget. It then counts federal reimbursements when received (e.g., under Medicaid, Title IV-E) as General Fund revenues. For example, a significant portion of the \$149.3 million General Fund appropriation for residential board and care in DCF's budget includes anticipated federal reimbursements under Title IV-E of the Social Security Act (50% reimbursement for the costs for IV-E eligible children in residential treatment). In March 2004, nearly 53% of the children in DCF out-of-home care were determined to be Title IV-E eligible.

significant reimbursements under Medicaid for health care spending on the vast majority of children in DCF care; in March, 2004, 72% of the children in DCF care were Medicaid-eligible.

There are two primary ways in which Connecticut's current use of federal funds contributes to DCF's increasing caseload and its soaring budget:

- *"Mis-allocations"* -- by diverting significant amounts of federal funds intended to stabilize families and divert children from foster care to uses that are not wholly consistent with these purposes, resulting in families having to be in crisis before Connecticut provides help.
- *"Missed opportunities"* -- by failing to be more creative and aggressive in claiming federal reimbursements to which Connecticut has a right (or option) under Medicaid and Title IV-E.

By addressing both issues, Connecticut could re-structure its child welfare financing to better control caseload and budget growth, and also serve children and families more effectively.

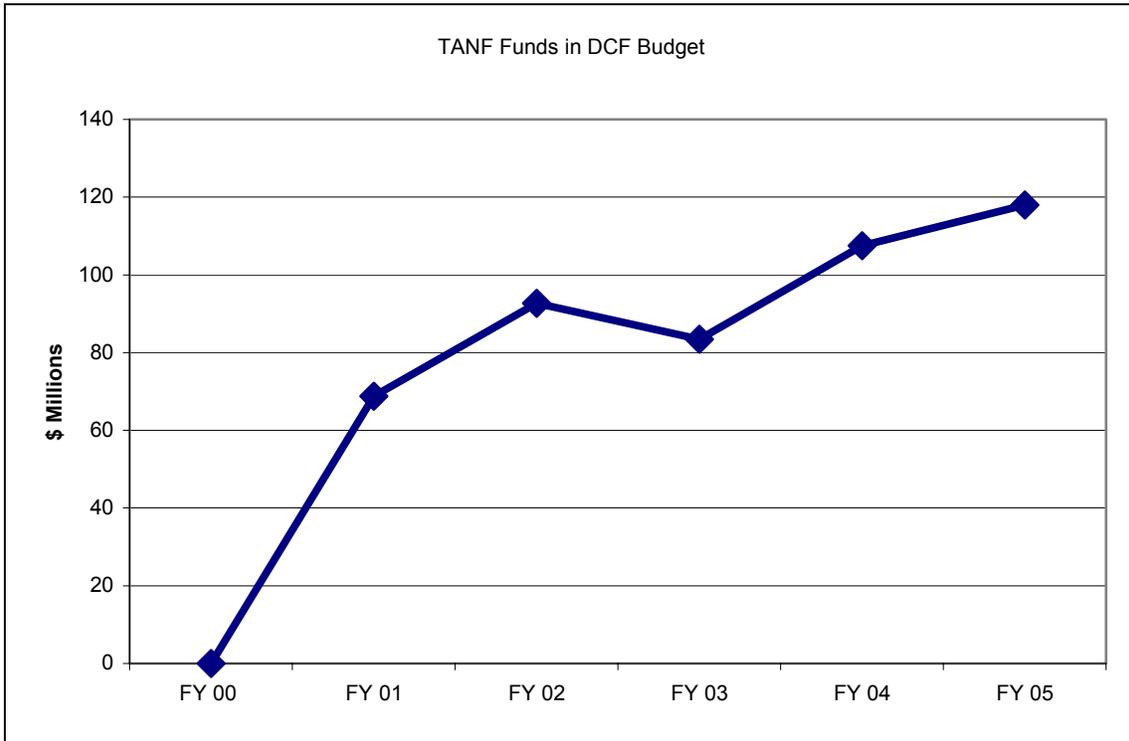
Diversion of federal "front-end" funds. As this report discusses in more detail, DCF's budget increasingly relies on federal funds that primarily are intended to *avert* families' involvement with child protective services. The following two examples illustrate this point:

- *Diversion of Title IV-B Funds to Fund DCF Staff.* By federal law, Title IV-B, subpart 1 funds are to be used for services to prevent child abuse and neglect, reduce foster care placements, reunite families, arrange adoption, and ensure adequate foster care. To assure that states focus *most* of these funds on services to *prevent* out-of-home placements, federal law limits the amount of these funds that can be used for other purposes. Despite the fact that Title IV-B, subpart 1 funds are already a small amount (and declining) source of very limited amounts of flexible federal funding that is targeted to preventive services, DCF uses these funds primarily for salaries for DCF staff at the Connecticut Children's Plan (formerly the State Receiving Home) and also for three staff positions located in area offices, *not* to prevent children's DCF involvement and out-of-home placement.

- *Diversion of TANF Block Grant Funds to Fund DCF staff.* Like Title IV-B, federal funds in the Temporary Assistance for Needy Families (TANF) block grant are intended to fund "front end" services: a) to provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives; b) to end the dependence of needy parents on government benefits by promoting job preparation, work and marriage; c) to prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and d) to encourage the formation and maintenance of two-parent families.

Prior to FFY 1999, no more than \$16 million of TANF funds were included in DCF's budget in any year (and in some years, *no* such funds were used). However, since 2001 this has markedly changed, as illustrated in the chart below.

In FFY 05, \$118 million of DCF's budget -- one in five of all dollars -- is to come from TANF. Further, more than four in ten of all TANF dollars (41%) will be spent on DCF programs and services.



The relationship between the current uses of the majority of these TANF funds in DCF's budget and the federally-authorized uses of TANF funds is fairly attenuated. In FFY 03 (when \$113.7 million of TANF funds were in DCF's budget), three-quarters of the TANF funds were spent either for DCF case management services (\$61 million) or DCF investigations (\$27 million in FFY 03). By comparison, far smaller amounts of TANF funds were used for services to prevent child abuse and neglect and support families so children would not need to come into DCF care, e.g., \$4.1 million for treatment and prevention of child abuse, \$2.5 million for early childhood development, \$4.6 million for family preservation, and \$3.7 million for intensive in-home services.

The clear -- and troubling -- trend is for an increasing proportion of TANF funds to be diverted to DCF to pay its staffing costs rather than being used to fund programs and services that help families on welfare and in low-wage jobs achieve economic self-sufficiency. A likely consequence of this shift is that children living in families unable to meet their basic needs are referred to DCF for services. That is, it is increasingly likely that families will receive help only when they reach crisis and reports of child neglect or abuse are made. In addition, core functions of our child welfare system will become

increasingly vulnerable to cuts in federal TANF funding, since an increasing share of DCF budget is being funded with TANF funds.

Missed Opportunities to Claim Federal Reimbursement. Connecticut has failed to maximize federal reimbursements for a variety of services provided to DCF-involved children and youth. As a result, there is less total funding to meet current needs and – importantly – also less funding to make the initial investments necessary to develop the robust continuum of home and community-based services that can avert, or reduce the duration of, many out-of-home placements.

As this report identifies, and as the second part of this two-part report will discuss in much greater detail, these missed opportunities include:

- *Failing to Make More DCF Children Eligible for Medicaid.* To meet the DCF's obligation to provide necessary health care services to all children in its care, children are enrolled in HUSKY A, Connecticut's Medicaid managed care program. For nearly three-quarters of the children in DCF's care and custody, these health benefits are federally-subsidized through Medicaid (Connecticut receives 50% reimbursement). In March 2004, for example, 72% of the children in DCF care were eligible for federally-funded Medicaid (8,464 DCF-related children out of 11,760). For children not eligible for federally-funded Medicaid, Connecticut provides *state-funded* HUSKY A coverage and DSS does *not* receive federal reimbursement for the cost of the services these children receive. As of March 2004, 3,296 DCF children were in state-funded HUSKY (about 28% of all DCF children).

Importantly, most of the DCF children in state-funded HUSKY are *not* disqualified from federally-funded benefits because of their immigration status³ or their placement in certain state institutions (such as detention centers), but because DCF fails to make application on their behalf in a timely fashion to determine their eligibility for federally funded benefits,⁴ or because they had turned 18 years of age. Almost all these children *could be* provided with federally funded Medicaid benefits through fairly simple changes in policy and procedures.

For example, when a child first comes into the care of DCF, the child receives state-funded benefits while eligibility for federally funded Medicaid coverage is being determined.⁵ Because the vast majority of children in DCF care are eligible for Medicaid, policies and procedures that assure timely application and speedy eligibility determinations would increase federal reimbursement to the state. Two ways to accomplish this are: a) to station a DSS worker at DCF to determine accept applications

³ In general, federally funded Medicaid benefits are not available for most legal immigrants who have been in the country less than five years and for any undocumented immigrants.

⁴ While Medicaid allows retroactive reimbursement (for up to three months from date of application) for care provided to a child determined to be Medicaid-eligible, delays in filing applications for Medicaid (or failure to file applications at all) can result in reduced reimbursements.

⁵ DCF caseworkers provide information to a special unit at DCF that completes HUSKY applications for the children and mails them to the regional DSS offices. Once at DSS, the application can take up to 45 days and sometimes longer to be acted on.

and eligibility; and b) to designate DCF a “qualified entity” able to provide immediate, temporary Medicaid eligibility to children entering DCF care.

In addition, currently *state*-funded HUSKY benefits are provided to the young adults who remain in DCF care past their 18th birthday under its Independent Living program who have income or resources that exceed the very low eligibility levels that would make them otherwise eligible for Medicaid. However, these youth *could* be eligible for federally funded Medicaid under the Foster Care Independence Act of 1999. This Act established a Medicaid option that would allow Connecticut to provide Medicaid coverage to *all* children in foster care on their 18th birthday until they reach the age of 21. By taking advantage of this federal option, Connecticut could receive federal reimbursement for the currently state-funded HUSKY A benefits provided to almost all of the young adults between 18 and 21 who are currently in DCF care and custody. In addition, young adults who leave foster care at age 18 *or any time before they turn 21* could also receive federally-subsidized HUSKY A coverage through this pathway to eligibility.

• *Failing to Fully Claim Medicaid Reimbursement for Covered and Optional Services.* Since at least 1989, consultants have advised Connecticut regarding ways in which federal reimbursements through Medicaid and Title IV-E for child welfare-related services could be enhanced.⁶ Recommended “re-financing” ideas have included:

- a) Medicaid targeted case management reimbursement for DCF’s direct service and administrative costs;
- b) The Medicaid rehabilitative services option to cover community services for children and youth not currently reimbursed by Medicaid;
- c) The Medicaid private non-medical institution (PNMI) coverage for treatment components of residential care programs;
- d) Title IV-E reimbursement for training not only of DCF case managers, but also for case assessment, case planning, case management, and consumer family training associated with the development of local systems of care, and for broad training initiatives that include *all* public agencies concerned with high-risk children and families.

While Connecticut now claims some federal reimbursement under PNMI for residential treatment, it has not taken full advantage of these ways to maximize federal revenues.

⁶ E.g., Connecticut Department of Children and Youth Services, *Refinancing and Expanding Services to Children Through a Controlled Use of Medicaid (Title XIX): A Proposal for the Consideration of the Department of Income Maintenance* (July 21, 1989); Maximus, *Children and Family Services Federal Reimbursement Options* (October 4, 1999); Connecticut Department of Social Services, *Delivering and Financing Children’s Behavioral Health Services in Connecticut: A Report to the Connecticut General Assembly Pursuant to Public Act 99-279, Section 36* (February 2000).

5. Current Federal Funding Rules Under Title IV-E of the Social Security Act Contribute to DCF's Problems in Funding Child Welfare Services in a Manner That is Cost-Effective and Serves Children's Best Interests.

Current restrictions placed on the use of federal funds for child welfare services also are impeding states' efforts to provide competent care. Not only is there a need for *increased* federal funding support, but also for increased *flexibility* in the use of child welfare funds.

As discussed more fully in the report, federal "front-end" funding for services targeted at preventing child abuse and neglect and averting out-of-home placements when maltreatment has occurred has grown slowly, if at all, over the last decade. The federal government contributes relatively little to states' efforts to keep children in their homes, or move them to permanency through such federal funding streams as Title IV-B and CAPTA. There is a need for *increased* federal funding for such services.

By comparison, federal funding under Title IV-E has grown far more significantly over the last decade. Here, there is a need for greater *flexibility* in the use of federal funds. Connecticut receives 50% reimbursement for the costs of a foster child's out-of-home care if the child is eligible for Title IV-E, but does *not* receive such reimbursement for the service costs associated with keeping a Title IV-E eligible child in his home (or returning the child to his home). As a result, the Title IV-E financing rules "reward" DCF for making out-of-home placements by providing matching federal funds. However, if DCF successfully averts a placement, or moves a child back home, it not only fails to receive federal matching funds for the services the child may then need in her home, but also *loses* the federal matching funds it had been provided when the child was in foster care.

In short, current federal funding requirements create a perverse incentive, making it more financially advantageous for states to place children out of home than to provide services to keep families together. As two child welfare experts note:

The federal foster care program provides open-ended funding for the room and board of certain eligible children in foster care, but only very limited funding for the development of alternative services for abused and neglected children and their families, both before a child must be placed in foster care or after a child returns home following placement. As a result, out-of-home care is often the easiest option for workers besieged with large caseloads and few other resources. Moreover, because funding under the federal foster care program is generally restricted to room and board, it is often difficult to give even those children placed in foster care the services and treatment they need.⁷

As will be discussed more fully in the second report in this two-part series, there are a variety of alternatives being considered to address the problems created by the current federal funding "straitjacket." These include – most significantly – the recommendations

⁷ M. Allen & M. Bissell, "Safety and Stability for Foster Children: The Policy Context" in *Children, Families, and Foster Care* (The David and Lucile Packard Foundation, The Future of Children, 14(1), 2004), p. 63.

of the Pew Commission on Foster Care.⁸ This Commission (a national, nonpartisan panel funded by The Pew Charitable Trusts and composed of leading experts in child welfare) recommended, inter alia:

- Preserving Title IV-E federal foster care maintenance and adoption assistance as an entitlement and expanding it to *all* children, regardless of their birth families' income and including Indian children and children in the U.S. territories;
- Providing federal guardianship assistance through Title IV-E to all children who leave foster care to live with a permanent legal guardian when a court has explicitly determined that neither reunification nor adoption are feasible permanence options;
- Helping states build a range of services from prevention, to treatment, to post-permanence by: (1) creating a flexible, indexed Safe Children, Strong Families Grant from funds currently included in Title IV-B and the administration and training components of Title IV-E; and (2) allowing states to "reinvest" federal and state foster care dollars into other child welfare services if they safely reduce their use of foster care;
- Encouraging innovation by expanding and simplifying the federal waiver process and providing incentives to states that: (1) make and maintain improvements in their child welfare workforce; and (2) increase all forms of safe permanence; and
- Strengthening the current Child and Family Services Review process to increase states' accountability for improving outcomes for children.

VI. In Sum: Careening Toward Crisis

State and federal spending on child welfare services *should* support the development of a system of services that furthers best practices in child welfare, meets all requirements of federal and state law, and serves the best interests of children and families. This includes working to ensure that children are maintained with family whenever possible, and are placed in the least restrictive, most family-like setting when this is not possible. Currently, that is not the case.

Federal funding constraints and state budget choices have resulted in a DCF budget that, in many respects, has been allocating its resources at cross-purposes to what is known to be best practice in child welfare. The second policy brief on this subject, to be released by Connecticut Voices for Children early in 2005, will examine ways to change this course -- through changes in state policy and different state budget choices, by taking advantage of existing options in and possible waivers to current federal law, and through changes to federal law.

⁸ <http://pewfostercare.org/>

I. Introduction

Connecticut was the first state in the nation to consolidate responsibility for child protection, children's mental health, and juvenile delinquency programs in a single agency focused on children – the Department of Children and Families (DCF).⁹ This short report focuses on one of the three populations of children and youth served by DCF – children referred because they have been abused, neglected, or are uncared for.

Each year, DCF investigates tens of thousands of reports of child abuse and neglect (95,214 in 2003). After an investigation, DCF substantiates some of these reports (21%, or 20,322 reports, in 2003), and takes action to protect the children who have been identified as being at risk. For the least serious cases, DCF can offer services to the family. For the most serious cases, DCF will remove the child from the parents' care and assume custody. Children can be placed by DCF with foster parents who are strangers to the child, with relatives who meet DCF criteria, and into more institutional placements. If the child cannot be safely returned to her parents after reasonable efforts are made to do so, DCF can move to terminate the parental rights of the child's parents and place the child for adoption, or can transfer guardianship to a relative through Connecticut's state-funded subsidized guardianship program. Until custody is transferred to an adoptive parent or subsidized guardian or the child "ages out" of foster care, DCF is the "parent" of these most at-risk children and youth. It carries the legal obligation to assure that the child's health, mental health, education and safety needs are met, and that decisions are made in the child's best interests. This does not always occur.

While much attention has been paid by the media and policymakers to shortcomings in state child protective services (including in Connecticut), less attention is paid to the ways in which current budget choices impact on states' capacity to competently fulfill their obligations to these children and youth. Even less attention is paid to the ways in which current restrictions placed on the federal financing of child welfare services may actually be impeding states' efforts to provide competent care to abused and neglected children. A theme common among those who have studied child welfare financing is that there is a need not only for increased federal financial support, but also for increased flexibility in the use of federal funds if states are to fulfill their child welfare responsibilities competently. The Urban Institute, which regularly reviews child welfare spending, noted, "The federal system is not in alignment with the goals of protecting children and providing stable, permanent placements."¹⁰

⁹ The intent of this consolidation in 1974 was to improve state leadership on the development of a comprehensive network of integrated publicly-operated and publicly-funded/privately-operated programs and services that could meet the needs of at risk children and youth, regardless of the reason for their initial referral to DCF. Consolidation had the potential to increase the "quality and effectiveness of children's services by clarifying administrative authority for program areas, eliminating gaps in services as well as overlapping responsibility, and allowing resources to be pooled funding could 'follow' a child's needs." Connecticut General Assembly, Legislative Program Review and Investigations Committee, *Department of Children and Families* (December 1999), p. 1.

¹⁰ R. Bess, et al, *The Cost of Protecting Vulnerable Children II: What Has Changed since 1996?* (The Urban Institute, Assessing the New Federalism Occasional Paper No. 46, 2001), p. 29.

This issue brief first outlines the nature and extent of Connecticut's legal obligations, under state and federal law, to its abused and neglected children. It then examines the funding that is available to Connecticut to meet these legal obligations through General Fund appropriations and from the federal government, summarizes changes in this funding over the last several years, and identifies two troublesome trends:

- a) A reduction in the share of funding provided for services that would help keep children safe and in their own families, resulting in families being forced to crisis before the state intervenes to provide help (e.g., increased use of TANF funds for DCF case management rather than for supporting and stabilizing low-wage families, reductions in funding for child abuse and neglect prevention);
- b) Increased spending on out-of-home and restrictive placements for DCF children and youth, but static or reduced spending on home and community-based services.

The brief concludes by summarizing how constraints placed by Congress on how federal funds can be used contribute to these troublesome trends. A second issue brief, to be released in early 2005, will identify some ways to reverse these trends through changes in federal law, federal waivers, and changes in state policy and budget practices.

II. Connecticut as "Parent" – The Scope of Government Responsibility for Children Who Have Been Reported as Abused or Neglected

To thrive, *all* children need at least one, lasting relationship with a loving and competent adult, access to high quality health care and educational experiences, adequate food, stable housing, and to be protected from harm. Children who have been abused and neglected have all of these most basic needs, but also -- because they have been victimized -- need to be protected from further harm by their caregivers, need prompt access to high quality health and mental health services to help them heal from their traumatic experiences and, if they were removed from their homes, need to reach permanency in a family setting as soon as possible.

When Connecticut removes a child from the care and custody of his parent or legal guardian on account of abuse or neglect, the Commissioner of the Department of Children and Families becomes that child's "parent" by law. The authority and responsibilities of the state, as parent, are defined in state and federal law and regulation, as interpreted by state and federal courts. State and federal law also define the scope of state authority and responsibility to attempt to prevent child abuse and neglect, and to investigate and intervene when such maltreatment is reported. This section very briefly summarizes the scope of that authority and responsibility and how it has evolved over time.

A. A Brief History Of Government Involvement In Child Welfare

Historically,¹¹ the federal government had *no* role in the care of abused and neglected children and the State of Connecticut's role was primarily supervisory.¹² Beginning in the early 1900s, state and federal governments began to assume increasing fiscal and programmatic responsibility for maltreated children. In Connecticut, it was not until 1974¹³ that responsibility for child welfare and child protective services was lodged in a state agency with responsibility only for children's issues – the Department of Children and Youth Services.

B. The Constitutional Context

Under the United States and Connecticut Constitutions, parents have a fundamental constitutional right to direct the care, custody and control of their children. Notwithstanding this right, courts recognize the interest of the state in protecting and promoting children's welfare. Only if a parent is proven to be unfit or unwilling to perform parental duties, however, may the state intervene and – even then – reunification must be the primary goal of child welfare services until a permanent decision regarding the parents' unfitness can be made. Moreover, even when parental unfitness *has* been determined, there remains a residual presumption that it is in the child's best interests to be raised by his parent. This presumption can only be overcome by clear and convincing evidence that the child's removal serves the child's best interest.

Given these constitutional principles, child welfare practice *ought* to focus on keeping children with their parents whenever possible, and then on reunifying children with their parents as soon as possible if removal was necessary to protect the child. However, as discussed later in this report, the largest share of current federal funding is available to

¹¹ For a more detailed summary of the evolution of federal child welfare law see M. Allen & M. Bissell, "Safety and Stability for Foster Children: The Policy Context" in *Children, Families, and Foster Care* (The David and Lucile Packard Foundation, The Future of Children, 14(1), 2004), pp. 49-73.

¹² Beginning in the 1800s, the State Board of Charities reviewed the activities of the county boards of management that were responsible for finding "temporary homes" (the precursor of today's foster homes) for dependent or neglected children. It was local welfare boards and organizations, not the state Board, that were responsible for placing children in out-of-home care. For a more detailed summary of the evolution of DCF's mandates, see Connecticut General Assembly, Legislative Program Review and Investigations Committee, *Department of Children and Families* (December 1999), pp. A-1-A-5.

¹³ In Connecticut, all responsibilities of the State Board of Charities were transferred to a new state public welfare department in 1921. Its child welfare bureau had supervisory responsibility for all dependent, abused, neglected, "defective," and delinquent children. It licensed and monitored child-caring facilities and persons, and supervised out-of-home placements. Placement decisions, however, were made by county boards and local agencies. Until the 1950s, child welfare services continued to be primarily provided by county branches of the state welfare department. In 1955, however, the state welfare department was given sole legal custody of the state's dependent, neglected and homeless children. The role of the state welfare department expanded further in 1965 when it was required to provide "protective services" for victims of child abuse and neglect and their families when it was determined that it was safe and appropriate to keep the child in her home, rather than be placed in foster care. Concern about a lack of resources and attention being devoted to children's services so long as they were a part of the state welfare department resulted in the creation of the Department of Children and Youth Services in 1974, with concurrent responsibility for protective services and juvenile delinquency. Responsibility for mental health services for children was transferred to this new agency from the Department of Mental Health in 1975, and responsibility for children's substance abuse services transferred in 1994.

states only when children are placed out-of-home. Far less is provided to provide services to families to avert out-of-home placements, and reduce their duration.

C. Scope Of State Responsibility To Abused And Neglected Children

The Connecticut General Statutes impose a set of responsibilities on the DCF Commissioner with regard to children alleged to be abused or neglected. These include (but are not limited to) requirements that the Commissioner:

- a) Provide a hotline to receive reports of child maltreatment [Conn. Gen. Stat. §17a-103a]
- b) Develop a training program for the identification and reporting of child abuse and neglect for state-mandated reporters [Conn. Gen. Stat. §17a-101]
- c) Promptly investigate allegations of maltreatment and take into state custody all children who are in imminent risk of physical harm [Conn. Gen. Stat. §17a-101g];
- d) Notify local law enforcement when a report of sexual abuse or serious physical abuse of a child has been substantiated [Conn. Gen. Stat. §17a-101j];
- e) Insure that all children under the commissioner's supervision "have adequate food, clothing, shelter and adequate medical, dental, psychiatric, psychological, social, religious and other services" [Conn. Gen. Stat. §17a-6(e)] as well as "suitable education" [Conn. Gen. Stat. §17a-6(l)];
- f) Prepare and maintain a "written plan for care, treatment and permanent placement of every child and youth under his supervision, which shall include but not be limited to a diagnosis of the problems of each child or youth, the proposed plan of treatment services and temporary placement and a goal for permanent placement of the child or youth, which may include reunification with the parent, long-term foster care, independent living, transfer of guardianship or adoption" [Conn. Gen. Stat. §17a-15];
- g) Ensure that the child's health and safety are the paramount concern in formulating this treatment plan and ensuring that the plan is reviewed at least every six months to assess its continued appropriateness. [Conn. Gen. Stat. §17a-15];
- h) Take all required steps to ensure a permanent home for each maltreated child, either through reunification with the child's family, transfer of guardianship, termination of parental rights and adoption, or assistance in attaining independent living skills [Conn. Gen. Stat. §17a-100 to 17a-126].

D. The Emerging Federal Role

Federal involvement in child welfare issues has expanded over the last 70 years primarily through the enactment of various funding initiatives. Congress appropriates funds for specific purposes and states' receipt of these federal funds is conditioned on compliance with the specified requirements set out in the federal enabling legislation.

The first major federal initiative in child welfare was the enactment of the Social Security Act in 1935. While one part of the Act provided financial support for indigent children (the precursor to AFDC), enabling many poor families to retrieve their children from "orphanages" where they had been placed because of parental poverty rather than

parental death or maltreatment, another part of the Act (Part 1 of Title IV-B, the Child Welfare Services Program) provided federal funding to states for a broad range of preventive and protective services for abused and neglected children. Grants to states also were authorized for training and research and demonstration programs on behalf of these children. While the focus of this section of the Social Security Act was expansive, and states' discretion in using the funds quite broad, funds were (and as discussed *infra*, still are) very limited.

The first federal foster care program was established in 1961 – the Aid to Families with Dependent Children – Foster Care Program. Enacted originally as Title IV-A of the Social Security Act (but transferred to a new section Title IV-E of the Act in 1980), it provided federal funds to states to care for children removed from their families because of abuse or neglect when the families had been receiving AFDC benefits.

Since that time, Congress has enacted at least 15 pieces of significant child welfare legislation, commonly using federal funds as the “carrot” to encourage states to do more to protect at-risk children and to reform their child welfare systems.

1. Key federal child welfare funding legislation. The federal legislation with the most direct fiscal and programmatic impacts on state child welfare systems includes:¹⁴

- *Child Abuse Prevention and Treatment Act, 1974.* Required states to mandate the reporting of suspected abuse and neglect to child protective service agencies and to

¹⁴ Other federal legislation adopted over this period that had very significant impact on abused and neglected children: a) prohibited states from placing abused and neglected children in juvenile or correctional facilities [Juvenile Delinquency and Prevention Act, 1974]; b) required states to afford children with disabilities (including children in foster care) the right to a free, appropriate public education in the least restrictive educational environment possible and required states to extend to children in foster care the right to allow surrogate parents to advocate on their behalf in defining their individualized education plans [Education for All Handicapped Children Act, 1975, which became the Individuals with Disabilities Education Act]; c) required states to establish a Protection and Advocacy system to protect the rights of developmentally-disabled persons (including children) and to enforce specific protections for such persons (including access to appropriate treatment, services, and rehabilitation in the least restrictive setting)[Developmentally Disabled Assistance Bill of Rights, 1975]; d) created a new federal funding stream to states for a range of social services for low-income individuals, including for child abuse prevention and treatment and foster care and adoption services (this became the Social Services Block Grant in 1981)[Title XX of the Social Security Act]; e) required specific placement preferences when Indian children were removed from their birth families: first, to place the child with his family or extended family, then in a home approved by the tribe, then in an Indian foster home, and only if these are not available in an institution for children approved by the tribe [Indian Child Welfare Act, 1978]; f) prohibited agencies that receive federal funding and are involved in foster care or adoptive placements from denying to any person the chance to become a foster or adoptive parent “solely” on the basis of race, color, or national origin, and also from delaying or denying the placement of a child “solely” on the basis of the race, color or national origin of the child or the potential foster or adoptive parent [Multiethnic Placement Act, 1994]; g) amended the Multiethnic Placement Act to eliminate its permissible consideration of race, color and ethnicity in placement decisions, re-affirmed the prohibition against delaying or denying a child’s placement for this reason, and imposed new financial penalties on agencies that discriminated [Inter-Ethnic Adoption Provisions, 1996]. For a more detailed summary of all of this federal legislation, see M. Allen & M. Bissell, “Safety and Stability for Foster Children: The Policy Context” in *Children, Families, and Foster Care* (The David and Lucile Packard Foundation, The Future of Children, 14(1), 2004), pp. 49-73 (from which much of this summary is drawn).

use the limited federal funding provided to them by the Act to prevent, identify, and treat child abuse and neglect.

- *Adoption Assistance and Child Welfare Act, 1980.* Established uniform national standards for states' response to abused and neglected children. Established the federal Foster Care and Adoption Assistance Program through a new Title in the Social Security Act (Title IV-E) that continued federal funding for foster care children from AFDC-eligible families and also provided new protections to ensure that children would not enter foster care unless states had made "reasonable efforts" to prevent the foster care placement. Required that children in foster care be placed in the least restrictive, most family-like setting appropriate to the child's individual needs. Required periodic reviews of care, "reasonable efforts" to reunify children with their families, and dispositional hearings to help move children to permanent families in a timely manner. Assured that children who were eligible for federally-subsidized foster care were automatically eligible for federal adoption assistance payments and for health benefits through Medicaid. Provided federal funds to states to establish procedural reforms and programs to serve more children in their own homes, prevent out-of-home placements, facilitate family reunification when children were placed out of their homes, and help pay adoption expenses for children with special needs.
- *Independent Living Program, 1986.* Established a new federal grant program under Title IV-E of the Social Security Act to help states fund a range of independent living services for children age sixteen and older who are "aging out" of the foster care system to ease the transition from foster care to living on their own.
- *Family Preservation and Support Services Program, 1993.* Required states to engage the community in a broad-based planning process to determine the right mix of services and supports for at risk children and families and established a new federal funding stream (under Part 2 of Title IV-B of the Social Security Act) to provide funds to states for family support and for planning and services to help communities build a system of services to avert foster care placements and assist children in care and those moving to adoptive homes.
- *Child Welfare Demonstration Waiver Program, 1994.* Allowed up to 10 states to receive waivers of current law to use their Title IV-B and Title IV-E federal funds more flexibly, so long as the new activities were consistent with the purposes of the programs, maintained current legal protections, and were cost neutral (i.e., would not result in a cost that exceeded the traditional program).
- *Adoption and Safe Families Act, 1997.* Required that a child's safety be the paramount consideration whenever a state is deciding what actions to take on behalf of a child in the child welfare system. Established expedited timelines for decision making for children in foster care, including for moving children into permanent homes (either by safely returning them home or by terminating parental rights and moving them

into adoptive homes or other permanent placements).¹⁵ Increased the circumstances in which “reasonable efforts” are not required of states before a child is removed from his home. Eliminated “long-term foster care” as a placement option. Formally recognized kinship care as a permanency option. Provided new incentives for adoption. Expanded the services that could use federal funds to include reunification and adoption promotion activities. Increased accountability of child welfare systems by requiring the tracking of specific outcome measures and reviewing states’ performance through Child and Family Service Reviews. Re-authorized the Family Preservation and Support Program, and changed its name to the Promoting Safe and Stable Families Program.

- *Foster Care Independence Act, 1999*. Replaced the Independent Living Initiative with a more comprehensive program (with additional federal funding). Permitted some of the federal independent living funds to be used for board and care for young people age 18 to 21 who were leaving foster care. Gave states the option of providing Medicaid coverage to young people between the ages of 18 and 21 who were in foster care on their 18th birthdays. Increased the amount of assets a young person in foster care could have and remain eligible for Title IV-E funding. Required that states adequately prepare foster parents to care for the older children placed with them.

2. Other federal legislation that impacts on abused and neglected children.

Other federal legislation has had an impact on child welfare populations and services, although it was not specifically targeted to do so. Of particular relevance to this report’s analysis of federal funding for child welfare services is:

- *The Personal Responsibility and Work Opportunity Reconciliation Act, 1996*. Replaced the AFDC entitlement program with a federal block grant (Temporary Assistance to Needy Families) that provides states with funds that can be used only for *time-limited* income assistance programs for needy families. This was a most significant shift -- from an entitlement to income assistance for very low income families with children to a time-limited program of assistance with more rigorous work requirements. It posed new risks, including children living in families with inadequate income to meet essential needs when cash assistance was no longer provided, and some more children left unattended while parents were working (i.e., potential grounds for child neglect referrals). The Act also limited eligibility for the Title IV-E assistance program to children who *would have been* eligible for AFDC benefits *as of July 16, 1996*. This change is predictably resulting in a decline in Title IV-E eligible children, since the 1996 income standard is not adjusted for inflation. The Act also substantially restricted the access of many immigrant families to federally-funded foster care, adoption assistance, and independent living services (although state and local funds may still be used to address these needs).

¹⁵ The act requires permanency hearings to be held no later than 12 months after a child enters foster care (rather than 18 months, as under prior federal law). It also requires states to initiate termination of parental rights proceedings when a child has been in state custody for 15 of the previous 22 months.

- *Medicaid*. All children whose foster care is eligible for federal reimbursement under Title IV-E are eligible also for Medicaid. In addition, the Adoption and Safe Families Act of 1997 requires that *all* children in foster care must be provided with health insurance, either through Medicaid or through a state-funded Medicaid replacement program. Medicaid requires states to provide a very generous health benefit package to children, which includes the Early and Periodic Screening, Diagnosis and Treatment program and all “medically-necessary” services (with that term given an expansive definition). However, eligibility for coverage does not necessarily assure timely access to care.¹⁶

E. The Role Of The Courts

Since 1991, DCF has been operating under a federal court Consent Decree. The underlying litigation, *Juan F. v O’Neill*,¹⁷ which was based on alleged violations of state and federal statutes and constitutional rights, challenged virtually every aspect of the operation of Connecticut’s child protection system, from failing to investigate all reports of child abuse and neglect through failure to place children into adoptive homes in a timely manner after parental rights had been terminated. The Consent Decree has resulted in a substantial, and essential, infusion of additional funds to the department, a reduction in caseloads, enhanced staff training, multi-disciplinary teams to help in assessment, and many other improvements. All agree, however, that there is still great room for improvement. Currently, DCF is seeking to comply by November 2006 with a set of twenty-two “Exit Plan” Outcome Measures¹⁸ in an effort to end the Consent Decree and federal court oversight of the department.

F. The Challenge

As discussed above, federal law has grown increasingly specific about how child welfare systems are to operate if they are to accept federal funds, and is demanding greater accountability. Yet, there is a very serious mismatch between the goals for a well-functioning child welfare system, as outlined in state and federal law, state budget choices, and the financial incentives built into federal funding streams. The report of the *Child Welfare Summit: Looking to the Future* convened by the Center for the Study of Social Policy and the Center for Community Partnerships in Child Welfare (April 2003) summarized this concern:

The basic structure of child welfare financing and incentives has not changed since 1980, when the first major federal reform of the child welfare system was enacted. While funding has increased, driven largely by the growing numbers of children in placement, the underlying framework has not adapted to the goals that have been enunciated for child welfare systems, to changes in related law and policy, or to community innovations that are mapping a pathway for best

¹⁶ See, e.g., Children’s Health Council, *Independent Assessment of Connecticut’s HUSKY A Program: Access and Quality of Care for Children with Special Health Care Needs* (December 2002), available at: http://www.ctkidslink.org/pub_detail_29.html.

¹⁷ *Juan F. v. O’Neill*, Civil Action No. H-89-859 (AHN)(Consent Decree, January 7, 1991).

¹⁸ The Outcome Measures can be found at: <http://www.state.ct.us/dcf/measures.htm>.

practice. It is time to undertake a major review and create a new framework for child welfare financing in the 21st century. (p. 49)

III. An Overview of Child Welfare Funding in Connecticut in SFY 05

A. Some Quick Context

DCF's budget for child welfare is in large part a function of the number of children and families it is serving and the costs of the various services being provided to them. While this report later will examine individual service costs in greater detail, the following table¹⁹ shows some changes over time in caseload size and in the number of children being cared for in various placement settings as of June 30 in each of the fiscal years shown:

Placement	FY 94	FY 96	FY 98	FY 00	FY 02	FY 04
Parent/relative/guardian	1007	1787	1281	1444	1054	1145
Foster family	2377	3916	4129	3633	3334	3411
Subsidized adoption	2301	2664	2338	3015	3921	4263
Subsidized guardianship					970	1248
Private residential institutions	942	1088	892	895	1024	1167
Group homes	205	223	196	175	190	235
Temporary shelters	141	152	79	99	101	91
Independent living programs	144	154	121	118	101	123
Riverview Hospital	41	31	96	34	41	47
High Meadows	45	39	19	34	32	41
CT Children's Place	56	53	22	24	28	32
Psychiatric hospital		48	5	17		
Maternity home		12	19	12		
TOTAL non-Juvenile Justice	7259	8380	9197	9500	10796	11803
CT Juvenile Training School/Long Lane	241	257	281	260	192	155
Other juvenile justice					337	289
TOTAL	7500	8637	9478	9760	11325	12247

Notably, between State Fiscal Year (SFY) 94²⁰ and SFY 04 the *total* number of children in DCF care and custody increased by 4,747 children (63.3%). The number of DCF children with no juvenile justice involvement increased by 4,544 (62.6%). The greatest growth was in subsidized guardianships (from none to 1,248 children) and subsidized adoptions (2,301 to 4,263 children (an 85.3% increase)).²¹ Foster family placements

¹⁹ State of Connecticut Auditors' Reports, *Department of Children and Families for the Fiscal Years Ended June 30, 1994- 2002*.

²⁰ The State Fiscal Year runs from July 1 through June 30 of the following year.

²¹ Note: Some of the subsidized adoptions provide medical subsidies only. As of June 30, 2004, there were 4,263 children in subsidized adoptions. Of these, 380 (about 9%) received a medical subsidy only. E-mail communication from A. Kalisher, DCF, November 3, 2004.

increased more modestly (2,377 to 3,411 children, a 43.5% increase), placements in residential institutions increased from 942 to 1,167 children (23.9%), placements in group homes increased from 205 to 235 (14.6%) and placements in Riverview Hospital increased from 41 to 47. By comparison, placements in independent living programs, High Meadows, and the Connecticut Children’s Place all declined.

B. The Revised SFY 05 Budget of the Connecticut Department of Children and Families²²

1. DCF’s SFY 05 budget, in brief. As shown in the following table, DCF’s General Fund budget for SFY 05 is \$642.6 million. There are an additional \$15.2 million in “federal contributions” and \$0.2 million in “private contributions.” DCF’s SFY 05 General Fund budget exceeds its SFY 01 budget by \$163.5 million. Growth in DCF’s General Fund budget was 3.6 times greater than growth in the total General Fund budget over this period (34% growth for DCF compared to 9.4% growth in the net General Fund budget).

The following table presents DCF’s current SFY 05 budget,²³ as well as its SFY 01 budget as a basis for comparison. In reviewing this table, it is important to recognize that additions to, or reductions in, particular accounts may simply reflect a re-allocation of funds among accounts.²⁴

DCF BUDGET SFY 01-SFY 05(rev.)	SFY 01 (\$M)	SFY 05 (rev) (\$M)	Change from FY01 to FY 05
			FT staff
Full-time Positions	3,398	3,520	122
			\$M
Personal Expenses	182.095	217.853	35.758
Other Expenses	26.624	39.713	13.089
Equipment	0.001	0.001	0.000

²² As noted earlier, DCF has multiple mandates, one of which is child protective services. This section reports on DCF’s total budget, so includes funding for DCF-funded children’s mental health and juvenile justice services as well.

²³ Descriptions of the types of programs and services the various budget accounts fund is taken from the Office of Policy and Management’s *Grant Information Sheets*, which also provide historical data regarding funding levels for each of these budget accounts.

²⁴ For example, the revised FY 05 budget includes \$10.292 million in funding for a newly-established Family Support Services account that is to support Family Support services teams, new group homes, increased foster and therapeutic foster care, community “wrap” services and program administration all for the purpose of enhancing “support for families of children returning home from residential treatment or prolonged hospitalization.” This funding increase is to be partially offset by: a) a 24% reduction in funding for Intensive Family Preservation and Intensive In-Home Services (in the Family Preservation Services account); b) a 24% cut to funding for Community-Based Prevention programs (e.g., Drug and Alcohol Prevention/School Mediation, Early Childhood, Family Support Center, Juvenile Review Board, Young Parent and Parent Education and Support Center services), and a \$2.3 million reduction in Board and Care expenses for residential care (anticipating 75 averted placements in FY 05). The net investment of *new* funds is about \$6 million.

Other Current Expenses			
Short-term Residential	0.625	0.657	0.032
Long Lane School Transition	0.296	0.000	-0.296
Wilderness School	0.096	0.000	-0.096
Substance Abuse Screening	1.509	1.679	0.170
Workmen's Compensation Claims	3.948	8.650	4.702
Local Systems of Care	0.845	1.870	1.025
Family Support Services	0.000	10.292	10.292
Emergency Needs ²⁵	0.000	0.950	0.950
Pmts to Other Than Local Governments			
Health Assessment & Consultation ²⁶	0.000	0.263	0.263
Psychiatric Clinics for Children ²⁷	11.138	12.679	1.541
Day Treatment Centers ²⁸	4.503	5.340	0.837
Juvenile Justice Outreach ²⁹	0.000	3.308	3.308
Child Abuse & Neglect Intervention ³⁰	5.211	5.319	0.108
Community Emergency Services ³¹	0.630	0.176	-0.454
Community-Based Prevention ³²	2.565	2.894	0.329
Aftercare	0.050	0.000	-0.050
Family Violence Outreach/Counseling ³³	0.459	0.498	0.039
Health & Community Services	1.268	0.000	-1.268

²⁵ Provides discretionary funds that DCF workers can access to meet family's individualized needs. Funds can be used for food, clothing, emergency shelter, rent to avoid eviction, heating bills, respite, emergency housing costs, specialized individual and family counseling and other services not covered under traditional contracted services.

²⁶ Supports activities of foster care clinics that provide multi-disciplinary evaluations to children placed by DCF for the first time. Funds support five clinics.

²⁷ Provides grants to non-profit community agencies and/or hospitals for child guidance clinic services and/or emergency psychiatric services. These programs are the primary way DCF provides community-based health services for children, youth and families. Services include crisis intervention, emergency and diagnostic services, treatment services, and consultation and education.

²⁸ Provides funds for extended day treatment programs for seriously disturbed children that would allow them to stay with their birth or foster parents while undergoing treatment.

²⁹ Supports five outreach tracking and reunification programs for youth discharged from state residential facilities, five juvenile criminal diversion programs, one juvenile offender treatment program, and three juvenile justice evaluation programs (to avoid in-patient evaluations at DCF's Riverview Hospital). Prior to FY 02, funds for these services were reflected under Health and Community Services and Juvenile Case Management.

³⁰ Provides funding for parent aide and therapeutic child care programs.

³¹ Provides funding for 24-hour emergency services (crisis intervention, outreach, and referral) through three community centers (Willimantic, Waterbury, Windham).

³² Provides funding for drug and alcohol abuse prevention, early childhood programs, family support centers, parent education and support centers, a young parent program, a juvenile review board and a school mediation program.

³³ Provides funds for programs that provide specialized counseling, advocacy, and supportive services to DCF families in which there are identified child and adult victims of violent crimes. Programs also provide coordination among DCF's regional offices, court services, other state agencies, and community programs that serve families in which the non-offending parent is also a victim.

Support for Recovering Families ³⁴	0.000	4.418	4.418
No Nexus Special Education ³⁵	4.621	7.458	2.837
Family Preservation Services ³⁶	5.797	4.933	-0.864
Substance Abuse Treatment ³⁷	2.724	3.825	1.101
Child Welfare Support Services ³⁸	2.019	0.375	-1.644
Juvenile Justice Case Mgmt	0.579	0.000	-0.579
Board and Care -- Adoption ³⁹	30.832	51.456	20.624
Board and Care -- Foster ⁴⁰	71.831	87.986	16.155
Board and Care -- Residential ⁴¹	114.783	149.320	34.537
Individualized Family Supports ⁴²	1.019	7.110	6.091

³⁴ Provides funding for services for at-risk substance abusing families (education, intensive family intervention, support services, health services, case management and substance abuse counseling) as well as supportive housing for recovering families (which includes subsidized housing and intensive case management services to enhance the family reunification process for substance abusing parents in treatment and children who have been placed in DCF care).

³⁵ Covers special education costs of children being educated at private residential institutions for whom no board of education is responsible.

³⁶ Provides intensive, short-term, in-home services to help prevent out-of-home placements.

³⁷ Provides funding for programs providing Multi-Systemic Therapy (MST) and other substance treatment services for children and youth.

³⁸ Provides funding for grants to local agencies providing community life skill programming for youth in independent living placements and other programs providing support to children in foster and adoptive homes (e.g., mentoring programs, aftercare, and positive youth development).

³⁹ Provides funding for subsidies to adoptive families of special needs children, as well as Connecticut's subsidized guardianship payments. Subsidized guardianships are for the benefit of children who are: a) in the care or custody of DCF; b) have been in DCF care for at least 18 months; c) are living with a relative caregiver for at least 12 months; and d) the relative caregiver requests the subsidy and requests that guardianship of the child be transferred from DCF to the caregiver. The monthly subsidy is equal to the prevailing foster care rate for a child of the same age. Children in subsidized guardianships are also entitled to a medical subsidy and a one-time exceptional expense subsidy (up to \$500/child). The subsidies are provided until the child reaches age 18, or 21 if the child is in full-time attendance at school or a job training program. In October 2004, there were 1,280 Connecticut children in these state-funded subsidized guardianships.

⁴⁰ Provides funding for board and care expenses for children in foster care and related costs (clothing, personal allowances, psychiatric evaluations, and other costs deemed necessary by the DCF work), as well as for the therapeutic foster care initiative (to recruit and train foster parents providing care to children with special needs), Foster/Adoptive Support Teams (FAST)(that support foster and adoptive placements that face placement disruption or involve children who have had multiple placements, including through in-home assessments, parent skills education, therapeutic respite care, behavioral management counseling), Independent Living/Community Housing Assistance programs (providing assistance to youth who are transitioning from foster care to independent living), and a contract with the CT Association of Foster and Adoptive Parents (CAFAP)(providing supportive services to these families).

⁴¹ Provides funding for private residential facilities that provide intensive and comprehensive care to children placed by DCF or the courts. Facilities include but are not limited to: group homes, residential treatment programs, emergency shelters, SAFE homes, short-term residential placements.

⁴² A flexible funding stream that provides funds to each DCF region for the purchase of individualized services based on a family's needs (e.g., intensive family preservation, parent aide services, child care, emergency mobile psychiatric services, individual and family counseling, parent education, respite care, drug and alcohol treatment for primary caregivers, group homes, shelters, and mentoring).

Community KidCare ⁴³	3.089	13.363	10.274
Covenant to Care ⁴⁴	0.000	0.150	0.150
Neighborhood Center ⁴⁵	0.000	0.100	0.100
General Fund Total	479.155	642.639	163.484
Federal Contributions	12.403	15.203	2.800
Carry Forward FY 00 Surplus	3.800	0.000	-3.800
Special Funds-Non-Appropriated	16.026	0.000	-16.026
Bond Funds	1.734	0.000	-1.734
Private Contributions	0.268	0.247	-0.021
Agency Grand Total	513.386	658.089	144.703

2. Areas of growth in DCF's budget. Areas of DCF's budget that grew by 30% or more of the period SFY 01 to SFY 05 are: Other Expenses (49% growth), Workmen's Compensation Claims (119%), Local Systems of Care (121%), No Nexus Special Education (61%), Substance Abuse Treatment (40%), Board and Care-Adoption (67%), Board and Care-Residential (30%), Individualized Family Supports (598%), and Community KidCare (333%).

It is important to note that the growth in actual dollars in the Individualized Family Supports and Community KidCare accounts was more modest than the percentage growth might suggest. Funding for Individualized Family Supports increased by \$6.1 million and for KidCare by \$10.3 million. Likewise, the 121% growth in Local Systems of Care represents the addition of just over \$1 million of funds. By comparison, the 30% growth in Board and Care payments for Residential Care represents a funding increase of \$34.5 million and the 20% growth in Personal Expenses a \$35.8 million increase.

3. The "hidden" federal funding in DCF's budget. Importantly, the manner in which Connecticut presents its budget fails to reflect on its face the full contribution of federal funds to the various budget accounts. Connecticut *gross* budgets. That is, it appropriates both state funds and also anticipated federal reimbursements in its General Fund budget. It then counts the federal reimbursements, when received, as General Fund revenues.

For example, the SFY 05 DCF budget reports a General Fund appropriation of \$149.3 million for the Board and Care expenses of children who are in residential treatment facilities. Some proportion of these children meet the eligibility requirements for Title IV-E, and so Connecticut can anticipate 50% reimbursement from the federal

⁴³ Provides funds for a local service delivery system for children with serious mental health needs that is designed to put more emphasis on preventing children's problems from escalating by expanding community-based care. Funding supports enhanced local mental health services, expanded mental health prevention programming, local system of care enhancements, development of a training curriculum and funding for family advocacy efforts.

⁴⁴ Funds for an initiative that links religious congregations to DCF offices to facilitate the provision of goods and services to children in DCF care and to recruit Latino and African-American foster and adoptive parents.

⁴⁵ Funding for Neighborhood Place, a pilot neighborhood center (in New Haven) directed by the Yale Child Study Center outpatient clinic.

government for the costs of their board and care. The \$149.3 million figure included in DCF's budget for this account includes as appropriated funds both state revenues *and also* the anticipated *federal reimbursements*.

In short, Connecticut relies on far more federal funding than the \$15.2 million in "federal contributions" to DCF's SFY 05 budget that are shown in the table. It relies also on tens of millions of dollars of federal reimbursements (including under Title IV-E and Medicaid) that are "hidden" in various of the budget accounts in the DCF budget and, with regard to Medicaid, in the DSS budget.

C. The Federal Funding Contribution to DCF's Budget in FY 05

1. Primary federal funding sources. The primary sources of federal child welfare funding are -- in order of size nationally -- Title IV-E of the Social Security Act, the Temporary Assistance for Needy Families block grant (TANF), the Social Services Block grant (SSGB), Medicaid,⁴⁶ Title IV-B, other individual federal grant programs (e.g., Child Abuse Prevention and Treatment Act [CAPTA] grants, Chafee Foster Care Independence Program [CFCIP] grants),⁴⁷ and Supplemental Security Income (SSI) and Survivors Insurance Benefits.⁴⁸

Of these sources of federal funds, Title IV-B and Title IV-E of the Social Security Act (administered by the United States Department of Health and Human Services) are the principal sources of federal funds that are *dedicated* to child welfare, foster care and adoption activities. While the other federal funding sources (such as TANF, SSBG, Medicaid) can be, and are, used for child welfare purposes, they serve other purposes as well.

2. Federal funds in DCF's FFY 05 budget. Each year, DCF must report to the federal government how it intends to spend its federal child welfare funds. This report (Form CFS-101) must also show how state, local, and donated funds are to be used for various categories of child and family services.

⁴⁶ As discussed in the section on Medicaid, many children in Connecticut's foster care system are eligible for federally-subsidized Medicaid benefits. However, the Urban Institute analysis on which this particular section of this report is based includes as Medicaid *child welfare* spending only the Title XIX Medicaid funds that are expended for *child welfare* services or for children for whom child welfare pays the Medicaid matching rate (e.g., under the Medicaid case management or rehabilitative service options). It does *not* include Medicaid spending on foster and adoptive children's health, mental health, vision, dental, and other health care services. See S. Waters Boots et al, *Child Welfare Spending at a Glance: A Supplemental Report to the Cost of Protecting Vulnerable Children* (The Urban Institute, Assessing the New Federalism Occasional Paper No. 20, Supplemental Report, 1999), p. 110.

⁴⁷ These include grants to states, local governments, and non-governmental agencies for prevention and treatment of child abuse and neglect, advocacy centers for victims of sexual abuse, services for abandoned infants and children with AIDS, promotion of adoption, child abuse-related training for judicial personnel, federally-administered research and demonstration projects, Indian child welfare programs, family violence programs, and a number of other small programs. Committee on Ways and Means, U.S. House of Representatives, *2004 Green Book*, p. 11-2.

⁴⁸ R. Bess, et al, *The Cost of Protecting Vulnerable Children III: What Factors Affect States' Fiscal Decisions?* (The Urban Institute, Assessing the New Federalism Occasional Paper Number 61, 2002).

DCF's report for the current *federal* fiscal year (October 2004 through September 2005) shows that "state, local, and donated" funds for FFY 05 total \$628.302 million (up from \$586.327 million in the prior federal fiscal year).⁴⁹ This is a bit misleading, for the amounts reported for IV-E, TANF/IV-A, and Medicaid are the total amount of funds that are appropriated by the General Assembly that are claimed for federal reimbursement under each of these programs. Because Connecticut gross budgets – appropriating both state funds and anticipated federal funds – there is therefore duplication in the funds that are reported in the IV-E, TANF/IV-A, and Medicaid columns and the amounts reported in the column titled "state, local, and donated" funds.⁵⁰ Adjusting for this double-counting, DCF's total FFY 05 budget is expected to be slightly over \$650 million.

Services/Activities (funding in millions) FFY 2005 (10/04-9/05)	IV-B (pt.1)	IV-B (pt. 2)	CAPTA	CFCIP	IV-E	SSBG	TANF /Title IV-A	Medicaid	Other Fed	State, Local & Donated Funds
1. Prevention & Family Support Services		632							1,776	110,754
2. Protective Services			175				107,000	1,900	684	140,987
3. Crisis Intervention (Family Preservation)		633					5,000			
A. Preplacement Prevention			74							2,196
B. Reunification										
4. Time-Limited Family Reunification		834								
5. Adoption Promotion & Support		710							555	1,819
6. Foster Care Maintenance										
A. Foster Family & Relative Foster Care					54,133		6,000			61,925
B. Group/Institutional Care	2,047							20,000		225,853
7. Adoption Subsidy					27,604					32,624

⁴⁹ NOTE: The state fiscal year runs from July 1 through June 30, and the federal fiscal year from October 1 through September 30. DCF spending as reported in this section will therefore differ slightly from spending reported in the prior section, since the spending reported is for two different, though somewhat overlapping, time periods. DCF's SFY 05 budget is \$658.089 million, which includes \$642.639 million in General Fund appropriations, \$15.203 million in "federal contributions" and another \$0.247 million in "private" contributions. As noted in the previous section, the General Fund appropriations *include* federal matching funds since Connecticut gross budgets.

⁵⁰ E-mail communication from G. Messner, Chief Fiscal Officer, Department of Children and Families (July 2004).

Payments										
8. Independent Living Services				1,909						4,814
9. Administration & Management		223			79,194					45,487
10. Staff Training				106	4,030				25	
11. Foster Parent Recruitment & Training			26		4,978					1,843
12. Adoptive Parent Recruitment & Training					4,434					
13. Child Care Related to Education/Training										
TOTAL	2,071	3,034	275	2,015	174,373	0	118,000	21,900	3,015	628,302

Source: DCF, *CFS-101, Annual Summary of Child and Family Services, State of Connecticut, for FFY October 04 to September 30, 2005*

Several points about this proposed spending plan merit special mention:

- *Title IV-B, part 1.* The \$2.1 million in Title IV-B, part 1, funds shown in this report (Child Welfare Services grants) are used primarily for DCF staff costs at one of the DCF-operated facilities (the Connecticut Children’s Place) and also for three staff positions located in area offices.⁵¹
- *Child Abuse Prevention and Treatment Act (CAPTA).* Most of these funds (\$175,000) are to be used to support part-time staff for fifteen multidisciplinary investigation teams (MDIT) in Connecticut’s judicial districts to improve the investigation and prosecution of serious physical and sexual abuse cases (while minimizing the trauma to the child through a coordinated investigation). Other of the funds are for a model high-risk newborn intensive services program in Waterbury that provides comprehensive assessments, home visits, and other needed services (\$74,000)⁵² and the balance for a certification and training program for caregivers of children in foster care with special medical needs (\$19,362).
- *Chafee Foster Care Independence Program (CFCIP) funds.* About a quarter of these funds (\$495,822) are for education and training vouchers for foster youth.⁵³
- *Title IV-E.* The \$174.4 million in appropriated funds that will be claimed for federal reimbursement under Title IV-E are to be spent as follows: \$54.1

⁵¹ E-mail communication from G. Messner, Chief Fiscal Officer, Department of Children and Families (July 2004).

⁵² Over the past five years, this program has prevented the removal of at-risk infants from their homes in an average of 96% of the 35-40 families/year served. DCF, *Child and Family Services Plan 2005-2009*, p. 48.

⁵³ DCF, *CFS-101, Part I, Annual Budget Request for Title IV-B, Subpart 1 & 2 Funds, CAPTA, Chafee Foster Care Independence Program (CFCIP) and Education and Training Vouchers (ETV): Fiscal Year 2005, October 1, 2004 through September 30, 2005.*

million on foster care maintenance payments, \$27.6 million on adoption subsidy payments, \$79.2 million on administration and management, \$4 million on staff training, \$5 million on recruiting and training foster parents, and \$4.4 million on recruiting and training adoptive parents. As mentioned earlier, the amounts are *both* state revenues and anticipated federal reimbursements under Title IV-E.⁵⁴

- *SSBG*. Although no funds from the Social Services Block Grant are included in this spending plan, in previous years such funds have been used for board and care payments to residential treatment providers.⁵⁵ Now, about \$3.21 million in funding for DCF residential treatment is claimed by DSS under TANF.⁵⁶
- *TANF/Title IV-A*. \$118 million of DCF's FFY 05 budget is to be funded with federal funds from the Temporary Assistance to Needy Families (TANF) block grant – nearly 1/5th of DCF's total budget. These funds are to be used for protective services (\$107 million), crisis intervention and family preservation (\$5 million), and foster care (\$6 million). A more detailed summary of the programs and services that TANF has funded in DCF's budget is provided later in this report.⁵⁷
- *Medicaid*. The \$21.9 million in Medicaid funds included here do *not* reflect the total amount spent on routine health care for children in DCF care and custody through Medicaid. Rather, the amount shown is for Medicaid expenditures for child welfare-related spending. In FFY 04, DCF proposed to spend the \$23.4 million in Medicaid funds in two ways: a) \$1.4 million for EPSDT (protective services) for direct expenses for health advocates, medical eligibility processing workers, and “social worker effort to provide for children’s health needs;”⁵⁸ and b) \$22.0 million for some services provided by Private Non-Medical Institutions under contract with DCF (group/institutional care).

⁵⁴ As of March 2004, nearly 53% of the children in DCF foster care were determined to be Title IV-E eligible as well as 77% of the children in subsidized adoptions. That is, federal reimbursement is available for the board and care costs of a little more than half the children in foster care and more than three-quarters of the children in subsidized adoptions. E-mail communication from G. Messner, Chief Fiscal Officer, Department of Children and Families (July 2004).

⁵⁵ During SFY 2001 and 2002, SSBG funds appropriated to DCF for residential treatment totaled \$3.526 million and \$4.407 million, respectively. State of Connecticut, *Auditors' Report, Department of Children and Families for the Fiscal Years Ended June 30, 2001 and 2002* (March 2004), p. 45. Comparable amounts of SSBG funds were also used for this purpose in SFY 1996-SFY 2000.

⁵⁶ E-mail communication from G. Messner, Chief Fiscal Officer, Department of Children and Families (July 2004).

⁵⁷ NOTE: In FFY 1996, the federal TANF block grant replaced not only AFDC but also the federal Title IV-A Emergency Assistance Program. In that year, only \$3.94 million of Title IV-A Emergency Assistance funds were used in Connecticut for child welfare purposes. See Child Welfare League of America, National Data Analysis System, *TANF vs. Emergency Assistance Funding for Years 1996 and 1998*.

⁵⁸ E-mail communication from G. Messner, Chief Fiscal Officer, Department of Children and Families (July 2004).

- *Other Federal.* Included in this category have been funds for the Greater Bridgeport Systems of Care grant and the Development of Comprehensive Drug & Alcohol Treatment Grant (line 1, prevention & family support services), funds for Abandoned Infants, the Justice for Abused Children grant, and Support for New Comprehensive Services grant (line 2, protective services), and the Adoption Incentive Payments grant (line 5, adoption promotion and support). In addition, as of June 2004 DCF had 275 children receiving SSI, a slight increase from the 197 children receiving SSI a year earlier.⁵⁹

Importantly, as this spending plan shows, DCF is now relying on federal funds for a substantial portion of the costs of certain types of child and family services *in addition to* its Title IV-E-reimbursed board and care, training, and administration costs. The following table illustrates this:

Child Welfare Services/Activities	% of CT's FFY 05 Funding from Federal Sources
Crisis Intervention (Family Preservation)	100%
Time-Limited Family Reunification Services	100%
Adoption Promotion & Support	41%
Independent Living Services	28%
Source: CT Voices' calculations based on data in DCF, <i>CFS 101, Annual Summary of Child and Family Services for FFY October 2004 to September 30, 2005</i>	

IV. A Closer Look at the Federal Funding in DCF's Budget

The section provides some greater detail about the primary sources of federal child welfare funding in Connecticut: a) Title IV-B of the Social Security Act; b) Title IV-E of the Social Security Act; c) the Chafee Foster Care Independence Program (also part of Title IV-E); d) Medicaid; and d) TANF.

Titles IV-B and IV-E of the Social Security Act are the primary sources of federal funds devoted solely to supporting states' child welfare, foster care, and adoption activities. These funding streams include both entitlements (for which the federal government has a binding obligation to make payments whenever eligibility criteria are met) and discretionary authorizations (for which the amount of funding is determined in an annual appropriations process). Some of the Title IV-E programs are means-tested, while others are not.

A. Title IV-B

Title IV-B of the Social Security Act is the "primary source of federal funding to help families address problems that lead to child abuse and neglect and to prevent the

⁵⁹ E-mail communication from G. Messner, Chief Fiscal Officer, Department of Children and Families (July 2004).

unnecessary separation of children from their families”⁶⁰ and provides funding under two subparts. The amount of subpart 1 funds a state receives is based on its population under the age of 21 and state per capita income. Subpart 2 funding is determined by the percentage of state children who receive food stamps. Although there is significant overlap among the services that may be funded under subparts 1 and 2, the range of services allowed under subpart 2 is more limited in some circumstances.⁶¹

1. Title IV-B requirements. The following table briefly describes the types of services that may be funded by Title IV-B, the eligibility criteria to receive such services, and the type of federal funding support:

Child Welfare Funding under Title IV-B of the Social Security Act⁶²			
Program	Eligible Services	Eligibility Criteria	Federal Level of Support
Title IV-B Child Welfare Services Program			
<i>-Subpart 1 – Child welfare services (est. in 1935)</i>	Services to prevent abuse and neglect, reduce foster care placements, reunite families, arrange adoption, & ensure adequate foster care ⁶³	Available to all families and children without regard to family income	Discretionary, non-entitlement with 75% federal match capped at states’ allotment
<i>-Subpart 2</i>			
<i>-Promoting Safe & Stable Families (est. in 1993, re-</i>	Family preservation services, ⁶⁵ community-based	Available to families and children without regard to family income	A capped entitlement with 75% federal

⁶⁰ United States General Accounting Office, *Child Welfare: Enhanced Federal Oversight of Title IV-B could Provide States Additional Information to Improve Services* (September 2003, GAO-03-956), p. 1.

⁶¹ For example, “time-limited family reunification services” funded with subpart 2 funds can be provided only during a child’s first 15 months in foster care, while no such limitation is placed on family reunification services provided with subpart 1 funds. Also, states must spend at least 20% of their subpart 2 funds on each of the four service categories unless the state has a strong rationale for a different spending pattern and can spend no more than 10% of subpart 2 funds on administrative costs. United States General Accounting Office, *Child Welfare: Enhanced Federal Oversight of Title IV-B could Provide States Additional Information to Improve Services* (September 2003, GAO-03-956), p. 10.

⁶² In addition to the programs described in this table, Title IV-B authorizes funds for research and demonstration activities and for direct federal grants to public and private entities for child welfare staff training. Also, a mentoring children of prisoners program was established by Public Law 107-133. It is available without regard to family income and is a discretionary, non-entitlement program that provides a 75% federal match in the first two fiscal years in which the grant is awarded and 50% in the third and each successive year, the total capped at the states’ allotment. As noted earlier, other sources of federal funds besides IV-B may also be used to support various of the services listed in this table, including capped entitlement funds through TANF and SSBG funds.

⁶³ Specifically, these services can include those that: protect and promote children’s welfare; prevent or remedy problems that may result in neglect, abuse, exploitation or delinquency of children; prevent the unnecessary separation of children from their families; reunite foster children with their families when possible; place children in adoptive families when appropriate; and ensure adequate care to children placed out of their homes when they cannot be returned home or be placed for adoption.

<i>named and allowable services expanded in 1997)</i> ⁶⁴	family support services, ⁶⁶ adoption promotion and support services ⁶⁷ & time-limited family reunification services. ⁶⁸		match capped at states' allotment
		Available to families and children without regard to family income	Discretionary, ⁶⁹ non-entitlement with 75% federal match capped at states' allotment
Sources: Committee on Ways and Means, U.S. House of Representatives, <i>2004 Green Book</i> ; R. Bess, et al, <i>The Cost of Protecting Vulnerable Children III: What Factors Affect States' Fiscal Decisions?</i> (The Urban Institute, Assessing the New Federalism Occasional Paper No. 61, 2003), p. 9.			

A specific limitation on the use of subpart 1 funds. To assure that states focus many of the Subpart 1 funds on the supportive services families need to *prevent* out-of-home placements, federal law limits the amount of these funds that may be used for foster care, adoption assistance or child care expenses related to a parent's employment or training to the state's total subpart 1 spending in 1979. A recent study by the United States General Accounting Office (GAO) determined that Connecticut was one of a number of states in which subpart 1 spending on foster care maintenance and adoption assistance payments *exceeded* this limit. As reported on form CFS-101 for FY 2002,

⁶⁴ Some Subpart 2 funds are reserved for specific activities (i.e., grants to state courts to improve child welfare proceedings, grants from HHS for research, technical assistance, and evaluation of Subpart 2 programs), and grants to Indian tribes.

⁶⁵ "Family preservation services" are defined as those that help families at risk or in crisis, and include services to: help reunify children with their families when appropriate; place children in permanent homes through adoption, guardianship or other permanent living arrangement; help children at risk of foster care placement stay with their families; provide follow-up services to a family when a child has been returned after a foster care placement; provide temporary respite care to parents and other caregivers (including foster parents); improve parenting skills; and provide services to support infant "safe haven" programs.

⁶⁶ "Family support services" are intended to reach families who are not yet in crisis and prevent child abuse and neglect from occurring, most commonly community-based programs designed to increase the strength and stability of families, increase parental competence, enhance child development, provide children with a safe and supportive family environment, and strengthen parental relationships and promote healthy marriages (e.g. parent skills training, home visiting programs for first-time parents of newborns, drop-in centers for families, information and referral services, and early developmental screening for children).

⁶⁷ "Adoption promotion and support services" seek to encourage the adoption of more children in foster care when adoption is in the child's best interests, including services to expedite the adoption process and support adoptive families.

⁶⁸ "Time-limited family reunification services" are services provided to a child in foster care and that child's parents to facilitate a safe reunification within 15 months of placement (e.g. counseling, substance abuse treatment, mental health services, assistance to address domestic violence, crisis nurseries, temporary child care, and transportation to and from these activities).

⁶⁹ The discretionary funding component of the Promoting Safe and Stable Families program was added by Public Law 107-133.

Connecticut's planned spending for foster care maintenance and adoption assistance payments was about three times greater than the statutory ceiling.⁷⁰

State plan and reporting requirements. To receive Title IV-B funds, states must submit a five-year Child and Family Services Plan to the United States Department of Health and Human Services (DHHS) that describes the state's goals and objectives in improving child safety, permanency, and well-being outcomes, and a description of the services and programs the state will use to achieve these goals. The state plan must assure that there is a case review system for each child in foster care, a statewide information system to provide information about children in foster care, a plan to recruit foster and adoptive families that reflect the racial and ethnic diversity of children in the state who need out-of-home care, and a description of steps taken to provide child welfare services and develop or expand such services. Subpart 2 specifically requires assurance that the safety of children be the paramount concern in administering services and that federal funds provided under Subpart 2 not supplant federal or nonfederal funds for existing services that promote the purposes of subpart 2.⁷¹ In addition to this 5-year plan, HHS requires states to submit an Annual Progress and Services Report (APSR) to discuss their progress in meeting the goals of the plan.

2. How Are Title IV-B Funds Being Used by States? Because Title IV-B has minimal federal reporting requirements, there are no reliable data at the state or national level on the exact number and characteristics of children and families served using Title IV-B funds or of the services that are being provided. A report published by the United States General Accounting Office (GAO) in September 2003 found, based on its own surveys, some important differences in how funds under subpart 1 and subpart 2 were spent. It found greater overlap in the types of children and families served by the two subparts than in the types of services funded. As noted above, Subpart 1 deals primarily with prevention of child abuse and neglect and Subpart 2 with family preservation.

The following table provides data about the *populations served* by Title IV-B at the national level. No comparable state-by-state data exist. It shows that states used funds from both subparts to target many of the same categories of children and families.

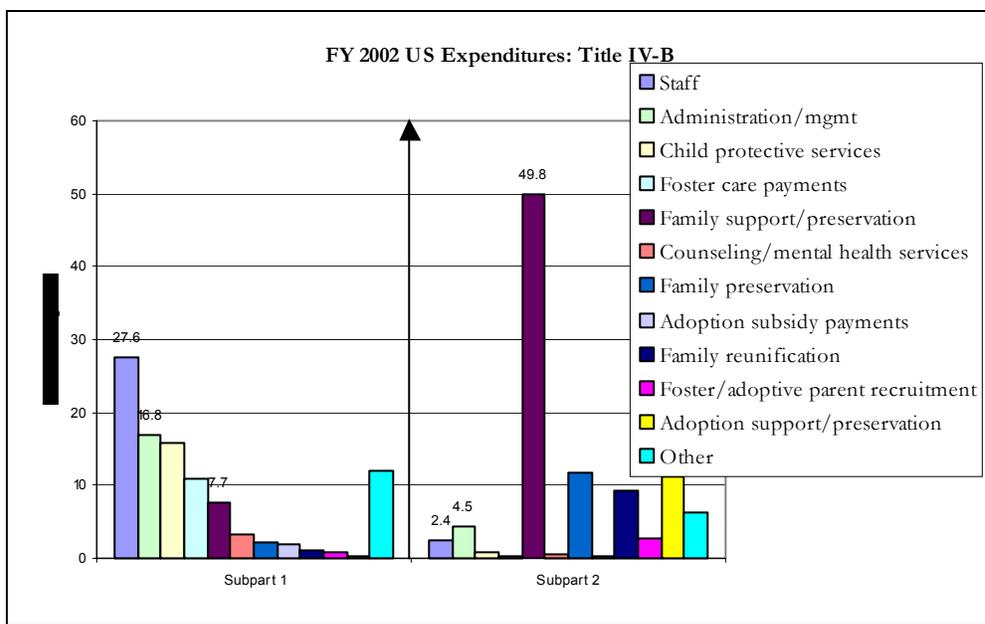
Populations Targeted by Services funded by Title IV-B, subparts 1 and 2 (FY 2002)			
Population Served	% of Subpart 1 funding	% of Subpart 2 funding	
Children in foster care and/or their parents	42%	9%	
Children at risk of child abuse and neglect and/or their parents	17%	44%	
Programs serving multiple populations	14%	11%	

⁷⁰ United States General Accounting Office, *Child Welfare: Enhanced Federal Oversight of Title IV-B Could Provide States Additional Information to Improve Services* (September 2003, GAO-03-956), p. 33.

⁷¹ For a useful chart describing key requirements for states to obtain grants under Title IV-B see United States General Accounting Office, *Child Welfare: Enhanced Federal Oversight of Title IV-B could Provide States Additional Information to Improve Services* (September 2003, GAO-03-956), p. 11.

Children at risk of child abuse or neglect and/or their parents and children living in foster care and/or their parents	9%	11%
Programs serving <i>all</i> populations	9%	7%
Children waiting for adoption, adopted children, and adoptive parents	5%	16%
Other populations (e.g. delinquent teens, foster parents)	4%	2%
United States General Accounting Office, <i>Child Welfare: Enhanced Federal Oversight of Title IV-B could Provide States Additional Information to Improve Services</i> (September 2003, GAO-03-956), p. 20.		

As shown in the following chart, the GAO report found greater difference in the *types of services funded* with Title IV-B subpart 1⁷² and subpart 2 funds,⁷³ with subpart 2 funds being used more commonly for preventive purposes:



⁷² States used Subpart 1 funds most frequently to fund staff salaries, with almost half of these funds designated for the salaries of social workers in protective services and another 20% for the salaries of other agency social workers who provided on-going support services and case management services. Funding for management and administration accounted for nearly 18% of subpart 1 funding, paying for rent and utilities for office space, travel costs for staff, and staff training. About 16% of Subpart 1 funds were used to pay for child protective services, including hotlines, emergency shelters for children removed from their homes, and investigative services. About 11% of subpart 1 funds were used for foster care payments for children who were not eligible for federal reimbursement through Title IV-E (e.g., because the family had income over the 1996 AFDC standard).

⁷³ States used about half their Subpart 2 funds to fund various family support services, including mentoring programs to help pregnant teens learn to be self-sufficient, financial assistance to low-income families to help with rent and utility payments, parenting classes, child care, and support groups. The second largest service category for subpart 2 funds was family preservation services. Adoption support and preservation services accounted for about 11% of subpart 2 spending, for such services as counseling for children, respite care for adoptive parents, and family preservation services for adoptive families. About 9% of subpart 2 funds were used for family reunification services, such as supervised visitation centers, coordinators for substance abuse treatment services for families, transportation, support groups, mentors and case managers.

3. Trends in Federal Title IV-B Funding. Federal funding for the Title IV-B, subpart 1 Child Welfare Services program has been relatively flat for several decades. While the total annual authorization increased from \$266 million (between 1977 and 1990) to \$325 million (beginning in FFY 1990), the *actual appropriation* for subpart 1 funds was consistently less (\$164 million in FFY 1981, \$295 million in FFY 94, and about \$292 million each year since 1997).⁷⁴

Funding for Title IV-B subpart 2 increased somewhat more rapidly over the 1990s than did subpart 1 funding. Authorized funding increased from \$60 million (in FFY 94) to \$305 million (by FFY 01). In addition, beginning in 2002, Congress authorized an additional \$200 million/year in discretionary funding, for a total subpart 2 authorization of \$505 million/year. Here too, however, the actual amount appropriated by Congress was less than what had been authorized; Congress appropriated only \$70 million of \$200 million of discretionary funding that was authorized for FFY 2002 and just \$99.4 million in FFY 2003.⁷⁵

4. Title IV-B Funding in Connecticut. Connecticut has received between \$5.2 and \$5.5 million in combined Title IV-B funds in recent years, as shown in the following table. This is just slightly more than the \$4.3 million in combined Title IV-B funds received by Connecticut in FFY 99. Indeed, the inflation-adjusted increase in Title IV-B funding between 1999 and 2003 was less than \$1 million (\$0.95 million):

CT's Funding under Title IV-B of the Social Security Act⁷⁶	
Program	CT's Federal Funds (in millions)
<i>Title IV-B</i>	
-Subpart 1 – Child welfare services	\$2.078 (FFY 02 final allocation) \$2.064 (FFY 03 allocation)
-Subpart 2 – Promoting Safe & Stable Families	\$3.149 (FFY 02 final allocation) \$3.452 (FFY 03 allocation)
Committee on Ways and Means, U.S. House of Representatives, <i>2004 Green Book</i> , p. 11-4.	

Mirroring trends in federal funding overall, Title IV-B subpart 1 funding has remained fairly constant for a decade while subpart 2 funds have increased modestly.

Subpart 1 funding. Connecticut's subpart 1 funding generally declined each year over the 1990s -- from \$2.143 million in 1989, to \$2.050 million in 1999 and \$1.884 million in 2000. Federal allotments for Connecticut have increased slightly since 2000-- to \$2.078 million in 2002 and \$2.064 million in 2003.⁷⁷

⁷⁴ Committee on Ways and Means, U.S. House of Representatives, *2004 Green Book*, pp. 11-8, 11-9.

⁷⁵ Committee on Ways and Means, U.S. House of Representatives, *2004 Green Book*, pp. 11-11, 11-12.

⁷⁶ As noted earlier, other federal funds may also be used to support these services, including capped entitlement funds through TANF and the SSBG.

⁷⁷ Committee on Ways and Means, U.S. House of Representatives, *2000 Green Book*, p. 652; Committee on Ways and Means, U.S. House of Representatives, *2004 Green Book*, p. 11-9.

Since FFY 1996, DCF's proposed spending plan, as set out in its Form CFS-101, has used *all* subpart 1 funds for "group/institutional care."⁷⁸ In FFY 04, the anticipated \$2.1 million in subpart 1 funds were to be used primarily for DCF staff costs at one of the DCF-operated facilities (the Connecticut Children's Place) and also for three staff positions located in area offices.⁷⁹ That is, 100% of these funds were to be used for DCF staff (as compared to the national average of 28% of subpart 1 funds being used for staff in 2002).

Subpart 2 funding. Connecticut has enjoyed a fairly steady increase in Title IV-B, subpart 2 funds: from \$1.067 million in FFY 1996 to \$1.805 million in FFY 1998, \$2.349 in FFY 2000, \$3.418 million in FFY 2002, and \$3.452 million in FFY 2004.⁸⁰ Funds in FFY 2005 are expected to decline somewhat. DCF's proposed⁸¹ uses of subpart 2 funds has varied somewhat over the last decade, as illustrated in the following table:

TITLE IV-B, part 2 (in millions)	95-6	96-7	97-8	98-9	99-0	00-01	01-02	02-03	03-04	04-05
Prevention & Support Services	534	881	903	432	461	487	524	693	722	634
Crisis Intervention (Family Preservation)	533	880	902	433	461	487	490	630	729	633
Time-Limited Family Reunification				433	461	693.5	675	882	1015	834
Adoption Promotion & Support				790	852	693.5	686	882	842	710
Staff Training				75	69	73	60	62	143	223
TOTAL	1067	1761	1805	2163	2304	2434	2435	3149	3452	3034
Source: DCF, <i>CFS-101, Annual Summary of Child and Family Services, State of Connecticut, for FFY 1996 through 2005.</i>										

In FFY 05,⁸² DCF proposes to use the \$3.034 million in Title IV-B, subpart 2 funds it expects to receive to:

⁷⁸ DCF projected it would receive \$2.4 million in subpart 1 funds in FFY 1996-2002, decreasing to \$2.047 million in FFY 2005. The amount actually received has been consistently less (e.g., \$1.884 million in FY 2000, rather than the \$2.4 million anticipated). Committee on Ways and Means, U.S. House of Representatives, *2004 Green Book*, p. 11-9; DCF, *CFS 101, FFY 1995-FFY 2005*.

⁷⁹ E-mail communication from G. Messner, Chief Fiscal Officer, Department of Children and Families (July 2004).

⁸⁰ Committee on Ways and Means, U.S. House of Representatives, *2000 Green Book*, p. 655; Committee on Ways and Means, U.S. House of Representatives, *2004 Green Book*, p. 11-13.

⁸¹ The final subpart 2 awards to Connecticut have differed from the amount Connecticut anticipated in its Form CFS-101. In some cases, the actual awards exceeded the amount anticipated. In others, less was received. Committee on Ways and Means, U.S. House of Representatives, *2004 Green Book*, p. 11-13; DCF, *CFS 101, FFY 1995-FFY 2005*.

⁸² In FFY 04, DCF proposed to spend \$2,200,700 for family support centers, \$375,000 for Community Collaboratives, \$10,000 for the work of the statewide Adoption Steering Committee, \$105,000 for a staff position to support and monitor the implementation of family support services through the Adoption and Safe Families Act (ASFA), as well as implementation of ASFA within DCF, \$122,872 in funding to support staff training, planning, coordination and information dissemination need to implement Promoting Safe and Stable Families, including \$20,000 in funding for planning activities through the Strategic Planning Division, \$20,000 in funding to support the Regional Advisory Councils (RACs), including stipends and training for parents/consumers, training for the RACs and RAC meeting expenses, \$47,200 to support Connecticut's celebration of Family Day, \$96,000 to support DCF's maltreatment/domestic violence initiatives and \$75,000 to support the evaluation of DCF's pilot

- Provide each region funds for family support centers and other activities for family reunification/visitation, and support to adoptive, foster and biological families (\$2.1 million)
- Support Community Collaboratives in each DCF region (at \$75,000 each) to develop and support foster and adoptive families (\$375,000)
- Support statewide recruitment/retention of foster and adoptive families (\$85,244)
- Fund positions to support/monitor the implementation of family support services through the Adoption and Safe Families Act (ASFA) (\$167,652).
- Support staff training, planning, coordination, and information dissemination needed for implementation, including activities through the Strategic Planning Division (\$25,000).
- Fund three program staff to support the program development/monitoring of community-based services in family preservation, family support, time-limited family reunification, and adoption promotion and support (\$325,000)
- Support the Regional Advisory Councils (including stipends, training, and meeting expenses) (\$30,000)
- Fund reunification services for families (\$250,962).⁸³

B. Title IV-E

While growth in federal spending for child welfare services under Title IV-B has been quite modest over the last decade, this has *not* been the case for federal spending under Title IV-E of the Social Security Act.

Title IV-E provides federal reimbursements in three primary areas: foster care, adoption assistance, and independent living. Over the past decade, Connecticut's federal reimbursements under Title IV-E have increased, although not consistently as the following table shows:

Title IV-E Funds Received by Connecticut: SFY 1994-2002 (in millions)	
1994	\$26.368
1995	\$51.220
1996	\$70.659
1997	\$76.959
1998	\$66.162
1999	\$108.826
2000	\$116.471
2001	\$109.169
2002	\$95.342

differential response system. CT Department of Children and Families, Table A.8, *2003/2004 ASFA Resource Allocation Plan*.

⁸³ CT Department of Children and Families, *Child and Family Services Plan 2005-2009*, p. 96.

2005 (anticipated)	\$92.100
State of CT, <i>Auditors' Report, DCF, for the Fiscal Years Ending June 30, 1994-June 30, 2002</i> ; OFA, <i>Connecticut State Budget 2003-2005 Revisions</i> , p. 261.	

1. **Title IV-E Foster Care and Adoption Assistance.** The following table briefly describes the services that may be funded by Title IV-E foster care and adoption assistance programs, the eligibility criteria to receive such services, and the type of federal funding support:

Child Welfare Funding under Title IV-E of the Social Security Act ⁸⁴			
Program	Eligible Services	Eligibility Criteria	Federal Level of Support
Title IV-E Foster Care Program			
<i>-Foster care assistance payments</i>	Payments to foster care providers ⁸⁵ to cover children's food, shelter, and parental visits, but <i>not</i> direct services ⁸⁶	Assistance only for children who: a) are removed from a family that would have been eligible for the old Aid for Families with Dependent Children (AFDC) program as that program existed on July 16, 1996: ⁸⁷ b) were removed from home and placed in foster care based either on a voluntary placement agreement signed by the child's parents/guardian or a judicial determination that remaining in the	Open-ended entitlement with federal match at Medicaid rate (which is 50% in CT)

⁸⁴ In addition to the programs described in this table, Title IV-E provides incentive payments to states that increase their number of adoptions of foster children (including children with specified needs) above specified baselines. Also, as noted earlier, other sources of federal funds besides IV-E may be used to support various of the services listed in this table, including capped entitlement funds through TANF and the SSBG block grants.

⁸⁵ States may claim reimbursement on behalf of eligible children who have been placed in licensed or approved foster family homes or child care institutions (which may be public or private, and for profit or non-profit). To be eligible for reimbursement, public child care institutions can accommodate no more than 25 children, but no such limitation applies to private institutions. Placements in detention facilities for children determined to be delinquent are not eligible for federal reimbursement.

⁸⁶ In 2000, Connecticut's foster care rates, set by the Juan F. consent decree to a specified federal USDA standard, were the highest in the nation: \$670/month for a foster child aged 2, \$690/month for a foster child aged 9, and \$760 for a foster child aged 16. The 50-state average was well below this: \$387/month for a 2 year old, \$404 for a 9 year old, and \$462 for a 16 year old. Committee on Ways and Means, U.S. House of Representatives, *2004 Green Book*, p. 11-28.

⁸⁷ E.g. family income for family of 3 under \$543/month (\$6,516/year). This is well below the 2004 federal poverty guideline of \$15,670/year for a family of 3. Indeed, it is just 42% of the 2004 poverty guideline, while in 1996 it was about 50% of the 1996 federal poverty guideline. Importantly, Connecticut's AFDC standard was not inflation-adjusted even before the 1996 "benchmark" standard used to measure Title IV-E eligibility was set. Because the standard is not inflation-adjusted, a smaller and smaller proportion of Connecticut children will meet the income eligibility test over time as family incomes rise but the standard does not.

		home would be contrary to the child's best interests; c) had reasonable efforts made to eliminate the need for removal or return the child home (subject to certain exemptions); <i>and</i> d) for whom care and placement of the child is the state's responsibility	
<i>-Placement services & administrative costs</i>	Placement services, case management, eligibility determinations, foster care recruitment, licensing & other administrative costs	Expenses associated with Title IV-E eligible children in foster care, and proportional administrative expenses for the on-going protective services population	Open-ended entitlement with federal match of 50% ⁸⁸
<i>-Training expenses</i>	Training of agency staff and foster parents	Cost of training proportional to the children on caseload eligible for Title IV-E	Open-ended entitlement with federal match of 75%
Title IV-E Adoption Assistance Program⁸⁹			
<i>-Adoption assistance payments</i>	Payments to adoptive parents (not to exceed comparable foster care payments) to cover basic maintenance costs, including food, shelter, daily supervision, school supplies, insurance, incidentals	Adoption assistance is available only for special needs children who are adopted and who are AFDC- or SSI-eligible. In addition, the state must have determined that the child cannot, or should not, be returned to the biological family and that reasonable efforts have been made to place the child without providing adoption assistance. NOTE: States have discretion to define the special-needs eligibility criteria and to determine if an individual child is eligible. ⁹⁰	Open-ended entitlement with federal match at Medicaid rate (which is 50% in CT)
<i>-Nonrecurring adoption expenses</i>	Reasonable & necessary adoption fees, court costs,	Non-recurring expenses for adoption of special needs children (regardless of whether they are	Open-ended entitlement with federal match of

⁸⁸ A 75% federal matching rate was available to states from FY 1994 through FY 1997 for certain costs related to data collection.

⁸⁹ The Adoption and Safe Families Act of 1997 also established an adoption incentive program to encourage states to increase the number of foster child adoptions, with additional incentives for adoption of special needs children. This discretionary program authorizes funds to make incentive payments equal to \$4,000 for each foster child, and an additional \$2,000 for each special needs child under age nine, whose adoption is finalized (over state-specific baselines). Connecticut has received varying amounts under this incentive program (\$88,000 in FFY 99, \$500,000 in FFY 00, \$384,000 in FFY 01, nothing in FFY 02, and \$547,000 in FFY 03).

⁹⁰ DCF defines a "special needs" child as a child who: a) has a physical, intellectual, or emotional handicap; b) is over the age of eight; c) is a member of a sibling group that needs to be placed together; and/or d) has racial or ethnic factors that are a barrier to adoption.

	attorney fees, and related expenses up to \$2,000 per child	AFDC or SSI eligible) up to \$2,000/child	50%
<i>-Placement services & administrative costs</i>	Child placement & other administrative activities	Expenses associated with those children who are eligible for IV-E adoption assistance	Open-ended entitlement with federal match of 50%
<i>-Training expenses</i>	Training of agency staff & adoptive parents	Cost of training proportional to the children on caseload eligible for Title IV-E adoption assistance	Open-ended entitlement with federal match of 75%

Sources: Committee on Ways and Means, U.S. House of Representatives, *2004 Green Book*; R. Bess, et al, *The Cost of Protecting Vulnerable Children III: What Factors Affect States' Fiscal Decisions?* (The Urban Institute, Assessing the New Federalism Occasional Paper No. 61, 2003), p. 9.

a. *What federal reimbursements are available.* As noted in the table above, Title IV-E provides reimbursement to Connecticut for 50% of eligible foster care and subsidized adoption payments. Title IV-E funds may also be used for administration and management, staff training, and the recruitment and training of foster and adoptive parents. For a foster care or subsidized adoption payment to be reimbursed by the federal Title IV-E program, the payment must be allowed under the Title IV-E requirements *and* have been for services provided during a reimbursable month. For a month to be reimbursable, the child must have been determined as eligible for Title IV-E and have been in a licensed facility. In addition, court orders documenting that DCF has met certain criteria must be on file and the child must have been in financial need, deprived of parental support and not in receipt of AFDC or Social Security Income (SSI).

b. *State-funded foster care and subsidized adoptions.* For children who are not eligible for Title IV-E, Connecticut operates state-funded programs.⁹¹ For example, DCF operates two separate, but coordinated, adoption subsidy programs to encourage the adoption of children with special needs. While one is partially (50%) funded by federal reimbursements through Title IV-E of the Social Security Act, the other is funded entirely by state funds. DCF uses the same special needs criteria for both programs. It certifies first that a child has special needs and is eligible for a subsidy and only then determines if the subsidy is federally-subsidized.⁹² The subsidy amount is based on the

⁹¹ Were federal eligibility guidelines for Title IV-E relaxed (such as by eliminating the requirement that a child be removed from a family that would have been eligible for the old AFDC program as it existed in July 16, as the Pew Commission on Foster Care suggests), states could claim federal reimbursements for the care of many children currently in state-funded programs.

⁹² A Connecticut child qualifies if he or she: a) has a physical or mental disability or is at high risk of developing such a disability; b) has serious emotional maladjustment; c) is over age eight (if this presents a barrier to adoption); d) is over age two and has racial or ethnic factors that present a barrier to adoption; or e) is a member of a sibling group that should be placed together. In addition to finding that the child has special needs, DCF must also find that: a) the child cannot or should not be returned to his birth parents' home; and b) a reasonable, but unsuccessful effort has been made to place the child in an adoptive home without a subsidy. However, the latter factor does not apply if making this attempt would not be in the child's best interest because of such factors as the existence of significant emotional ties with foster parents who are the prospective adoptive parents.

child's needs, not the source of the funding, but no subsidy can exceed the amount DCF pays to foster parents (currently \$7,953/year for a child 0-5, \$8,209 for a child 6-11, \$9,056 for a child 12 and over, and \$15,300 for a child with complex medical needs). DCF annually reviews the continuing need for the subsidy and its amount, with the subsidy continuing until the child reaches age 18, the parents are no longer legally responsible for the child's support (e. g., the parents' rights are terminated or the child joins the military), or DCF determines that the parents are no longer supporting the child.⁹³

c. State prerequisites to receipt of Title IV-E funds. As with Title IV-B, receipt of Title IV-E reimbursements is conditioned on Connecticut complying with a variety of federal mandates intended to protect foster children and children at risk of foster care placement. These pertain to such issues as requirements for a case planning and case review system, permanency hearings and planning goals, making reasonable efforts to preserve and reunify the family (subject to certain exceptions), implementing a statewide information system to keep track of children in care, and initiating termination of parental rights proceedings when a child has been in foster care for a certain period of time or in certain other specified circumstances.⁹⁴

d. National trends. The Congressional Budget Office reports that between 2003 and 2008, the federally-funded foster care caseload is projected to *decrease* by 9% (from 250,000 to 228,000), while the adoption assistance caseload is projected to *increase* 42% (from 317,000 to 451,000). Title IV-E foster care payments to the states are projected to increase from \$4.6 billion to \$5.2 billion (14%), while adoption assistance payments are projected to increase from \$1.5 billion to \$2.5 billion (66%).⁹⁵

e. Proportion of DCF children who are Title IV-E Eligible. Over the past five years,⁹⁶ the proportion of Connecticut foster children determined to be Title IV-E eligible has been

⁹³ See generally Office of Legislative Research, *Adoption Subsidies* (2004-R-0008)(January 2004).

⁹⁴ For a more comprehensive description, see Committee on Ways and Means, U.S. House of Representatives, *2004 Green Book*, pp. 11-26 to 11-11-33.

⁹⁵ Committee on Ways and Means, U.S. House of Representatives, *2004 Green Book*, p. 11-4. Note: the projections from DHHS differ somewhat. DHHS projects the IV-E eligible foster care caseload will decline less between 2003 and 2008 than does the CBO – from 245,000 to 237,000 – and the IV-E eligible adoption assistance caseload will increase more -- from 317,000 to 489,000. Projected federal outlays for the two programs therefore also differ. DHHS projects a very modest increase in federal spending on the Title IV-E foster care independence program -- from \$182 million in 2003 to \$200 million in 2008.

⁹⁶ Problems with eligibility determinations existed before this. For example, in 1995, Connecticut's Auditors of Public Accounts' performance audit of DCF's Title IV-E claiming found many eligible cases that were not claimed for federal reimbursement. As a result, Connecticut received significantly less federal funding than the amount to which it was entitled. Errors included DCF's failures to: a) ensure that the reasonable efforts court finding was present in every new case file; b) maintain a current list of eligible facilities (i.e. that were licensed and non-profit); c) assign cases any eligibility code; d) determine if cases that are not eligible for reimbursement under Title IV-E are eligible under Title IV-A; and e) make timely adjustments for errors in cases claimed or not claimed under Title IV-E or Title IV-A. To increase DCF's rate of claiming, DCF contracted with a private consultant to complete an eligibility review on the case files of all DCF children in out-of-home care who had not been determined to be Title IV-E eligible. The consultant (Maximus) was to determine if the cases were Title IV-E or Title IV-A eligible and would receive compensation equal to 10.5% of the claimed reimbursements. (With estimated additional federal recoveries of \$13.5 million, compensation to Maximus would have been \$1.4 million). The Auditors of

“volatile.”⁹⁷ In 1999, 60% of Connecticut’s foster care children were determined to be IV-E eligible. The proportion declined to 47% in 2000 and to 38% in 2001.⁹⁸ The low was reached in March 2002, when just 29% of the children in foster care in Connecticut were determined to be Title IV-E eligible. As of March 2004, the proportion of children in DCF care who were determined to be Title IV-E eligible had increased to 53%

Importantly, children in the care and custody of DCF can be *ineligible* for IV-E payments for reasons other than income, although more children than before are being disqualified because they are over the income limits.⁹⁹ Of the 47% of children *ineligible* for Title IV-E in 2004, about 16% were ineligible because of family income and the remaining 31% were ineligible for other reasons. The March 2002 dip was attributed in part to the federal government’s tightening its interpretation of IV-E requirements and requiring annual permanency plans.¹⁰⁰ The increase in eligibility to 53% by March 2004 was due in part to an increased DCF focus on obtaining and recording the correct legal determinations necessary for claiming.¹⁰¹

Title IV-E eligibility is higher among Connecticut children in subsidized adoptions than children in foster care. In March 2004, there were 3,777 Connecticut children receiving subsidized adoptions. Of these, 2,889 (76.5%) were determined to be Title IV-E eligible.¹⁰²

f. Title IV-E funding in Connecticut. The following table reports federal Title IV-E reimbursements to Connecticut solely for foster care maintenance and adoption assistance for FFY 01, FFY 02, and FFY 03.

Public Accounts concluded: “We believe this type of effort and expense would have been unnecessary if the potential IV-E cases were processed correctly from the inception. The consultant’s case review corrects past mistakes; it does not prevent future cases from errors in processing. The Department needs to provide the necessary resources and establish strict processing procedures to eliminate the types of errors noted in our review.” Auditors of Public Accounts, *Auditors’ Report: Department of Children and Families Central Office, Regions and Facilities for the Fiscal Year Ended June 30, 1995*.

⁹⁷ E-mail communication from G. Messner, Chief Fiscal Officer, Department of Children and Families (July 2004).

⁹⁸ In 1999, 4,528 of the 7,487 children in foster care in Connecticut were determined to be IV-E eligible, as compared to 3,292 children out of 6,996 in 2000 and 2,788 out of 7,440 in 2001. Committee on Ways and Means, U.S. House of Representatives, *2004 Green Book*, p.11-20

⁹⁹ DCF estimates that the proportion of children who are now being disqualified because family income exceeds the old 1996 AFDC standard is some 5 percentage points higher than it was five years ago. E-mail communication from G. Messner, Chief Fiscal Officer, Department of Children and Families (July 2004).

¹⁰⁰ DCF estimates that if the pre-2001 Title IV-E eligibility rules were used to determine eligibility among children in foster care in March 2004, eligibility would have been about 6.4 percentage points greater than the 52.6% eligibility rate that was determined in March 2004. E-mail communication from G. Messner, Chief Fiscal Officer, Department of Children and Families (July 2004).

¹⁰¹ Multiple reports by the State Auditors have chronicled the additional revenue that could have been gained through Title IV-E claims (if DCF had been more careful in case management, eligibility determinations, and claiming procedures) and made recommendations to DCF to enhance its federal claiming. In SFY 01, an additional \$6.72 million could have been claimed through Title IV-E, according to the Auditors, and an additional \$8.18 million in SFY 02. State of Connecticut Auditors’ Report, *Department of Children and Families for the Fiscal Years Ended June 30, 2001 and 2002* (March 2004), pp. 12-14.

¹⁰² E-mail communication from G. Messner, Chief Fiscal Officer, Department of Children and Families (July 2004).

Federal IV-E Funding in Connecticut (in millions)			
	2001	2002	2003
Foster Care Maintenance	\$31.467	\$13.090	\$22.130
Adoption Assistance	\$9.976	\$11.710	\$13.148
TOTAL	\$41.442	\$24.800	\$35.278
Source: Summary by R. Geen, The Urban Institute (2004)			

The dip in foster care maintenance reimbursements in 2002 can be attributed in part to the problems DCF was having establishing Title IV-E eligibility (as discussed above). In addition the number of children in foster care at the end of 2002 was lower than in any of the preceding three years (6,007 children in 2002, compared to 7,440 in 2001, 6,996 in 2000 and 7,487 in 1999).

Connecticut receives federal reimbursements under Title IV-E for more than just the costs of foster care maintenance and adoption subsidies. Federal reimbursement is also provided for placement services and administrative costs associated with both programs, as well as training expenses and non-recurring adoption expenses. The following table shows for FFY 02 the total reimbursement Connecticut received for these two programs.

CT's Funding under Title IV-E Foster Care & Adoption Assistance (FFY 2002)	
	CT's Federal Funds
<i>Title IV-E Foster Care Program</i>	
-Foster care maintenance payments	\$13,090,111 (net claim) ¹⁰³
-Placement services & administrative costs	\$34,458,341
-Training expenses	\$2,660,269
Total	\$50,174,891
<i>Title IV-E Adoption Assistance Program</i>	
-Adoption assistance payments	\$11,709,542
-Placement services & administrative costs	\$2,747,447
-Training expenses	\$2,237,039
Total	\$16,694,028
Grand Total	\$66,868,919
Committee on Ways and Means, U.S. House of Representatives, 2004 <i>Green Book</i> , pp. 11-23, 11—38	

g. *Trends in Title IV-E funding.* Nationally, between 1991 and 2002, Title IV-E reimbursements for foster care expenses nationally increased by 149% -- from \$1,819 million to \$4,523 million. Growth differed substantially, however, between Title IV-E funds for foster care maintenance and those for other Title IV-E reimbursable costs. Title IV-E reimbursements for child placement services, administration and training

¹⁰³ Net maintenance payments are claimed maintenance payments less the state child support collections that are used to make maintenance payments.

increased by 211% (\$789 million to \$2,450 million) while the percentage growth in foster care maintenance was half this (\$1,030 million to \$2,073 million).¹⁰⁴

Connecticut's trend was similar, although growth over this period in Title IV-E reimbursements was less. Between 1991 and 2002 total Title IV-E *foster care* claims increased from \$24 million to \$50 million – a 109% increase. Claims for child placement services, administration and training increased by 134% (from \$16 million in 1991 to \$37 million in 2002), while claims for foster care maintenance increased by 60% (from \$8 million to \$13 million). Although Connecticut's growth in total Title IV-E foster care reimbursements over this period was the 9th lowest in the nation, as noted earlier in this report, Connecticut's Title IV-E claiming was at an all-time low in 2002 for some administrative reasons. Because DCF has been addressing these issue, this finding less meaningful.¹⁰⁵

Growth in IV-E Reimbursements, US & CT: 1991-2002			
	Foster care maintenance	Placement, Admin & Training	TOTAL
US	+100%	+211%	+149%
CT	+60%	+134%	+109%

Committee on Ways and Means, U.S. House of Representatives, 2004 *Green Book*, pp. 11-132, 11-134.

b. A decreasing proportion of IV-E funds are being used for foster care maintenance. Because the growth in IV-E foster care administrative, child placement, and training costs has exceeded the growth in IV-E foster care maintenance costs, the share of total IV-E funding being used for foster care maintenance has decreased, while the share for administrative, placement and training has increased.

Nationally, in 1991, placement, administration and training represented 43% of total IV-E expenditures. By 2002, it had increased to 54%. The United States Department of Health and Human Services projects a continuation of this trend (to 58% of total IV-E spending by 2008) as does the Congressional Budget Office (to 56% by 2008). [Green Book, p. 11-132].

In Connecticut, the shift was not quite as great. Between 1991 and 2002 the proportion of IV-E funds used for child placement, administration, and training increased from 66% to 74% -- or 8 percentage points compared to the 11 percentage point national increase. The *share* of Connecticut Title IV-E funds claimed for foster care maintenance in 2002 was much less than the national average, and the share used for child placement, administration, and training much greater, as shown in the following table. A factor contributing to the increase in DCF's spending on administration and training is its need to respond to the requirements of the Juan F. Consent Decree to reduce caseloads (including by hiring more workers) and improve training:

¹⁰⁴ Committee on Ways and Means, U.S. House of Representatives, 2004 *Green Book*, pp. 11-132.

¹⁰⁵ Committee on Ways and Means, U.S. House of Representatives, 2004 *Green Book*, pp. 11-134.

**The Share of CT IV-E Funds Spent on Foster Care Maintenance
Is Less Than the National Average, and Declining**

	United States Total		Connecticut	
	1991	2002	1991	2002
Placement services, administration, training	43%	54%	66%	74%
Maintenance	57%	46%	34%	26%

Committee on Ways and Means, U.S. House of Representatives, *2004 Green Book*, Tables 11-49 and 11-50, pp. 11-132, 11-134

2. Title IV-E Independent Living Program. The following table briefly describes the services that may be funded by the Title IV-E independent living program, the eligibility criteria to receive such services, and the type of federal funding support:

**Child Welfare Funding under Title IV-E of the Social Security Act –
Independent Living Program**

Program	Eligible Services	Eligibility Criteria	Federal Level of Support
<i>-Chafee Foster Care Independence Program</i>	Basic living skills training, education, employment initiatives, substance abuse prevention, and preventive health activities to assist youth transitioning from foster care to independent living. No more than 30% can be used for housing youth 18-	Independent living services for youth who are likely to remain in state care until age 18, as well as former foster children between the ages of 18-21. There is no minimum age for the services and youth are eligible regardless of whether they were eligible for IV-E foster care assistance	A capped entitlement, with states required to provide a 20% non-federal match; 80% federal funding capped at state's allotment ¹⁰⁶

¹⁰⁶ As discussed *supra*, the Chafee Program replaced the previous Independent Living program in 1999. From FY 1991 through FY 1999, states had to provide 50% matching funds for any federal funding claim that exceeded \$45 million. When the Chafee program was enacted, the federal share of spending increased to 80%.

	20.		
-Education training vouchers ¹⁰⁷	Vouchers worth up to \$5,000 per year for the cost of attendance at an institution of higher learning	Youth otherwise eligible for the Chafee program, as well as youth who are adopted from foster care after reaching 16 years of age. States may allow youths participating in the education and training voucher program when they reach age 21 to remain eligible for the program until age 23 so long as they are enrolled in a post-secondary education or training program and are making satisfactory progress toward completion	Discretionary, non-entitlement with 80% federal funding with total capped at states' allotment
Sources: Committee on Ways and Means, U.S. House of Representatives, <i>2004 Green Book</i> ; R. Bess, et al, <i>The Cost of Protecting Vulnerable Children III: What Factors Affect States' Fiscal Decisions?</i> (The Urban Institute, Assessing the New Federalism Occasional Paper No. 61, 2003), p. 9.			

a. *CFCIP.* The Chafee Foster Care Independence Act of 1999 made a number of significant changes to the Title IV-E program. While providing a capped federal grant for states' independent living programs, it: a) extends eligibility for transition assistance for former foster children up to age 21 (three years longer than had previously been available); b) doubles funding for independent living services and establishes a \$500,000 minimum allotment for states; c) permits states to use federal funds to support a variety of financial, housing, counseling, employment, education, and other services that can help foster youth transition to self-sufficiency; d) clarifies that independent living services can occur concurrently with efforts to find adoptive homes; e) allows states to use up to 30% of funds for board and care for youths 18-21 who are transitioning from foster care; f) gives states the option to extend Medicaid to older youths transitioning from foster care; g) allows states to use federal foster care funds to provide adoptive parents with training to help them understand and address issues confronting youth preparing for independent living; h) requires state child welfare agencies to document the effectiveness of their efforts to help former foster youth become self-sufficient; and i) allows federal funding to be used to provide emotional support to these youth, through mentors. In addition, education and training vouchers worth up to \$5,000/year/youth are provided.

b. *Services provided.* Among the services DCF funds for foster care youth are: mentoring programs, life skills programs, supported living (group homes, Transitional Living Programs, and the Community Housing Assistance Program), the Wilderness School, and employment and training. Training funds are used to provide training to foster and adoptive parents, private providers, DCF staff, and the youth themselves.¹⁰⁸

c. *DCF funding.* In FFY 2003, Connecticut was allotted a total of \$2.339 million in federal Foster Care Independence Program funds: \$1.793 million for the general

¹⁰⁷ The vouchers program was established through Public Law 107-133 in 2001.

¹⁰⁸ DCF, *Child and Family Services Plan 2005-2009* (June 2004).

program (of which \$0.4 million was used for training and the balance for independent living services) and \$0.546 million for education and training vouchers.

In FFY 2004, DCF was provided \$2.378 million in federal Foster Care Independence program funds that DCF planned to use for two DCF staff (\$0.219 million), CHAP vouchers (\$24,000), and the balance to fund contracts with various community agencies to provide mentoring programs, camperships, community life skills training, job training, Wilderness School tuition, training and other related services. DCF also was to receive \$0.545 million for education and training vouchers. DCF planned to spend only \$125,000 of this sum on vouchers (for 25 youth at \$5,000/youth). The balance was to be spent on computers for the CT Association of Foster and Adoptive Parents (\$250,000) and a marketing campaign (\$177,772).¹⁰⁹

In FFY 05, DCF anticipates funding for the general program to be \$2.015 million (of which \$0.106 million is to be used for training) and \$0.496 million for education and training vouchers.¹¹⁰

C. Medicaid/HUSKY

To meet the Department's obligation to provide necessary health care services to all children in its care,¹¹¹ children in DCF's care and custody are enrolled in HUSKY A, Connecticut's Medicaid managed care program.¹¹² For most children in the care and custody of DCF, these health benefits are federally-subsidized through Medicaid. In March 2004, for example, 72% of the children in DCF care were Medicaid-eligible (8,464 DCF-related children out of 11,760).¹¹³ DCF children not eligible for federally-subsidized Medicaid receive state-funded benefits that are administered in the exactly the same way as the federally-funded benefits. The only difference is that the Department of

¹⁰⁹ DCF, *Spending Plan for the Period 10/1/2003-9/30/2004, Education and Training Voucher Program and Independent Living Program*.

¹¹⁰ *Id.*

¹¹¹ Section 17a-6(e) of the Connecticut General Statutes states that the Commissioner of DCF must "insure that all children under the commissioner's supervision have adequate food, clothing, shelter and adequate medical, dental, psychiatric, psychological, social, religious and other services." There is also a state and federal constitutional obligation for the state to provide adequate health care to persons in its custody.

¹¹² Overall enrollment in HUSKY has increased dramatically over the last three years, from 239,829 enrollees in HUSKY A/Medicaid on July 1, 2001 to 303,404 enrollees on June 1, 2004. HUSKY B enrollment (Connecticut's SCHIP program) has grown from about 8,500 enrollees to 14,571 over the same period.

¹¹³ Throughout the period from June 2000 through May 2001, there were *at least* 8,300 child and youth in DCF care and custody receiving Medicaid benefits. As discussed in this report, most children in DCF care and custody are in the Medicaid coverage groups D01 and D02. These are the children who are eligible for Medicaid because they are eligible for Title IV-E foster care or adoption assistance. However, there are other children in DCF care and custody who also are eligible for Medicaid under the poverty-related financial eligibility criteria who are included in the F25 coverage group. As of December 2002, the identities of these DCF children could only be determined through manual review of the enrollment data for children in the F25 coverage group to determine if a DCF worker was listed as an authorized representative of the child. Children's Health Council, *Independent Assessment of Connecticut's HUSKY A Program: Access and Quality of Care for Children with Special Health Care Needs* (December 2002).

Social Services (DSS) does not receive federal reimbursement for the cost of the services the ineligible children receive.

1. HUSKY A Eligibility. Children in the care and custody of DCF are eligible for federally-subsidized Medicaid/HUSKY A through several eligibility pathways:

- *Children Eligible for Title IV-E Payments.* All children eligible for Title IV-E foster care payments are automatically eligible for Medicaid. As noted earlier in this report, children are financially eligible for IV-E payments if their family would have been eligible for cash assistance under the AFDC rules in place in 1996.¹¹⁴
- *Non-Title IV-E Foster Care Children.* Connecticut also provides HUSKY A to all children receiving *state-funded* foster care payments whose family income would have met AFDC income and resource standards, but who would not have been eligible for AFDC because of eligibility factors other than income and resources. For example, a child who lived with *both* parents (rather than a *single* parent) would not be eligible for AFDC even if the family met AFDC income and resource standards. This child, however, *could* receive Medicaid under this category if the child was removed from his home by DCF. Under the federal Medicaid statute, this is an optional coverage group that Connecticut has chosen to include in its Medicaid program.
- *Children with Family Income Below 185% of the Federal Poverty Level.* The de-linking of Medicaid eligibility from AFDC eligibility and Connecticut's expansion of Medicaid eligibility to children in families with income above the cash assistance level has made it easier for children in foster care to get Medicaid. Most children in foster care who do not meet the former AFDC income and resource rules are eligible under the "poverty-related" coverage group that provides HUSKY A coverage to all children up to age 19 in families with income below 185% of the federal poverty level (\$28,990 per year for a family of 3). Resources are not considered in determining eligibility and the income of the child's family of origin is not counted after one month.
- *Low-income 19 and 20 year olds.* Under the AFDC rules used to determine IV-E eligibility, 18-year olds in DCF care are eligible only if they will complete secondary school by the time they reach age 19. While the higher income level for HUSKY A/Medicaid applies until children reach age 19, it is likely that not all of the children in the IV-E coverage group will transition to this other coverage group at age 18 as they should because of limitations in the eligibility management system used by DSS. Further, although young adults up to the age of 21 are categorically eligible for Medicaid, the financial eligibility levels for 19 and 20 year olds are considerably

¹¹⁴ As noted earlier, in Connecticut, as in most other states, these standards are well below the federal poverty level. For a family of three, Connecticut's AFDC payment standard is \$543 per month. Also as discussed earlier, children in DCF's care and custody can be ineligible for IV-E payments for reasons other than income. In March 2004, about 53% of children were determined to be Title IV-E eligible, 16% were ineligible because of family income, and the remaining 31% were ineligible for other reasons.

below those for children under 19.¹¹⁵ Thus, some 19 and 20-year olds are not eligible for federally-funded Medicaid benefits, because their income or resources exceed these eligibility levels.

- *Children in DCF-Subsidized Adoptions.* Children receiving an adoption subsidy from DCF are automatically covered by Medicaid/HUSKY. The state can claim federal reimbursement for those children who are Medicaid-eligible.

State-funded Medicaid/HUSKY. Connecticut provides *state-funded* Medicaid/HUSKY A coverage to DCF children and children in DCF subsidized adoptions who are not eligible for federally-funded Medicaid benefits. Importantly, because HUSKY A now has a higher income eligibility level and the income of the child's family of origin is excluded from eligibility consideration after one month, *most* of the children under 19 in the state-funded category are ineligible for federally-funded benefits for reasons *other than* their income and resources. The primary factors that could disqualify a Connecticut child in DCF care from federally-funded Medicaid benefits are immigration status and placement in certain state institutions such as detention facilities.¹¹⁶

During 2003, Connecticut provided state-funded Medicaid benefits to about 3,300 children each month. As of March 2004, 3,296 DCF children were on state-funded HUSKY A/Medicaid (about 28% of all DCF children). Importantly, most of these children were not disqualified from federally-funded benefits because of their immigration status or placement, but because DCF fails to make application on their behalf in a timely fashion to determine eligibility for federally funded benefits,¹¹⁷ or because they had turned 18 years of age. Almost all these children *could be* provided with federally funded Medicaid benefits through fairly simple changes in policy and procedures.

For example, when a child first comes into the care of DCF, the child receives state-funded benefits while eligibility for federally funded Medicaid coverage is being determined.¹¹⁸ Because the vast majority of children in DCF care are eligible for Medicaid, policies and procedures that could assure timely application and speed up the eligibility determination process could increase federal reimbursement to the state. Two of the options proposed are to station a DSS worker at DCF to determine eligibility and

¹¹⁵ Currently, the monthly income eligibility standard for these 19 and 20-year olds is \$476 a month and the young adult cannot have countable resources that exceed \$1600 in value. While young adults up to the age of 23 can remain in the Independent Living program, under federal Medicaid rules, categorical eligibility for Medicaid ends at age 21 unless the individual is eligible as the parent of an eligible child.

¹¹⁶ In general, federally funded Medicaid benefits not available for most legal immigrants who have been in the country less than five years and for any undocumented immigrants.

¹¹⁷ While Medicaid allows retroactive reimbursement (for up to three months from date of application) for care provided to a child determined to be Medicaid-eligible, delays in filing applications for Medicaid (or failure to file applications at all) can result in reduced reimbursements.

¹¹⁸ DCF caseworkers provide information to a special unit at DCF that completes HUSKY applications for the children and mails them to the regional DSS offices. Once at DSS, the application can take up to 45 days and sometimes longer to be acted on.

to designate DCF a “qualified entity” able to provide immediate, temporary Medicaid eligibility to children entering DCF care.¹¹⁹

In addition, currently *state-funded* HUSKY benefits are provided to the young adults who remain in DCF care past their 18th birthday under its Independent Living program who have income or resources above the very low eligibility levels that would make them otherwise eligible for Medicaid. However, these youth *could* be eligible for federally funded Medicaid under the Foster Care Independence Act of 1999.

This Act established a Medicaid option that would allow a state to provide Medicaid coverage to all children in foster care on their 18th birthday until they reach the age of 21. By taking advantage of this federal option, Connecticut could receive federal reimbursement for HUSKY A/Medicaid benefits provided to almost all of the young adults between 18 and 21 who are currently in DCF care and custody. In addition, young adults who leave foster care at age 18 *or any time before they turn 21* could also receive federally-subsidized HUSKY A coverage through this pathway to eligibility.¹²⁰ Currently, these young adults are only eligible once they turn 19 if they meet the strict income and resource limitations applicable to 19 and 20-year olds.¹²¹ States choosing this option can set their own income and resource levels, or can choose to disregard income and resources in determining eligibility.

2. HUSKY A/Medicaid’s Role in Financing Services to Children in DCF Custody. The Medicaid program provides federal matching funds for state expenditures

¹¹⁹ Steps have been taken in this direction. While a position for a DSS worker at DCF who could determine eligibility has been approved, it has not been filled. Also, before the elimination of presumptive eligibility in 2003, DSS and DCF were considering having DCF be designated as a “qualified entity” able to provide immediate, temporary Medicaid eligibility to children entering DCF care while their eligibility was being processed by DSS. Should presumptive eligibility be restored, streamlining the eligibility process in this way for children in the care of DCF would increase federal reimbursement. One of DSS’ FY 06 budget options would allow DCF to “grant F25 medical cases,” i.e., determine Medicaid eligibility for the coverage group of children and youth from families with income below 185% of the federal poverty level.

¹²⁰ This option could help offset *some* of the costs for behavioral health services now being provided to young adults by the Department of Mental Health and Addiction Services through its Young Adult Services (YAS) program. The number of youth being referred by DCF to DMHAS as they “age out” of DCF has increased substantially since 1997. DMHAS is finding that these youth have significant behavioral health needs, often after years of residential placements and psychiatric hospitalizations. In the first quarter of 2004 also there were 59 referrals from DCF to DMHAS (or an estimated 236 referrals in a full year if the same pace continued). This compares to a total of 99 referrals from DCF to DMHAS in all of FY 2003. Because it is in the state’s interest to encourage these youth to earn income when possible, this option would provide a means to continue federally-subsidized health care without requiring the youth to be destitute to receive it. Importantly, DMHAS is also reporting an increase in referrals of clients aged 18 to 25 from other sources (e.g., schools, jails, hospitals, and family/self). In SFY 2002, DMHAS served 3,622 clients this age. In FY 2003, this increased to 4,244. DMHAS has reported in the Community Mental Health Services Block grant plan that it anticipates 5,000 unduplicated young adults aged 18-25 in 2005.

¹²¹ It is hard to know how many youth this change would affect. The coverage group in which they would be currently has about 3,200 members now, although not all of these youth are or were DCF-related. However, the youth in this coverage group *now* are the ones who would have met Medicaid’s strict income and asset rules for 19 and 20 year olds. By comparison, the Medicaid option under the Foster Care Independence Act would allow Connecticut to set its own income and resource levels (or choose to disregard income and resources) in determining eligibility for the subset of youth who are aging out of foster care.

on behalf of eligible individuals. Connecticut's matching rate is 50 percent, so the state receives fifty cents for every dollar it spends to provide health care services to children in the program. However, federal matching funds are not available for expenditures on behalf of the children in state-funded HUSKY.

a. Managed care. Since 1995, Connecticut has provided health care services to children and families through its Medicaid managed care program, known as HUSKY A. Children in the care of DCF were enrolled in the Medicaid managed care program beginning in 1996, and almost all these children now receive health care services through the four managed care organizations that participate in the HUSKY A managed care program.

The health plans in Connecticut's program receive a monthly capitation fee to provide all health care services to enrollees.¹²² The rates vary by health plan, age, sex, and county of residence but are not adjusted for health status. Capitation rates for SFY 2004, averaged across all counties and health plans, are \$616.91 per month for infants under one year of age, \$113.70 per month for children aged one to fourteen, and \$142.70 per month for male youth and men aged 15-39 and \$237.03 per month for female youth and women aged 15-39. By comparison, in SFY 2002 the capitation rates paid to the largest health plan ranged from \$500.03 per month to \$675.11 per month for infants under one (depending on the county of residence) and from \$95.39 to \$122.45 per month for one to fourteen year olds.

b. The broad, but unfulfilled, protections of EPSDT. The federal Medicaid statute includes special provisions designed to ensure that children (defined as individuals up to age 21) receive the services they need to stay healthy. This special program is known as the Early and Periodic, Screening, Diagnosis and Treatment program (EPSDT). The EPSDT program is designed to ensure that children in state Medicaid programs receive regular and comprehensive well-child examinations and all medically necessary diagnostic and treatment services. All medically necessary services that can be covered under Medicaid must be provided to children regardless of whether the state has chosen to provide the particular service for adults and without any restrictions on the amount, duration or scope of services. The definition of medical necessity is broad, and includes "health care provided to correct or diminish the adverse effect of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from happening."¹²³ Because of the breadth of this Medicaid benefit package for children, the program *should be* covering *all* the health and mental health care services children in DCF care need.

c. The unrealized opportunity to claim federal funding for certain state-funded services. In addition, Medicaid benefit categories such as rehabilitation services and targeted case management provide states with the opportunity to receive federal matching funds for

¹²² The only services currently not included are services provided as part of a child's Birth-to-Three or special education plan. Note, however, that there are plans to "carve out" of HUSKY managed care dental and behavioral health services.

¹²³ Section 17b-262-673 of the regulations of Connecticut State Agencies.

certain services that currently are being provided with only state funds.¹²⁴ For example, a 2000 report to the Connecticut General Assembly from the Department of Social Services identified at least \$15 million in children's behavioral health services that could be submitted for federal reimbursement under Medicaid, primarily by including specified state-funded services in Connecticut's state Medicaid plan under the "rehabilitation services" category."¹²⁵

In addition, according to a report prepared by Mercer Consulting to determine the cost neutrality of the Behavioral Health Partnership (which would have integrated behavioral health services provided through DSS, DCF, and the Department of Mental Health and Addiction Services), DCF spent over \$77 million on residential treatment and inpatient and outpatient psychiatric services on behalf of children in HUSKY. About \$22 million of this amount was spent on children in state-funded HUSKY A. While not all of these expenditures could be covered under federally-subsidized HUSKY A/Medicaid, substantial potential for increasing federal reimbursement clearly exists, particularly through the rehabilitation services category of services.

Importantly, Connecticut's state Medicaid plan already includes services included in Birth-to-Three and special education service plans, as well as some services provided by psychiatric clinics and private non-medical institutions (PNMI) under contract with DCF. Following the 2000 report, Connecticut started planning to expand the range of services included under the rehabilitation services option, but no final action has been taken.¹²⁶

3. What Health Services Do Children in the Care of DCF Receive? In January 2002, the Children's Health Council released a report that examined the health care services provided to most of the children in the care of DCF during 2000 and 2001. The report described the services provided to children in two Medicaid coverage groups: D01 and D02. The D01 coverage group includes children eligible for Medicaid under

¹²⁴ See R. Bess et al, *The Cost of Protecting Vulnerable Children III: What Factors Affect States' Fiscal Decisions?* (The Urban Institute Occasional Paper Number 61), pp. 22-23, for a discussion of the increased use of Medicaid financing for services previously claimed for reimbursement under Title IV-E or services that are currently state funded.

¹²⁵ Rehabilitation services "include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." 42 CFR §440.130(d). For example, New York covers a wide variety of community mental health services for children under its Medicaid clinic and rehabilitation options. Among the rehabilitation services covered are school-based day treatment, other day treatment, therapeutic pre-school, therapeutic foster care, and independent living skills training. C. Koyanagi & R. Semansky, *Assessing Child Mental Health Services in New York: A Report on Three Focus Groups* (Bazelon Center for Mental Health Law, Winter 2003), available at www.bazelon.org.

¹²⁶ Other federal maximization alternatives under Medicaid are home and community-based services waivers and the Katie Beckett pathway to Medicaid eligibility. The later benefits children under age 19 who are disabled, living in a family who is not poor but who cannot afford to keep a child with costly health care needs at home, and who – but for Medicaid eligibility that could fund the home and community-based services necessary to keep the child at home – would be placed in an institution. These, as well as other options mentioned in the text, will be explored in the second issue brief that CT Voices will release early in 2005. A. Schneider, *The Medicaid Resource Book* (The Kaiser Commission on Medicaid and the Uninsured)(July 2002), p. 99.

the stricter eligibility requirements of IV-E, and D02 includes children in state-funded Medicaid. Both coverage groups also include children in subsidized adoptions as well as those in DCF foster care. The report does not include services provided to children in the higher-income poverty-related coverage group. Currently there is no simple way to identify these children and separately monitor their care even though federal regulations require that states monitor the care provided to all children in foster care when the children are enrolled in mandatory managed care programs.¹²⁷

The Children's Health Council report found that children in DCF care were more likely than other children in HUSKY A to have timely well-child care and preventive dental care. Substantial improvements in the rates of well-child care occurred when DCF began using health care advocates to monitor the provision of care.¹²⁸ The children in DCF custody also were significantly more likely to have had emergency care or to have been hospitalized for behavioral health care. Specifically, in a one-year period, children in DCF care were at seven times greater risk for being hospitalized for behavioral health care. Length of stay was longer and discharges were far more likely to be followed by readmissions. These findings are consistent with the 2000 DSS report that found that children in DCF custody are 5 percent of the children in HUSKY A, but account for 60 percent of the HUSKY A behavioral health expenditures.

4. The Wastefulness of Connecticut's Spending on Reinsurance. Soon after children in the care of DCF were enrolled in the Medicaid managed care program, issues arose concerning discharge of children from psychiatric hospitals. The Medicaid managed care organizations often determined that a child was no longer in need of inpatient treatment, but DCF had no appropriate placement to which the child could be moved. The first DSS contract contained a provision known as "Appendix K," which required the health plans to pay for up to 7 business days of care after the planned discharge date when no placement could be found. After the seven days, the health plans could refuse to pay and the hospitals often were not paid for extended stays.

However, since September 1998, the discharge issue has been addressed through reinsurance. Under the current contract between the health plans and DSS, the health plans are fully responsible for the first fifteen days of care at both the acute and sub-acute levels. From day 16 to day 45, the state assumes 75% of the cost of care; from day 46 to day 60, the state pays 90%; and after 60 days, the state is fully responsible for the care that is provided to the child.

The reinsurance program is extremely costly to Connecticut. In 2002, DSS made over \$23 million in reinsurance payments to the managed care organizations. These payments were *in addition to* the monthly capitation payments the health plans already had been paid to provide needed behavioral health care to enrolled children. During the first half of

¹²⁷ It is likely that the 2000 DSS report that described the utilization of behavioral health services also included some children in subsidized adoptions and did not include some children in the care of DCF, and for the same reasons.

¹²⁸ However, in the last quarter of 2001, the rate of timely well-child care was slightly lower for DCF children than the rate for other children in HUSKY A. This reversal was apparently due to staff turnover among DCF health care advocates, as well as procedural changes that meant that the health advocates were no longer responsible for monitoring well-child care.

2003, the payments totaled over \$12 million, the same amount that was projected for *all* of 2000. In 2002, the amount of reinsurance payments that were made to the managed care organizations represented 46% of *all* the health plans' behavioral health expenditures, and in the first half of 2003, the reinsurance payments were 42% of behavioral health expenditures. The Mercer analysis prepared for the Behavioral Health Partnership found that in 2001 the average length of stay for a child enrolled in one of the HUSKY managed care organizations was 38.03 days and the average cost was \$513.14 per day. In projecting costs forward, Mercer projected the average annual cost per user would be \$22,067 for SFY 2004 and \$23,171 for SFY 2005.

DCF reports each month on the number of children receiving inpatient psychiatric services. While these reports have been issued on a monthly basis since October 1999, the reporting format changed in 2002, making it difficult to compare the content of the reports. Until 2001, DCF reported on the monthly census, including information on the number of children in acute care and sub-acute care and the average length of stay for each group. The census information for Riverview Hospital was reported separately:

	April 2000	April 2001
Acute census	34	27
Average length of stay (acute)	50 days	65 days
Sub-acute census	48	32
Average length of stay (sub-acute)	83 days	133 days
Riverview acute census	51	59
Riverview average length of stay (acute)	148 days	157 days
Riverview sub-acute census	38	37
Riverview average length of stay (sub-acute)	232 days	237 days

Beginning in 2002, the reports are based on the number of monthly discharges and the child's status as acute or sub-acute is reported only at admission and not at discharge. Therefore, almost all the children are included in the acute category. In addition, information for Riverview Hospital is no longer included in the reports.

	April 2002	April 2003	April 2004
Total discharges	43	80	46
Average length of stay of discharged children	31 days	27 days	27 days

The data for Riverview Hospital is especially important as it certainly contributes to the overall cost of the reinsurance program. According to a report by the Connecticut Office of the Public Auditors for SFY 2001, over \$7 million was billed to Medicaid for the care of children at Riverview at a per diem rate of \$1,036.76. It is not clear from the auditor's report how much of this was paid by the managed care organizations and how much was ultimately billed back to the state by the health plans as reinsurance.

Importantly, Connecticut's costly reinsurance program is a great disincentive to providing appropriate community-based services to children. While it absolves the

managed care organizations and the mental health care providers of having to pay for care at a level of acuity that is no longer needed, it also removes any incentives that the health plans and hospitals had previously to find community-based placements for the children when the need for in-patient hospitalization was over. Instead, children remain in the hospital longer than they need to be, taking beds that are then not available to other children who need care in the hospital.

The fact that Connecticut is now spending tens of millions of dollars on reinsurance – i.e., on essentially paying *twice* for behavioral health care – also means there is less funding available for the home and community-based services that could help address the underlying problem of gridlock in the system. With substantial state funding going toward this clinically-inappropriate care, funding to develop more appropriate placements and services is lacking.

Finally, the cost of the reinsurance program to the state is compounded by the number of children inappropriately placed in state-funded Medicaid. Reinsurance payments for care provided to these children are being paid *solely* with state dollars without any federal reimbursement.

D. The Temporary Assistance to Needy Families Block Grant

1. The TANF Block Grant: An Overview. In 1996, the federal Temporary Assistance for Needy Families (TANF) block grant replaced the Aid to Families with Dependent Children (AFDC) and several related programs.¹²⁹ Each state's TANF block grant was set at the largest total yearly amount received from the federal government during the fiscal year 1992-1995 time period for AFDC (benefits, child care, and administration), Emergency Assistance to Needy Families (EA), and the Job Opportunities and Basic Skills Training Program (JOBS).

Connecticut receives \$266.8 million in federal funds through the TANF block grant each year. In addition, Connecticut has been awarded TANF High Performance Bonus Funds for multiple years. In FFY 04, Connecticut was awarded \$11.745 million in such bonus funds,¹³⁰ for a total of \$278.5 million in TANF-related federal funds. Federal TANF funds that are not spent in one fiscal year may be spent in subsequent years, but any such carry-forward funds may be used only for cash assistance and related administrative expenses.

¹²⁹ AFDC was an entitlement program under which Connecticut was reimbursed 50% of the costs of providing cash assistance payments to low-income eligible families. There was no time limit placed on receipt of these cash assistance benefits, so long as there was an eligible child under age 18 in the household.

¹³⁰ These funds were appropriated by the General Assembly to be spent in SFY 2005 and 2006 on the child care certificate program (\$4 million in SFY 05), family supportive housing (\$0.69 million in each year), enhanced job entry initiatives (\$0.58 million in each year), transitional rental subsidies (\$0.72 million in FY 05 and \$0.4 million in FY 06), as well as lesser amounts on other welfare-to-work related programs and services (including \$0.4 million for a child care apprentices program). Connecticut General Assembly, Office of Fiscal Analysis, *Connecticut State Budget 2003-2005 Revisions*, p. 254.

a. *CT's "maintenance of effort" (MOE) requirement.* To receive its full allotment, Connecticut must meet a maintenance of effort (MOE) requirement by spending 75% of the state funds it had spent in FFY 1994 for AFDC, EA, JOBS, and AFDC-related child care.¹³¹ Connecticut's current MOE requirement is \$183.4 million. Expenditures of state funds count toward the MOE requirement only if they are used for cash assistance, child care, education activities for TANF recipients, administrative costs, and other activities that further the goals of the TANF program.

b. *Allowable uses of TANF block grant funds.* Connecticut may use federal TANF block grant funds "in any manner reasonably calculated" to promote any one or more of the four stated purposes of TANF:

- To provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives;
- To end the dependence of needy parents on government benefits by promoting job preparation, work and marriage;
- To prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and
- To encourage the formation and maintenance of two-parent families.

Spending for the first two goals must be for the benefit of needy families but spending on the third and fourth goals can be on behalf of all families (including those who are not needy). States may also use the block grant for other activities in which they were previously engaged under AFDC, Emergency Assistance (EA), or the Job Opportunities and Basic Skills (JOBS) program regardless of whether these activities are directed at the four purposes of the TANF block grant that replaced these programs.

In addition, states may make limited transfers of TANF funds (totaling 30%) to the Child Care Development Fund (CCDF) and the Social Services Block Grant (SSBG)(with the transfer to SSBG no more than 10%), or the Job Access Transportation Grant. To date, Connecticut has not transferred TANF funds to the CCDF, but only to the SSBG: \$5.97 million in FFY 1997, \$23.8 million in FFY 1998, \$24.1 million in FFY 1999, \$24.4 million in FFY 2000, and \$26.7 million since FFY 2001.

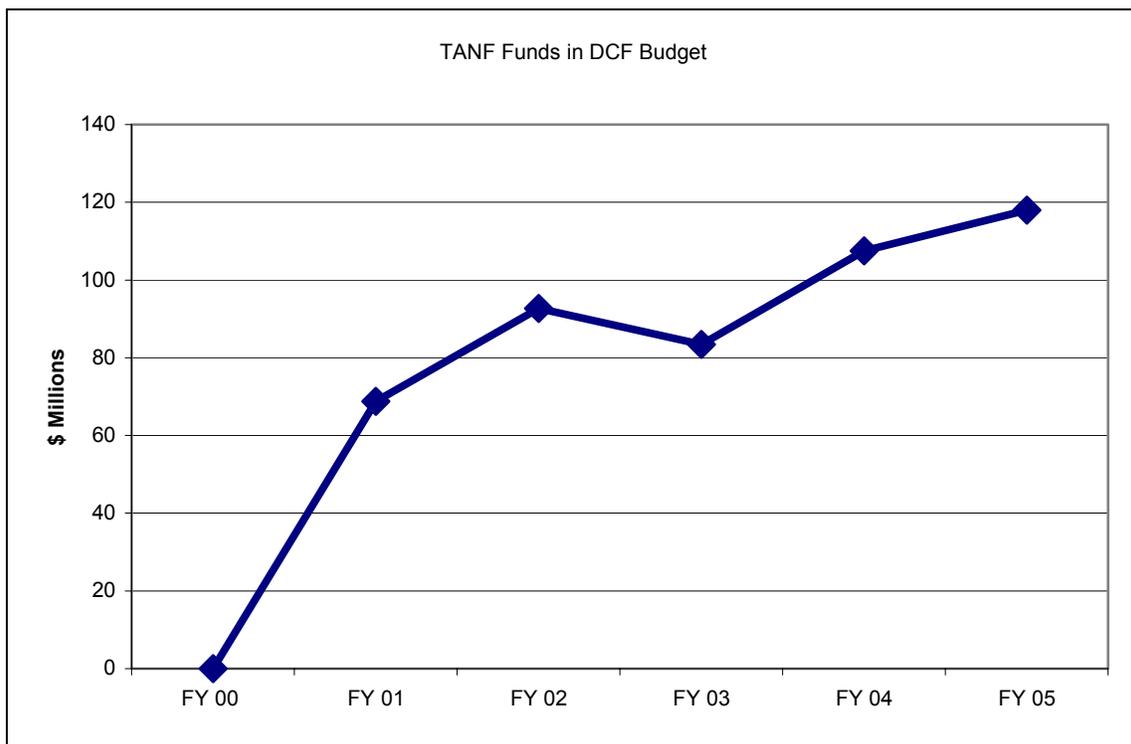
2. Connecticut's Increasing Use Of TANF Block Grant Funds For Child Welfare Purposes. Prior to FFY 1999, no more than \$16 million of Title IV-A/TANF funds were included in DCF's budget in any given year (and in some years, *no* such funds were used). Since 2001, however, this has markedly changed. Though TANF funds are ultimately claimed and deposited in the General Fund by the Department of Social Services, they have become an increasingly significant part of DCF's budget.

¹³¹ Connecticut need only spend 75% of its historic (FFY 94) spending because it is meeting (and indeed has met for each year of the grant) the work participation rate for active TANF recipients. If it were not meeting the work participation rates it would be required to spend a minimum of 80% of its historic spending—or \$195.6 million.

In SFY 2001, DSS claimed \$68.813 million, and in SFY 2002 \$92.687 million, in TANF funds to offset costs incurred by DCF.¹³² DCF's *Annual Summary of Child and Family Services* (CFS-101) proposes to use \$118.0 million of TANF funds in the DCF budget in FFY 2005 for DCF child welfare-related costs (as compared to \$83.4 million in FFY 2003 and \$107.5 million in FFY 2004). DCF proposes to use these \$118.0 million in TANF funds for protective services (\$107.0 million), crisis intervention/family preservation services (\$5.0 million) and foster care (\$6.0 million).¹³³

Importantly, over the past several years the *actual* amount of TANF funds used in DCF's budget has tended to exceed the amount projected in DCF's *Annual Summary of Child and Family Services* spending plan.¹³⁴ In FFY 2003, for example, over \$113.7 million of TANF funds were spent on various of DCF's programs and services (\$20 million more than the \$83.4 million proposed in that year's federal spending plan).

Growth in the use of TANF funds in DCF's budget¹³⁵ is illustrated in the following chart:



¹³² State of Connecticut, *Auditors' Report, Department of Children and Families for the Fiscal Years Ended June 30, 2001 and 2002* (March, 2004), p. 5. Note, however, that as of June 2003, DCF reported the actual receipt of \$105.2 million in Title IV-A/TANF funds in FFY 2002 and estimated \$107.5 million in such funds in FFY 2004. DCF, *FFY '04 Title IV-E, Title IV-A/TANF and Title XIX Projections* (prepared June 10, 2003).

¹³³ DCF, *Annual Survey of Child and Family Services for FFY October 04 to September 30, 2005*.

¹³⁴ DCF's *Annual Summary of Child and Family Services* for FFY 2000, 2001, and 2002 proposed the use of *no* TANF funds, yet as noted in the text DSS claimed \$68.8 million in TANF in SFY 2001 and \$92.7 million in SFY 02 to offset costs incurred by DCF for various child welfare related services.

¹³⁵ This chart does not include TANF funds transferred to the SSBG that are then used by DCF for residential treatment.

A clear trend is emerging. Increasingly, TANF funds are being diverted from funding the programs and services that help families on welfare and in low-wage jobs achieve economic self-sufficiency to various of the programs, services, and staffing needs at DCF. In addition, TANF funds are becoming an increasingly significant part of DCF's budget. In FFY 2004, for example, the TANF funds spent on DCF programs and services represented 41% of Connecticut's total TANF block grant. Importantly, these TANF funds also represented 19.4% of DCF's total SFY 03 budget – or nearly \$1 in every \$5 spent by DCF.¹³⁶

A likely consequence of this shift is that children living in families unable to meet their basic needs will be referred to DCF for services. That is, help increasingly will be provided only when families reach crisis and children are placed at significant risk of harm. In addition, our child welfare system will become increasingly vulnerable to any cuts in federal TANF funding (which increasingly are likely as the federal deficit soars).

3. DCF's Uses Of TANF Funds. The following table shows the DCF programs and services that were funded (in whole or part) with TANF funds in FFY 2003:

FFY 2003 TANF Federal Funds Used for DCF Programs and Services, (by ACF-196 Financial Report Expenditure Categories)	
TANF Funds Awarded	\$278,533,139
Transferred to SSBG	\$26,678,810
Net Available TANF Grant	\$251,854,329
EXPENDITURE CATEGORIES	
Expenditures on Assistance	
Line 5d. Assistance Authorized Solely Under Prior Law	
-DCF Months 5-12 foster care	1,585,243
Expenditures on Non-Assistance	
Line 6h. To Prevent Out-of-Wedlock Pregnancy	
-DCF Early Childhood Development	2,111,683
Line 6j. Administration	
-DCF Case Management Services Admin/Investigation Admin	10,593,818
Line 6l. Authorized Under Prior Law –Emergency Assistance for Families (EAF)	
-DCF Case Mgmt Services Prior Law EAF	10,162,315
-DCF Family Preservation Prior Law EAF	1,217,487
-DCF EA Foster Care & Residential Treatment	2,713,804
-DCF Foster Care Non-Claimable Balance-claimable under TANF	1,781,687
Line 6m. Other	
-DCF Case Management Services Other	40,085,407
-DCF Substance Abuse Screening	494,883
-DCF Treatment & Prevention of Child Abuse	4,068,491
-DCF Family Preservation Services	3,342,391
-DCF Substance Abuse Services	774,840

¹³⁶ Note that this presentation to the General Assembly reported that 46% of TANF funds in FY 04 went to DCF. L. Voghel, Director, Division of Fiscal Analysis, Department of Social Services, *Temporary Assistance to Needy Families (TANF) Expenditure Report* (April 2, 2004).

-DCF Local Systems of Care	365,556
-DCF Community Emergency Services	81,499
-DCF Family Violence Services	286,189
-DCF Early Childhood Development	406,788
-DCF Support for Recovering Families	2,609,161
-DCF Individualized Family Supports	102,595
-DCF Intensive In-home Services	3,688,174
-DCF Investigations	27,192,350
Total DCF	113,664,361
DCF spending as % of total TANF grant	41%
DCF spending as % of net TANF grant (after transfer to SSBG)	45%
Source: Department of Social Services, <i>Temporary Assistance for Needy Families Expenditure Report to Co-Chairs of Human Services and Appropriations Committees</i> (January 22, 2004)	

Nearly \$16 million of these child welfare and child protection services (including foster care, residential treatment and some case management services), were claimed under the explicit statutory authorization to use TANF block grant funds for activities that had been funded through the state's former Emergency Assistance (EA) program. Interestingly, however, Connecticut spent only \$3.94 million in Emergency Assistance funds on such services in the last year of this program (1996).¹³⁷

Also, \$60.8 million in TANF funds are allocated to DCF case management and an additional \$27.2 million for DCF investigations – a total of more than \$88 million of the \$113.7 million or more than three-quarters of the TANF funds (77%). The nexus between these expenses and TANF's explicit purposes appears attenuated, particularly given that a number of programs and services more directly related to the TANF purposes (e.g., Care4Kids child care subsidies, job training) have had their funding reduced over this same period. Other DCF services and activities to be funded with TANF funds (e.g., treatment and prevention of child abuse, family preservation services, individual family support, and substance abuse services) have a closer nexus to the TANF goal of "providing assistance to needy families so that children may be cared for in their own homes or in the homes of relatives."

Beyond the TANF expenditures for DCF noted on the table above, some additional TANF funds have fairly consistently been spent on DCF residential treatment, but as part of the TANF funds that are transferred to the Social Services Block Grant. In FFY 05, for example, \$3,209,614 of TANF funds in addition to those listed in the table above are allocated for DCF residential treatment. DCF receives these funds from DSS through the Social Services Block grant. The funds received, however, are from the \$26.7 million in TANF funds that were transferred to the SSBG.¹³⁸

¹³⁷ See Child Welfare League of America, National Data Analysis System, *TANF vs. Emergency Assistance Funding for Years 1996 and 1998*.

¹³⁸ Connecticut General Assembly, Office of Fiscal Analysis, *Connecticut State Budget 2003-2005 Revisions*, p. 260.

V. **Careening Toward Crisis: How Federal Funding Constraints and State Budget Decisions Are Working At Cross Purposes to What Is in Many Children's Best Interests**

State and federal spending on child welfare services *should* support the development of a system of services that furthers best practices in child welfare, meets all requirements of federal and state law, and serves the best interests of children and families. This includes working to ensure that children are maintained with family whenever possible and are placed in the least restrictive, most family-like setting when this is not possible. Currently, that is not the case. Federal funding constraints and state budget choices have converged to produce two particularly troublesome trends:

- *Forcing families to crisis.* There has been a reduction in the share of total child welfare funding that is being provided for services that would help keep children safe and in their own families, resulting in families being forced to crisis before the state intervenes to provide help (e.g., increased use of TANF funds for DCF case management, residential care, and other programs and services for children already reported as abused or neglected, rather than for supporting and stabilizing at risk and poor families *before* a referral to DCF needs to be made; reductions in funding for child abuse and neglect prevention);
- *Increased spending on out-of-home placements.* Connecticut has had a steady increase in spending on out-of-home placements, but static or reduced spending on home and community-based services. Also, in Connecticut, growth in spending on out-of-home placements has favored more restrictive, institutional settings; growth in spending on residential treatment has far exceeded growth in spending on foster family care for children who must be removed from their families.

This section briefly summarizes trends in child welfare financing in Connecticut and examines how federal funding constraints and state budget choices have resulted in a DCF budget that, in many respects, has been allocating its resources at cross-purposes to what is known to be best practice in child welfare. The second policy brief on this subject, to be released by CT Voices early in 2005, will examine ways to change this course, through changes in federal law, by taking advantage of existing federal options including federal waivers of existing law, and through changes in state policy and different state budget choices.

A. **Troublesome Trend #1: Forcing Families to Crisis**

1. **Federal Funding for Services to Avert DCF Involvement and Placements into Foster Care Lag Funding for Out-of-Home Placements.** As discussed earlier in this report, federal funding for programs and services targeted at reducing child abuse and neglect and averting out-of-home placements has been extremely modest. The significant growth in federal funding has been in Title IV-E reimbursements to reimburse Connecticut for board and care expenses for children placed out-of-home.

Specifically, Connecticut's Title IV-B, part 1 funds have remained at about \$2 million/year since at least 1989, and DCF uses these funds primarily for DCF staff salaries at the Connecticut Children's Place. Title IV-B, part 2 funds increased from about \$1.067 million in FFY 1996 to \$3.452 million in FFY 2004 (modest growth after adjusting for inflation). Over the period FFY 1996-FFY 2005, federal funds under the Child Abuse Prevention and Treatment Act (CAPTA) have ranged from a low of \$0.26 million (FFY 2001) to a high of \$0.3 million (FFY 1997). Funding in Connecticut from all other federal funding sources for prevention and support, protective services, and pre-placement prevention has ranged from a low of \$0.9 million (FFY 1999) to a high of \$3.7 million (FFY 2004), but has averaged just over \$1 million/year.¹³⁹

By comparison, Connecticut's federal Title IV-E funding, available only when children have been removed from their homes, increased from \$26.4 million in SFY 1994 to \$116.5 million in SFY 2000, declining modestly since then (\$95.3 million in SFY 02 and a projected \$92.1 million in SFY 05).

2. Increasing Disparity Between DCF Funding for Out-of-Home Placements and for the Programs and Services That Can Avert or Reduce Such Placements.

Connecticut's spending over the past decade has mirrored this national trend of increased federal funding for out-of-home care (through Title IV-E) yet static (and inadequate) investment in programs and services to avert out-of-home placements or reduce their duration (through Title IV-B, CAPTA, TANF and other federal funding streams).

As the following table illustrates, DCF's investments in "front-end" services that can reduce the need for out-of-home placements and reduce the length of time a child needs to be in state care remained relatively constant over the 1990s (after adjusting for inflation), despite increasing caseloads. By comparison, DCF spending on residential treatment soared, and spending on foster care also increased substantially.

Importantly, in the past several years there has been an infusion of some new funds into some "front end" services at DCF, such as KidCare and "emergency needs."¹⁴⁰ However, the total amount of new funds appropriated remains far less than the growth in spending on out-of-home care and – even more troubling -- there has been some re-allocation of existing funds for DCF's "front end" services toward the back end.

For example, the revised SFY 05 budget cuts funding by 24% to both DCF's Family Preservations Services account and the Community-Based Prevention Programs account to help fund a new DCF "Family Support Services" account that is to provide funds for "enhanced support for the families of children returning home from residential treatment or prolonged hospitalizations." The Community-Based Prevention Programs account has funded such programs as Parent Education and Support Centers (which

¹³⁹ DCF, *CFS-101, Annual Summary of Child and Family Services, State of Connecticut, for FFY October 04 to September 30, 2005*

¹⁴⁰ There also has been a modest increase (from \$4.6 million in SFY 01 to \$6.1 million in SFY 05) in funding for the Children's Trust Fund (formerly a part of DCF, but now separate). The Trust Fund's Nurturing Families program is a highly successful child abuse prevention program that is incrementally being expanded statewide.

provided parenting programs, parent support groups, and other services to help reduce child abuse and neglect), early childhood programs, and Family Support Centers. As a result of this re-allocation, DCF is now cutting funds to many of these “front-end” programs.

DCF Spending: FY 94 -FY 05				
(in millions)				
	FY 93-94	FY 97-98	FY 01-02	FY 04-05
	(actual)	(actual)	(actual)	(approp.)
Bd & Care-Residential Treatment	46.92	61.969	130.074	149.320
Bd & Care-Foster Care	23.13	63.289	73.935	87.986
Child Guidance Clinics	9.446	10.172	12.704	12.679
Day Treatment	2.007	4.441	5.453	5.340
Child Abuse/Neglect Intervention	3.304	5.041	5.528	5.319
Community Based Prevention	3.074	2.439	2.662	2.969
Substance Abuse Treatment	1.367	1.586	2.599	3.825
Support for Recovering Families	0	0	1.760	4.418
Family Preservation Services	4.056	5.683	6.492	4.933
Individualized Family Supports	0	0	4.802	7.110
Community KidCare ¹⁴¹	0	0	6.367	13.363
Family Support Services	0	0	0	10.292
Emergency Needs	0	0	0	0.95

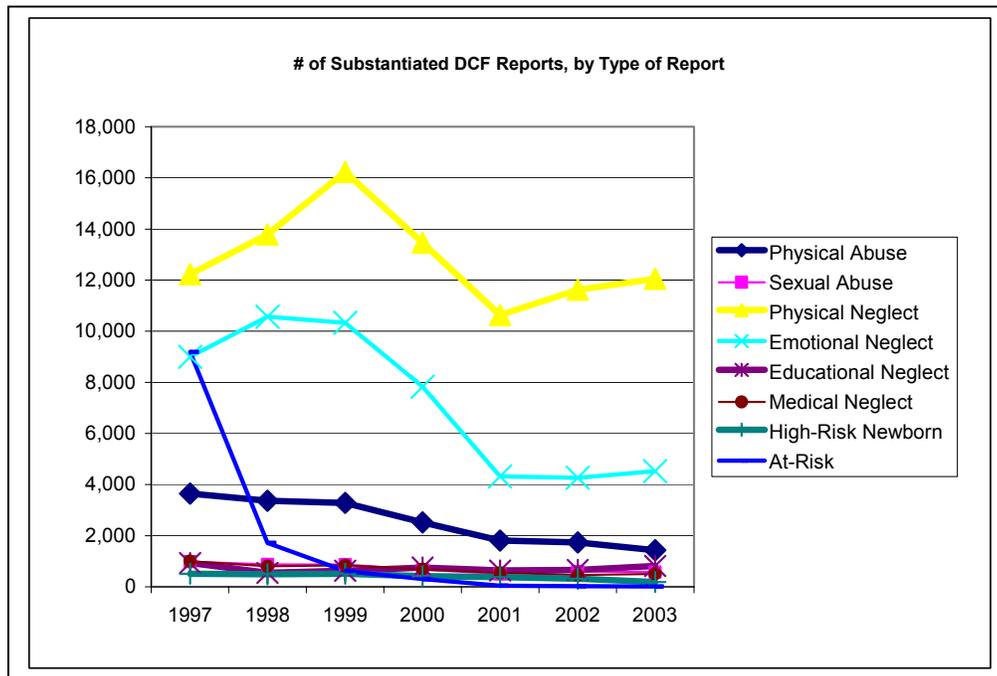
3. Increasing Amounts of TANF Funds in the DCF Budget. As discussed earlier, DCF's budget is relying increasingly on funds from the TANF block grant. Currently, nearly more than 4 in 10 of all Connecticut's TANF dollars are being used by DCF, rather than being directed to help families on cash assistance, in low-wage jobs, or living in poverty meet their families' essential needs for housing, child care, job training, cash assistance, food, utilities and other necessities *before a referral to DCF needs to be made*. Because TANF funds are finite – since unlike the old AFDC program federal funds do not increase as need increases – the diversion of these resources to balance DCF's budget means that there are less funds available to help families avoid DCF involvement in the first instance.

The following chart shows trends in substantiated child abuse and neglect reports in Connecticut. Two points merit explicit mention:

- *Substantiated "at risk" reports have fallen precipitously.* This is a direct result of the passage of PA 96-246 that changed the standard for reporting to DCF (and substantiation by DCF) of children who are "at risk." Specifically, the standard narrowed from children who are "in danger of being abused or neglected" to children who are "placed at imminent risk of serious harm." In response to this statutory change, DCF amended its policy. Investigators could no longer substantiate a report if they had reasonable cause to believe that children were in situations that *could* cause harm, but only when injury or harm was very likely to occur in the near future because of direction action or inaction of a parent or guardian. In short, children and families have to be much closer to crisis for DCF to provide services to help.

¹⁴¹ Community KidCare is DCF's evolving initiative to expand community mental health services for children and youth.

- *Physical neglect reports are on the rise.* Substantiated reports of physical neglect, the most common of all DCF child maltreatment reports, began increasing again in 2001, concurrent with the shift of increasing amounts of TANF funds into the DCF budget and Connecticut’s deficit (which resulted in spending cuts to many services that support our most at risk families). By comparison, over this period reports of substantiated physical abuse have declined, and reports of sexual abuse remained relatively constant.



4. DCF as Connecticut’s New Safety Net for Families Struggling to Make Ends Meet. With elimination of cash assistance as an entitlement, and recent funding cuts to various programs and services that serve our poorest families, the adequacy of Connecticut’s “safety net” for children living in poverty is in serious doubt. Recently, DCF has been provided with two pools of flexible funding to avert placements of children into out-of-home care. Recent evaluations of the uses of these funds suggest that DCF increasingly is becoming that safety net.

The first evaluation examined the use of about \$1 million of flexible funds to avert the voluntary placement of children with severe behavioral health problems into DCF.¹⁴² The second evaluated the use of about the same amount of flexible funds by DCF protective service workers to help keep families intact, place a child with a relative, reunify families, and preserve placements.¹⁴³

¹⁴² K. Mika, *Flexible Funding for Non-DCF Children Requiring Behavioral Health Supports* (Connecticut Community Mental Health Strategy Board, May 2004).

¹⁴³ Juan F. Court Monitor’s Office, *The Overwhelming Majority of Flex Funds are Used to Meet Essential Needs of DCF Clients: The Findings of the Juan F. Court Monitor’s Office Regarding the Use of Flex Funds Expended April-August 2004* (October 2004).

In both cases, a significant proportion of the flex funds were used to meet families' basic subsistence needs. *Nearly a third* of the flexible funds that were to be used for home and community-based services to avert the voluntary placement of children with behavioral health needs into DCF were used for housing, security deposits, utilities, groceries, clothing, furniture, appliances, and transportation. The remaining funds provided services that were more clinical in nature (e.g., medical, assessment, therapy, behavior management, respite, mentoring, recreation services).

Similarly, "flexible" funds made available to DCF social workers were used for food, utilities, emergency shelter, rent to avoid eviction, security deposits, furniture (e.g., a bed to take in an extra child), heat and utility bills, day care, transportation, and phone bills, as well as to address unmet medical and dental needs and provide counseling. Workers reported that these funds provided a much needed resource in instances of service gaps, wait lists, and immediate client need that could not be addressed with the existing limited resources in the community. Of particular concern was the finding that DSS was *denying* families help with daycare, utility bills and housing costs *based on the availability* of the DCF flex funding. In particular, the use of flex funding for day care was more common than "just a few isolated instances." In fact, flexible funds were used for family basic needs in *half* the investigation cases reviewed, with the evaluation noting that the flex funds were used for "ameliorating poverty issues impacting the homes." The evaluation included as one of its recommendations that the Interagency Task Force look at the "responsibility of all state agencies and clarify roles to ensure that the safety net is in place to support DCF involved clients in providing safe and nurturing environments for their children."¹⁴⁴

5. Forcing Families to Crisis. In sum, Connecticut's own budget choices, coupled with skewed federal funding support, are working at cross-purposes to what is best for children and families. Connecticut is diverting funds from DSS to DCF that *should* be used to support at risk, and low-income families and *avert* referrals to DCF. In addition, rather than helping early -- when problems are new, small, and less difficult and costly to address -- DCF is pushing families to crisis before it intervenes to help. It then also spends the bulk of its resources on keeping children in out-of-home placements rather than providing the home and community-based services that would avert such placements.

Connecticut is not unique.

A 1997 study funded by the United States Department of Health and Human Services (HHS) compared the number of children receiving child welfare services in 1977 to those receiving such services in 1994 (just prior to full implementation of the Promoting Safe and Stable Families program). The study found a significant decline in the number of children receiving child welfare services -- from an estimated 1.8 million children in 1977 to an estimated 1 million children in 1994. This overall decline was attributed to a

¹⁴⁴ Juan F. Court Monitor's Office, *The Overwhelming Majority of Flex Funds are Used to Meet Essential Needs of DCF Clients: The Findings of the Juan F. Court Monitor's Office Regarding the Use of Flex Funds Expended April-August 2004* (October 2004), p. 17.

sharp drop in the number of children receiving services while still living at home, since roughly the same number of children were in foster care (543,000 in 1977 and 502,000 in 1994). The study also reported a substantial increase in the proportion of children receiving services as a result of parental abuse or neglect (45% in 1977 compared to 80% in 1994). The report concluded that child welfare agencies were dealing with more difficult cases requiring more intensive services in 1994, and therefore had narrowed their focus from protecting a broader population of children to assisting children and families in more immediate crisis.¹⁴⁵

Connecticut's exclusion of many "at risk" cases from DCF's services as of 1996 has had a similar result. DCF opens cases now only when there is documented abuse or neglect or a child is at in imminent risk of serious harm. While services *could* be provided to "at risk" children without DCF opening a case (e.g., through foster care diversion programs), it becomes increasingly difficult to fund such services as TANF funds are moved into DCF's budget. In addition, with relatively few resources to help keep children safe with their families, DCF quickly turns to out-of-home placements (including more institutional residential care). Were Connecticut to re-direct its TANF funds to support its most at risk families, be provided with additional federal funding to serve "at risk" children and families (or with additional flexibility to use existing federal funds for that purpose), and/or devote additional state funds to help at risk children and families, it *could* intervene earlier to help these children and families when the human and financial costs of intervention are far less.

B. Troublesome Trend #2: Increased Spending on Out-of-Home Placements

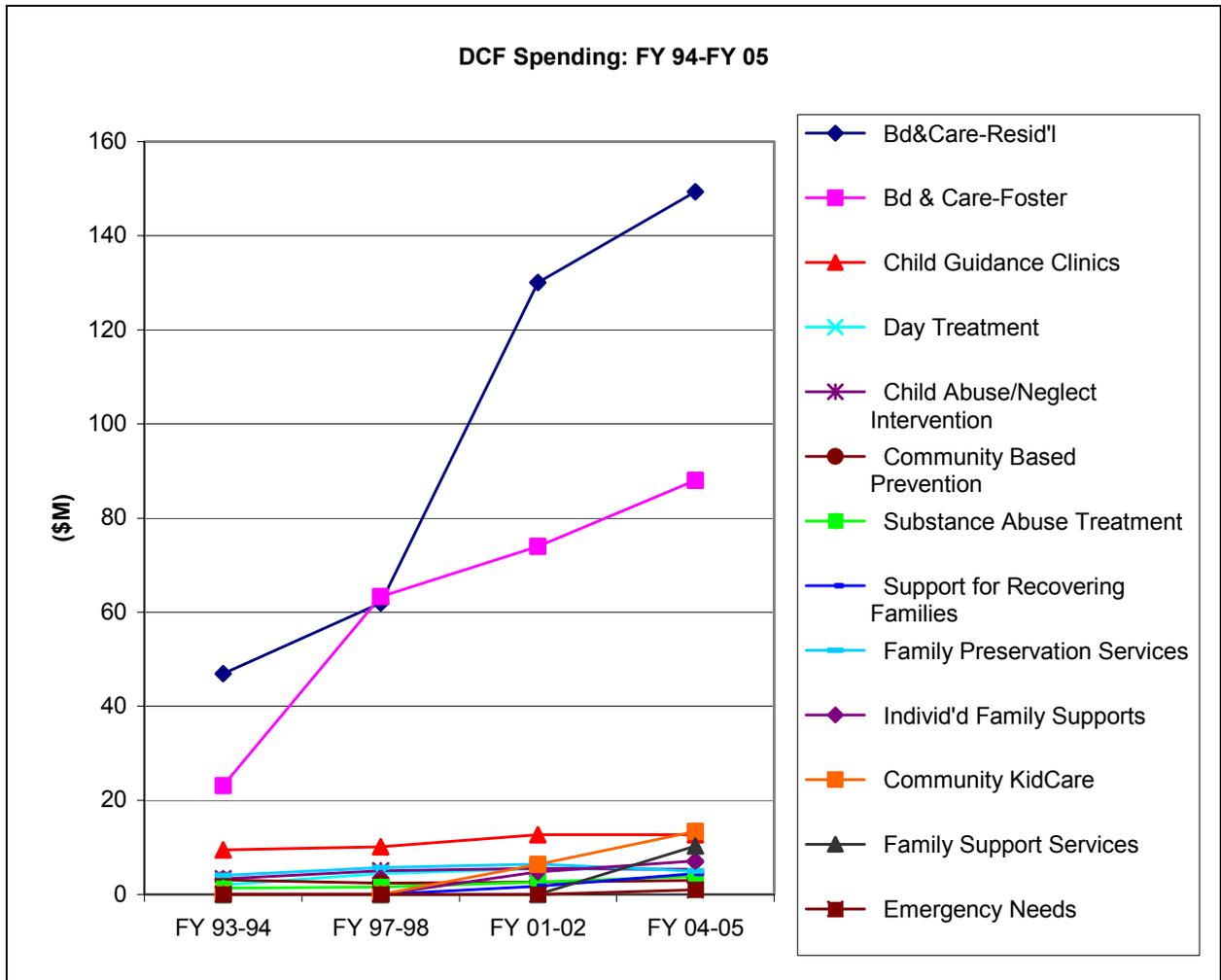
Related to the preceding trend is Connecticut's markedly increased spending on out-of-home placements, and particularly on placements in residential treatment and other institutional care.

As noted earlier in this report, DCF caseloads have increased over the last decade. Many in the field also report that the needs of children in DCF care have grown more severe. Notably, however, the growth in the number of children and youth in residential care (942 children on June 30, 1994 to 1,167 children on June 30, 2004, a 24% increase) is much less than the growth in DCF's spending on residential treatment (\$46.9 million in SFY 94 to \$149.3 million in SFY 04, a 218% increase).¹⁴⁶

Moreover, as the following chart graphically illustrates, DCF's spending on out-of-home placements generally has far exceeded growth in spending on the various DCF programs and services that could help avert such placements:

¹⁴⁵ Committee on Ways and Means, U.S. House of Representatives, *2004 Green Book*, p. 11-11. Note that this study preceded the very significant federal and state welfare reform initiatives that began in the mid-1990s.

¹⁴⁶ Data about the average length of stay and occupancy rates in each of these two years may help explain some of this difference, but likely not all of it.



1. State Factors Contributing to Increased “Back End” Funding at DCF. A number of factors -- *other than* the clinical needs of the children and youth in care – are contributing DCF’s increased spending at the “back end” – for in-patient, residential, and foster care.

First, as illustrated in the following chart, the annual cost for a child to stay in an in-patient facility or a residential treatment program far exceeds the annual cost of the comprehensive home and community-based services that might allow a child to remain in a less restrictive, more family-like, out-of-home placement. For example, for the cost of maintaining a child at DCF’s Riverview Hospital for a year (\$492,000/child), DCF could provide in-home therapy services to 65 children for a year (\$7,500/child).

Because Connecticut has not invested in building a comprehensive continuum of home and community-based services, DCF ends up placing children in these more restrictive, *and costly*, placements. Some even have claimed that it is *because* Connecticut is so wealthy that it could afford to place so many children out of their homes, rather than being forced to find community-based solutions that were less costly. Moreover, now that Connecticut has many agencies providing residential treatment, with fixed costs

associated with operating their facilities, there is significant political pressure opposing any efforts to “close” beds and move children back to their homes and communities.

A Sampling of Costs of State-Funded Programs and Services	
	Cost Per Year, Per Bed/Child ¹⁴⁷
DCF-Riverview Hospital ¹⁴⁸	\$492,020
DCF-High Meadows	\$456,615
DCF-CT Children’s Place	\$339,450
DCF-CT Juvenile Training School	\$325,215
DCF-Funded Private Residential Treatment	
High: Wellspring	\$123,560
Stonington Institute	\$112,610
Low: APT Foundation/Alpha House	\$40,898
New Hope Manor	\$38,504
After-School Extended Day Treatment	\$32,000
Special Needs Day Care	\$31,200
Head Start with Parent Partnering	\$10,630
Intensive Case Management	\$9,600
Multi-systemic Therapy	\$6,800
Home Visiting for At-Risk Children (by nurses)	\$6,200
Intensive In-Home Child & Family Therapy	\$7,500
Medication and Monitoring	\$6,000
Home Visiting for At-Risk Children (by trained paraprofessionals)	\$3,200
Supportive Case Management	\$3,200
Average Cash Assistance Grant under Temporary Family Assistance for a family of 3	\$6,500/year/family of 3 (2004)
Sources: DCF facility per capita costs (as of July, 2003) are from <i>Letter from Office of the State Comptroller to Commissioner of Department of Administrative Services</i> (July 17, 2003). Other cost data is from Office of the Child Advocate & Attorney General of Connecticut, <i>The Cost of Failure</i> (2003), pp.18-21.	

Second, state law guarantees Connecticut’s private residential treatment facilities a cost-based rate of reimbursement [Conn. Gen. Stat. §17a-17(b)]. Thus, as the facilities’ costs of operation increase, so too does the rate they are paid by DCF. By comparison, there is no cost-based reimbursement for home- and community-based services (such as child guidance clinics, family preservation services, family support programs). Indeed, rate increases for such services over the last decade have not kept pace even with inflation, further limiting the capacity of this part of the service sector.

¹⁴⁷ NOTE: There may be some federal reimbursement for certain of the health-related and foster care-related costs shown on this table, including through Medicaid and Title IV-E of the Social Security Act. Costs shown are for FY 03 unless otherwise noted.

¹⁴⁸ DCF per capita costs are as of July, 2003. *Letter from Office of the State Comptroller to Commissioner of Department of Administrative Services* (July 17, 2003).

Third, it is well understood that if Connecticut is to conform its child welfare practice to what is required by professional best practice and federal and state law it needs to expand its continuum of home and community-based services. Despite this common understanding, however, Connecticut squandered an important opportunity in the late 1990s to markedly ramp up these services using state General Fund surplus funds.¹⁴⁹ Had Connecticut built “front-end” capacity in these years, it would now be far easier to move children and youth out of more restrictive settings and maintain children with their families.¹⁵⁰

2. The Impact of Current Federal Funding Constraints on Connecticut’s Efforts to Improve Its Child Welfare System. Critically important to this analysis is the impact of federal child welfare financing constraints.

Connecticut receives 50% reimbursement for the costs of a foster child’s out-of-home board and care costs (assuming the child is Title IV-E eligible) but does *not* receive such reimbursement for the service costs associated with keeping a child in his home (or returning the child to his home). Federal financing rules, therefore, essentially “reward” DCF for making out-of-home placements by providing it with matching federal funds. However, if DCF successfully averts a placement, or moves a child back home, it not only fails to receive federal matching funds for the services the child may then need in her home, but also *loses* the federal matching funds it had been provided when the child was in foster care.

Further, because federal “front-end” funding – through Title IV-B, CAPTA, and some of the other federal funding programs – has grown slowly, if at all, the federal government contributes relatively little through these funding streams to states’ efforts to keep children in their homes, or move them to permanency through these other federal funding streams.

In short, current federal funding requirements create a perverse incentive, making it more financially advantageous for states to place children out of home than to provide services to keep families together. As two child welfare experts note:

The federal foster care program provides open-ended funding for the room and board of certain eligible children in foster care, but only very limited funding for

¹⁴⁹ Like the time when the polio vaccine was developed and governments found themselves briefly paying both for the costs of the vaccine to prevent future cases and also the costs for the care of those who had developed polio, some period of “double” funding is necessary in Connecticut to build capacity among providers of home and community-based services before children can be moved out of residential and in-patient care into less restrictive placements. Rather than make this “double” investment when the state had large budget surpluses, the decision was made to reduce taxes. One contrasting example of Connecticut taking advantage of state surplus funds was the creation of the Community Mental Health Strategic Investment Fund, which seeded a number of initiatives to improve community-based mental health services.

¹⁵⁰ Were Connecticut to have a robust continuum of services and reduce the gridlock in the existing system of services, it also could reduce the extraordinary amount of funds it is spending on re-insurance for children stuck in hospital in-patient settings for want of a less restrictive, clinically-appropriate placement.

the development of alternative services for abused and neglected children and their families, both before a child must be placed in foster care or after a child returns home following placement. As a result, out-of-home care is often the easiest option for workers besieged with large caseloads and few other resources. Moreover, because funding under the federal foster care program is generally restricted to room and board, it is often difficult to give even those children placed in foster care the services and treatment they need.

M. Allen & M. Bissell, "Safety and Stability for Foster Children: The Policy Context" in *Children, Families, and Foster Care* (The David and Lucile Packard Foundation, *The Future of Children*, 14(1), 2004), p. 63.

As one comprehensive study of these funding trends concluded:

Policymakers, researchers, and advocates have all criticized the existing federal child welfare financing structure as being inflexible and too heavily focused on out-of-home placement at the expense of prevention. The federal system is not in alignment with the goals of protecting children and providing stable, permanent placements. The largest funding stream targeted for child welfare, title IV-E, provides an open-ended reimbursement to the states for costs associated with the out-of-home placement of eligible children, while title IV-B, the federal funding stream for prevention and family preservation services, is capped.

On the basis of the current financing structure, many have argued that states have little financial incentive to move children out of foster care into more permanent placements. When states achieve the desired goal of permanency for a child, the savings of removing that child from foster care are returned to the federal government, rather than remaining with the state.

R. Bess, et al, *The Cost of Protecting Vulnerable Children II: What Has Changed since 1996?* (The Urban Institute, *Assessing the New Federalism Occasional Paper* February 1, 2001), p. 25.

Indeed, as DCF strives to meet Juan F. outcome measures and more foster care placements are prevented, time in care is reduced, utilization of residential treatment is cut, and re-entries into care decline, DCF's "reward" will be a reduction in its federal reimbursements. As one expert explained:

As it now stands, the harder child welfare providers try to reduce foster care utilization from current levels – either by lowering admission rates (placement prevention), reducing time in care (earlier permanency for children), utilizing less-restrictive settings, or lowering the rate of reentry – the less federal revenue will be available to provide services, even if the changes in service utilization are predicated on the judgments of professionals who choose alternatives to foster care as a way to meet client needs....Without a permanent solution to this structural dilemma, the federal government's financial commitment to foster

children will diminish over time, as states successfully meet federal reunification standards.

F. Wulczyn, *Family Reunification*, in *Children, Families, and Foster Care* (The David and Lucile Packard Foundation, *The Future of Children*, 14(1), 2004), p. 63.

VI. Conclusion

Perverse federal funding incentives, coupled with some imprudent state budget choices, are resulting in DCF, as well as the children and families it is to serve, careening toward crisis. Connecticut's budget invests far too little in the home and community-based services that can prevent child abuse and neglect in the first instance, and then also avert out-of-home placements once a child is referred to DCF. Instead, families are helped primarily when crises erupt, children are harmed, and the problems have become more difficult and costly to address.

Connecticut has a number of options if it wants to reverse this current course. Some involve changes in existing state policy and budget choices. Others involve taking advantage of existing flexibility in federal funding rules, while others involve advocating for fundamental change in federal funding restrictions. These options will be explored in a second issue brief, to be released by CT Voices early in 2005.

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