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I. INTRODUCTION

Insurance, in its most basic form, involves an exchange between two parties, in which one party pays and the other promises to provide protection in some form.[1] The payer seeks to have some recourse should some unforeseen misfortune arise; the payee agrees to provide the protection against misfortune for a fee or premium. The insurance industry covers a wide and varied spectrum of protections including life, casualty, property, and health. The evolution of the modern health insurance industry can be traced back to the late 1920s when Baylor Hospital introduced a "pre-paid hospital insurance plan" for a group of contracted school teachers.[2] Health insurance can be obtained either individually or often by groups with some specific common characteristic, such as, children in foster care, which is the focus of this Comment. As the health insurance industry evolved, foster children – a vulnerable group highly in need of the protection insurance offers – has been overlooked.[3] When children enter foster care, they often do so with a complicated medical history which can include everything from physical and mental health needs to developmental and behavioral challenges.[4] Without access to adequate medical care, these issues only compound on each other and lead to negative long term health and life

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1. *A Brief History of Private Insurance in the United States*, Acad. Health Plans, https://www.ahpcare.com/a-brief-history-of-private-insurance-in-the-united-states/ (last visited Dec. 1, 2020).

2. *Timeline: History of Health Reform in the U.S.*, KAISER FAM, FOUND., https://www.kff.org/wp-content/uploads/2011/03/5-02-13-history-of-health-reform.pdf (last visited Jan. 14, 2021).

3. Catalyst Ctr., *Foster Care*, Boston Univ. Sch. Soc. Work, https://ciswh.org/project/the-catalyst-center/financing-strategy/foster-care/ (last visited Feb. 19, 2021).

4. Moira A. Szilagyi et al., *Health Care Issues for Children and Adolescents in Foster Care and Kinship Care*, 136 PEDIATRICS 1131, 1132 (2015), https://pediatrics.aappublications.org/content/136/4/e1131.

outcomes ranging from heart disease to homelessness.[5] Challenges of this magnitude are difficult for anyone, but the nature of foster care adds another hurdle that the average person does not face. These challenges pose a variety of questions, such as, how quickly can a foster child see a health care provider? Will the provider be knowledgeable about the challenges facing foster children that often lead to their health care needs? How will a foster child and their foster family fund a visit to expensive specialty providers that are often needed? The answer to these questions lies with ensuring access to Medicaid and other similar plans for foster children. Although the majority of children in foster care qualify for insurance coverage under Medicaid and other similar plans, many still do not receive the essential care they need.[6] In order for children in foster care to gain access to the comprehensive care that they need, it is imperative that the public health system take advantage of critical policy opportunities which could change the trajectory of a child's life simply by making health care more accessible and comprehensive.

Part II of this Comment provides background on the foster care system, including the health and general life outcomes of children in foster care and the challenges to accessing care.[7] Then, Part III of this Comment analyzes the various ways in which Medicaid has attempted to provide the comprehensive care foster children require.[8] Section III.A discusses Medicaid, and Section III.B examines Medicaid's framework for the care of children in the foster care system.[9] Part IV provides an overview of policy opportunities for continued improvement in public insurance coverage for children living in foster care.[10] Finally, Part V briefly concludes.[11]

II. BACKGROUND

In 1853, Charles Loring Brace established the first "foster care" program in the United States: "The Placing Out System of the New York Children's Aid Society."[12] The goal of the program was to "dispos[e] of vagrant children."[13] He

5. *See Health-Care Coverage for Youth in Foster Care- and After*, CHILD WELFARE INFO. GATEWAY 2 (May 2015), https://www.childwelfare.gov/pubPDFs/health_care_foster.pdf (listing other potential health risks such as suicide, HIV, and early death).

6. *Id.*; Szilagyi et al., *supra* note 4.

7. *See infra* Part II.

8. *See infra* Part III.

9. *See infra* Sections III.A & III.B.

10. *See infra* Part IV.

[11] *See infra* Part V.

12. Thomas McDonald et al., *Assessing the Long Term Effects of Foster Care: A Research Synthesis*, INST. FOR RSCH. ON POVERTY (forthcoming) (manuscript at 23), https://www.irp.wisc.edu/publications/focus/pdfs/foc142g.pdf (last visited Jan. 8, 2020).

13. *Id.* Despite the goal of the program itself, many disadvantaged children and impoverished families saw the program as a blessing, an opportunity for "self-improvement in a more healthful environment." MARILYN IRVIN HOLT, THE ORPHAN TRAINS: PLACING OUT IN AMERICA 27 (University

believed that by removing children from an environment of poverty and squalor, even though this meant taking them away from everything they knew and loved, children could be turned into productive citizens that benefit society.[14] Through this program, children living in poverty, on the streets, and in various institutions were gathered together and shipped from the city to more rural communities in what became known as the "Orphan Train Movement."[15] Families in these rural communities would take the children in and theoretically care for them, but often the children were exploited for self-serving purposes like free farm labor.[16] As time went on, strong opposition to the program began to grow because many of the children shipped off were not orphans at all, but had at least one living parent.[17]

Around the same time as "The Placing Out System," society was also beginning to utilize institutional care.[18] These institutions were public orphanages or "orphan asylums" meant to provide temporary housing and care for impoverished children whose parents could not afford the financial burden of a child at the time.[19] These orphanages were also seen as a place to "teach values" to poor children whose parents were not providing them with adequate care, a distinction made not by family but welfare officials.[20] While these institutions indentured children, they offered a sort of "salvation" from an otherwise dismal life or so the argument went.[21] From the inception of "placing out" programs in 1853, a debate over whether placing out or orphanages were better for disenfranchised children captured national attention.[22] Ultimately, in 1909, President Theodore Roosevelt announced at the first White House Conference on Children that, if possible, children should be placed with foster families, as opposed to the orphanages, because it was the best alternative to the natural home.[23] Despite the public's opposition, by 1923, thirty-four states had formed

of Nebraska Press: Lincoln and London 1992). Many children from troublesome homes saw the program as a way to escape. *Id.* Many poor parents saw the program as a chance to alleviate some of their burdens by eliminating childcare. *Id.* at 33–34.

14. MARILYN IRVIN HOLT, THE ORPHAN TRAINS: PLACING OUT IN AMERICA 26 (University of Nebraska Press: Lincoln and London 1992).

15. McDonald et. al., *supra* note 12, manuscript at 23; Erin Blakemore, *'Orphan Trains' Brought Homeless NYC Children to Work on Farms Out West*, HISTORY, https://www.history.com/news/orphan-trains-childrens-aid-society.

16. McDonald et al., *supra* note 12, manuscript at 23.

17. MINNESOTA DEPARTMENT OF HUMAN SERVICES, ORPHANAGES: AN HISTORICAL OVERVIEW 2 (MAR. 1995), https://www.leg.state.mn.us/docs/pre2003/other/950265.pdf.

18. McDonald et al., *supra* note 12.

19. *Id.*; Holt, *supra* note 14, at 24.

20. MINNESOTA DEPARTMENT OF HUMAN SERVICES, *supra* note 17; Holt, *supra* note 14, at 24.

21. Holt, *supra* note 14, at 23.

22. McDonald et al., *supra* note 12.

23. *Id.*

private organizations to round up and ship city children to rural areas.[24] In New York alone, estimates suggest that 100,000 children were "placed" in homes between the 1850s and 1920s.[25]

Unlike the original foster care system, the goal of the modern system is to promote the health, safety, and well-being of the placed children.[26] About 1% of all children in the United States will spend time in a foster family in any given year, and 6% of all children in the United States spend time in foster care at some point before the age of 18.[27] This means that on any given day, there are over 400,000 children in the United States living with a foster family and not their biological family.[28] Generally, a child is considered for placement after a report of abuse or neglect is sent to governmental officials staffing the child welfare system.[29] Children are subsequently placed in a variety of situations such as a group home, a relative foster home, or a non-relative foster home.[30]

Often, prior to entering care, foster children live in unstable homes deprived of care, where adults come in and out of their lives with little predictability.[31] Between 70% to 80% of children that enter foster care have been exposed to significant levels of violence including a history of child abuse and/or neglect.[32] Early experience characterized by this type of trauma and stress adversely affects the neurobiology of the brain, and studies have shown that this type of complex trauma underlies many of the medical problems experienced by children in foster care.[33] The negative physical and mental health conditions foster children are at a greater risk of include: upper and lower respiratory illnesses, teeth and jaw disorders, impulse control disorders, negative self-image, inability to form secure

24. *Id.*

25. *Id.*

26. *Goal Three: Promote Safety and Wellbeing of Children, Youth, and Families*, ADMIN. CHILD. & FAMS., https://www.acf.hhs.gov/acf-strategic-initiatives-goal-three-strategies-objectives-lead-office (last visited Jan. 8, 2020).

27. Kristin Turney & Christopher Wildeman, *Mental and Physical Health of Children in Foster Care*, 138 PEDIATRICS 1, 2 (2016). https://pediatrics.aappublications.org/content/pediatrics/138/5/e20161118.full.pdf.

28. U.S. DEP'T OF HEALTH AND HUM. SERVS., CHILDREN'S BUREAU, THE AFCARS REPORT 1 (2019), https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport27.pdf.

29. *What is Foster Care?*, THE ANNIE E. CASEY FOUND. (April 4, 2020), https://www.aecf.org/blog/what-is-foster-care/.

30. *Foster Care Statistics 2018*, CHILD WELFARE INFO. GATEWAY 2 (May 2020), https://www.childwelfare.gov/pubPDFs/foster.pdf.

31. Szilagyi et al., *supra* note 4, at 1132.

32. *Id.*; *see also* U.S. DEP'T OF HEALTH AND HUM. SERVS., *supra* note 28.

33. Szilagyi et al., *supra* note 4; Sandra H. Jee & Moira A. Szilagyi, *Comprehensive Health Care for Children in Foster Care*, UpToDate 2 (June 29, 2020), https://www.uptodate.com/contents/comprehensive-health-care-for-children-in-foster-care#H30.

attachments, blindness, mood disorders, developmental disorders, and anxiety disorders.[34]

The process of removal from the family home is emotionally traumatizing for nearly all children; this additional early childhood trauma only exacerbates prior health concerns that the child may be dealing with.[35] Not surprisingly, foster children significantly outrank non-placed children in number of medical diagnoses. For example, 20.6% of foster children will experience blindness and other vision defects compared to 11.7% of non-placed children; 14.2% of foster children will experience mood disorders compared to 2.3% of non-placed children; 8.9% of foster children will suffer from a developmental disorder while only 3.9% of non-placed children do.[36] Approximately 60% of placed children suffer some chronic illness, and placed children use both inpatient and outpatient mental health services at a rate between fifteen to twenty times greater than that of the general pediatric population.[37] Evidence also suggests that if these physical, mental, and developmental health concerns are not addressed, foster children will face negative long term outcomes such as low educational attainment, homelessness, and unemployment.[38] These statistics are presented not as an indictment of the foster care system, but rather to emphasize the challenges facing those within its care. Due to these expansive medical concerns, the American Academy of Pediatrics classifies foster children as a population of children with special health care needs.[39]

Once placed, one of the biggest challenges faced by foster children is receiving sufficient medical care for their special health needs.[40] In theory, this practice should not be difficult as a system has developed and all that is necessary is for the professionals to follow the systematic process. Upon placement, the American Academy of Pediatrics recommends the child should receive an initial health screening within seventy two hours (or 3 days) of removal from the birth

34. U.S. DEP'T OF HEALTH AND HUM. SERVS., DIAGNOSES AND HEALTH CARE UTILIZATION OF CHILDREN WHO ARE IN FOSTER CARE AND COVERED BY MEDICAID 8 (2013); Letter from George H. Sheldon et al., Act. Assistant Sec'y, Admin. for Child. and Families, to State Director (July 11, 2013), https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf.

35. Szilagyi et al., *supra* note 4.

36. U.S. DEP'T OF HEALTH AND HUM. SERVS., *supra* note 34; *see also* Turney & Wildeman, *supra* note 27, at 2 (adding that children in foster care also tend to "struggle in school, have trouble finding employment, and abuse drugs and alcohol").

37. Szilagyi et al., *supra* note 4, at 1148; *Mental Health and Foster Care*, NCSL (Nov. 1, 2019), https://www.ncsl.org/research/human-services/mental-health-and-foster-care.aspx.

38. Szilagyi et al., *supra* note 4, at 1132.

39. *Id.* The American Academy of Pediatrics defines health in the case of foster children to include physical and mental health, and developmental, educational, oral, and psychological well-being as opposed to just physical and mental health. *Id.*

40. Szilagyi et al., *supra* note 4, at 1132.

parent.[41] This screening is meant to identify signs of abuse or neglect, contagious diseases, acute mental health issues, and acute or chronic health needs requiring immediate attention.[42] Within a month of placement, a comprehensive health screening should be conducted to identify each health problem and formulate individual health management plans.[43]

Even with these required assessments and identification of health needs, there are still a number of barriers between access to health care and foster children. Once such barrier is that, generally, foster parents and case workers do not understand or appreciate the full extent of the child's health needs and lack the medical expertise to sufficiently advocate for their children.[44] As a consequence, receipt of care is not preventative or even planned, but is often fragmented or crisis induced.[45] The transient nature of foster care often results in a lack of medical documentation leading to delays in referrals to the health professionals needed to address the health concerns enforcing the fragmentation of care.[46] These types of delays and barriers to treatment exacerbate current health concerns, increase the risk of development of new health concerns, and ultimately lead to negative long-term life outcomes.[47] The situation is intensified by the fact that, as a whole, pediatricians are not familiar with the intricacies and overall structure of the child welfare system.[48] As such, pediatricians are often faced with an incomplete or complete lack of a documented health history, which prevents them from fully understanding the extent of the child's health needs.[49]

Additionally, there is a diffusion of responsibility for the health care of foster children resulting in confusion over who has the power to consent to treatment for the child.[50] The child welfare system is responsible for the health of the children, but birth parents retain legal guardianship and consent rights.[51] This means that in the majority of states, foster caregivers who have physical custody, do not have the right to consent to health care for the foster children.[52] As a result, foster children often cannot seek treatment because the legal right to consent to treatment is not given to their foster care parents.

41. Jee & Szilagyi, *supra* note 33; *see infra* Section IV.A Receipt of Care for additional discussion on receipt of screenings.

42. Jee & Szilagyi, *supra* note 33.

43. *Id.*

44. Szilagyi et al., *supra* note 4, at 1133.

45. *Id.*

46. *Id.*; Jee & Szilagyi, *supra* note 33.

47. Jee & Szilagyi, *supra* note 33; Natalie McGill, *Making Health a Priority for Children in Foster Care System: Connecting to Care, Wherever Kids Are*, 46 THE NATION'S HEALTH 1, 2 (2016), http://thenationshealth.aphapublications.org/content/46/7/1.2.

48. Szilagyi et al., *supra* note 4, at 1133.

49. *Id.*

50. Jee & Szilagyi, *supra* note 33, at 12.

51. *Id.*

52. *Id.*

The consensus among medical professionals is that these children require a coordination of care.[53] The Fostering Connections to Success and Increasing Adoptions Act, adopted in 2008, amended the Social Security Act to require states to "develop . . . in consultation with pediatricians, other experts in health care, and experts in and recipients of child welfare services, a plan for the ongoing oversight and coordination of health care services for any child in foster care placement."[54] The Act requires the child welfare system to include care for physical, mental, and dental health.[55] Despite the structural protocols and policies in place, such as mandatory health screenings and this Act, foster children still struggle to receive appropriate and affordable care.

III. OVERVIEW OF PUBLIC INSURANCE

Typically, health insurance is a contract between an individual and their health insurer requiring the insurer to pay some, or all, of the health care costs in exchange for a premium. Public health insurance is a type of health insurance in which the health insurer is the federal, state, or local government. This type of government prescribed plan is a relatively new concept in the United States originating in the Medicaid and Medicare authorizations of the Social Security Act.[56] The following sections will provide an overview of Medicaid as insurance for foster children and the benefits it provides them.

A. Foster Care and Medicaid Eligibility

Medicaid is a public insurance system that provides health coverage to millions of Americans.[57] It is a joint federal-state program meaning it is funded both by federal and state resources and is administered by the states according to federal guidelines.[58] Although federal child welfare funds cannot be used to

53. *Id.* at 10.

54. Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351, § 205, 122 Stat. 3949, 3961 (2008).

55. *Id.*

56. During the Great Depression, President Roosevelt had an opportunity to include funding for public health insurance in the Social Security Act, but the funding was ultimately removed from the Act for fear that it would prevent passage of the legislation as a whole. *Timeline: History of Health Reform in the U.S.*, KAISER FAM. FOUND., https://www.kff.org/wp-content/uploads/2011/03/5-02-13-history-of-health-reform.pdf (last visited Jan. 8, 2020). It was not until thirty years later, when Medicaid and Medicare were authorized by Title XIX of the Social Security Act by President Johnson that the United States began to fund public insurance. *Id.* The following sections will provide an overview of Medicaid as insurance for foster children and the benefits it affords them. *Id.*

57. *What is Medicaid?* SOCIAL SECURITY ADMIN., https://www.ssa.gov/disabilityresearch/wi/medicaid.htm (last visited Jan. 8, 2020); *Medicaid*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/index.html (last visited Jan. 8, 2020).

58. *What is Medicaid?* SOCIAL SECURITY ADMIN., https://www.ssa.gov/disabilityresearch/wi/medicaid.htm (last visited Jan. 8, 2020); *Medicaid*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/index.html (last visited Jan. 8, 2020).

cover the state portion of Medicaid, the federal government does provide states with partial reimbursement to help states defray the costs incurred on behalf of eligible children.[59]

Each state sets criteria for eligibility that must be met in order to become a recipient of Medicaid coverage, but children in foster care are almost always eligible for coverage.[60] There are a number of different ways that they can qualify, but the most common eligibility pathway is through Title IV-E, the Foster Care, Prevention and Permanency Program – a program created with the purpose of providing financial assistance to Title IV-E agencies and families caring for foster children.[61] Title IV-E of the Social Security Act provides funding to support safe, secure, and reliable care for children who are removed from their homes e.g., children in foster care.[62] Title IV-E is not Medicaid but rather a category of mandatory Medicaid eligibility that creates automatic Medicaid eligibility for any child receiving Title IV-E payments.[63] Within Title IV-E, there are three categories a foster child might fall into making them eligible for coverage: (1) Maintenance Payments, (2) The Adoption Assistance Program, and (3) The Guardianship Assistance Program.[64] Further, some foster children receive Medicaid coverage outside of Title IV-E.[65]

1. Category One: Maintenance Payments

The first category is comprised of children who receive foster care maintenance payments, "payments to cover the cost of providing food, clothing, shelter, daily supervision . . ." and more.[66] The majority of foster children fall into this category.[67] To qualify for these payments, certain criteria for the removal and placement of the child must be met, including that: the removal and placement must be in accordance with "a voluntary placement agreement" or "a judicial determination;" the child's placement and care be the responsibility of "the state agency [or any other public agency] administering the state plan" or "Indian tribe . . . that has a plan approved;" and the child has "been placed in a foster home or child care institution."[68]

59. 42 U.S.C. § 1396b; *Health-Care Coverage for Youth in Foster Care- and After*, *supra* note 5, at 2.

60. 42 U.S.C. § 1396e; *Health-Care Coverage for Youth in Foster Care- and After*, *supra* note 5.

61. 42 U.S.C. § 1396e; *Health-Care Coverage for Youth in Foster Care- and After*, *supra* note 5, at 4; U.S. DEP'T OF HEALTH AND HUM. SERVS., TITLE IV-E FOSTER CARE ELIGIBILITY REVIEW GUIDE 39 (2012).

62. 42 U.S.C. § 670.

63. *Id.* § 671(a)(3).

64. *Id.* §§ 671(a)(1), (15).

65 *See infra* Section III.A.4 (explaining other avenues in which foster children can receive Medicaid coverage).

66. 42 U.S.C.. § 672(a)(1); 42 U.S.C.. § 675(4)(A).

67. *Health-Care Coverage for Youth in Foster Care- and After*, *supra* note 5, at 2.

68. 42 U.S.C. § 672(a)(2)(A-C).

In addition to the above requirements, the child must also meet the Aid to Families with Dependent Children ("AFDC") eligibility requirements established in 1996, but there was federal legislation introduced in 2019 to remove these requirements.[69] Because these requirements may be removed, I will not go into detail on what is required but will provide some context to the requirements. The Social Security Act of 1935 established the a grant program which allows states to provide welfare payments for disadvantaged children whose parents were incapacitated, deceased, or absent from the home in some other way.[70] Each state defined "need," set their own benefit levels, established income and resource limits within federal limitations, and administered the program or supervised its administration.[71] Additionally, states were entitled to unlimited federal funds for reimbursement of benefit payments, at "matching" rates that were inversely related to the state's per capita income.[72] All persons who were in classes eligible under federal law and whose income and resources were within state-set limits were entitled to aid from their state.[73] Although the AFDC was replaced by the Temporary Assistance for Needy Families ("TANF")

69. *Id.* §672(a)(3).

> "**(A)** In general. A child would have met the AFDC eligibility requirement of this paragraph if the child—
> **(i)** would have received aid under the State plan approved under section 602 of this title (as in effect on July 16, 1996) in the home, in or for the month in which the agreement was entered into or court proceedings leading to the determination referred to in paragraph (2)(A)(ii) of this subsection were initiated; or
> **(ii) (I)** would have received the aid in the home, in or for the month referred to in clause (i), if application had been made therefor; or **(II)** had been living in the home within 6 months before the month in which the agreement was entered into or the proceedings were initiated, and would have received the aid in or for such month, if, in such month, the child had been living in the home with the relative referred to in paragraph (1) and application for the aid had been made.
> **(B)**For purposes of subparagraph (A), in determining whether a child would have received aid under a State plan approved under section 602 (as in effect on July 16, 1996), a child whose resources (determined pursuant to section 602(a)(7)(B), as so in effect) have a combined value of not more than $10,000 shall be considered a child whose resources have a combined value of not more than $1,000 (or such lower amount as the State may determine for purposes of section 602(a)(7)(B))."

Id.; Family First Transition and Support Act of 2019, S. 1376 116th Cong. (2019).

70. Office of the Assistant Secretary for Planning and Evaluation, *Aid to Families with Dependent (AFDC) Children Temporary Assistance for Needy Families (TANF) – Overview*, U.S. DEP'T OF HEALTH AND HUM. SERVS. (Nov. 30, 2009), https://aspe.hhs.gov/aid-families-dependent-children-afdc-and-temporary-assistance-needy-families-tanf-overview-0.

71. *Id.*

72. *Id.*

73. *Id.*

program in 1996, TANF requires Title IV-E agencies to apply the AFDC requirements, the AFDC and Title IV-E have remained linked.[74]

The AFDC requirements create an additional unnecessary barrier to coverage. Assuming that the removal legislation does pass, foster children will only need to satisfy the requirements set out in 42 U.S.C. §672(a)(2) which hopefully opens the door to more expansive coverage. Under this first category of eligibility, a child, who meets the above criteria and on whose behalf these payments are made, is categorically covered by Medicaid in their state of residence.

2. Category Two: The Adoption Assistance Program

The second pathway to Title IV-E eligibility and thus coverage under Medicaid is through the Adoption Assistance Program.[75] The Adoption Assistance Program provides payments to families who are adopting a child with special needs from foster care.[76] As applied to Title IV-E eligibility, the term "special needs" has a broad meaning. Generally, a child is considered to have special needs if the state determines that: (1) the child "cannot or should not" return to the parental home; (2) there is some factor which prevents the child from being placed with adoptive parents without assistance; and (3) the appropriate effort was made to place the child in an adoptive home without assistance.[77] Based on these three criteria, each state decides on a case-by-case basis whether a child qualifies for coverage under Title IV-E.[78] Once the state determines that a child is eligible, an adoption assistance agreement is made to determine the amount paid and whether payment will be a one time, nonrecurring payment, or an ongoing, recurring payment.[79] Under this second category, when a child is eligible for payments under the adoption assistance program, they are also categorically eligible for Medicaid coverage.

74. U.S. DEP'T OF HEALTH AND HUM. SERVS., TITLE IV-E FOSTER CARE ELIGIBILITY REVIEW GUIDE 39 (2012).

75. 42 U.S.C. § 673.

76. *Id.* § 673(a)(1)(A).

77. *Id.* § 673(c)(2).

78. *Id.* Some of the guidelines that help make the "special needs" determination include: the age of the child, physical disability, mental disability, emotional disability, being a member of a minority group, a family history that suggests the child will need help reaching developmental milestones, or the child qualifies for supplemental security income benefits. CONG. RSCH. SERV., CHILD WELFARE: HEALTH CARE NEEDS OF CHILDREN IN FOSTER CARE AND OTHER RELATED FEDERAL ISSUES 36 (2014), https://www.everycrsreport.com/files/20141216_R42378_c1a5d26fd74a608e077f1eeedbe144807f886fe2.pdf.

79. *Adoption Assistance for Children Adopted from Foster Care*, CHILD WELFARE INFO. GATEWAY 2 (Feb. 2011), https://www.childwelfare.gov/pubPDFs/f_subsid.pdf.

3. Category Three: The Guardianship Assistance Program

The third pathway to eligibility is through Guardianship Assistance Program ("GAP") payments.[80] All states operate a Title IV-E program in which they must provide foster care maintenance payments to each eligible child in foster care and must enter into adoption assistance agreements with parents of each eligible adopted child.[81] However, states are not required, but may elect, to provide kinship guardianship assistance to eligible children.[82] Guardianship is a judicially-created relationship between a child and adult in which the adult steps into the role of parent, assumes many of the rights and responsibilities of the child's biological parents, and is granted permanent care, custody, and control of the child without terminating parental rights.[83] The guardian is traditionally a relative but can also be a close friend.[84] A child and guardian are eligible for assistance if the guardian can care for the child in all respects except complete financial responsibility.[85]

To be eligible for GAP payments, several criteria must be met. First, the child must have been "removed from his or her home pursuant to a voluntary placement or . . . judicial determination" and must be "eligible for foster care maintenance payments" for at least six consecutive months.[86] Second, the Title IV-E agency must be responsible for the placement of the child and must determine that both returning home and adoption "are not appropriate permanent options."[87] Third, the child must "demonstrate a strong attachment" to the guardian and the guardian must demonstrate a "strong commitment to caring for" the child.[88] With respect to children fourteen years of age or older, the child must be consulted on placement in a guardianship.[89] Finally, the prospective guardian must negotiate and enter into and receive a copy of a written, binding kinship guardianship assistance agreement with the Title IV-E agency.[90] Although states

80. 42 U.S.C. § 673(d).

81. CONG. RSCH. SERV., *supra* note 78, at 8.

82. *Id.*

83. *Children's Bureau, Kinship Guardianship as a Permanency Option*, CHILD WELFARE INFO. GATEWAY 2 (July 2018), https://www.childwelfare.gov/pubPDFs/kinshipguardianship.pdf.

84. *Id.*

85. *Id.*

86. 42 U.S.C. § 673(d)(3)(A)(i).

87. *Id.* § 673(d)(3)(A)(ii).

88. *Id.*§ 673(d)(3)(A)(iii).

89. *Id.* § 673(d)(3)(A)(iv).

90. *Id.* § 673(d)(1). A kinship guardianship agreement has four minimum requirements. *Id.* First, the agreement must contain details related to the amount of, and manner in which, each kinship guardianship assistance payment will be provided and the manner in which the payment may be adjusted periodically, based on the needs of the child. *Id.* Second, the agreement must specify the additional services and assistance that the child and relative guardian will be eligible for under the agreement. *Id.* Third, the agreement must specify the procedure by which the relative guardian may apply for additional services as needed. *Id.* Fourth, the agreement must detail that the State will pay the total cost of

make these determinations based on criteria that they set, all criteria must fall within these four federal guidelines. However, a state agency may make GAP payments for a child who does not meet all the requirements when that child is the sibling of an eligible child and the siblings are in the same guardianship.[91] Under this third pathway, a child who is eligible for GAP payments is also categorically eligible for care under Medicaid.

4. Eligibility Without Title IV-E

If a foster child is not eligible for Medicaid coverage under Title IV-E, they can still qualify for Medicaid coverage in a couple different ways. For example, states are required to provide Medicaid coverage for children under the age of 19 whose household income is less than 133% of the federal poverty line.[92] States are free to establish a higher limit for different age groups.[93] Generally, the foster child's personal income is all that is considered for eligibility based household income; therefore, the majority of children under age nineteen who do not qualify through Title IV-E qualify this way.[94] The health challenges faced by children in foster care do not disappear as soon as they leave the system. Many of these struggles are lifelong and former foster children still require access to quality health care. Former foster children are eligible for Medicaid coverage through this second alternative pathway – the Affordable Care Act's mandatory Medicaid coverage for children and youth under the age of twenty-six who were in "foster care under the responsibility of the state" and receiving Medicaid when they turned eighteen.[95] Under this pathway, a former foster child is eligible for their state's full Medicaid coverage regardless of income.[96] Due to the multitude of available avenues to Medicaid eligibility available to foster children, the odds that a foster child is not be covered by Medicaid are actually extremely low.

B. Benefits of Medicaid for Children in Foster Care

As a joint federal and state program, each state implements their own Medicaid programs and develops a strategy that addresses the health care needs of each child in foster care within the bounds of federal guidelines and rules.[97] Under federal law, through the Foster Connections to Success and Increasing Adoption Act of 2008, states are required to develop a plan in consultation with

nonrecurring expenses associated with obtaining legal guardianship of the child, to the extent the total cost does not exceed $2,000. *Id.*

91. 42 U.S.C. § 673(d).

92. *Health-Care Coverage for Youth in Foster Care- and After*, *supra* note 5.

93. *Id.*

94. *Id.*

95. 42 U.S.C. § 1396(a)(10)(A)(i)(IX).

96. *Health-Care Coverage for Youth in Foster Care- and After*, *supra* note 5, at 4.

97. CONG. RSCH. SERV., *supra* note 78, at 13.

pediatricians and other experts for the oversight and coordination of health care services for foster care children.[98] The average plan must outline: (1) a schedule for initial and follow up health screenings; (2) a system for how health needs will be identified, updated, and shared; (3) steps to ensure continuity of health care; (4) oversight of prescription medication; and (5) a system for how the state will consult with physicians and other professionals in assessing the health and well-being of foster children.[99] Additionally, the Child and Family Services Improvement and Innovation Act built on the well-being provisions of the Fostering Connections to Success and Increasing Adoptions Act to support children's emotional and developmental health.[100] The Child and Family Services Improvement and Innovation Act requires states to outline how identified emotional traumas due to maltreatment prior to removal from the home and trauma resulting from removal from the home will be monitored and treated, including protocols for the appropriate use and monitoring of psychotropic medications, and much more.[101]

States have the option and authority to impose on Medicaid beneficiaries premiums or other cost-sharing requirements and to enroll some in Medicaid alternative benefit plans ("ABP").[102] A Medicaid ABP typically covers fewer services than traditional Medicaid benefit packages.[103] However, Title IV-E children in foster care and children who leave foster care for adoption or guardianship are not subjected to the cost-sharing requirements, and states are prohibited from requiring their mandatory enrollment in Medicaid ABPs.[104] These restrictions on what the state can do ensure that the services required by the child will likely be covered and the child will not have to pay an expensive out-of-pocket cost.

Furthermore, Medicaid provides numerous services that states are mandated to provide including: in-network physicians, in-patient and out-patient hospital services, rural health clinic services, laboratory, and x-ray services.[105] In addition to these mandatory services, states also have the discretion to provide certain optional benefits, such as, prescription drugs, physical therapy, dental services, prosthetics, and hospice.[106] Services for children and youth in foster

98. Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351, § 205, 122 Stat. 3949, 3961 (2008).

99. *Id.*

100. 42 U.S.C. § 622.

101. *Id.* § 622(b)(15)(A)(ii); *Id.* §622(b)(18).

102. 42 U.S.C. § 1396O-1(a)(1).

103. CONG. RSCH. SERV., *supra* note 78, at 13.

104. *Id.* at 15.

105. *Mandatory & Optional Medicaid Benefits*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html (last visited Jan. 9, 2020).

106. *Id.*

care generally include preventive, screening, diagnostic, and treatment services necessary for achieving optimal physical and behavioral health.[107]

Additionally, the Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") program, a comprehensive and preventive benefit for children under the age of twenty-one enrolled in Medicaid, including foster children, is a mandatory service under the Federal Medicaid program.[108] EPSDT provides early screening and testing and the continuation of that testing at intervals that are age appropriate and in line with medical standards with the goal of identifying and treating health problems as early as possible.[109] This preventive aspect of EPSDT helps to ensure that health problems are diagnosed and treated early so they do not develop into more serious and complex issues.[110] At a minimum, EPSDT screenings must include: a comprehensive history; a comprehensive unclothed physical exam; vision, dental, and hearing services; immunizations; laboratory testing; and any other medically necessary services.[111]

In addition, states are required to provide all federally-allowed treatment to correct health problems identified through screenings, even if the specific treatment needed is not otherwise covered under a given state's Medicaid plan.[112] This means that states may be required to cover services for children that would otherwise be optional or not originally covered for adults.[113] The purpose of this federally-allowed treatment is to ensure that medical issues are diagnosed and treated early on, rather than letting a medical issue unnecessarily develop into a more serious and complex problem later on.[114] As noted in Part II,[115] children in the foster care system have gone through and continue to go through significant traumas; therefore, the child welfare system places a strong emphasis on the identification and treatment of trauma in children in foster care.[116] Under the EPSDT program, diagnosis and treatment of mental and behavioral health issues

107. CONG. RSCH. SERV., *supra* note 78, at 7.

108. 42 U.S.C. §§ 1396d(a)(i), (r); *Health-Care Coverage for Youth in Foster Care- and After*, *supra* note 5, at 7.

109. *Early, Periodic, Screening, Diagnostic, and Treatment*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/benefits/epsdt/index.html (last visited Jan. 9, 2020).

110. Letter from George H. Sheldon, Act. Assistant Sec'y, Admin. For Child. and Families, to State Director (July 11, 2013), https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf.

111. 42 U.S.C. § 1369(d)(r). Vision and hearing services must include diagnosis and treatment for defects in vision and hearing. *Id.* Dental services must include relief of pain and infections, restoration of teeth, and maintenance of dental hygiene. *Id.*

112. CONG. RSCH. SERV., *supra* note 78, at 15.

113. *Id*. at n.52.

114. *Id.* at 15.

115. *See supra* Part II.

116. *Health-Care Coverage for Youth in Foster Care- and After*, *supra* note 5, at 8.

are covered in the same way as physical health issues even if they would not be covered for adults – an important benefit.[117]

IV. POLICY OPPORTUNITIES

There are, of course, concerns about the health of all the children enrolled in Medicaid, but due to the heightened health issues and complex needs resulting from serious trauma, the concern for children in foster care is much greater.[118] Their significant unmet health needs are deeply rooted due to their complex trauma histories and compounded by barriers causing inadequate access to health care. Among other things, concerns for children in foster care often involve issues such as, too little funding for too few professionals, continuity of care, receipt of timely care, receipt of appropriate care, and access to care.[119] Before anything else can be accomplished, two priorities for Medicaid coverage of foster children are ensuring receipt of care, and once care is received, ensuring communication and coordination among providers.

A. Receipt of Care

Despite the federally mandated EPSDT program, reports show that not all foster children receive their screenings. In 2015, the Office of Inspector General for the U.S. Department of Health and Human Services ("HHS OIG") reported that nearly one third of all foster children enrolled in Medicaid had not received at least one screening.[120] Additionally, over one quarter of children in foster care enrolled in Medicaid had received at least one late screening.[121] The HHS OIG also found that the Administration for Children and Families ("ACF"), which is responsible for monitoring state foster care programs, failed to ensure that children in foster care were receiving the required screenings according to the state screening schedules.[122] If the screenings are not administered in a timely manner or at all, the EPSDT program becomes futile because the ultimate goal of treatment is nullified without the initial screening and diagnosis.

The Medicaid EPSDT benefit has been the subject of civil suits against several states because of the variations in interpretation and implementation of

117. *Id.*

118. MACPAC, THE INTERSECTION OF MEDICAID AND CHILD WELFARE 57 (2015), https://www.macpac.gov/wp-content/uploads/2015/06/Intersection-of-Medicaid-and-Child-Welfare.pdf.

119. *Id*. at 72–75.

120. U.S. DEP'T OF HEALTH & HUM. SERVS., NOT ALL CHILDREN IN FOSTER CARE WHO WERE ENROLLED IN MEDICAID RECEIVED REQUIRED HEALTH SCREENINGS 7 (Mar. 2015), https://oig.hhs.gov/oei/reports/oei-07-13-00460.pdf.

121. *Id.*

122. *Id.* at 8.

the requirements.[123] The subject matter of these suits has shifted over time but the current emphasis is on protecting access to treatment services.[124] For example, a recent class action in Illinois demonstrates the concerns of many who are bringing suit.[125] In *O.B. v. Norwood*, the Medicaid agency determined that the child plaintiffs qualified for coverage for a certain amount of in-home nursing services.[126] However, the children did not receiving adequate care, resulting in the placement of these children in institutions, hospitals, or suffering at home.[127] The plaintiffs brought suit under two Medicaid provisions: (1) the EPSDT provision requiring the state Medicaid agency to arrange for the child to receive the necessary treatment and (2) another provision requiring the state Medicaid agency to ensure reasonable promptness in providing the necessary services.[128] The district court entered a class-wide preliminary injunction requiring Norwood to "take immediate and affirmative steps" to implement the necessary care.[129] This obligation was later affirmed by the U.S. Court of Appeals for the Seventh Circuit.[130]

The immediate and affirmative obligation to implement necessary care was not specific to the *Norwood* case. All children are entitled to access the necessary care covered by Medicaid, but that is unfortunately not the case. States which participate in the EPSDT program should actively be working to ensure the provision of these services. The HHS OIG has made recommendations over the years for ways in which states can help ensure that all foster children receive their regular screenings and other services. Two of these recommendations stand out as ones states should be actively working to implement. First, states need to identify and dismantle all barriers that prevent children from accessing screenings, including family attitudes, problems with provider access, and a general lack of knowledge of the EPSDT.[131] Second, the scope of ACF reviews should be expanded to include not only whether states are providing health screenings but also whether children are actually receiving the screenings within the specified timeline and on a consistent basis.[132] These two recommendations build off of each other. Timely and consistent screenings are not going to become

123. JANE PERKINS, FACT SHEET: MEDICAID EPSDT LITIGATION – CASE TRENDS 2 (NHELP 2016), https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2016/05/EPSDT-trends-June-2016-update.pdf.

124. *Id.* at 3.

125. O.B. v. Norwood, 170 F. Supp. 3d 1186 (N.D. Ill. 2016).

126. *Id.* at 1190.

127. *Id.* at 1194.

128. *Id.* at 1191.

129. *Id.* at 1197, 1201.

130. O.B. v. Norwood, 838 F.3d 837, 843 (7th Cir. 2016).

131. U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 120, at 9.

132. *Id.* Those states that fail to provide consistent screenings must face some accountability; however, what that accountability looks like is beyond the scope of this Comment. *Id.*

the norm until the barriers to access are addressed which is why those barriers must be identified and addressed first. Once states identify these and other barriers in their communities, ACF and states should implement strategies for overcoming the barriers, such as, increasing the number of providers that accept Medicaid. Additionally, states should disperse educational material to or provide educational seminars for families and providers that are not only accurate but also accessible to the everyday person. Moreover, the federal government could incentivize participation in screenings by providing additional funding to the state. Once a plan to overcome these barriers is in place, the state can then move forward in ensuring that families are actually bringing children in for their screenings consistently and on time. It is important for foster children to not just receive these screenings but to receive them in a timely fashion. The longer that they go without a screening the less likely it is that they will ever receive a screening and the more likely it is that they will not receive the care that they require. Preventative care not reactive care is what will stop the development of greater and more harmful concerns down the line. It is the primary way to identify the multitude of health concerns that foster children more than likely have.[133] The longer they go without screenings, the more complex the issues may become, and eventually the long-term adverse concerns will manifest and hinder the foster child's mental, physical, and emotional growth and development.

B. Interoperability – Ensuring Communication Among Providers

Achieving well-being among foster children requires more than just putting a band-aid on the problem; once receipt of care is ensured, an interdisciplinary, cross-system approach is necessary.[134] One person or one group cannot do everything alone; solving the access problem requires a truly integrated health care plan. This approach requires a collaboration across professions to integrate and monitor screenings, assessments, referrals, and interventions. Interoperability, the ability of different information systems to access, exchange, and integrate information across organizational boundaries, is a major hurdle for the health care system and is paramount in ensuring continuity of care and receipt of appropriate care.[135] Successful outcomes for foster children rests on the effective collaboration of professionals and the integration of the services each professional provides.[136] However, logistically, for this approach to work, a system of communication across disciplines, professionals, and families,

133. Letter from George H. Sheldon et al., Act. Assistant Sec'y, Admin. for Child. and Families, to State Director 2 (July 11, 2013), https://www.imedicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf.

134. *Id.* at 4.

135. AM. ACAD. OF PEDIATRICS, FOSTERING HEATH: HEALTH CARE FOR CHILDREN AND ADOLESCENTS IN FOSTER CARE 6 (2nd ed. 2005).

136. *Id.*

including the follow up of health care information, must be implemented.[137] This communication system must facilitate the exchange of electronic health information among health care providers and foster families to ensure that everyone requiring a complete record of health conditions and services has it and will likely require an expanded oversight and delivery mechanism. This will require added expense, but without efficient communication, it is nearly impossible for providers and families alike to keep track of all the child's complex diagnoses, treatments, and services, especially considering the difficulties families might have in completely understanding the information and the transient nature of children in foster care.

The Fostering Connections to Success and Increasing Adoptions Act of 2008 and the Child and Family Services Improvement and Innovation Act of 2011 both acknowledge the need for collaboration across professionals and required states to develop plans to better monitor and coordinate health services.[138] Together, they promote opportunities for collaboration and consultation among Medicaid, child welfare and behavioral health experts, and pediatricians in order to develop coordinated care systems that include periodic health assessments, shared health information, provision of care in the context of a medical home, and oversight of prescription medications.[139] The opportunities need to be taken advantage of for the purpose of these Acts to be served.

Some states have successfully implemented interoperability policies in Medicaid programs for foster care. For example, Tennessee's Department of Child Services ("DCS") and TennCare, the state Medicaid agency, have developed an interagency agreement to coordinate the continued enrollment and delivery of health services for all of the foster children in the state.[140] Once a child enters the foster system, TennCare *Select*, the Medicaid managed care system dedicated to foster children, is notified by DCS.[141] As a mere function of entering the foster system, the child is eligible for TennCare *Select* and is assigned to a primary care practitioner who operates as the "medical home" for the child.[142] As the medical home, the primary care practitioner, a member of TennCare *Select* Best Practice Network of physicians, dentists, and behavioral health specialists, is then responsible for coordinating all physical and behavior health services for the child and is required to fulfill the roles and responsibilities

137. *Id.*

138. Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351, § 205, 122 Stat. 3949, 3961 (2008); 42 U.S.C. §622(b)(2).

139. Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351, § 205, 122 Stat. 3949, 3961 (2008); 42 U.S.C. §622(b)(2); KAMALA D. ALLEN & TAYLOR HENDRICKS, MEDICAID AND CHILDREN IN FOSTER CARE 6 (SPARC 2013).

140. Allen & Hendriks, *supra* note 139, at 7.

141. *Id.*

142. *Id.*

associated with management of children in foster care.[143] TennCare *Select* also provides valuable services tailored to the needs of the DCS families such as a toll-free phone line staffed by personnel familiar with the DCS process for families to call with questions or concerns.[144] DCS and TennCare *Select* meet regularly to develop and implement strategies centered on issues such as the use of medications, informed consent, coordination of care, management reporting, and meeting the physical and behavioral needs of the children.[145]

TennCare *Select* does at least two important things every state should also do to ensure interoperability. First, TennCare *Select* has created a "medical home" for every child that enters foster care which serves as a base location for all ongoing primary care services and periodic reassessments of health, development, and emotional status.[146] Enrollment in a medical home is a vital step in ensuring the receipt of superior care because, as a centralized location, it provides all of the child's providers – pediatricians, mental health workers, social workers, and any other provider a child may have – and the family with access to records of diagnoses, treatments, and other medical information providing the complete picture necessary for comprehensive continuous care. Thus, the medical home is crucial to interoperability because it prevents fragmented care to which foster children so often fall victim.[147] Additionally, TennCare *Select* maintains a system to keep the families informed through access to their child's medical home and with the toll-free phone number.[148] Care can be successful only when foster parents are educated on the medical needs of the child. Educating foster parents supports the concept of interoperability because it allows the foster parent to have informed discussions about the health of the child with all providers. Despite an increase in the Tennessee foster care population, the TennCare *Select* system remains successful, with 88% of children entering foster care receiving their initial screening in the first thirty days and expanded data and child tracking capabilities ensuring communication.[149] The Tennessee system is a model to other states in interoperability policy and system design for the health care of foster children. TennCare *Select* is successful in a state with an ever-increasing foster care population, it can certainly be successful across the country.

143. *Id.*

144. *Id.*

145. *Id.*

146. AM. ACAD. OF PEDIATRICS, *supra* note 135, at 132.

147. *Id.* at 89.

148. Allen & Hedricks, *supra* note 139, at 7; *Tennessee Medical Home Project*, AM. ACAD. OF PEDIATRICS TENN. CHAPTER, https://www.tnaap.org/programs/tennessee-medical-home/tennessee-medical-home-overview (last visited Jan. 9, 2020).

149. THE CTR. FOR STATE CHILD WELFARE DATA, TENNESSEE ACCOUNTABILITY CENTER REPORT 3 COMPANION DISPARITY REPORT 40 (2018), https://fcda.chapinhall.org/wp-content/uploads/2018/12/Tennessee_Accountability_Center_Report3.pdf.

Additionally, the "health passport" system, such as the one implemented by Texas, is another example of successful implementation of interoperability policies.[150] The health passport is an online health record which, while not a complete record, does contain the patient's demographics, claimed visits, allergies, test results, immunizations, and filled medications.[151] While not perfect, the health passport does provide medical professionals with access to much more patient information, located in a centralized place, than they had in the past.[152] The centralization of the information prevents errors such as subjecting children to duplicate tests or immunizations as a result of missing information and facilitates increased communication between providers.[153] However, due to the mere fact that the medical record is incomplete, foster children are still at a disadvantage and susceptible to fragmented care under the "health passport" model of coordination.

It is imperative that across disciplines everyone, including both providers and families, knows as much about the child's history as possible. Because the health passport is only a centralized location to view an incomplete medical record, the Tennessee TennCare *Select* model is a better approach to achieve interoperability and should remain primary interoperability example. The health passport is a strong secondary option or intermediate developmental step for states that may not be in the position to adopt a full TennCare *Select* approach.

V. CONCLUSION

Health care is an expensive but crucial necessity. This necessity is never more evident than when an individual is facing an unexpected health concern. As children in the foster system have health needs that are often substantial, complex, chronic, and rooted in trauma, they tend to experience health consequences more than most other children. Even in relatively stable situations, it is difficult to face these types of health concerns, but many foster children do not grow up in stable or predictable situations. If these health concerns are not addressed early and consistently in the child's life, they have the potential to grow even more complex, leading the child to develop even more adverse long-term health outcomes. Medicaid provides the overwhelming majority of foster children an opportunity to access the health care that they need, but there are still barriers to care that should not exist, such as, poor care coordination and

150. Szilagyi et al., *supra* note 4, at 1134; *Health Passport*, TEX. DEP'T OF FAM. AND PROT. SERVS., https://www.dfps.state.tx.us/Child_Protection/Medical_Services/Health_Passport.asp (last visited Jan. 9, 2020).

151. *Frequently Asked Questions – What is a Health Passport?*, STAR HEALTH, https://www.fostercaretx.com/for-providers/health-passport/health-passport-faqs.html (last visited Jan. 9, 2020).

152. *Id.*

153. *Id.*

communication between providers and families; too few providers accepting Medicaid; inadequate financing; and the State's individual plan not covering the necessary services. Of these, the most critical barriers involve issues related to interoperability and receipt of care. An entire system cannot be fixed overnight, but if systems and policies ensuring receipt of care and interoperability are put in place across the country, the health care system will have taken significant steps towards improving the health and welfare of the foster care population.