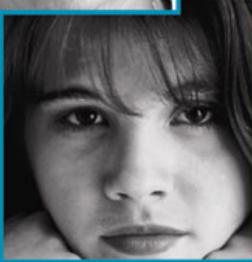


CONNECTICUT
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Moving Away from Crisis?

Alternatives in Financing Child Welfare Services in Connecticut

Shelley Geballe, JD, MPH
Sharon Langer, JD

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New Haven Office
33 Whitney Ave.
New Haven CT 06510
Phone: 203.498.4240
Fax: 203.498.4242

Hartford Office
60 Gillett St. Suite 204
Hartford CT 06105
Phone: 860.548.1661
Fax: 860.548.1783

Web Site: www.ctkidslink.org
E-mail: voices@ctkidslink.org

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I. INTRODUCTION

*Careening Toward Crisis: State and Federal Funding of Child Welfare Services in Connecticut*¹ (Connecticut Voices for Children, 2005) documented how Connecticut's current funding of child welfare-related services forces families, as well as Connecticut's Department of Children and Families (DCF), toward crisis. Our current allocation of TANF, Title IV-B and IV-E, Medicaid, and other federal and state funds fails to adequately support children and families who are at-risk until they hit crisis. Additionally, when DCF decides it is necessary to remove children from their homes because of parental abuse or neglect it relies excessively on more expensive out-of-home and institutional placements than on comprehensive home- and community-based services that could help maintain children safely in their families and communities.

While one reason for this crisis stems from imprudent state budget choices. Another is rigid federal financing rules that "stifle innovation and severely restrict spending federal dollars on services that could help reduce the number of children in foster care."² Other causes for this crisis result from Connecticut's failure to take full advantage of what flexibility *does* exist in current federal financing rules for Title IV-E and Medicaid. Indeed, since at least the late 1980's and most recently in March of this year, the executive and legislative branches have sought guidance from inside and outside state government on how to better serve at-risk, neglected, and abused children through greater claiming of federal dollars.³

This report, the second in this two-part series, explores *some* of the financing options that are available to Connecticut to create a more cost-effective, child- and family-supportive child welfare system. It also highlights proposals by the Pew Commission on Children in Foster Care to reform federal funding rules so that the federal government can be a more effective partner in this effort.

II. MEDICAID STRATEGIES

Current Medicaid law authorizes a variety of strategies that would enable Connecticut to increase federal Medicaid matching funds for child welfare services. Some have been adopted by DCF and the Department of Social Services (DSS, Connecticut's lead Medicaid agency), while others have not yet been embraced. Several of these suggestions were recommended by OFA in 2003, as well as by others over the past fifteen years.⁴

¹ S. Geballe & J. Solomon, *Careening Toward Crisis: State and Federal Funding of Child Welfare Services in Connecticut* (Connecticut Voices for Children, 2005) ("*Careening*"), available at: www.ctkidslink.org.

² J. McDonald, N. Salyers, & M. Shaver, *The Foster Care Straitjacket: Innovation, Federal Financing & Accountability in State Foster Care Reform* (Fostering Results, March 2004), available at: www.fosteringresults.org.

³ S. Geballe & J. Solomon, *Careening* at p. 11. On March 8, 2005, the General Assembly's appropriations and finance committees held a joint informational hearing to learn about ways to maximize federal revenue. At this hearing, the Office of Fiscal Analysis (OFA) distributed a fact sheet about federal revenue maximization and its 2003 memorandum on the same subject: Office of Fiscal Analysis, *Federal Revenue Maximization* (May 27, 2003).

⁴ S. Geballe & J. Solomon, *Careening*, at p. 11.

A. Medicaid, In Brief

Currently, the DCF budget includes about \$23 million in appropriated and claimed Medicaid reimbursement primarily for treatment services for children and youth living in group or institutional care.⁵ This amount does *not* include the Medicaid funding provided through the Department of Social Services' (DSS) budget for health and mental health services for children and youth under DCF jurisdiction who are enrolled in Medicaid (HUSKY A).

For every dollar that Connecticut spends on Medicaid, the state receives 50 cents back from the federal government. Medicaid is a mandatory (i.e., entitlement) program. This means that so long as an individual is eligible for Medicaid and the service is covered under the program, the state will receive federal financial participation ("FFP") at the designated match rate.

Under federal Medicaid law, children under the age of 21, including those in the care of DCF, are entitled to a broad array of health services through the Early and Periodic, Diagnostic, and Treatment program (EPSDT). EPSDT 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. Although states can choose not to provide certain optional Medicaid services to eligible adults, they must provide all "medically necessary" services to children. The statute's definition of medical necessity is broad. It 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."⁶ EPSDT also requires states to provide outreach and information to eligible families about their child's entitlement to medical and mental health screens to identify any conditions requiring treatment.

B. Strategies for Maximizing Federal Medicaid Reimbursements

Strategies that Connecticut can employ to bring additional federal Medicaid reimbursements into the state fall into four general categories: a) strategies to improve agency coordination and outreach that would maximize current claiming of federal funds; b) strategies that would require amendment of state law and/or state regulations, but would require *no* federal approval; c) strategies that would require amendment of Connecticut's state Medicaid plan and federal approval of that amendment (with corresponding changes in state law and regulation); and d) strategies that would require Connecticut to seek, and successfully secure approval of, a federal waiver of Medicaid rules. Obviously, those that require only state administrative or statutory changes are easier to implement quickly than the other options.

⁵ 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;" and b) \$22.0 million for some services provided by Private Non-Medical Institutions under contract with DCF (group/institutional care).

⁶ S. Geballe & J. Solomon, *Careening*, at p. 52.

1. Require DCF and DSS to expedite enrollment of eligible children and youth in Medicaid to maximize federal claiming⁷

a. Timely processing of Medicaid (HUSKY A) applications. There are steps that DCF and DSS can take right now without the need for state legislative changes or federal approval to make sure that all children within DCF care and custody who are eligible for Medicaid receive it. This involves changing the policy and procedures of the two agencies.

As mentioned in *Careening*, about 28% of all children in DCF care are receiving *state funded* HUSKY. Most often, these children were not receiving federally-reimbursed HUSKY because their applications had not been processed in a timely fashion, or because the children had turned 18 years of age.⁸

Two changes in administrative policies or procedures would assure more timely processing of HUSKY eligibility determinations, and in turn, would increase federal reimbursement to the state: a) stationing a DSS worker at DCF to make the Medicaid eligibility determination; and b) designating DCF a “qualified entity” able to provide immediate, temporary Medicaid eligibility to children entering DCF care if presumptive eligibility⁹ is re-established.

Notably, the Appropriations Committee’s proposed budget for FY 06-07 recommends the addition of 20 staff positions in the DSS regional offices to expedite Medicaid eligibility determinations. The proposed budget also would restore presumptive eligibility in the Medicaid program. These measures are intended to address some of Medicaid eligibility determination process issues identified in the Legislative Program Review and Investigations Committee’s recent report, *Medicaid Eligibility Determination Process*.¹⁰ Both changes would enhance federal claiming.

b. Outreach and enrollment of youth in new coverage groups. DSS recently added two new coverage groups that will enable youth in non-IV-E subsidized adoptions and those aging out of the foster care system at age 18 to maintain access to needed health and mental health care benefits until age 21. (See below for further discussion of the new coverage groups at page 6) To be certain that these young adults receive their HUSKY A health benefits, DCF and DSS must ensure that eligibility information is transmitted in a timely manner from one agency to the other. In

⁷ Although this report focuses on Connecticut’s child welfare population, a significant proportion of the children and youth in Connecticut’s juvenile justice system are on DCF’s protective services caseload. By providing post-adjudication placements in community-based settings, rather than in the Connecticut Juvenile Training School, DCF and DSS can claim Medicaid reimbursement for the significant health and mental health services provided to this very needy population of youth. Federal reimbursement is *not* allowed for otherwise Medicaid-eligible youth if they are “deprived of liberty” (according to a Medicaid Directors letter), i.e., confined in a secure correctional setting such as CJTS or the Judicial Department’s Juvenile Detention Centers. Accordingly, the recent and proposed increases in community-based programs and services for juvenile justice youth, with concurrent diversion from detention and CJTS, also will increase available federal Medicaid reimbursements.

⁸ *Careening*, at p. 50.

⁹ Presumptive eligibility is an administrative procedure for expediting enrollment of children in Medicaid by permitting a “qualified provider” (e.g., a community health center or hospital) to make the initial financial eligibility determination which is followed with a “formal determination” by DSS. A. Schneider, *The Medicaid Resource Book* (The Kaiser Commission on the Uninsured, July 2002), at p. 170.

¹⁰ Connecticut General Assembly, Program Review and Investigations Committee, *Medicaid Eligibility Determination Process* (December 2004), available at: http://www.cga.ct.gov/2004/pridata/Studies/pdf/Medicaid_Final_Report.pdf

addition, there must be education and outreach to DCF workers to be sure that they know which clients are entitled to coverage under the new categories, and outreach to eligible families and young adults so they understand that coverage for needed health care is available now through Medicaid (HUSKY A).

2. Claim federal reimbursement under EPSDT by amending state regulations (without the need for federal approval)

One way to take advantage of federal claiming without the need for federal approval or state legislative change is for DCF and/or DSS to claim services eligible for federal reimbursement under Medicaid's Early Periodic Screening Diagnostic Treatment (EPSDT) program that are not already being claimed under other provisions of Medicaid or IV-E.

To utilize federal claiming under EPSDT, Connecticut would need to pay providers (such as child guidance clinics) on a fee-for-service basis, rather than on a grant-funded basis as is done now. For example, instead of submitting a state plan amendment to the federal government to claim services under the Medicaid rehabilitation ("rehab") option,¹¹ DSS could create fee codes for various rehabilitation services that could be reimbursed under EPSDT and then pay for them on a fee-for-service basis. This would allow providers to bill for a range of home- and community-based services central to the Connecticut Community KidCare ("KidCare") initiative,¹² such as intensive in-home services, therapeutic mentoring and care coordination. To establish clear rules regarding what services would be reimbursed, DSS would need to promulgate a regulation that defines and sets payment rates for each service. As compared to the current grant-based system for child guidance clinics (and others), fee-for-service payment could facilitate a more rapid expansion of services by these providers, as well as greater accountability.

3. File a Medicaid state plan amendment with the federal government and amend state statutes and/or state regulations to expand health coverage to children and youth who have been in the care of DCF

a. To provide Medicaid coverage to children and youth in subsidized adoptions who are not currently Medicaid eligible and to those aging out of the foster care system. Effective October 2004, DSS has added two new

¹¹ 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 Sec. 440.130(d). For further discussion of the Rehab option], see below at p. 7, and S. Geballe & J. Solomon, *Careening*, p. 53.

¹² KidCare is a statewide effort to reform the way children's behavioral health services are coordinated, financed and delivered to children and their families. An initiative that started in October 2000, it is focused in particular on improving the quality and availability of community-based services and supports. DCF states, "KidCare refers to a set of clinical and non-traditional services that address children's mental health needs....In addition to services, KidCare refers to a philosophy that places parents and caregivers at the center of treatment planning activities, and that relies heavily on collaboration between various service systems." (DCF, *Guide to Connecticut Community KidCare*, available at: www.state.ct.us/DCF/RFP/Communities_guide_to_KidCare_011503.pdf). One of the financing reforms proposed through KidCare is a "carve out" of mental health services for families in HUSKY A, children in HUSKY B, and children and youth in the care and custody of DCF, including those receiving voluntary services from DCF. "Carve out" is "[t]he term used informally to describe the exclusion of certain services to which Medicaid beneficiaries are entitled from a risk contract between a state Medicaid agency and a [Managed Care Organization]." A. Schneider, *The Medicaid Resource Book*, p. 165. In Connecticut, the proposed carve out is to be administered by an administrative services organization (ASO).

Medicaid coverage categories for youth and young adults served by DCF. DSS recently received approval of its state plan amendment,¹³ and has promulgated a proposed state regulation¹⁴ that will extend Medicaid coverage to the following two groups of children and youth:

- *Children in non-Title IV-E subsidized adoptions:* These are children whose family income is above a very restrictive income eligibility level dictated by Title IV-E rules.¹⁵
- *Youth who are in the care of DCF and who “age out” of the program (i.e., leave foster care on their eighteenth birthdays).*¹⁶

Both groups of children will remain eligible for Medicaid until their 21st birthday. These regulatory changes will assist in providing critical health care coverage to at risk youth and young adults, while at the same time assisting the state in obtaining federal matching funds.¹⁷

However, as noted above, for these new coverage categories to translate into actual health coverage, DCF and DSS must ensure that eligibility information is transmitted in a timely manner from one agency to the other and expand education and outreach activities to inform families and young adults that coverage for needed health care is available through Medicaid (HUSKY).

b. To cover certain care provided in private non-medical institutions (PNMI). DCF has implemented the suggestion from earlier federal revenue maximization analyses to claim federal reimbursement for the treatment components of certain residential treatment programs or group homes for children in its care. It was anticipated in 1998 that this would reap an additional \$3 million in federal reimbursement. DCF should also be able to cover care provided by the DCF-operated Connecticut Children’s Place and High Meadows under PNMI.¹⁸

c. To cover community services through the rehabilitative services option. The Medicaid rehabilitation services option (Rehab Option) can provide federal reimbursement for a range of community services for children and youth.¹⁹ By utilizing this option, Connecticut can extend in-home and community-based clinical services to children enrolled in Medicaid who are in need of mental health treatment because “[n]early all services” for Medicaid eligible recipients currently funded under KidCare would qualify for up to a 50% federal match.²⁰ If Connecticut receives federal reimbursement for services under the Rehab Option, this new federal money -- along with the savings realized from a reduced reliance on more costly institutional care -- could then be invested in an expansion of community based mental health services.

¹³ Communication with Kevin Loveland, DSS Director of Family Services, March, 2005.

¹⁴ Notice of Intent to Amend Regulation published in the Connecticut Law Journal, Jan. 4, 2005.

¹⁵ Title IV-E income eligibility rules are tied to the former AFDC cash assistance income eligibility limits in effect in 1996. For a more detailed discussion of the coverage categories described in the text, see, S. Geballe & J. Solomon, *Careening*, pp. 49-50.

¹⁶ *Id.*

¹⁷ There are two other potential coverage groups -- for children in the juvenile justice system -- that, according to DSS, can help cover behavioral health needs. E-mail to S. Langer from C. Massicotte, Connecticut Department of Social Services (January 19, 2005)

¹⁸ Conversation with Carl Valentine (March 2005).

¹⁹ See fn. 11 above for the federal Medicaid definition of rehabilitation services.

²⁰ Office of Fiscal Analysis, *Federal Funds Maximization Forum Fact Sheet* (March 8, 2005). For a description of KidCare, see fn. 12.

Past consultants estimated that this option would bring in about \$11.3 million in federal reimbursement without any additional expenditure of state funds.²¹ To do so, it is recommended that the state define in statute or regulation the services that qualify under the Rehab Option and delineate the rate structure for these services.

However, at this time, many experts and state officials²² agree that the state would be wise to forego the Rehab Option because the federal government has been hostile to what it perceives as over-zealous federal claiming for these types of services by the states. There appears to be agreement, however, that the state can legitimately seek federal financial participation for rehabilitation services under the EPSDT program, as suggested above.²³

d. *To cover certain DCF administrative expenses through the Medicaid targeted case management option.* Targeted case management is available to help children who are eligible for Medicaid (which includes most children under DCF care) to obtain access to necessary care and services, and coordinate their access to health, social, and developmental services.

Because DCF currently claims these administrative services under Title IV-E, the agency is receiving less federal reimbursement than it could under Medicaid. This is because only about half of children under the care of DCF are Title IV-E eligible (i.e., IV-E eligibility is tied to the very low income eligibility limit of the former AFDC program in effect in 1996), while a much larger percentage of these children meet the higher Medicaid income limit (family income under 185% of the federal poverty level). By claiming these costs under Medicaid, the state would receive additional federal revenues.

Six years ago a consultant estimated that the state could gain a net \$9.4 million in additional federal revenue under this shift in claiming.²⁴ The anticipated federal reimbursement should be significantly more now since the 1997 estimate was based on 70% of the children in DCF care being IV-E eligible, rather than the half (or so) of children who now are eligible under IV-E.

Vermont, for example, combined the rehabilitation and targeted case management options to provide support services to young adults with mental health needs. Its analysis showed that the state received more money in taxes from the employed young adults in the program than the state paid for the services to them. In addition, Vermont received federal reimbursement for about 42% of total program costs.²⁵

To receive Medicaid matching funds for targeted case management, a state plan amendment would have to be submitted and approved by the federal government. This may not be a viable option at this time since the federal government is not looking favorably on state efforts to claim Medicaid funds for case management where Medicaid and IV-E case management appear to overlap. Therefore, the federal government is not likely to grant the required state plan amendment that would allow this claiming of additional federal funds.

²¹ *Children and Youth Services Federal Options Report* prepared for DCF by MAXIMUS, Oct. 4, 1999.

²² Conversation with David Parrella, DSS Director of Medical Care Administration (April 2005).

²³ See discussion of EPSDT claiming above, p. 6. One difference between the Rehabilitation Option for rehabilitation services for children and claiming these services as covered services under EPSDT is that the option would require DSS to adopt regulations specifying how services are to be provided.

²⁴ *Children and Youth Services Federal Options Report* prepared for DCF by MAXIMUS, Oct. 4, 1999

²⁵ Lt. Governor's Mental Health Cabinet, *Best Practices Work Group Preliminary Recommendations* (October 18, 2004), p. 8.

e. *To provide Medicaid coverage to children with serious mental disorders who are at risk of placement into institutional settings and/or DCF involvement to receive needed services.* The Medicaid programs in twenty states use the Medicaid eligibility option known as TEFRA²⁶ to expand eligibility to certain children with physical and mental disabilities (as defined in SSI regulations)²⁷ so that they can receive home-based services to avoid placement in an institution. Under the TEFRA option, children with serious physical or mental disabilities whose family income exceeds the low eligibility level for Medicaid can nonetheless be covered under Medicaid. To qualify under this Medicaid coverage category, the child must require the level of care that normally would be provided in an institutional setting,²⁸ but *could* be provided while at home with the proper intensive home- and community-based services (thereby avoiding an institutional placement). In addition, the cost of these home- and community-based services may not exceed the cost of institutional care.

The advantages of the TEFRA option for children and families are clear. These are families whose income exceeds Medicaid-eligibility limits, but who lack private health insurance or whose health care plan does not provide sufficient coverage to meet their child's mental health needs, or fails to cover the specific types of services that would be most beneficial to the child (e.g., intensive community-based services). Without help through Medicaid, these families simply cannot afford to pay for their children's specialized needs. Some may incur significant debt, while others may turn to DCF voluntary services for care.²⁹ Some youth may end up in the juvenile justice system if their behaviors, in the absence of treatment, result in such a referral. In short, the TEFRA option provides coverage for the mental health services needed to keep the child at home and out of a more costly institutional placement. There are *no* arbitrary limits on the number of children who may be served under this coverage category.

The advantage to the state is also clear. Without this option, such families will turn to DCF voluntary services program for care and, in the extreme, may feel forced to commit their child to DCF custody to get services.³⁰

²⁶ This option was authorized by the Tax Equity and Financial Responsibility Act of 1982 (TEFRA). It is sometimes called the Katie Beckett option after the child whose situation inspired it. This option was originally a waiver program designed to address the plight of this technology-dependent child who was required to reside in an institution to qualify for Medicaid and receive medical services. Her parents' income exceeded Medicaid guidelines, but was insufficient to meet her health care needs. The program was converted into a Medicaid option, known as the TEFRA 134 option, by section 134 of the Tax Equity and Financial Responsibility Act of 1982 (P.L. 97-248).

²⁷ The Supplemental Security Income program (SSI) is a mandatory federal program that provides cash assistance to low-income aged, blind, or disabled individuals [42 U.S.C. §1381 *et seq.*]. In amendments to the Social Security Act enacted in 1972, Congress created this program to provide cash assistance to low-income elderly and disabled persons. Under current SSI regulations, children under age 18 are defined as disabled when their "physical or mental impairment or combination of impairments...causes marked and severe functional limitations...that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months." If a youth is engaged in "substantial gainful activity" the youth is not considered disabled, notwithstanding the preceding definition of disability. 42 C.F.R. §416.906

²⁸ Under current Medicaid law, all children become eligible for Medicaid after the first 30 days when in institutional placements for treatment. At that time, their family's income and resources are no longer counted and so the child can become financially-eligible for Medicaid.

²⁹ As of January 2005, there were about 1,110 families in DCF voluntary services. E-mail from Mariette McCourt, Medicaid Managed Care Council (February 2005).

³⁰ A Minnesota study of TEFRA found that TEFRA ends up paying only 23% of the total health care costs for children involved with private insurance, schools, and families paying the rest. Bazelon Center for Mental Health Law, *Fact Sheet: States Using TEFRA Option for Children with Serious Mental Disorders*.

Currently, however, Connecticut *cannot choose* the TEFRA option due to federal Medicaid rules that have nothing to do with the merits of the TEFRA option. In most states, eligibility for SSI confers automatic eligibility for Medicaid. However, a minority of states (including Connecticut) chose to use the “209(b)” option that allows them to continue to use their more restrictive eligibility criteria from 1972 (the year in which the SSI program was created).³¹ Among the more restrictive criteria that continue in effect in Connecticut is that *children* with disabilities under age of 18 are not to be considered “disabled individuals.” For the most part, this does not affect low-income children’s eligibility for Medicaid in Connecticut because there are other pathways to Medicaid eligibility (e.g., HUSKY A). However, because Connecticut has chosen to exclude children under the age of 18 from the disabled-related SSI Medicaid coverage category, Connecticut also cannot use the TEFRA option.³²

To be able to take advantage of the TEFRA option, Connecticut would have to forego being a 209(b) state, something DSS officials and policy makers have considered over the years. In light of the prohibition on using the TEFRA option, it may be time for Connecticut to jettison its 209(b) status once and for all.³³ If the TEFRA option were to become available to Connecticut, this coverage category could help children and youth whose families’ incomes exceed Medicaid guidelines to receive needed mental health services and avoid placement with DCF or in institutional settings.³⁴

4. Seek a federal Medicaid waiver to provide appropriate and cost-effective home- and community-based services to children as an alternative to institutionalization

a. What is a federal waiver? Federal waivers provide increased flexibility in how states run their Medicaid programs by permitting states to forego following certain mandates of the federal Medicaid statute and regulations. In exchange for this flexibility the waiver program must be “budget neutral” to the federal government. That is, the cost to the federal purse can be no more than if no waiver were implemented. Essentially, federal budget neutrality means capped federal funding. To achieve federal budget neutrality, states typically must cut optional services or eliminate coverage of optional populations to pay for expanded services or expansion groups, although budget neutrality also can be attained by more cost-effective expenditures of existing funds. Moreover, the waiver process -- which includes an opportunity for public input, state legislative oversight, and the need for federal government approval -- can be very lengthy, taking years to complete.

³¹ When the SSI program was established in 1972, Congress gave states the option of continuing to use their own eligibility criteria in determining Medicaid eligibility for the elderly and disabled, *rather than* extending Medicaid coverage to all individuals who qualify for SSI benefits. As of 1998, eleven states had elected this option (the “209(b)” option to apply their 1972 eligibility criteria to aged or disabled persons receiving SSI benefits for the purposes of determining Medicaid eligibility. A. Schneider, *The Medicaid Resource Book* (The Kaiser Commission on the Uninsured, July 2002), at p. 172. Connecticut was one of these states.

³² Conversation with Allen Bryan, Centers for Medicare and Medicaid Services (CMS), Boston Regional Office (May 2005).

³³ The other major difference between the state’s Medicaid and federal SSI eligibility criteria is related to the asset limits for the two programs. Connecticut’s Medicaid asset limit for the aged, blind and disabled is \$1,600 for an individual and \$2,400 for a couple while the SSI asset limits are \$2,000 and \$3,000, respectively – a negligible difference.

³⁴ For additional information, see Bazelon Center for Mental Health Law, *Avoiding Cruel Choices* (November 2002), available at www.bazelon.org.

For example, Connecticut now is in the process of amending the federal waiver that allows it to provide health services to children and families on Medicaid (HUSKY A) through a managed care program.³⁵ The proposed amendment calls for a “carve out” of mental health services that would then be administered by an Administrative Services Organization (ASO). A portion of the monthly per member per month fees paid to the managed care organizations (MCOs) would be diverted and blended with funding from DCF and the approximately \$28 million in Medicaid funding for children’s psychiatric hospital care through “reinsurance” payments. These reinsurance payments, paid by DSS after a child has been hospitalized for more than a specified period of time, have been *in addition* to the monthly capitation payments the health plans already have been paid to provide needed behavioral health care to enrolled children, and are passed through to the hospitals themselves.³⁶ As noted in *Careening*, this creates a financial disincentive for the hospitals and health plans to move children out of in-patient settings when there is no longer a therapeutic reason for their hospitalization. As a result, these children often languish in hospitals because of the lack of appropriate placements.

The goal of the proposed carve out is to provide a more complete and appropriate continuum of mental health services so children can be served in the least restrictive setting and in the most cost efficient manner. While there remain questions about whether sufficient funding is being allocated to the carve out to reduce the gridlock experienced by children needing intensive behavioral health services, redirecting these costly reinsurance payments to building home and community-based services is a more sensible approach to providing needed care to children in crisis.

b. *Home- and Community-Based Waivers.* Home- and Community-Based Medicaid waivers under Section 1915(c) allow Medicaid to pay for home- and community-based care for children with mental disabilities (as defined in SSI) as an alternatives to institutionalization. The waiver would allow Connecticut to expand the number of children eligible for Medicaid because children may be included regardless of family income if they would otherwise require care in an institution. The waiver would also allow Connecticut to offer these children (and their families) an expanded set of home and community-based services to enable the child to remain at home.

Home and Community Based waiver services can include, for example, case management, homemaker services, home health aides, personal care services, and family respite services. Connecticut currently uses the Katie Beckett Model Waiver to provide medical services at home to children under the age of 19 who would otherwise reside in a medical institution.³⁷ This waiver *could* be used to provide home and community based services also to children with severe mental disorders so they can continue to reside with their families.³⁸

Experience in the three states that have waivers that cover children with mental or emotional disorders show annual costs per child to be quite low: \$12,900 per child for home and community-based services in Kansas (2001), \$23,344 in Vermont (2001), and \$40,000 in New

³⁵ To review the proposed waiver amendment, and comments regarding it, see CT Department of Social Services, *HUSKY A Waiver*, available at: www.dss.state.ct.us/pubs/waiver/.

³⁶ For a more detailed explanation of reinsurance, see S. Geballe & J. Solomon, *Careening*, pp. 54-56.

³⁷ Sec. 1915 of the SSA [42 U.S.C. §1396n]

³⁸ Bazelon Center for Mental Health Law, *Avoiding Cruel Choices* (November 2002), available at www.bazelon.org.

Although forty-nine states have home- and community-based waivers for children with developmental disabilities, only three have such waivers for children with mental or emotional disorders: Kansas, Vermont and New York.

York (2001), as compared to per child institutional costs per year of \$25,600 in Kansas, \$52,988 in Vermont and \$77,429 in New York. Also, since states can limit the number of slots, the waiver can be started with a relatively small state investment. First year costs for the Kansas waiver were \$1 million and New York began by serving 25 children.³⁹

One major impediment to using the model waiver to increase access to needed home and community services for children is the requirement that an individual would otherwise need to be institutionalized in one of the specified types of institutions in the absence of the provision of these services. That is a difficult standard to meet since most children with disabilities are in fact living with families and are not at risk of institutionalization. Moreover, the federal rules regarding these waivers narrowly define the institutions from which the covered child would be discharged or diverted as limited to “hospitals, nursing homes, and Intermediate Care Facilities for Mental Retardation.”⁴⁰ The federal Centers for Medicare and Medicaid Services (CMS) has made it clear that this waiver may *not* be used for children in need of *residential treatment* programs, a far more common locus for care in Connecticut. Connecticut would need to prepare documentation showing that a significant number of children in residential treatment have conditions that require a hospital level of care (even if the child is not in a hospital), and also the costs of such care, for a home- and community-based waiver for children with mental health needs.⁴¹

Currently, Connecticut is authorized to have 200 slots under its Katie Beckett waiver, with 125 of them funded. Notably, the Appropriations Committee’s budget for FY 06-07 would provide DSS with \$2 million more in annual funds to fully fund the 200 slots allowed under our waiver. To add more slots, the waiver would have to be amended.

C. Reasons to Aggressively Claim Federal Medicaid Reimbursement

There are two major reasons Connecticut should energetically pursue additional Medicaid federal reimbursements *now*. The first is that the state needs to address the current services deficit in the FY 06 budget that begins July 1, 2005 that is estimated to be between \$600 million (OFA estimate) and more than \$1 billion (Governor’s estimate). Claiming federal matching funds for services that are wholly state-funded now (e.g., state-funded HUSKY for children under the care of DCF) can free up state dollars for other urgently needed programs that might otherwise be vulnerable to the budget cuts.

The second reason has to do with the federal budget debate now taking place in Congress. To address the surging federal deficit, Congress this year is debating the future of the Medicaid program. There is currently bi-partisan support in the Senate and growing bi-partisan support in the House of Representatives to establish a Commission to study possible reforms to the Medicaid program during the next federal fiscal year. The federal government has been

³⁹ Bazelon Center for Mental Health Law, *Fact Sheet for States Interested in Creating a Home- and Community-Based Waiver for Children with Serious Mental Disorders*, available at www.bazelon.org.

⁴⁰ Bazelon Center for Mental Health Law, *Avoiding Cruel Choices* (November 2002), available at www.bazelon.org. Legislation has been proposed in Congress to include residential treatment centers within the definition of institution under Section 1915(c).

⁴¹ Bazelon Center for Mental Health Law, *Fact Sheet for States Interested in Creating a Home- and Community-Based Waiver for Children with Serious Mental Disorders*, available at www.bazelon.org.

interested in restricting federal funding through such mechanisms as a block grant. If a block grant program were enacted that is similar to the funding structure of the Temporary Assistance to Needy Families block grant, for example, the funding formula for the block grant would be tied to a particular year or years in the past to determine a baseline for the federal block grant. It is in Connecticut's interest then to ensure that the base line funding level is as high as possible to obtain a fair share of federal funds under a block grant.

III. TITLE IV-E STRATEGIES

A. Title IV-E, In Brief.⁴²

Title IV-E of the Social Security Act provides federal reimbursement to Connecticut for foster care assistance, adoption assistance, and independent living services, as well as for associated costs 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 for whom reimbursement is sought 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 and deprived of parental support.

Eligibility for Title IV-E is based in part on family income. DCF can claim reimbursement for assistance only for those children who were removed from a family that *would have been* eligible for the old Aid for Families with Dependent Children (AFDC) program, as that program existed in Connecticut on July 16, 1996. Since the income guidelines have *not* been adjusted upward since 1996, a *declining* share of children referred to DCF will be Title IV-E eligible.⁴³ Currently, a little more than half the children in DCF care (54%) have been determined to be Title IV-E eligible, allowing DCF to claim federal reimbursement for a share of their costs of care.

B. The Federal Financing "Straitjacket"

Federal funding for foster care through Title IV-E originated as a well-intentioned effort to eliminate financial disincentives to removing children from unsuitable homes by placing them temporarily in foster care. By reimbursing Connecticut for 50% of the cost of such placements, the federal government becomes a financial partner in helping to offset the costs of out-of-home placements. It was assumed that other federal funding streams⁴⁴ would be available to reduce the need for removals from home and to shorten the stays in foster care for those children who *had*

⁴² For a more detailed summary of the requirements of Title IV-E and the history of Connecticut's receipt of Title IV-E funds, see S. Geballe & J. Solomon, *Careening Toward Crisis: State and Federal Funding of Child Welfare Services in Connecticut* (Connecticut Voices for Children, 2005), pp. 39-48, available at: www.ctkidslink.org.

⁴³ 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).

⁴⁴ E.g., Title IV-B, Child Abuse Prevention and Treatment Act (CAPTA), Title IV-A/Temporary Assistance for Needy Families, Social Services Block Grant, Medicaid.

to be removed for their safety. Specifically, these other programs were to provide federal financial support for services that could: a) prevent child abuse and neglect; b) maintain many children safely with their families even when such maltreatment occurred; and c) for those children who needed to be removed for their protection, provide supports to the children and families so the removal could be as short as possible and, if return home was not feasible, move the child to an alternative permanent home as quickly as possible.

It all has not worked out quite as expected. In fact, because Title IV-E funding is an unlimited entitlement that grows lock-step with increased out-of-home placements and increased out-of-home care costs, while funding for the non-Title IV-E programs has remained relatively static, federal funding is now essentially *rewarding* out-of-home placements, while undermining efforts to keep children with their families. As the National Governor's Association commented:

The current child welfare financing structure does not support the desired outcomes and goals of the child welfare system. For example, the majority of federal funding for child welfare programs is targeted towards out-of-home care, with a much smaller portion of federal funds focused on services that protect child safety, prevent the need for out-of-home placement, promote family stability or reunification when appropriate, and promote adoption...Although federal funding for foster care assistance through Title IV-E has grown significantly, funding for front-end and preventive services, such as those funded through Title IV-B, has remained stagnant.⁴⁵

The inflexibility in the allowable uses of Title IV-E funding is one key problem. For example:

- A significant number of Connecticut children and youth are placed into foster care *not* on account of parental abuse, but to obtain mental health services that are not otherwise available for the children.⁴⁶ Others are placed for reasons associated with family poverty (e.g., homelessness).⁴⁷ Yet, Title IV-E funds cannot be used to provide services to avert placements for such reasons, *nor* to provide mental health and foster family support services that could reduce placement moves for children once in foster care.
- Although the federal government expects DCF to reduce the length of time a child spends in foster care prior to reunification with a parent, such reunification usually requires that a set of services be provided to the parent to address the problem that caused the removal. Yet Title IV-E funds cannot be used to fund such services. For example, while the United States

⁴⁵ National Governor's Association, *Policy Position: HHS-14, Child Welfare Financing Policy* (adopted Annual Meeting 2000; revised Annual Meeting 2002), available at www.nga.org.

⁴⁶ The children may be uninsured, or under-insured (i.e., the family insurance policy has restrictions on amount, duration or scope of services that are resulting in a delay or denial of necessary care). Indeed, DCF reported to the General Accounting Office that in Fiscal Year 2001, 738 children were placed in Connecticut's child welfare system to obtain mental health services. General Accounting Office, *Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services* (April 2003).

⁴⁷ DCF Deputy Commissioner Stacy Gerber reported at a forum on Education and Housing (held at the Lyceum in March 2005) that 30% or more of children now in DCF custody *could be returned* to their families if the families had adequate housing. Analysis of how funds from DCF's flexible "emergency needs" account have been spent document the extent to which these funds are being used to address issues of family poverty, not parental abuse. 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.

General Accounting Office has found that parental substance abuse (and related issues) is a factor contributing to up to 70% of child welfare interventions nationally,⁴⁸ Title IV-E funds cannot be used to support “activities associated with social services provided to a child, or a child’s family,”⁴⁹ such as substance abuse treatment.

- The federal government also expects DCF to provide children who *cannot* return to their parents with a speedy transition to a permanent home. Yet Title IV-E provides federal financial assistance only if the parent’s rights are terminated and the child is legally adopted, despite compelling evidence that legal guardianship can provide permanency to a child (and is often preferred when the child is in the care of a relative). Connecticut cannot claim federal reimbursement for its highly successful subsidized guardianship program; wholly state funds support this initiative. The other option for kin caregivers, a low monthly child-only benefit through DSS’ Temporary Family Assistance program, often provides too little financial support for legal guardians and those pursuing legal guardianship.⁵⁰
- Although children and youth who have been in foster care are known to have greater health and mental health needs than other children and youth, Title IV-E does not provide federal matching funds for social and health services after these children have been adopted or placed with legal guardians. Because such supports need to be wholly state funded (*unless* the child is eligible for Medicaid and the service is one that is covered by Medicaid), they commonly are not adequate. This creates a disincentive for foster parents and relatives (particularly those providing care for very compromised children) to agree to adoption or a transfer of guardianship, even when that would be in the child’s (and the state’s) best interests.

C. Options to Increase Title IV-E Claiming Under Existing State and Federal Law

Multiple performance evaluations by Connecticut’s Auditors of Public Accounts have examined DCF’s efforts to claim federal reimbursement under Title IV-E for costs associated with our foster care and adoption assistance programs. Most recently, in two separate audit reports (issued October 30, 2002 and April 25, 2003), the Auditors found that Connecticut *could* have claimed substantial additional federal reimbursements under Title IV-E for foster care maintenance payments, adoption subsidy payments, and DCF’s related administrative costs *but for* apparent administrative deficiencies. The auditors found that an additional \$8.18 million could have been claimed in FY 99, and \$6.72 million more in FY 01.⁵¹

The two reports made a series of recommendations to improve administrative procedures to maximize Title IV-E claiming. They were:

⁴⁸ General Accounting Office, *Parental Substance Abuse: Implications for Children, the Child Welfare System, and Foster Care Outcomes* (1997).

⁴⁹ 45 C.F.R. 1356.60 (b)(2).

⁵⁰ Connecticut Department of Social Services, UPM, Sec. 8540.30.

⁵¹ Auditors of Public Accounts, *Auditors’ Report, Department of Children and Families for the Fiscal Years Ended June 30, 2001 and 2002* (March 10, 2004).

- DCF should immediately review court orders to determine whether they contain the proper language concerning “reasonable efforts” so that revisions to the court orders can be made, if necessary and appropriate. DCF should obtain copies of court orders for children placed in its care and file the orders in the child’s case record.
- DCF should obtain court orders for children placed in its care by voluntary placement agreements within 180 days of the agreements and file the orders in the case records.
- DCF should establish procedures to ensure that children placed in its care by the Probate Court can be claimed, if appropriate, for federal reimbursement.
- DCF should review unlicensed homes in a timely manner so that necessary corrections to the foster home licenses can be made, if appropriate.
- DCF should review adoption subsidy payments that are not being claimed for federal reimbursement to determine if adequate documentation can be obtained that would allow for a correction, if appropriate, to the Title IV-E eligibility determinations.
- DCF should establish procedures to apply for Supplemental Security Income (SSI) benefits prior to adoption, as applicable, to ensure that adoption subsidy payments made on behalf of children who are eligible for SSI are claimed for federal reimbursement under the Adoption Assistance program;
- DCF case workers should document effectively in the child’s case record: a) whether the child was deprived of parental support; b) whether the child was living with a specified relative within six months of the child’s removal from the home; and c) the wages of the child’s parents, so a complete Title IV-E eligibility determination can be made.
- DCF should perform eligibility determinations in a timely manner so children eligible for Title IV-E are properly and promptly identified to ensure that maximum allowed federal reimbursement can be claimed.

A more recent Title IV-E foster care eligibility review⁵² by staff from the regional and central offices of the federal Administration for Children and Families found DCF in “substantial compliance” with Title IV-E eligibility requirements, with 73 of 80 cases reviewed found to be eligible for Title IV-E and 7 found to be in error (i.e., just below the allocable threshold of 8 erroneous claims). Unlike the audits by Connecticut’s Auditors of Public Accounts, however, this eligibility review did *not* look at cases in which a claim under Title IV-E *could* have been made, but was not.

Notably, both the Governor’s and the Appropriations Committee’s budgets for FY 06 propose at least \$1 million in new state funds to support a contract to develop an automated Title IV-E eligibility determination module for DCF’s statewide LINK computer system that is compliant with federal Statewide Automated Child Welfare System (SACWIS) requirements. This new funding should be approved.

⁵² This review assesses the accuracy of Connecticut’s IV-E claims to ensure that appropriate payments were made on behalf of eligible children, to eligible homes and institutions, and at allowable rates. United States Department of Health and Human Services, Administration on Children and Families, *Connecticut Department of Children and Families Title IV-E Foster Care Eligibility Review: March 24, 2003 to March 28, 2003*.

D. Options To Gain Greater Flexibility in the Use of Title IV-E Funds

There are two basic ways to gain greater flexibility in the use of Title IV-E funds so the funds can more effectively support efforts to create a well-functioning child welfare system: a) federal waivers of current funding restrictions; and b) changes to Title IV-E itself.

1. Title IV-E Waivers

To give states flexibility to design innovative child welfare programs (and to foster innovation within states that might provide insight into effective reforms nationwide), Congress in 1994⁵³ authorized the Secretary of the Department of Health and Human Services to approve up to ten demonstration projects requiring waivers of requirements in Title IV-E. The Adoption and Safe Families Act in 1997 allowed HHS to approve an additional ten demonstration projects in *each* of fiscal years 1998-2002. Subsequently, authority to grant new waivers was re-authorized for fiscal years 2003 and 2004.

Demonstration projects are limited to five years, with extensions of up to five years allowable. All demonstration projects must be cost-neutral to the federal government (i.e., not require more federal funding than would otherwise be provided without the waiver) and be evaluated by an independent contractor to compare outcomes for children and families in the demonstration project with outcomes for children and families served under the existing state plan, and to assess the demonstration projects with respect to efficiency, economy, and other appropriate measures of program management.

By May 2004, a total of twenty-five child welfare demonstration projects had been implemented by seventeen states through twenty Title IV-E waiver agreements. Some states have completed their projects; other states (including Connecticut) ended their demonstration projects early. As of May 2004, a total of twelve states had demonstration projects that were active (involving seventeen interventions).⁵⁴ In addition, in response to Information Memorandum ACYF-CB-IM-03-06 inviting new proposals for child welfare demonstration projects, twelve states submitted formal proposals (Alaska, Arizona, Florida, Maine, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, Virginia, Washington, and Wisconsin).⁵⁵ Some states have multiple waivers (e.g., Illinois had three approved).

The following table summarizes these Title IV-E demonstration projects. Some target interventions to specific child welfare populations, while others experiment with the flexible use of funds to try to effect systems' reform. Collectively, they seek to reduce the number of children in out-of-home care, the length of time in care, the use of more restrictive and costly placements, repeat abuse, and re-entry into care.

⁵³ Public Law 103-432.

⁵⁴ United States Department of Health and Human Services, Administration for Children & Families, *Summary of Title IV-E Child Welfare Demonstration Projects: May 2004*, available at: www.acf.hhs.gov/programs/cb/initiatives/cwwaiver/summary.htm.

⁵⁵ For short descriptions of these proposals, see United States Department of Health and Human Services, Administration for Children & Families, Children's Bureau, *Summary of State Proposals for New Child Welfare Demonstration Projects Authorized by Section 1130 of the Social Security Act and Opportunity for Public Comment*, available at: www.acf.hhs.gov/programs/cb/initiatives/cwwaiver/proposals/index.htm.

Many of these demonstration project models – in particular, subsidized guardianship, services for substance-abusing caregivers, intensive services to avert out-of-home placements, adoption services, and enhanced training for child welfare staff – would further child welfare practice in Connecticut. *Until federal financing rules are relaxed, Connecticut should take full advantage of the waiver process to allow such innovations to occur in Connecticut, as well.* Indeed, a waiver to establish a Title IV-E subsidized guardianship program would enable Connecticut to claim federal reimbursement for the costs of this program that is – currently – funded with state funds.

Title IV-E Waiver Demonstration Projects: May 2004		
Type of Project	Intervention	States ⁵⁶
Subsidized guardianship	States give relatives and other caregivers the option to become legal guardians and receive a monthly stipend up to the amount of a monthly foster care payment	DE*, IL*, MD*, MT, NM, NC,* OR* ⁵⁷
Capped IV-E allocations & flexibility to local agencies	States give counties or other local entities the option to use IV-E funds more flexibly to enhance the array of services available, but cap the funds available	IN*, NC*, OH*, OR* ⁵⁸
Services for substance-abusing caregivers	States use Title IV-E funds to address needs of caregivers with substance abuse problems	DE*, IL, MD**, NH ⁵⁹
Managed care payment systems	States test alternative financing mechanisms for specific services and populations	CO**, CT**, MD**, MI*, WA** ⁶⁰
Intensive services options	States increase the nature and extent of available services to try to reduce out-of-home placements and achieve safety and permanence for children	CA, MS ⁶¹
Adoption services	States test ways to improve permanency by promoting and strengthening adoption	ME ⁶²
Tribal administration of IV-E funds	States work with tribes to develop the administrative and financial systems necessary for the tribes to administer their Title IV-E foster care program and claim federal reimbursement directly	NM
Enhanced training for child welfare staff	States enhance training for public and private sector child welfare professionals serving children in placement and their families to improve competencies in assessment and decision-making and improve permanency outcomes	IL

⁵⁶ States with a “*” have completed their demonstration projects. States with a “**” terminated their demonstration projects in 2003.

⁵⁷ Five of the seven states that had implemented a project sought an extension; the other two are on-going.

⁵⁸ All four states sought waiver extensions to continue these demonstrations.

⁵⁹ Delaware’s request for an extension of its waiver was denied.

⁶⁰ Notably, *no* state requested an extension of these waivers.

⁶¹ California received approval to extend its demonstration on a short-term basis.

⁶² Maine was granted short-term approval to extend its demonstration.

United States Department of Health and Human Services, Administration for Children & Families, *Summary of Title IV-E Child Welfare Demonstration Projects: May 2004*, available at: www.acf.hhs.gov/programs/cb/initiatives/cw waiver/summary.htm; Committee on Ways and Means, U.S. House of Representatives, *2004 Green Book*, pp. 11-66 to 11-73.

Highlights of these demonstration projects are as follows:⁶³

a. Subsidized guardianships. The states seeking waivers to establish federally-subsidized guardianship programs offered this option to relatives and foster parents of foster children for whom neither adoption nor reunification was an option. These caregivers had to have been providing stable homes to these children (typically for at least one year). All states provided a monthly stipend equal to (or less than) the current foster care payment; savings were expected to accrue primarily from reductions in agency case management costs and court costs. The guardianships were also expected to result in a greater sense of permanency for the children and their caregivers (as the caregivers would be able to make decisions about the children, rather than the foster care agency).⁶⁴

- The **Illinois** demonstration provided guardians across the state a subsidy payment equal to the adoption subsidy payment along with a variety of support services (e.g., counseling, payment of one-time court costs and legal fees, periodic casework assistance, emergency stabilization services, and special services, like physical therapy). The Illinois evaluation found that children in the experimental group (those receiving subsidized guardianships) were significantly more likely to achieve permanency than children in the control group (78% v. 72%) and that the withdrawal of regular agency oversight and casework services for the experimental group did not result in higher rates of child abuse and neglect. In fact, guardianship was comparable to adoption in terms of keeping children safe, ensuring their physical and mental well-being, and providing them with a stable home and a sense of belonging. Over a nearly five year period, more than 6,800 children were transferred from state custody to guardianships.
- The **Maryland** demonstration offered assisted guardianship to foster children who had been living with a relative or kinship caregiver for a minimum of six months. When the caregiver became legal guardian of the child, the caregiver would receive \$300/month (an amount between the foster care subsidy of \$600/month and the TANF child-only payment for kinship caregivers of \$211/month). The evaluation found that significantly more children in the experimental group exited foster care (29%) as compared to children in the control group (23%), but the payment difference between the guardianship assistance and the foster care subsidy discouraged some relative foster parents from choosing guardianship.

⁶³ For far more detail on these demonstration projects, see United States Department of Health and Human Services, Administration for Children & Families, *Profiles of the Child Welfare Demonstration Projects: May 2004*, available at: www.acf.hhs.gov/programs/cb/initiatives/cw waiver/index.htm.

⁶⁴ The Delaware demonstration provided assisted guardianship for Title IV-E-eligible children who had been living in a foster placement for at least one year, and who had a strong attachment to the potential guardian. The state provided the guardian a payment equal to the foster care payment and the project was implemented statewide. The evaluation was inconclusive.

- The **Montana** demonstration provided assisted guardianships to caretakers of foster children if they had been in their care for at least six months and the children had special needs. The monthly subsidy amount when guardianship was transferred could not exceed the foster care subsidy. Families and caseworkers reported increased self-esteem among children who entered guardianships.
- **New Mexico's** demonstration (available to children in state or tribal custody) provided subsidy payments to guardians that could not exceed adoption assistance.
- Eight of the nineteen counties in **North Carolina's** capped IV-E demonstration chose to implement an assisted guardianship initiative as part of their project. These eight found that assisted guardianship met the needs of some African-American teens who resisted termination of parental rights. Those that did not use assisted guardians cited concern about financial risk of continuing guardianship payments after the demonstration's end, confusion about rules and regulations, and caseworkers' beliefs about the appropriateness of guardianship arrangements as barriers to use.
- **Oregon's** assisted guardianship program was available for children who had been in foster care for more than twelve months, had lived with the prospective guardian for at least six months, and were at least twelve years old if the prospective guardian was not a relative (or any age if the prospective guardian *was* a relative). Oregon reported that about 70% of the guardians were relatives of the children and nearly all placements remained stable one year after agreements were established.

b. Capped IV-E allocations and flexibility to local agencies. In Indiana, North Carolina, Ohio, and Oregon, states provided counties (or other local entities) flexibility in the use of their Title IV-E funds, but fixed the total IV-E allotment. The state and participating counties agreed to share the risks and rewards if expenses are either above, or below, their IV-E allotments. There were multiple variations on this general theme:

- **Indiana** set aside 4,000 "slots"⁶⁵ and allowed counties to use up to \$9,000 per slot annually to develop increased capacity for intensive home- or community-based service alternatives to institutional placements. Participating counties would pay for any costs for out-of-home care or related administrative expenses that exceed the \$9,000. Services most frequently paid for with IV-E funds were child and family counseling, respite care, basic household assistance, parenting education, family preservation services, and special education services. The evaluation found that children and families receiving these intensive services avoided placement more often (46% v. 38%), were placed out of state less often, spent less time in placement, were reunified with their biological parents more often, and were more often in school. There was no difference between the children in the demonstration and control groups on recurrence of abuse or out-of-home placement.
- **North Carolina** provided nineteen counties a capped amount of IV-E funds that they could use flexibly; if county expenses exceeded this allotment, the state and county would

⁶⁵ Eligible children included: a) children in placement or at risk of placement; b) children for whom abuse or neglect had been substantiated; c) adjudicated delinquents; and d) children otherwise identified as being at risk of abuse, neglect, or delinquency.

share the excess costs. Thirteen of the counties used funds to meet needs on a case-by-case basis, while others developed new services (e.g., family support, assessment, substance abuse and mental health treatment). The evaluation found that although the risk profile for children entering foster care in the demonstration counties exceeded that of children in the control counties, their length of stay in out-of-home care was less.

- **Ohio** allowed fourteen counties to experiment with a diverse array of managed care strategies, providing each with a capped amount of funds.⁶⁶ Counties, in turn, negotiated financial and risk-sharing agreements with private providers. Managed care strategies employed included an expanded array of services (including increase prevention services), improved case management and care coordination, utilization review, and new quality assurance systems. The evaluation found that the demonstration counties were more likely than the comparison counties to express a strong commitment to prevention and to target new prevention activities to areas identified previously as inadequate, although there were no statistically significant differences between them in how they spent funds. There were no significant differences between the demonstration and comparison counties in safety and permanency outcomes, but there was some evidence that the demonstration counties contained out-of-home costs more than comparison sites. In January 2005, DHHS approved a five year extension for this waiver.⁶⁷
- **Oregon** used its waiver to accelerate the implementation of a Strengths/Needs-Based System of Care approach to planning and service provision. It allowed interested branch offices to spend a portion of their foster care budgets more flexibly to prevent out-of-home care placements, expand established services, and create innovative service plans. Key strategies used were family decision meetings, enhanced visitation, in-home parenting services, early childhood assessment, and facilitation of drug and alcohol treatment. The evaluation found that children in demonstration projects were more likely to remain in their homes one year after a maltreatment report, but there were no other significant differences in likelihood of returning home and subsequent maltreatment.

c. *Services for substance-abusing caretakers.* Four states focused their demonstration projects on meeting the needs of caretakers with substance abuse problems.

- **Delaware** co-located substance abuse counselors with child protective service staff to accompany CPS staff on initial visits, identify families in need of treatment, arrange for treatment, and provide case management. Children in the demonstration group did not enter out-of-home care as often, and spent 31% less time in out of home care. Barriers to implementation included lack of appropriate treatment programs and lack of insurance or restrictions placed on treatment by managed care, as well as philosophical differences between the counselors and CPS staff.
- **Illinois** referred parents with substance-abuse problems to the Juvenile Court Assessment Program where they were assessed and referred for treatment. In addition to substance

⁶⁶ The capped amount was based on historical and projected numbers of days in out-of-home care, costs of care, and proportion of Title IV-E-eligible children.

⁶⁷ United States Department of Health & Human Services, Administration for Children & Families, *HHS Announces Extension of Child Welfare Waiver in Ohio* (January 25, 2005).

abuse treatment and traditional child welfare services, the demonstration group participants were provided with Recovery Coaches to help families early in the treatment process and provide support during and after treatment to prevent relapse and facilitate reunification. While children in the demonstration group reached permanency more quickly, there were no significant differences between the groups in repeat maltreatment and relatively few children in either group were living at home. For many parents, treatment services were discontinued for a multitude of reasons, but there was also evidence that substance-abusing parents in the demonstration group were more likely than parents in the control group to access treatment and to do so quickly.

- **Maryland's** demonstration provided multi-disciplinary Family Support Services Teams (substance abuse counselors, child welfare agency staff, treatment providers, parent aides and mentors) and three treatment options (in-patient for parents and their children; intermediate care; and intensive out-patient treatment). Services were to include case management, individual, family and group therapy, housing, employment, child care, and transportation assistance, health care, and parent skills training. The demonstration was terminated early for a variety of reasons including workers' lack of training in identifying substance abuse issues, reducing referrals and resulting, therefore, in weak enrollment.
- **New Hampshire** also linked substance abuse specialists with child protective services staff to refer parents to treatment, link children to supportive services, and provide intensive substance abuse case management. High CPS caseloads, role confusion, clients' lack of readiness to enter treatment, and staff turnover were all barriers to implementation. There was some evidence that demonstration group families had fewer repeat CPS referrals, more stable child placements, and lower self-reported rates of drug and alcohol abuse.

d. Managed care payment systems. Five states, including *Connecticut*, have tested managed care financing models for specific services, or for specific populations.

- In **Colorado**, one county negotiated a risk-based, performance-based contract with a consortium of services providers to provide care to children age 10 or older who were experiencing "placement drift" and who were at significant risk of aging out of foster care without a permanent family relationship, as well as youth in high-cost residential care. The county paid the consortium a monthly rate for case coordination and residential care treatment for each referred youth; non-residential services were paid on a fee-for-service basis. The state intended to calculate the average per case costs for youth in the treatment and control groups (excluding the 5% of youth in each group with the highest costs) and share the savings with the providers if the costs of treatment group were less than control group costs, but hold the provider responsible for a portion of the costs of the treatment group if they exceeded control group costs. The demonstration was terminated early, however, due to state budget problems and other difficulties. A trend toward shorter lengths of stay were noted for the experimental group.
- **Connecticut** used a Title IV-E waiver to launch a demonstration project in July 1999 to evaluate whether the well-being of children in need of residential mental health services could be improved, and the lengths of stay in restrictive residential placements reduced, by

providing case rate payments to a community agency. This demonstration is discussed more detail in the next section.

- **Maryland** contracted with a single licensed child placement organization to serve as a lead agency to manage out-of-home care in the city of Baltimore for three groups of children: children entering out-of-home placement directly from home after a hearing; children entering out-of-home care from kinship care; and children in care who were age five and under. Siblings of any of these children also became part of the managed care group. The state negotiated a case rate with the agency for each of 500 referred children. While the providers assumed a risk of financial loss of as much as 10% of the case rate, they also could redirect cost savings to enhanced services for project participants. The demonstration was terminated early because the fixed rate was found to be inadequate to meet the lead agency's costs of care and the lead agency was unfamiliar with the local out-of-home care population and their needs and issues. While more children in the experimental group were found to exit out-of-home care to adoption than in the control group, there were no significant differences between the two groups in the overall proportion of children leaving out-of-home care.
- **Michigan's** demonstration ("Michigan's Families") involved contracts with non-profit providers, for-profit providers, and community mental health centers in six counties. A monthly capitated case rate was paid to a "fiduciary" agency for each enrolled child. This agency was responsible all expenditures associated with services and care for the child and charged with developing wraparound services. Targeted children were those in out-of-home care (or at imminent risk of removal). At first, the contracts called for a monthly payment of \$1,500 per child, but these rates were negotiated to a single case rate for each child served (\$14,272, paid in nine monthly installments) regardless of the length of time services were provided.⁶⁸ If the child was adopted, reunified, placed in a permanent foster care home or transitioned to independent living, the provider received an additional \$1,586 bonus. The evaluation showed that the children in the managed care group received a broader and more flexible range of mental health and support services (e.g., respite care, child care, assistance with household expenses), but no statistically significant differences were found between the experimental and control groups in placement stability, re-entry into care, or child safety.⁶⁹
- The waiver granted to the state of **Washington** allowed it to test different managed care approaches in up to six different counties. It was implemented in only two counties. Under the waiver, the state made fixed monthly payments for each child enrolled in the demonstration group to a single contracted care coordinator. Children selected were ages 6 to 17 who were at risk of entering high-cost group or foster family care and who were already involved in the mental health or special education system. The monthly payments were higher for youth needing group care. Funds could be used flexibly to develop wraparound services for each enrolled child children; services included crisis foster care, 24-hour crisis intervention services and support, respite care, therapeutic care, group care, and

⁶⁸ The fixed monthly payment system was found to provide no incentive to end unnecessary services.

⁶⁹ However, the evaluation found that 5 of the 6 sites bypassed random assignment, providing services to the control group similar to those provided to the experimental group, resulting in contamination of the research design and findings.

out-of-home placement services. If costs for one child exceeded the fixed rate, the county could use some of the pooled funds to cover these costs. However, the county assumed risk for service costs that exceeded the amount set aside in the pool for *all* youth. Problems contracting with the lead service provider and inadequate referrals resulted in early termination for this demonstration.

e. Intensive service options. California and Mississippi used waivers to increase the variety and availability of services that could reduce out-of-home placements and achieve safety and permanence for children:

- In **California's** waiver, seven counties were authorized to develop their own intensive, strengths-based service programs to prevent out-of-home placements. Two counties used family conferencing (to build on family strengths, involve families in decision-making and improve family decision-making skills) and five relied on wraparound services (and developed a tracking tool to quantify the services provided).
- **Mississippi** tried a child-focused, family-centered practice approach in eight counties that targeted factors that contribute to abuse and neglect. Title IV-E funds could be used for existing and newly created services. Of the 17 services being tracked for the evaluation, those most requested by families included: a) assistance for families' personal needs; b) clothing; c) payments to foster care and independent living facilities; d) school supplies; e) medical care; and f) housing and utility payments. More of the children and families in the demonstration group received services being tracked for the evaluation.

f. Adoption services. **Maine's** waiver sought to enhance permanency by promoting and strengthening the adoption of children with special needs who were in the state foster care system through training and supplemental support services:

- *Training.* The demonstration included a two-part adoption competency training program for public and private sector clinical social workers, case managers, psychologists and psychiatrists who, in turn, provided services to adoptive families. In the first part of the training, eight training teams were developed and trained (each with an adoptive parent, a clinician/therapist, and a state agency adoption caseworker). In the second part of the training, the teams conducted training workshops that targeted community members and professionals (such as therapists, school staff, and respite providers) who could provide support for adoptive parents and adopted children. Training topics included family systems, child development, open adoption, integrating adopted children into existing families, the effects on children of abuse and trauma, infant mental health and adoption subsidies.
- *Post-adoption services.* The demonstration also used IV-E funds to provide a range of post-adoption support services (called "Guided Services" to prevent disruption or dissolution of the adoptive placements. A family-centered assessment (covering family culture, parenting style, child's history of trauma and capacity for attachment, etc.) was used to frame an initial service plan. Post-adoption support services included case management, parent education, information and referral services, crisis stabilization services, individual/family counseling related to adoption, respite care, adoption support groups, recreational services, advocacy services, therapy services (such as

occupational, physical and speech), residential services, standard board payments, and research/search assistance related to birth family issues.

Although few statistically-significant differences were found between the demonstration and control groups on child-level outcomes (including well-being, behavior, and permanency), there were significant differences in favor of the post-adoption services model on four family-level variables: a) physical and emotional health of the caregivers; b) family members' attachment to the adopted child; c) trust between the caregiver and the adopted child; and d) the caregivers' assessment of the quality of family life after adoption.

g. Enhanced training of child welfare staff. **Illinois** used a Title IV-E waiver to provide enhanced training to all newly hired DCFS staff, as well as a random sample of newly-hired *private* child welfare agency staff. The goal was to improve permanency outcomes by increasing professional competencies in assessing child and family needs, providing appropriate services, and decision-making. In addition to a four-week, classroom-based training program, new private agency hires received structured field support for a year (including coaching and “shadowing” from trainers and post-training quarterly “booster” sessions). Based on results from a pilot phase and feedback from child welfare experts, the curriculum was enhanced and includes such topics as: a) assessing safety and risk within families; b) family group decision-making; c) family team meetings; d) assessment; e) service, permanency, and concurrent planning; f) preparing for juvenile court; g) cultural competency; h) child development; and i) working with adolescents and foster parents. This Enhanced Training built on the competencies taught in the agency's foundation training and included enhanced clinical practice, on-the-job preparation and field support.

2. Connecticut's Title IV-E Waiver

As noted in the prior section, in 1999 Connecticut launched a Title IV-E demonstration project to test if a case rate paid to a community agency could reduce lengths of stay in restrictive placements and improve outcomes among youth with significant mental health needs. In this demonstration, DCF established contracts with two local service agencies (LSAs)⁷⁰ to provide a continuum of services in treatment facilities and community-based settings. Services were to include case management, group care, home-based services, out-patient services, residential treatment, and aftercare. Each LSA was paid a fixed rate for each referred child -- equal to the average cost of 12 months of residential placement -- with which to provide care for 15 months. The community agencies were required to organize and manage a comprehensive continuum of services, and use the case rate flexibly to increase the community-based care provided to children and families.

Under this demonstration, DCF and the LSAs shared financial risk. The rates allowed for a risk corridor, in which the agencies were protected if the services required expenditures above 110% of the case rate. The contracts also included an incentive that allowed the LSAs to retain the *full* rate if the actual expenditures were between 90% and 100% of the case rate. The LSA was required to return funds to DCF if expenditures fell below 90% of the case rate.

⁷⁰ In the North Central Region, Klingberg Family Services functioned as the LSA, and in the South Central Region, Middlesex Hospital, in collaboration with the Middlesex Child and Adolescent Services System Program, was the LSA.

The target population for this waiver were youth aged 7-15 with behavior problems⁷¹ who were already in, or who were authorized to be in, residential or group home care.

The demonstration project operated in two of DCF's 5 regions, and was originally designed to operate for five years and serve 240 children. However, from the outset, intake for the program lagged pre-implementation projections (because of inadequate referrals) and, within a year of project implementation, Connecticut began to roll out a statewide redesign of its children's behavioral health system (KidCare). According to the waiver evaluation, the "broader agency-wide system eclipsed the activities taking place through the demonstration" and, by the beginning of year three of the demonstration, "the number of children referred for the Waiver sites dwindled to a level that made the demonstration contracts unsustainable for the Local Service Agency contractors."⁷² DCF closed intake in February 2002, terminating the demonstration project early.

Evaluation of Connecticut's waiver found that youth in the experimental group (as compared to the control group): a) received more case management, family support, and transportation services;⁷³ b) were placed less often in residential treatment and in-patient hospitalization and received less frequent medication/treatment monitoring; c) spent less time in residential care (in the first year of the demonstration); and d) were placed more often in in-home settings.⁷⁴ No statistically-significant differences were noted between the experimental and control groups in mental health outcomes. For *both* groups, children placed at home showed the most improvement in behavior and functioning.⁷⁵

⁷¹ The evaluation noted while the waiver was designed to focus on children with *moderate* levels of mental health needs, the children in *both* the experimental and control groups showed *extreme* levels of mental health symptoms and related dysfunction. 81% of the youth presented symptoms at or above the clinical range and 9% were assessed as having marked or severe levels of functional impairment. Yet, relative to other children being referred by DCF to residential treatment, these children *had* more moderate needs. In fact, two-thirds of the youth evaluated for inclusion in the demonstration were found to be ineligible because their acuity levels were too high. The evaluation recommended earlier screening and intervention, noting that "[u]sing a point after a youth has been referred for residential treatment may be too late in the services process for identification and intake." ORC Macro, *Connecticut Title IV-E Waiver Demonstration Project: Final Report* (2003), pp. iv, viii.

⁷² ORC Macro, *Connecticut Title IV-E Waiver Demonstration Project: Final Report* (2003), p. ii. The final evaluation report noted that the "clinical service implementation successes did not extend to system development activities." It found that "expanding system resources proved to be highly challenging" primarily because the majority of the youth referred to the project were committed to DCF on account of child abuse or neglect. The evaluators noted that "[t]his reality affected a range of issues from ability to obtain substitute care arrangements and initiate discharge from the projects, to relationships between the demonstrations, the courts, and DCF protective services caseworkers." *Id.*, at p. iii.)

⁷³ The evaluation found that differences in programming by the LSAs and DCF were largely in the intensity, direction and quality of case management, with the LSAs devoting significant attention to building their clinical care coordination personnel and services, reducing caseloads, and using these resources as "the primary alternative to residential treatment" for youth in their care. The models focused on "intensive in-home support of parents and caretakers throughout the service process, through interdisciplinary assessments of the mental health needs and strengths of assigned youths, and regular monitoring and collaboration with service providers." The LSAs planned and delivered a range of community-based services that showed "greater diversity and intensity" than those provided by DCF. *Id.*, at p. ii.

⁷⁴ At 12 months, 38% of the children in the experimental group were living in family placements, compared to just 14% of the control group. By comparison, at 24 months, 44% of the children who had received services from the LSAs were in in-home placements, compared to 37% who received care through DCF. The evaluation *did* find a significant difference *between* the two LSAs in the proportion of youth placed at home at discharge with just 41% of the youth served by Klingberg placed at home, compared to 64% for Middlesex.

⁷⁵ *Id.*, at p. vi.

The evaluation's cost analysis found that the *average* 15-month expenditure per child at the LSAs (\$49,310) was less than was estimated for 15 months of residential treatment (\$62,000). Overall, 46% of the children served by the LSAs required expenditures that were below 90% of the case rate, while 40% required expenditures that were 110% or more of the case rate. Less than 15% of the children the LSAs served required expenditures within the 90%-110% risk corridor. The evaluation concluded that in this essentially cost-neutral demonstration resulted in youth being returned home more often (especially in the first 12 months), spending less time in restrictive placements, and showing improvement in multiple domains.⁷⁶

3. Amendment of Title IV-E to Allow Other Uses of Title IV-E Funds

a. Pew Commission recommendations. As illustrated by the alternative uses of Title IV-E funding proposed in the various waivers just summarized, greater flexibility in the use of Title IV-E funds can enhance child welfare practice. The Pew Commission on Children in Foster Care stated:

Simply put, current funding mechanisms for child welfare encourage an over-reliance on foster care at the expense of other services to keep families safely together and to move children swiftly and safely from foster care to permanent families, whether their birth families or a new adoptive family or legal guardian.⁷⁷

Rather than maintain the current “foster care straitjacket,” the Pew Commission on Children in Foster Care – after a year of intensive work by noted child welfare experts – made a series of inter-related recommendations on needed changes in the federal financing of child welfare services:

1. **Because every child needs a safe, permanent family, the Commission recommends:**
 - Providing federal adoption assistance to *all* children adopted from foster care;
 - Providing federal *guardianship assistance* to *all* children who leave foster care to live with a permanent, legal guardian.⁷⁸

2. **Because every child needs to be protected from abuse and neglect, the Commission recommends that the federal government join states in paying for foster care for every child⁷⁹ who needs this protection:**
 - Regardless of family income (i.e., the income of the family from which the child is removed)
 - Including children who are members of Indian tribes; and
 - Including children who live in the U.S. territories.

⁷⁶ Id. At p. vii.

⁷⁷ The Pew Commission on Foster Care, *Fostering the Future: Safety, Permanence and Well-Being for Children in Foster Care* (2004), p. 13, available at: <http://pewfostercare.org/research/docs/FinalReport.pdf>.

⁷⁸ Federal eligibility for adoption or guardianship assistance would *not* be based on the income of the child's birth family.

⁷⁹ Currently, the federal government reimburses a portion of the costs of foster care for children whose family income is less than the 1996 AFDC income standards while states, in contrast, pay the full cost of foster care for every other child who needs this protection.

3. **Because every child needs a permanent family, the Commission recommends allowing states to “reinvest” federal dollars that would have been expended on foster care into other child welfare services if they safely reduce the use of foster care. States could use these funds for any service to keep children out of foster care or to leave foster care safely.**

4. **Children need skillful help to safely return home to their families, join a new family, or avoid entering foster care in the first place. For caseworkers to provide this help, states need flexible, sufficient, and reliable funding from the federal government. The Commission recommends an indexed Safe Children, Strong Families Grant that combines federal funding for Title IV-B, Title IV-E Administration, and Title IV-E Training into a flexible source of funding. The Commission further recommends that additional funding be provided in the first year, and that the grant be indexed in future years.**
 - Each state’s grant amount would be based on its historical spending for Title IV-B and Title IV-E Administration and Training;
 - In addition, the total base funding level would be enhanced by \$200 million in the first year of implementation;
 - In subsequent years, each state’s allocation would grow by 2% plus the inflation rate, as measured by the Consumer Price Index; and
 - States would be required to match the federal grant funds, just as they currently are required to match federal IV-B and IV-E dollars.

5. **To guarantee that public funds are used effectively to meet the needs of children who have been abused or neglected and to increase public accountability, the Commission recommends improvements to the federal Child and Family Services Reviews (CFSRs).**
 - The CFSRs should include more and better measures of child well-being, use longitudinal data to yield more accurate assessments of performance over time, and HHS should direct that a portion of any penalties resulting from the review process be reinvested into a state’s Program Improvement Plan;
 - The federal government should continue to help states build their accountability systems by maintaining the federal match for State Automated Child Welfare Information Systems; and
 - Congress should direct the National Academy of Sciences, through its Board on Children, Youth, and Families, to convene a foster care expert panel to recommend the best outcomes and measures to use in data collection.

6. **To promote innovation and constant exploration of the best ways to help children who have been abused and neglected, the Commission recommends that the federal government:**
 - Expand and improve its successful child welfare waiver program;
 - Continue to reserve funds for research, evaluation, and sharing of best practices; and

- Provide bonuses to states that make workforce improvements and increase all forms of safe permanence for children in foster care.

Impact on Connecticut. Based on an analysis of the fiscal impacts of Pew Commission recommendations by Rob Geen at the Urban Institute, DCF prepared a *Summary of Financial Impact from Recent Federal Proposals to Alter Child Welfare Financing*. The following table provides the part of that summary that concerns fiscal impacts of Pew Commission recommendations on Connecticut:

Summary of Financial Impact of Pew Commission Recommendations on Connecticut (FFY 04)		
Projected FFY 04 Revenue with Existing Entitlement		\$ 98,276,412
Net Fiscal Impact of Pew Commission Recommendations		\$ 2,513,293
TOTAL (if Pew Commission recommendations adopted)		\$100,789,705
Potential Title IV-E Modifications Addressed by Pew Commission	Program Changes	Fiscal Impact
Adoption Assistance	Remains open-ended entitlement	\$0
Guardianship Assistance	Makes guardianship payments eligible for open-ended federal reimbursement	\$2,313,293
Foster Care Maintenance	Remains open-ended entitlement	\$0
Administration and Training	Remains open-ended entitlement	\$0
IV-E Eligibility	Removes income and family relationship requirements (AFDC standards) for federal foster care and adoption assistance	\$9,999,442
Level of federal reimbursement	Reduces federal per child reimbursement for both foster care and adoption assistance by 35%; provides claims adjustments to avoid state winners or losers	(\$15,474,290)
Claims adjustment	Provides claims adjustments for AFDC standards and federal financial participation adjustment to avoid state winners and losers	\$5,474,848
Indian Tribes	Allows tribes to receive direct Title IV-E funding	\$0
Reinvestment of savings	Allows federal foster care “savings” to be reinvested into Safe Children, Strong Families Grant with state match	N/A. Allows for flexibility in program development
IV-E administration	Funds rolled into Safe Children, Strong Families Grant	N/A. Allows for flexibility in program development
IV-E training	Funds rolled into Safe Children, Strong Families Grant	\$0

IV-E SACWIS	Funding remains open-ended entitlement	\$0
Potential Title IV-B Modifications Addressed by Pew Commission	Program Changes	Fiscal Impact
IV-B (Subparts 1 & 2)	Rolled into Safe Children, Strong Families Grant	
Safe Children, Strong Families Grant	Title IV-B funds and IV-E administration and training funds rolled into this new grant. Initial funding of about \$3.9 billion based on historical spending, plus additional \$200 million. Annual increases in grant of 2% plus the CPI. State share is based on share of the historical spending. Weighted adjusted average state match rate is about 32%	\$200,000
Mentoring for Children of Prisoners	Not discussed	\$0
Other Provisions		
Waivers	Eliminates cap on the allowable number of waivers HHS may approve. Prohibits denial of a waiver solely because it replicates demonstrations already implemented.	\$0
Incentives	Replaces current Adoption Incentives with a Permanence Incentive (modeled on the existing Adoption Incentive) that rewards states for achieving a variety of permanency goals. Creates workforce performance bonus for states that achieve a certain level of competence in their child welfare workforce and recommended worker-to-child caseload ratios (according to standards sent by expert working groups)	\$0
TOTAL FISCAL IMPACT FFY 04		\$2,513,298

b. *Federal proposals.* Although Representative Herger has not re-introduced his Child Safety, Adoption, and Family Enhancement (Child SAFE) Act bill (HR 4856), it remains a template for potential Congressional action for Title IV-E financing reform.

Based on analysis of the fiscal impacts of the Child Safety, Adoption, and Family Enhancement (Child SAFE) Act of 2003 by Rob Geen at the Urban Institute, DCF prepared a *Summary of Financial Impact from Recent Federal Proposals to Alter Child Welfare Financing*. The following table highlights fiscal impacts on Connecticut of HR 4856, as proposed by Representative Herger and his Subcommittee on Human Resources staff in the House Ways and Means Committee:

**Summary of Financial Impact of Child SAFE Act of 2003
on Connecticut (FFY 04)**

Projected FFY 04 Revenue with Existing Entitlement		\$ 98,276,412
Net Fiscal Impact of Pew Commission Recommendations		(\$15,232,578)
TOTAL (if Pew Commission recommendations adopted)		\$ 83,043,834
Potential Title IV-E Modifications Addressed by Pew Commission	Program Changes	Fiscal Impact
Adoption Assistance	Remains open-ended entitlement	\$0
Guardianship Assistance	Not discussed. Gives states flexibility to establish separate licensing standards for relative foster homes	\$0
Foster Care Maintenance	Total funding capped at Congressional Budget Office projected levels. State's funding based on FY 2003 share of foster care maintenance payment expenditures	(\$12,579,726)
Administration and Training	Total funding capped at average of FFY 01, 02 and 03	\$0
Contingency Fund	Allows states to access TANF contingency fund if crisis conditions are met	\$0
IV-E Eligibility	Removes income and family relationship requirements (AFDC standards) for federal foster care and adoption assistance	(\$3,052,852)
Level of federal reimbursement	Reduces federal per child reimbursement for both foster care and adoption assistance by 35%; provides claims adjustments to avoid state winners or losers	-\$15,474,290
Claims adjustment	Provides claims adjustments for AFDC standards and federal financial participation adjustment to avoid state winners and losers	\$5,474,848
Indian Tribes	Allows tribes to receive direct Title IV-E funding	\$0
Reinvestment of savings	Allows federal foster care "savings" to be reinvested into Safe Children, Strong Families Grant with state match	N/A. Allows for flexibility in program development
IV-E administration	Funds rolled into Safe Children, Strong Families Grant	N/A. Allows for flexibility in program development
IV-E training	Funds rolled into Safe Children, Strong Families Grant	\$0
IV-E SACWIS	Funding remains open-ended entitlement	\$0

Potential Title IV-B Modifications Addressed by Pew Commission	Program Changes	Fiscal Impact
IV-B (Subparts 1 & 2)	Rolled into Safe Children, Strong Families Grant	
Safe Children, Strong Families Grant	Title IV-B funds and IV-E administration and training funds rolled into this new grant. Initial funding of about \$3.9 billion based on historical spending, plus additional \$200 million. Annual increases in grant of 2% plus the CPI. State share is based on share of the historical spending. Weighted adjusted average state match rate is about 32%	\$200,000
Mentoring for Children of Prisoners	Not discussed	\$0
Other Provisions		
Waivers	Eliminates cap on the allowable number of waivers HHS may approve. Prohibits denial of a waiver solely because it replicates demonstrations already implemented.	\$0
Incentives	Replaces current Adoption Incentives with a Permanence Incentive (modeled on the existing Adoption Incentive) that rewards states for achieving a variety of permanency goals. Creates workforce performance bonus for states that achieve a certain level of competence in their child welfare workforce and recommended worker-to-child caseload ratios (according to standards sent by expert working groups)	\$0
TOTAL FISCAL IMPACT FFY 04		(\$15,232,578)

IV. RE-ALLOCATION OF OTHER FEDERAL FUNDING

As multiple reports have advised,⁸⁰ much can be done to integrate social and health services through the blending and braiding of state and federal funds despite multiple restrictions in federal funding law, including on the allowable specific uses of federal funds, on eligibility, and on the sharing of information among agencies.

Careening Toward Crisis identified some of the questionable budget choices that have been made in Connecticut's current use of federal and state dollars, such as the increasing reliance on TANF

⁸⁰ See, e.g., R. Hutson, *Providing Comprehensive, Integrated Social Services to Vulnerable Children and Families: Are There Legal Barriers at the Federal Level to Moving Forward?* (Center for Law and Social Policy, February 2004), available at: www.clasp.org; C. Lind, *Developing and Supporting a Continuum of Child Welfare Services* (The Finance Project, December 2004)

funds in the DCF budget⁸¹ rather than continuing the use of TANF funds through DSS to provide services that could *avert* referrals to DCF in the first instance (e.g., housing, heat, transportation, child care) and the questionable use of Title IV-B, part 1 funds to pay for DCF staff costs at the Connecticut Children’s Place.

Re-financing some of the services now being funded with TANF, Title IV-B, and other federal funds through Medicaid and/or Title IV-E could free these more flexible federal funds for uses that are more consistent with Congress’ original intentions, including the prevention of child abuse and neglect, supports for families to reduce referrals to DCF, and financial and treatment assistance to families so that children can be returned home safely whenever possible. Similarly, identifying programs and services that currently are funded with state-only funds (e.g., subsidized guardianships and many KidCare services) that could be federally-reimbursed, and seeking the waivers necessary to make such claims, would free state funds to expand Connecticut’s investment in prevention and early intervention services, saving state funds and improving the well-being of some of Connecticut’s most at-risk children and youth.

V. CONCLUSION

The course that Connecticut currently is on – cutting and re-allocating funding for programs and services that reduce child abuse and neglect and support at-risk families, while markedly increasing funding for foster and residential care and DCF staffing – is a course that is not only fiscally imprudent, but not optimally helpful to children and their families.

It is time for DSS and DCF to implement more of the proposals that have been suggested by experts since the late 1980s to change how Connecticut finances child welfare services, and to work together with Connecticut’s Congressional delegation to gain greater flexibility in the use of federal dollars, while maintaining *full* federal funding commitments.

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⁸¹ Of the \$113.7 million of TANF funds claimed in FFY 03 in the DCF budget, \$60.8 million were allocated to DCF case management and an additional \$27.2 million for DCF investigations – a total of more than \$88 million (more than three-quarters) of TANF funds claimed. If, for example, federal reimbursement for DCF case management were claimed under Medicaid, these TANF funds could be used to help families *avoid* placement into DCF in the first instance (a use more consistent with the goals of TANF).