QUALITY HEALTH CARE SERVICES FOR CHILDREN IN OUT-OF-HOME CARE

TASK FORCE ON HEALTH CARE FOR CHILDREN IN OUT-OF-HOME CARE
REPORT TO THE LEGISLATURE

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Executive Summary

BACKGROUND

The 1999-2001 Wisconsin state budget contained a provision requiring the Department of Health and Family Services to develop a managed care pilot program to integrate and oversee the social, behavioral and physical health care needs of children in out-of-home care in Milwaukee. In response to this statutory requirement the Division of Children and Family Services, in full partnership with the Division of Health Care Financing, created the *Task Force on Health Care for Children in Out-of-Home Placement* (Task Force). The Task Force was specifically charged with developing a model to improve the access and quality of health care for children in foster care. The proposed model is to be used as a basis for requesting a federal waiver. The waiver would provide the Department of Health and Family Services (DHFS) with the authority to require children in foster care to enroll in a managed care plan as a condition of receiving Wisconsin Medicaid.

ISSUE

Foster children in out-of-home care have difficulty obtaining adequate medical and behavioral health care in the current Medicaid fee-for-service health care delivery system. It has become increasingly difficult for foster care families to find medical providers willing to accept foster children on a Medicaid fee-for-service basis. Exacerbating this problem has been the fact that many foster care children have involved and complex medical needs and often lack an accessible, adequately documented medical history which makes further medical treatment difficult.

It is based upon these factors that the Task Force sought ways to both improve access and quality of health care delivery for children in the foster care system. While the Task Force's directive was to recommend a foster care pilot program in Milwaukee County, the ultimate goal of the Task Force was to develop a statewide managed care model for children in out-of-home care. As part of this effort the Task Force recommended that, at the option of the adoptive parents, children in subsidized adoption would be included in the Department's long-term goal of managed care for children in out-of-home care. Therefore, for purposes of this report, the term "children in out-of-home care" includes children in subsidized adoption and court-ordered placements. These court-ordered placements may include episodes in and out of care as long as the child remains under court-ordered foster care.

ANALYSIS

Children in foster care and certain other out-of-home care are typically children with special needs and typically categorically eligible for health care services under Medicaid. Research reviewed by the Task Force revealed that this population includes children with more complex physical, mental, and emotional health care needs than that of the general Medicaid population. Children in foster care are generally more likely to experience chronic health problems, congenital disorders, developmental and growth delays, mental health problems, and birth

defects. Additionally, these children are more likely to need referral to specialty care, counseling, and special education services. They are also more likely to have a family history of substance abuse or mental illness. Generally, children with birth defects are likely to be placed in out-of-home care earlier in life than those who do not have birth defects. Moreover, these children are more likely to remain in this type of care for nearly twice as long as usual.

The Task Force has taken the position that the complexity and cost of care for children in out-of-home care represents an opportunity for improvement in the area of access, comprehensive assessments, coordination of care, quality, and to provide better outcomes with an emphasis on prevention through a quality health care delivery system. The concept of health care prevention was taken up by the Task Force which expressed interest in emphasizing physical fitness through general aerobic activity and participation in organized sport activities.

TASK FORCE FINDINGS

The research reviewed by the Task Force consistently showed that the growing number of children in out-of-home care demonstrate a marked increase in the prevalence of their health problems. A failure to address these needs results in poor health outcomes for the children. A failure to address developmental delays translates into poor academic performance. Lack of care coordination results in expensive, fragmented, and ineffective care.

The Task Force considered issues affecting foster parents, birth parents, managed care options, and regulatory issues associated with managed health care delivery systems. The Task Force made recommendations on the creation of a system to manage health care services for children in the Milwaukee area and statewide.

The Task Force intentionally chose not to make a specific recommendation on the type of managed care model or approach. They did, however, develop a Health Care Management Functional Model for children in out-of-home care. This functional model identifies a framework of vital and desirable characteristics for an out-of-home health care management system. The Task Force also developed recommendations regarding important components of the health care system design. The key achievements made by the Task Force include:

- Development of a conceptual framework of a health care delivery model for foster care children.
- Development of guidelines for a quality improvement process necessary to evaluate the new health care delivery system for foster care children.
- Development of a process for advocacy by or for caregivers, birthparents, foster care children and providers.
- Preliminary development of costs for sustaining the foster care managed care program in Milwaukee County and Statewide.
- Recommending that the DHFS proceed with a federal waiver request and the procurement process.

Additionally, the Task Force recommended the following immediate steps be taken to address current health care problems:

- The Bureau of Milwaukee Child Welfare should perform the initial assessment of children immediately upon custody of a child. (This procedure was implemented immediately.)

- Within thirty days of the child being placed in custody, a comprehensive physical and behavioral assessment should be made. Case planning which specifically addresses the unique needs of each child should also be performed within this period. (This process was recently implemented by Children's Hospital of Wisconsin.)

- Emergency mental health crisis intervention services should be expanded to include increased coverage for consultation and support for foster families during evening, nighttime, and weekend hours. (Funding issues associated with this recommendation are currently being reviewed.)

- The training of foster care parents with regard to the specific health care issues of children in out-of-home care should be expanded. Specifically, address through additional training, the unique health care challenges and needs of children with special health care issues. (The foster parent cirrocumuli has recently been expanded to include training on the health care needs for children with special health care needs.)

- The Department of Health and Family Services (DHFS) should arrange for access for MBCW caseworkers on the status of Medicaid eligibility and access to Medicaid covered services for children in out-of-home care.

- The DHFS should also arrange for access to fee-for-service and managed care encounter data for physicians, MBCW caseworkers and foster parents. The data would include basic health status information (immunization status, current medications, and primary care providers) and would be immediately available to all primary care providers, MBCW caseworkers and foster parents upon custody of the child by MBCW.

- The DHFS should train MBCW caseworkers on case management techniques to assist with development of effective and efficient case management services for children in out-of-home care.

This report summarizes the data, findings and recommendations made by the Task Force and used to create the proposed functional model. The following page is a representation of the Task Forces' proposed health care management model for children in out-of-home care. This model is referred to in subsequent pages of this report.

Health Care Management Functional Model for Children in Out-of-Home Care

STEP 1: CHILD ENTERS FOSTER CARE PLACEMENT

- Coverage begins with physical custody
- Health care manager assigned, available 24/7
- Care coordination begins: health appointments, transportation, etc.
- Brief medical form to caregiver-basic health assessment provided.
- Release of information authorization and parental/court-ordered consent acquired
- Medicaid data obtained, if applicable, included in record

STEP 2: INITIAL HEALTH SCREEN

- Within 24 hours, arranged by child welfare
- Identifies immediate health care needs
- Standardized screen by trained/certified practitioners, includes mental health issues
- Forensic exam is not part of screen—referral for exam and specialty care made
- Screening available at convenient site(s)
- Results of screen data immediately provided to case manager, foster family and child welfare

STEP 3: INITIATE HEALTH CASE MANAGEMENT

- Initial care planning meeting
- Initial health care plan written
- Primary health care provider selected from the enrollee handbook
- Focus is on immediate needs of child
- Ongoing case management available 24/7
- Case manager qualifications appropriate to needs

STEP 4: COMPREHENSIVE PHYSICAL/BEHAVIORAL HEALTH TEAM ASSESSMENT

- Within 4-6 weeks of placement
- Standardized assessment performed
  - Foster/birth parent involved
  - Child welfare input included
- Comprehensive health care plan completed
- Referral to specialty care when needed
- Creates comprehensive needs list
  - Data included when possible
- Health case manager is responsible for maintaining plan updates
- Reassessment based on child's need and established process.

STEP 5: ON-GOING HEALTH CARE COORDINATION—CHILD

- Primary care including dental, vision and hearing services
- Specialty care/therapy
- Coordination with child welfare services
- Crisis intervention & mental health services available 24/7

BIRTH AND FOSTER PARENT

- Input on goals and health care plan
- Coordination with child welfare

STEP 6: HEALTH CARE CASE CLOSURE

- Permanency plan implemented
- Case summary/review
- Transitional planning & follow-up must include continuity of care and be consistent with primary goals, including preparing children who will encounter the age limit of the foster care system.
- Transition and follow-up consistent with permanency goal
- Disenrollment (may occur earlier based on exemption criteria)

- On-going medical/health services, including referrals to specialists
- Internal and external advocacy for foster children

ACKNOWLEDGEMENTS

The Task Force included foster parents, physicians, mental health providers, social workers, advocates, court commissioners, and other professionals involved in the care of foster children. The Task Force reviewed the current condition of health care access and services currently available for children in foster care. After evaluating access and availability of services, Task Force members drew upon their considerable expertise and began to design an ideal system of care for children in out-of-home care. A model health care program emerged with a considerable amount of detail for the types of assessments and services foster children should receive. Included in this model were the timeframes for the delivery of these services.

The importance of developing standards for individual health assessment and care, along with the desire for more complete and accessible medical records, were topics the Task Force pursued in great detail throughout their assignment. Workgroups met between Task Force meetings and developed recommendations in these areas. Members also volunteered to continue working past the Task Force's conclusion in order to advise DHFS on key points of a health care system redesign that could be implemented immediately without waiting for full implementation of the recommended model managed care program. The Task Force anticipates continued collaboration with the Department throughout the implementation of a managed care model for children in out-of-home care.

The Wisconsin Department of Health and Family Services gratefully acknowledges the contribution of time and talent by the following:

COMMITTEE MEMBERS, STAKEHOLDERS, FOSTER PARENTS, AND PROFESSIONALS

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TASK FORCE MISSION AND HISTORY

The Wisconsin Task Force on Health Care for Children in Out-of-Home Care was convened in June 2000 and met through January 2001. The Task Force was created in response to a legislative directive seeking the development of a pilot program to manage health care services for children placed by the juvenile court outside of their homes. All meetings were open to the public and were properly posted as prescribed under Wisconsin's Open Meetings law. The mission of the Task Force was the following:

> "The mission of the Task Force on Health Care for Children in Out-of-Home Care is to develop and describe the critical components of a comprehensive health care system for children who have been removed from their homes by court order which is designed to assure that these children have access to and are provided physical and mental health services appropriate to and commensurate with needs identified through a timely and ongoing assessment of those needs."

The steps undertaken by the Task Force to achieve its mission included the following:

- Gathered input from stakeholders regarding the functioning of the present health care system for out-of-home children, specifically regarding foster care and court-ordered Kinship Care, and identified the strengths and weaknesses within the current system.

- Gathered and reviewed research on the subject of the health care needs of children in out-of-home care.

- Gathered and reviewed reports and other literature on various models of health care delivery systems currently functioning in other states, including types of managed care.

- Developed a consensus on the fundamental features needed to meet the unique health care needs of children in out-of-home care. These features were incorporated in a new health care delivery system designed to address the shortcomings and problems in the current out-of-home system.

- Developed recommendations to the Department of Health and Family Services for the construction of a model to guide the creation of a new system for the delivery of health care services, using managed care principles, for these children.

- Developed supporting recommendations for creating a request for proposals, including general contract provisions and standards for implementation of the new system.

GROUP NORMS AND VALUES

In pursuit of its mission the Task Force established consensus norms and values to guide its consideration of research and other input within the context of creating a new system. The Task Force developed and applied the following norms and values:

- Assure ourselves that the end result of our work will be a health care system in which we and our families would willingly participate.
- Create a model of service delivery that works for the vulnerable children we serve and values the goals of safety, permanency and well-being of the child.
- Always keep in mind that achieving the end-result is the main goal; that is, to present the Legislature with what we believe is the most effective model of system delivery possible.
- Listen to the experienced insights and perspectives of individuals involved with the issues.
- Be interested in creative and collaborative efforts to meet the mental, emotional, and physical health needs of these children.
- Establish a system that is culturally competent and culturally supportive of all children.
- Maintain a child and family-friendly approach service model.

To facilitate discussion on key issues in health care for children in out-of-home care, the Task Force hosted presentations on the following:

1. *Health Care Needs of Children in Out-of-home Placement*, by Mark Simms, M.D., M.P.H., Medical College of Wisconsin.
2. *Quality in Wisconsin's Medicaid/BadgerCare Managed Health Care System*, by Gary Ilminen, RN, Nurse Consultant, DHFS, DHCF, Bureau of Managed Health Care Programs.
3. *Common and Not-so-common Managed Health Care Systems*, by Gary Ilminen, RN, Nurse Consultant, DHFS, DHCF, Bureau of Managed Health Care Programs.
4. *Overview of Managed Care Programs for Children in Out-of-home Placement in Other States*, by Desiree Morris, Program/Policy Analyst, DHFS, DHCF, Bureau of Managed Health Care Programs.
5. *Bureau of Milwaukee Child Welfare Responsibilities for Health Care of Children in Out-of-Home Care*, by Denise Revels Robinson, Director BMCW.

6. *Foster Care Children Medicaid Cost and Eligibility Data,* by Angela Dombrowicki, Director, Bureau of Managed Health Care Programs.

7. *Summary of Medicaid Managed Care Programs by State for Children in Foster Care or Out-of-Home Placement*, by Pam Hartman, president of the United Foster Parent Association of Greater Milwaukee, and Angela Dombrowicki, Director, Bureau of Managed Health Care Programs.

8. *Confidentiality and Consent Issues for Children in Foster Care or Out-of-Home Placement in Milwaukee County for Milwaukee Public Schools Records and Special Education Services,* by Angela Dombrowicki, Director, Bureau of Managed Health Care Programs.

9. *A Functional Model for Health Care for Children in Out-of-Home Placement,* by Angela Dombrowicki, Director, Bureau of Managed Health Care Programs.

10. *Overview of Contract Monitoring and Advocacy Functions for Medicaid/BadgerCare Managed Care,* by Angela Dombrowicki, Director, Bureau of Managed Health Care Programs.

11. *Milwaukee Family Project/Target on Prevention,* by Colleen Cantlon, Infant and Child Health Care Consultant, Bureau of Family and Community Health, Division of Public Health.

In addition, a significant quantity of relevant literature on health care services and managed care for children in out-of-home care was provided to the Task Force for review. (See Appendix A for a complete listing.)

FACTS AND FINDINGS ABOUT CHILDREN IN OUT-OF-HOME CARE

Special Health Care Needs of Children in Out-of-Home Care:

> *"As a group,* [*children entering foster care*] *are sicker than homeless children and children living in the poorest sections of inner cities. Of particular concern is the health of young foster children since conditions left untreated during the first three years of life can influence functioning into adulthood and impede a child's ability to become self-sufficient later in life."*
>
> -- U.S. GAO, Foster Care: Health Needs of Many Young Children are Unknown and Unmet. Washington, D.C. 1995.

The Task Force explored ways in which the health of children in foster care lags behind national standards for the health care of all children. The Task Force explored the causes of this health delay and also the impact of poor health on the children's development and overall well being. The Task Force's primary findings are summarized below, with citations to support the research. Complete copies of the research reviewed by the Task Force are available from the Department of Health and Family Services. Unfortunately there are no studies available which specifically

address the health of children in foster care in Wisconsin. It is the experience of Task Force members (some of whom are health care providers for these children) that the following studies are reflective of the problems of Wisconsin children in out-of-home care.

1. **Children in foster care have much greater rates of physical, developmental and emotional illness than comparable children of the same social and ethnic background.**

   - Between 1989 and 1991 in response to a consent decree settling a class-action lawsuit, 1407 children received initial health screens within five days of entering foster care in Baltimore, Maryland. Physical examinations indicated that more than 90% of the children had at least one abnormality in at least one body system. The incidence of growth delay and short stature was approximately three times higher than the expected rate among children in the general population. A total of 53% of the children required referrals for further medical evaluations and 55% of the children required mental health evaluations and treatment. One-fourth of the children received referrals for three or more services. (Chernoff et. al., 1994.)

2. **There is an interrelationship between the child welfare and the health care systems. Most children who enter foster care show substantial improvements in physical, developmental and behavioral status over time. However, many factors may interfere with this progress and some children are exposed to neglect and/or deprivation within the care. Children with chronic illness and/or developmental and behavioral problems are less likely to exit the foster care system.**

   - Two samples of children entering foster care who remained in care for at least 18 months found that 35% of the children entering care were in poor health. The health of some of the children improved such that 19% of the children who were in care remained in poor health. "Those children whose health status improved had conditions that adequate health care could correct. Those whose health status remained poor generally had chronic health problems such as severe emotional disorders or physical problems such as seizure disorders or asthma." (White and Benedict, 1986.)

   - A prospective study of preschool age children entering foster care in central Connecticut found "catch-up" growth rates of children in foster placements:

     - ✓ At the time of placement there was global retardation of growth across all height ranges (11% below the 5th percentile and 4% above the 90th percentile).

     - ✓ After one year, the group had normalized (4% below the 5th percentile and 11% above the 90th percentile). Fifty percent of the children in placement showed accelerated "catch-up" growth velocity; 30% showed normal growth velocity; 20% showed decelerated growth velocity. This change in growth velocity was not related to other variables such as age, initial height or gender. (Wyatt, Simms, Horwitz, 1995.)

- One hundred twenty children ages 11 to 74 months placed for the first time in foster care in central Connecticut were followed for one year. Vineland Adaptive Behavior Scale scores which measure social sufficiency and independence rose from a mean of 79.5 at baseline to mean of 94.5 at 12 months. (Horwitz, Balestracci, Simms, 2000.)

- Children with birth defects were placed in foster care at an earlier age and spent more of their lives in foster care than children without birth defects. (Simms, 1989.)

3. Children in foster care are higher users of health care services than comparable children. Lack of systematic evaluations and follow-up result in incomplete, fragmented and poorly coordinated heath care that is more costly, yet yields inconsistent results. Without systematic multidisciplinary evaluation, children with developmental and mental health problems are not likely to receive appropriate services in a timely fashion.

- Use of a multidisciplinary assessment identified needs of foster children that customary health providers missed. Multidisciplinary evaluations of 62 children in a Foster Care Clinic setting found that children were more likely to be identified with developmental and mental health problems than children followed by customary health care providers (n=58). A full 56.5% of children in the Foster Care Clinic were identified with developmental health problems vs. 8.6% provided customary care. A total of 37.1% of children provided a multidisciplinary screening in the Foster Care Clinic were identified with mental health problems vs. 13.8% who were screened by customary health providers. (Horwitz, Owens, Simms, 2000.)

- Decisions relating to a foster child's health care are often made by the caregiver or case manager based on whether or not a child "appears healthy." Thus, children whom workers and caregivers perceive as healthy were more likely to miss out on routine health screenings, health care supervision, and services. Thirty four percent of the children in this survey received no immunizations; 32% had at least one medical need that was unmet; 78% were "high-risk" for HIV as a result of parental drug abuse but only 9% of the children were tested for HIV. Children in Kinship Care were three times less likely to receive health care services than those in standard foster care arrangements (GAO, 1995).

- Study of California Medicaid claims data for 1988 for foster children found:

  - ✓ Hospitalization was the major expense category (Chief reasons for hospitalization include perinatal, mental health and infectious diseases treatment).

- ✓ Longer lengths of stay (on average, foster child stays were 10.9 days vs. 6 days for other Medicaid children; foster children had 36% longer stays for mental conditions and 27% longer stays for children with perinatal conditions).

- ✓ Foster children accounted for 55% of all psychologist visits and 45% of all psychiatric visits although they were only 4% of the Medicaid population. (Halfon, et. al, 1992. Note: this study was based on submitted claims. The author suggests that children were underdiagnosed and services were underutilized).

- Study of Washington state Medicaid claims data for foster care and AFDC children in 1990. Children in this study received coverage for at least one year.

  - ✓ Mean health expenditures were $3075 for foster care children vs. $543 for AFDC children

  - ✓ Twice as many children in foster care than AFDC children used medical equipment or specialist services or were hospitalized. (Takayama, Bergman, Connell, 1994)

  - ✓ Takayama cautioned that ***"despite high utilization and cost of mental health services, previous research suggests there may be underutilization of these services compared with need"***

- Data collected on 22,000 infants and toddlers in foster care in California, New York and Pennsylvania found that only 1% of the children received early periodic screening diagnosis and treatment (EPSDT) services. (GAO, 1995)

4. There is an interrelationship between the child welfare and the health care systems. Most children who enter foster care show substantial improvements in physical, developmental and behavioral status over time. However, many factors may interfere with this progress including accessibility and the fact that some children are exposed to neglect and/or deprivation within the care. Children with chronic illness and/or developmental and behavioral problems are less likely to exit the foster care system in a timely fashion.

5. Children in foster care are higher utilizers of health care services than comparable children. Lack of systematic evaluations and follow-up result in incomplete, fragmented and poorly coordinated heath care which is more costly, yet yields inconsistent results. Without systematic multidisciplinary evaluation, children with developmental and mental health problems are not likely to receive appropriate services in a timely fashion.

- In the Foster Care Program at the Center for the Vulnerable Child in Oakland, CA 213 children received physical examinations and developmental, emotional and behavioral assessments by a multidisciplinary team. Most of the children were

under 6 years of age. Eighty-two percent of the children had at least one chronic medical condition. Developmental and emotional problems were identified in 84 percent of the children. (Halfon et al., 1995.)

- One hundred thirteen children between the ages of one month and six years received physical examinations and multidisciplinary screenings in Waterbury, Connecticut at the Foster Care Clinic (1985-1987). Almost two-thirds of the children had developmental delays. More than one-third had at least one chronic medical condition such as cerebral palsy, asthma or AIDS. (Simms, 1989.)

Task Force members examined numerous other studies in addition to those described above. The research consistently showed that the growing number of children in out-of-home care demonstrate a marked increase in the prevalence of their health problems. A failure to address these needs results in poor health outcomes for the children. A failure to address developmental delays translates into poor academic performance. Lack of care coordination results in expensive, fragmented, and ineffective care.

ANALYSIS OF COSTS FOR CHILDREN IN OUT-OF-HOME CARE

The Department of Health and Family Services conducted a preliminary analysis of health care costs for children in out-of-home placement (including court ordered kinship care and subsidized adoption cases) in Milwaukee County for calendar years 1998-2000.

The data demonstrated the following trends in the number of children in out-of-home placement and the Medicaid expenditures for children in out-of-home placement:

Milwaukee County Medicaid Expenditures for Children in Out-of-Home Placement

Year	Total number of children in out-of-home placement	Medicaid Expenditures
1998	6,656	$14,843,970
1999	7,973	$15,749,347
2000	8,057	$18,469,079

The utilization data covering services provided to Foster children in out-of-home placement in Milwaukee County in CY 2000 provides a basis for current and future data analysis to assist the program in achieving improved health care outcomes for this vulnerable population. This data can serve as the basis for Care Analysis Programs (CAPs) in areas of concern. CAPs is an analytical approach to administrative data where there are concerns regarding a particular disease or service about adequacy, appropriateness, and the impact of service delivery on health care outcomes. CAPs analysis in Foster Care can be utilized where service delivery appears inadequate or where a specific diagnosis does not appear to respond to services as they are currently delivered; i.e., asthma hospitalizations compared to outpatient office visits and pharmacy use of medications to control asthma. At a minimum, the CY 2000 utilization data demonstrates that the children in this population are receiving services in crucial areas such as

mental health and chronic disease. The current data is insufficient to determine the adequacy of the services and the relationship between services delivered and health care outcomes. The future utilization of CAPs should permit analysis that results in targeted disease management for specific recipients with diseases and who are served by specific providers.

The Task Force made the following observations with respect to health care costs for children in out-of-home placement:

- Costs may actually increase initially under a new health management system due to pent-up demand and unmet needs caused by lack of access under the current system.
- A new health care system should not be implemented for the sole purpose of cutting costs.
- Lack of case management and health assessment leads to higher medical and societal costs as foster care children become adults.

Further analysis of the data will be conducted by the Department and additional workgroups if a decision is made to implement the model health care system recommended in this report.

DELIVERY SYSTEM OPTIONS FOR CHILDREN IN OUT-OF-HOME CARE

Various delivery system options are available for state Medicaid programs under federal law. Implementation of a managed care delivery system for children in out-of-home care must comply with various federal requirements established under the Balanced Budget Act of 1997 (BBA). While the BBA removed some waiver requirements states must fulfill in order to use managed care in Medicaid, it added numerous protections including access to emergency services, network adequacy, grievance processes, external quality review and liability protections for enrollees. The BBA also required the federal Department of Health and Human Services (HHS) to develop quality assessment/performance improvement requirements. Those requirements are found in 42 CFR, Part 400, Subpart E, of the Medicaid Managed Care Proposed Rule.

As a result of a state plan amendment to the BBA, states are allowed to mandate enrollment in managed care for most beneficiaries without the need for federal waivers under §1915(b). However, the following children are exempt from compulsory enrollment: children under the age of 19 with special needs—including children eligible for SSI; children with special health care needs under Title V of the Social Security Act; certain institutionalized children; children in foster care under Title IV-E; children otherwise in out-of-home care; and any dually eligible (Medicare/Medicaid) individuals. These individuals may enroll voluntarily. Therefore, a §1915(b) waiver would be required to implement a mandatory managed care system for delivery of health care services for children in foster care. A §1915(b) waiver would allow:

- Mandatory enrollment in the Quality Health Care delivery system;
- Implementation of the system on a less than statewide basis;
- Creation of a “carve-out” or stand alone system for mental health or other services; and

- Provide an enhanced set of health care services.

Another waiver option is the §1115 Research and Demonstration project waiver. These waivers are designed to allow states to test the merit of new policies or program approaches. Under an §1115 waiver:

- A state has more flexibility in terms of eligibility and services provided;
- Projects are approved for five years;
- A variety of managed care types may be used.
- Project must be "budget neutral," with services delivered at no higher cost than as when they are provided without the waiver.
- The BBA created several new categories for managed care entities (MCEs). They are:

1. Managed care organizations (MCOs) which operate under comprehensive risk contacts. A comprehensive risk contract includes coverage of primary, specialty, acute and inpatient care services, as in the case of health maintenance organizations (HMOs).

2. Primary care case management systems (PCCM) which do not have comprehensive risk contracts and services are limited to primary care case management. This service model does not require a federal waiver.

3. Prepaid health plans (PHPs) which generally do not have comprehensive risk contracts and have a limited range of services.

4. Various HMO models, including those delivering specialized services, such as mental health. HMOs may take several forms:

    - *Staff model:* Physicians and other providers are employees of the organization and may not practice on an independent fee-for-service basis.

    - *Individual Practice Association (IPA):* The IPA contracts with independent physicians who work in their own private practices and may see fee-for-service patients as well as HMO enrollees.

    - *Group model:* The HMO contracts with a physician group practice for a set of specific services and pays a set fee per month per enrollee (capitation). The physicians usually do not have fee-for-service patients.

    - *Network model:* A network of group practices under the management of one HMO.

- *Point of Service model (POS):* Enrollees may see network providers or go outside the provider network, but if non-network providers are used, the enrollee has a larger copay than if they stayed in network.

- *Hybrid model:* A combination of at least two managed care organization models in a single health plan.

Wisconsin has experience with both HMO comprehensive risk contracting and non-comprehensive risk contracting arrangements in Medicaid. Currently, 13 HMOs serve Medicaid AFDC/BadgerCare enrollees statewide and an HMO serves SSI eligible individuals in the Milwaukee area. In addition, six non-HMO special managed care organizations serve special populations in Medicaid including children with severe emotional disorders (Children Come First and WrapAround Milwaukee), and the elderly and disabled (Elder Care of Dane County, Community Living Alliance, Community Health Partnership, and Community Care Organization).

While the Task Force did not recommend a specific managed care model or approach, it did develop a Health Care Management Functional Model for Children in Out-of-Home care (see page 7.) This model outlines a framework of the most desirable characteristics identified in the health care management system. In creating this model, the Task Force sought to provide flexibility and elicit ingenuity from potential contractors in system design. Some of the specific implications of our findings follow below:

- **Team Approach.** A team approach is desirable with input from all concerned parties (including birth parents) contributing to the care of the child. This means that the role of each party in the health system must be clear among systems and among each team supporting a specific child and family:

  - ✓ The role of foster parents in the system must be defined, to include the relationship of the foster parent with the health case managers.

  - ✓ Children in court-ordered kinship care should be included in the health system, and they should be accorded the same consideration and support as any other foster child. The role of kinship caregivers in the health system should also be clearly defined, inclusive of their relationship to health case managers.

  - ✓ The role of the health case manager must be clear and should include being a resource person who identifies and finds ways of resolving children's health needs in a way that supports the child's placement.

  - ✓ Transportation and other specific needs that affect the ability to provide care must be included among the services provided. The Task Force views transportation as a critical access issue and believes every child's treatment plan must include planning for transportation.

- **Training:** The unique, multiple needs of children in out-of-home care require that case managers and providers have specialized skills. The health system should provide or fund the necessary training.

- **Cost:** The health care system should not be implemented to cut costs. While early screening and access to services may reduce high-end hospitalization costs, the screenings are also likely to identify child health needs that are currently not identified or treated. The goals of the health system should be to assure access to primary and specialty care to children in foster and kinship care and to assure that all children in out-of-home care receive a comprehensive evaluation and quality service delivery.

- **Statewide Implementation:** Any future implementation of a health plan outside of Milwaukee County must address the differences in access and availability of health care providers, particularly specialists, between urban and rural settings.

- **Capacity:** The health care system must identify inequalities between need and service availability, and work to remedy these inequalities. This is particularly important in the area of mental health service delivery.

The data presented in this section illustrates the complexity, variety and intensity of the health care service needs of children in foster and kinship care. The data has implications for the sophistication of case management systems, completeness of provider networks, diversity of providers, specialization of training of case managers and providers and potential costs for provision of adequate care.

FINDINGS AND RECOMMENDATIONS OF TASK FORCE SUBCOMMITTEES

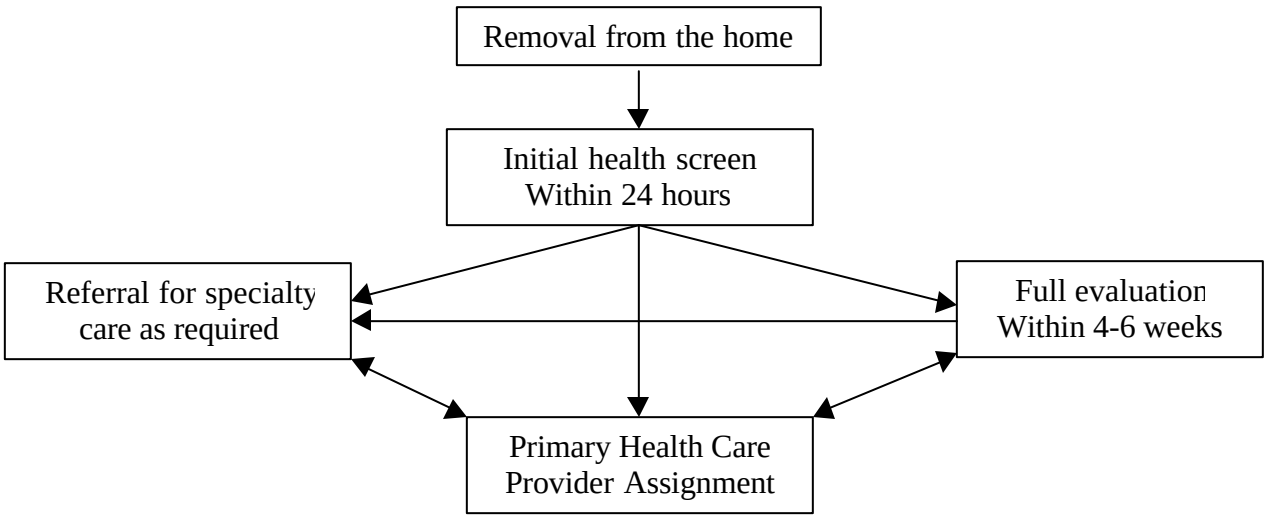
Four subcommittees were formed to support the work of the Task Force:

Access and Intake Assessment
Care Coordination, Provider Network, Transition/re-entry
Quality Assurance and Outcomes
Caregivers and Advocacy

Subcommittee recommendations are summarized below:

Access and Intake Assessment Subcommittee:

The Access and Intake Assessment subcommittee developed the following model for all children entering out-of-home care. This model establishes a standardized protocol and time frame for the initial health screen and a comprehensive physical, developmental and mental health assessment. The diagram on the following page represents the model for the intake and follow-up process as well as the system characteristics.



The following issues were also raised during both subcommittee and Task Force discussions. These standards and recommendations were made in order to assure that there are no barriers to health care access, and to standardize health-related information collection, and communication in the child welfare system:

- Eligibility for health care should be immediate and occur simultaneously with entry into the child welfare system. Documentation of coverage should be available to foster parent/caregiver immediately so provision of care and medications can occur as soon as possible.

- Initial health screen should be a "system" function, and not necessarily the function of foster parents. Screen should be standardized and performed immediately for abandoned children, and within one business day for other cases.

- Initial health screening should be conducted at the level of primary care, evaluating for communicable diseases, emerging illness, and uncontrolled chronic illness. Referral for forensic exam and/or sub-specialist evaluation should occur when indicated.

- Assignment of a primary care provider should occur at the time of the initial health screen. Flexibility should exist in the system to allow changes of primary care provider when necessary, taking into account the health needs of the child and the input of the foster parent/caregiver. It would be beneficial to support the concept of "a medical home" for the foster child, once it has been established with a competent primary care provider. This would provide continuity of medical care for a child.

- Brief medical information form should be completed with the birth parent(s) or significant caregiver at the time of removal. The medical information form should gather:

  - Child's name with correct spelling and nickname if applicable

  - Name/spelling of birth parent(s) and/or significant caregiver

- Child's birth date
- Name/clinic of child's physician
- Known health problems of child, including any medication and environmental allergies
- Medications the child takes (bring along recent prescription bottle-if possible)
- Special care needs of the child, including any therapies or services the child is receiving
- The caseworker must provide information as required under CH. HF337 (CFS-873 form) to the caregiver as soon as possible

- A health care case manager should be responsible for health care coordination for an individual in the child welfare system. The case management system should be held accountable for the delivery of quality services to the child in an efficient and effective manner. Health care case manager assignment for each child should take place when the agency takes physical custody.

- A comprehensive health assessment must be completed within 4-6 weeks of placement for a child entering the child welfare system. The assessment will include a complete medical, dental, developmental (or school-based), and mental health evaluation.

- This comprehensive evaluation should be repeated at least every 6 months until the child is in a stable placement and the foster parent and health care case manager feel there are no ongoing problems which need to be addressed. At a minimum, a face-to-face meeting of the foster parent and the health care case manager (with input of the primary care provider, child welfare worker, teachers, therapists, and any practitioner providing services to the child) should occur every 6 months while the individual is in the child welfare system.

- Comprehensive assessment data becomes part of the child's medical database, is available to practitioners providing services to the child, and forms the basis for the health care plan.

Care Coordination, Provider Network, and Transition/re-entry Subcommittee:

- Benefit design will affect case management.

- Case management and philosophy should be holistic and consider foster parent needs as well as the needs of the child.

- System should provide for children who require additional use of higher care.

- Network should emphasize specifically qualified providers and be an “open” design.
- Care planning should include a “community team” that addresses foster parent issues.
- Care plan and case manager should be culturally competent.
- Birth parents should be included in care plan development and in goal achievement.
- System should be responsive to child, family, case managers and care givers and provide for monitoring the delivery of services and implementation of the care plan.
- Care protocols should be in place to guide the utilization management process.
- Transition plan must have a high degree of integration with birth parents and be geared toward reunification.
- The system must assure continuity of care and sharing of assessment and plan option implementation regardless of permanency outcome.

Caregivers and Advocacy Subcommittee:

- Standards of care should be established and include checks and balances.
- Access to mental health and dental services should be improved in the new system.
- System should support timely access to services and assure they are available 24 hours a day, seven days a week (24/7) when necessary.
- A third party advocate for the child and birth parents should be available.
- Support for caregivers should include training.

Quality Assurance and Outcomes Subcommittee:

- Performance indicators should be selected or developed using criteria that allow for the evaluation of indicators in terms of relevance, validity, and feasibility. The Task Force subgroup suggested use of Foundation for Accountability (FACCT) performance indicator selection criteria for this. An information sheet on the criteria is provided in Appendix B.
- Indicator design should consider the requirements of the Medicaid Managed Care Proposed Rule. A grid of relevant federal requirements was provided.
- Indicators should be designed to use existing electronic data sources wherever possible.

- Tools for creating performance indicators, along with detailed development of proposed clinical and non-clinical indicators, were provided by the Task Force.

- Indicators should support overall goals. Stakeholders, the managed care organization and the state should collaboratively develop specific performance indicators.

FUTURE OF HEALTH CARE ACCESS FOR CHILDREN IN OUT-OF-HOME CARE

The legislative charge to the Task Force was to create a pilot program in Milwaukee to improve access to health care services for children in out-of-home care. The Task Force concluded their efforts through the recommendations of this report which outline the basis of a model pilot program.

The original legislative directive was to expand the Milwaukee pilot program statewide to increase health care access for all state residents in out-of-home care. The Task Force has concluded that prior to expanding the Milwaukee pilot program statewide, additional input from stakeholders across the state will, of fundamental necessity, be required to ensure future expansion success.

Small workgroups will be formed to finalize these concepts initiated by the Task Force Committee. These small workgroups will include many of the same stakeholders from the Task Force whose dedication and commitment to this issue is embodied in this report.

OUT-OF-HOME CARE TIMELINE

September 2001 -	Transmit Task Force Report to Legislature.
September/October 2001 -	Complete Draft Request for Proposals (RFP), Waiver Application Model Contract.
October/November 2001 -	DHFS Secretary approval of draft RFP, Waiver Application and Contract.
December 2001 - April 2002 -	Circulate draft RFP, Waiver and Contract for public comment.
April/May 2002 -	Revise RFP, Waiver Application and Contract.
June-September 2002 -	Center for Medicare and Medicaid Services (CMS) and potential bidders review RFP, Waiver and Contract.
October 2002/January 2003 -	HCFA approval – RFP, Waiver and Contract.
February 2003 -	DHFS selects vendor based on review panel.

April 2003 -	DHFS and vendor negotiate contract
August/September -	Vendor start-up and enrollment begins.

Note: The Stakeholder committee will have input throughout the process. The Task Force will continue to meet on a quarterly basis during the drafting and evaluation process.

INTERIM STEPS TO IMPROVE HEALTH CARE FOR CHILDREN IN OUT-OF-HOME CARE

The Department of Health and Family Services, in conjunction with input from the Task Force, developed further strategies for improving access to health care for children in out-of-home care prior to implementation of a managed care system. These strategies and the status of those strategies include:

- Exploring the possibility of expanding emergency mental health crisis intervention services to include increased coverage for consultation and support for foster families during evening, nighttime, and weekend hours.

- Expansion of the training of foster care parents with regard to the specific health care issues of children in out-of-home care. Specifically, address through additional training, the unique health care challenges and needs of children with special health care issues. (The foster parent curriculum has recently been expanded to include training on the health care needs for children with special health care needs.)

- Access for BMCW caseworkers on the status of Medicaid eligibility and access to Medicaid covered services for children in out-of-home care. (Plans are currently under way to provide BMCW caseworkers with access to Medicaid eligibility screens. In addition, the Department is currently reviewing plans to establish a specialized unit within BMCW to handle "emergency" eligibility issues, including funding for medical services while a foster parent is waiting for a Medicaid eligibility card.)

- Access to fee-for-service claims data for physicians, BMCW caseworkers and foster parents that would provide basic information (immunization status, current medications and primary care provider's name) on the health care status of children in out-of-home care immediately upon custody of the child by BMCW. (Currently, the Department is exploring data resources and will seek input from the Task Force members on the best methodology for sharing this information with physicians, BMCW and foster parents.)

APPENDICES

Appendix A

LITERATURE REVIEWED

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4. *"Creating Healthy Connections for Children in Foster Care—Executive Summary,"* Child Welfare League of America and American Academy of Pediatrics, September 1996.

5. *"Defining Medical Necessity: Strategies for Promoting Access to Quality Care for Persons with Developmental Disabilities, Mental Retardation, and Other Special Health Care Needs, Executive Summary,"* Henry T. Ireys, Ph.D., et. al. HHS, HRSA. September 1999.

6. *"Fiddlin' Around in Arkansas, State Officials Didn't Give Carve-out a Chance,"* Tim Coakley, Behavioral Healthcare Tomorrow, August 2000.

7. *"Health and Mental Health Services for Children in Foster Care Placement,"* Mark D. Simms, M.D., M.P.H., (prepublication).

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9. *"'I was Tooken,' How Children Experience Removal from their Parents Preliminary to Placement into Foster Care,"* Rosalind Folman, Adoption Quarterly, Vol. 2, 1998.

10. *"Identification and Care of HIV-Exposed and HIV-Infected Infants, Children, and Adolescents in Foster Care,"* American Academy of Pediatrics, Committee on Pediatric AIDS. PEDIATRICS, Vol. 106, No. 1, July 2000.

11. *"Independent Living for Children in Out-of-Home Care,"* Independent Living Advisory Committee, Wisconsin Department of Health and Family Services, Division of Children and Family Services, June 2000.

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14. *"Optional Purchasing Specifications: Medicaid Managed Care for Children with Special Health Care Needs,"* George Washington University School of Public Health Services, August 2000.

15. *"Power Through Choices: the Development of Sexuality Education Curriculum for Youths in Out-of-Home Care,"* Marla G. Becker and Richard P. Barth, CHILD WELFARE, Child Welfare League of America, Vol. LXXIX, No. 3, May/June 2000.

16. *"The Family Reunification Project: Facilitating Regular Contact Among Foster Children, Biological Families, and Foster Families,"* Mark D. Simms, M.D., M.P.H., Barbara J. Bolden, CHILD WELFARE, Child Welfare League of America, Vol. LXX, No. 6, November/December 1991.

17. *"Health Care for Children in Foster Care and Transition to Medi-Cal Managed Care,"* Linda Burden, M.D., M.P.H., The California Children's Partnership, May 1994.

18. *"Foster Care Program Manual,"* Center for the Vulnerable Child, Children's Hospital Oakland, Oakland, CA. November 1992.

19. *"The Foster Care Clinic: A Community Program to Identify Treatment Needs of Children in Foster Care,"* Mark D. Simms, M.D., M.P.H. DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS, Vol. 10, No. 3, June 1989.

20. *"A Comprehensive, Multidisciplinary* Approach *to Providing Health Care for Children in Out-of-Home Care,"* Steven D. Blatt, et. al. CHILD WELFARE, Child Welfare League of America, Vol. LXXVI, No. 2, March/April 1997.

21. *"Home-based Developmental Screening of Children in Foster Care,"* Maureen T. O'Hara, et. al., PEDIATRIC NURSING, Vol. 24, No. 2, March/April 1998.

22. *"Relationship Between Reason for Placement and Medical Findings Among* Children *in Foster Care,"* John I. Takayama, M.D., M.P.H., et. al. PEDIATRICS, 1998.

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24. *"Standards for Health Care Services for Children in Out-of-Home Care,"* Child Welfare League of America, 1988.

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APPENDIX B

RECOMMENDED CRITERIA FOR DEVELOPMENT/ADAPTATION OF PERFORMANCE MEASURES

Measures are developed utilizing the following criteria (adapted from the Foundation for Accountability—FACCT):

Relevance. The measure should address features of the health plan or provider that are relevant to purchasers/consumers making choices between plans or providers, that are useful in negotiating with these entities or that stimulate internal quality improvement efforts.

1. **Meaningful.** The measure should be meaningful to the following audiences: consumers, purchasers or health plans/providers.

2. **Clinically important.** Measures should capture as much of the plan's/provider's activities related to quality as possible. Factors to consider include: health importance of the measure (e.g., outcome vs. process), the prevalence of the medical conditions to which the measure applies and the seriousness of the health outcomes affected.

3. **Financially important.** Measures should relate to outcomes that have high financial costs to plans, providers or consumers.

4. **Cost-effective.** The measure should encourage the use of cost-effective activities and/or discourage the use of activities that are not cost-effective.

5. **Strategically important.** Measures should encourage activities that deserve high priority in terms of using resources most efficiently to improve or sustain the health of the members.

6. **Controllable.** Measures should be able to be influenced by the plan/provider by their actions. Outcome measures should have one or more processes that the plan/provider can influence which have important effects on the outcome. Process measures should be under the control of the plan/providers and relate strongly to outcomes.

7. **Variance.** If the primary purpose of the measure is to differentiate among plans/ providers, there should be potentially wide variations with respect to the measure.

8. **Potential for improvement.** There should be substantial room for improvement in performance on the measure.

9. **Easily interpreted.** Consumers and other users of the information should be able to clearly understand the measure. The direction of the measure should be clear--the implications of a high or low score should be clearly understood.

Scientific validity:

1. **Reproducible.** The measure should produce the same results when repeated in the same setting and population including when different instruments are used.

2. **Valid.** The measure should make sense logically, clinically and, if it focuses on a financially important aspect of care, financially (face validity). It should correlate well with other measures of the same aspect of care (construct validity). The measure should provide as comprehensive a picture of care being provided as possible (content validity).

3. **Accurate.** The measure should accurately reflect what is actually happening with a high degree of precision.

4. **Risk adjustable.** If the measure is being used for comparison, and is able to be affected by variables beyond the plan's/provider's control (covariates) they should be known and there should be validated, models for calculating an adjusted result that corrects for the effects of the covariates.

5. **Comparability of data sources.** Accuracy, validity, reproducibility and risk adjustment of the measure should not be affected if different data sources are used for the measure.

6. **Degree of professional agreement.** Strong clinical consensus should exist regarding the efficacy of a given process or outcome.

7. **Acceptance by the patient.** Measures should not judge plans/providers on a service that members do not want performed.

Feasibility:

1. **Precisely defined.** Measures should be clear in definitions of specifications of data sources, methods for data collection and reporting.

2. **Reasonable cost.** Measures should not be burdensome in terms of cost for gathering and reporting the data.

3. **Confidentiality.** Accepted standards of member confidentiality should not be violated by data collection for the measure.

4. **Logistically feasible.** Data required for the measure must be available during the time period allowed for collection. The measure should not be so complex the delivery system does not have the capacity to measure it.

5. **Auditable.** The measure should be able to be audited for accuracy of data.

APPENDIX C

HEALTH CARE UTILIZATION DATA FOR CHILDREN IN OUT-OF-HOME CARE

Utilization data for calendar year 2000 (CY 2000) has been reviewed to get an estimate of Medicaid-covered services provided to children in out-of-home placement in Milwaukee County. The data was broken down into (1) Diagnosis, (2) Procedures, (3) Hospital Services, (4) Pharmacy, and (5) Children with no services. All provider types (hospitals, physician, institutions, etc.) were reimbursed a total of approximately $18,469,000.00 for services supplied to 8, 057 Foster Children in Milwaukee County in CY 2000.

In this report format it is not possible to connect a recipient with a unique list of diagnoses and procedures. The data tells us what unique service was provided for x number of Foster Children, and that this constituted (x) percent of eligible children to receive that service.

Diagnosis Codes

- 2,865 children had a diagnosis of care of Healthy Child. This is the top diagnosis and represents 35.5% of eligible foster children who received an examination.
- 2,675 children had a dental examination. This is the second diagnosis listed and represents 33.2% of eligible foster children. Since other diagnosis codes are present throughout the report, not included in the "dental examination" examination code (V72) the percent of foster children who had a dental service is estimated to be at least 33.2%.
- 806 children had a mental health diagnosis of Attention Deficit Disorder (ADD). This is the top diagnosis for a mental health condition. ADD is one of the top diagnosis in the FFS Medicaid population as well.
- 1,165 children had the diagnoses of Upper Respiratory Infection (URI). This was the chief acute diagnosis and represented 14.5% of the population. Asthma was the number one chronic medical diagnoses. 558 children or (6.9%) had a diagnosis of asthma.
- There are 6,400 mental health diagnoses among the possible 8,057 recipients. A single recipient may have been reported in any number of categories, or in a single category.

Procedure Codes

- The top two procedures listed for children in out-of-home care were for a physician office/outpatient visit for an established patient that included a history and physical examination. A total of 4,004 children in out-of-home care had either type physician's office visit.
- Emergency department visit including a focused history, examination and medical treatment was provided to 992 Foster Children.
- Almost 4 times as many children were seen in routine office visits as opposed to emergency room visits.
- Using a compressed number of service categories for reporting resulted in the following findings for all recipients in Foster/Kinship Care, Ages 0-20 years:

Unduplicated Recipients

A.	Office visits	4,723
B.	Emergency room visit	1,442
C.	Psychiatric services	1,304
D.	Crisis intervention	501
E.	Dental services	1,752
F.	School-based service	498
G.	Physical Medicine/ rehabilitation service	428

- The vast majority of providers rendered services to 10 or fewer children in out-of home care.

Hospital Services

Inpatient:

- A total of 466 admissions and 517 discharges occurred in CY 2000.
- Psychiatric diagnoses explained admissions for 144 recipients who had 164 discharges.
- Obstetrical services accounted for 74 admissions and 75 discharges.
- Children's Hospital of Wisconsin accounted for 131 admissions for children in out-of-home care.
- The majority of hospital services were supplied by four Milwaukee hospitals.

Outpatient:

- The most frequent outpatient service was emergency room visit for 1,742 recipients. Fourteen Milwaukee area hospitals provided the majority of the outpatient services.

Pharmacy

- Medications associated with the treatment of asthma were provided to 2,601 Foster Care recipients with a total of 4,969 prescriptions.
- Antibiotics were prescribed for 2,856 FC recipients with a total of 3,921 prescriptions.
- Medications to treat epilepsy were provided to 171 recipients with a total of 983 prescriptions.
- Psychotropic (mental health) medications were provided to 1,368 FC recipients with a total of 6,770 prescriptions.

Children with no Services

- Approximately 455 Foster Children had no services listed at the time of the data extraction – 7-26-01.
- Reasons for no services listed could include a short enrollment time in the program so that services were either not yet provided, or if provided, not yet billed to the Wisconsin Medical Assistance Program.

Footnotes on Data

Three sources were utilized to extract the data for the analysis of utilization of health care services by children in out-of-home care. Those sources were:

- Client assistance for Reemployment and Economic support (CARES)
- Wisconsin Statewide Automated child Welfare System (WiSACWIS)
- Medicaid Management of Information System

The CARES system was used to identify children who are in "kinship" care or out-of-home care by a relative.

WiSACWIS was used to identify children who were in court-ordered kinship care or court-ordered out-of-home care by a relative.

MMIS system was used to extract utilization data for children in out-of-home care.

The data is for calendar year 2000 for Milwaukee County children who are in out-of-home care. This includes children in traditional foster care or placed with non-relatives, and children who are in court-ordered kinship care or placed with a relative by the court.

There were a total of 8,057 children under the jurisdiction of the court during 2000. The majority are in out-of-home placement. A small number have been returned home, but remain under the court's jurisdiction. In addition, the data includes about twenty children who are in subsidized adoption in Milwaukee County. This report does not draw any distinctions between foster care and court-ordered kinship care children.

This report also includes 520 children (out of the 8,057) in out-of-home care who were participating in Milwaukee Wraparound (WAM). Milwaukee Wraparound is a behavioral health managed care organization which receives a per member per month payment for providing behavioral health services to children who are severely emotionally disturbed (SED). This report does compare the data between non-Wraparound children and the children who are in Wraparound.

Children who are in non-court ordered kinship care are not included in this data. The utilization data was extracted in order for the Department to request a waiver from the Center for Medicaid/Medicare Services (formerly HCFA) to develop rates for a managed care program for children in out-of-home care in Milwaukee County. Children in non-court-ordered kinship care will not be included in Wisconsin's waiver request. Therefore, utilization data was not retrieved for these children.