

1. Does the child welfare workforce currently have the capacity to ensure that every child who is at risk of abuse or neglect, or who is the victim of such maltreatment, is receiving a full range of prevention and/or intervention services?

There is a substantial body of evidence that suggests this workforce capacity does not exist. We have consistently found in the annual reports on child abuse and neglect that nearly 40 percent of the 900,000 children who are substantiated as being the victims of child abuse or neglect do not receive follow up services. While there can be several reasons for this in some states, clearly a lack of services due to a workforce shortage is an important contributing factor. In the most recent copy of the CWLA national child welfare factsheet we include some recent research:

- A 2003 General Accounting Office (GAO) report documented that staff shortages, high caseloads, high worker turnover and low salaries impinge on the delivery of services to achieve safety, permanence and well being for children.
- The 2003 GAO report cites that the average caseload for a child welfare/foster care caseworker is 24 to 31 and that these high caseloads contribute to high worker turnover rates and to insufficient services being provided to children and families.
- According to a 2005 child welfare workforce survey, the average caseload size where child is defined as the case was 26.3 for child protective service workers. CWLA recommends that a CPS caseworker responsible for the initial assessment/investigation have no more than 12 active cases per month.
- The average vacancy rate for child protective service workers at public agencies was 8.5% in 2004 down from 9.3% in 2000. The average number of weeks required to fill a vacant child protective service position was 10 weeks.
- The turnover rate for child protective workers increased from 19.9% in 2000 to 22.1% in 2004.
- The findings of the federal Child and Family Service Reviews have clearly demonstrated that the more time a caseworker spends with a child and family, the better the outcomes for those children and families.

During the testimony before the Subcommittee on February 27, I referenced a study by the New York State Office of Children and Family Services, the *New York State Child Welfare Workload Study*, conducted by Walter R McDonald Associates, Inc and the American Humane Association. As I indicated,

“on average, district offices and voluntary agencies are spending between .6 and 1.5 hours (approximately 35 to 90 minutes) of face-to-face contact with children and their families per case per month.”

Further if we followed the report recommendations regarding caseloads for workers in the range of services,

“For Child Protective Services investigations, on average, a caseworker would be able to spend 10.5 hours per investigation per month compared to the current estimates of 6.4 per investigation...”

The same holds true for other areas including preventive case planning and foster care case planning. While this may seem like a lot we need to recognize this kind of investment will benefit children and in some instances prevent abuse at an enormous cost savings to society and to the government.

- 2. As you know, the Centers for Medicare and Medicaid Services (CMS) plans to implement a rule that will roll back Medicaid’s coverage of targeted case management (TCM) services, which has the potential to drastically restrict the health services for children in the foster care system being covered by Medicaid.**

What types of services are provided under TCM for foster children and why is TCM so important to their care?

As the statutory definition indicates, states can use Medicaid funds to fund case management services that help Medicaid-eligible individuals gain access to much needed medical, social, educational or other services.

In FFY 2005, there were 506,483 children in out-of-home care, with “out-of-home care” and approximately 800,000 children spent at least some time in a foster care setting. Data and reality consistently show that these youngsters are at an extremely high risk for and experience a disproportionate amount of physical and mental health issues. For instance, between 50-80% of children in foster care experience moderate to severe mental health and behavioral problems. Approximately 60% of children in care have a chronic medical condition and one-quarter have three or more chronic health conditions. When compared to the general population, children younger than 6 in out-of-home care have higher rates of respiratory illness (27%), skin problems (21%), anemia (10%), and poor vision (9%). These extreme health needs have complex bases, but are thought to stem from one or a combination of the following: biological factors, maltreatment they were exposed to at home, the life-altering impact of breaking familial ties, and/or the continued instability from associated factors that often ensues. In addition to health needs, children and youth involved with the child welfare and foster care systems have multiple social, educational, and other needs. Taking into account this extreme vulnerability, at least 38 states employ the Medicaid *targeted* case management option to ensure that children in foster care receive a comprehensive approach and greater coordination of care.

The immediate and long-term impact of TCM services is overwhelmingly positive and cost-effective, as studies have shown that children in foster care who receive TCM

services are more likely than non-recipients to receive physician services, prescription drugs, dental services, rehabilitative services, inpatient services, and clinic services, potentially restoring them to permanent placements most securely and in a more timely manner. Simply put, the case management and TCM options as they stand now fulfill their purpose and place vulnerable members of society, including children and youth involved with the child welfare and foster care systems, on a healthy trajectory and increase their opportunity for long-term well-being and success.

When this rule goes into effect, would another agency—such as a State foster care agency—be in a position to pick up the costs for continuing case management and TCM services to children in care?

Because the rule goes well beyond Medicaid third party liability rules by stating that if case management/TCM services are deemed “integral to” the administration of another program (child welfare, foster care, etc), Medicaid simply won’t pay—yes, this is essentially a cost shift to state/local programs who in turn, must either draw down other federal funds or kick in state/local dollars to continue these vital services. On *whether* states would be able to shoulder this burden, a couple points:

- The Preamble to the rule anticipates a cost shift to the Title IV-E program in the amount of \$369 million/five years. This is problematic (1) because it is questionable whether IV-E is even permitted to pick up these costs. Federal law explicitly allows Medicaid payment for health care and medical services to children and youth in foster care, while Title IV-E rules expressly prohibit the use of IV-E funds for medical services. In a January 21, 2001 letter to State Child Welfare and State Medicaid Directors regarding State plan case management, CMS recognized this distinction, noting because Title IV-E is “not liable for the assessment, care planning, and monitoring of medical needs,” the cost for such case management activities “could be billed to the State Medicaid program.”

(2) Assuming IV-E is allowed to pick up the costs (which is unclear at best), less than 50% of children in foster care are eligible for federal IV-E foster care assistance due to Title IV-E’s outdated eligibility link to a now non-existent program, Aid to Families with Dependent Children (AFDC). Put another way, for the over 200,000 children and youth in foster care who currently do not qualify for IV-E assistance, states would have to delve into other funding streams.

- 21 states were able to quantify the fiscal impact of the case management/TCM rule in a report recently issued by the House Oversight and Government Reform Committee—states estimated anywhere between a \$9.2 million to \$431 million loss in federal Medicaid dollars over five years as a result of this rule alone. So, to continue these valuable services, as aforementioned, states will first have to fill this significant funding void with either other federal streams or w/ state dollars. State dollars are obviously already tight in the areas of child welfare and foster

care, and particularly now—in this period of economic downturn. State dollars will also have to be invested to—if possible—bring state programs into compliance with the regulation.

- As Bart Baldwin, President of Kentucky’s Children’s Alliance, was quoted in a February 22, 2008 Courier-Journal article: “[The rule] would shut down a couple of programs and then where are the kids going to go at that point?” he said. "Are you going to send them back to an abusive home? Are you going to send them back to the streets?"