DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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FROM: Brian Ritchie
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SUBJECT: "Children's Use of Health Care Services While in Foster Care: Common Themes," OEI-07-00-00645

The Office of Inspector General (OIG) would like to take this opportunity to share the attached document, which provides information regarding access to health care services for children in foster care. The document is based on eight studies that our office conducted, the last of which was recently released. Upon completion of the studies, we reviewed the experiences of all eight States and have identified common themes and additional information we believe noteworthy and of importance to you and to all States in your continuing efforts to ensure access to health care services and favorable outcomes for children in foster care, especially with respect to:

- Ensuring the identification of health and mental health needs of children entering foster care,

- Increasing the number of Early Periodic Screening, Diagnosis, and Treatment and other required examinations received within required timeframes,

- Emphasizing the importance of case workers' obtaining medical information for children in foster care and foster care providers' receipt of health information for the children in their care,

- Documenting, updating, and managing health and mental health information for children in foster care,

- Enhancing communication between the State agencies responsible for administering the foster care and Medicaid programs, and

- Using multiple sources of information to identify the services children in foster care have received or may be lacking.

OIG offered recommendations for improvement in each of the individual State reports. The attached document does not contain any additional recommendations and requires no formal comment from you. However, we would welcome any comments you might wish to share.

If you have any questions regarding this information, or if we can be of any further assistance, please do not hesitate to call me or your staff may contact Elise Stein, Director, Public Health and Human Services Branch, at (202) 619-2686 or through e-mail [Elise.Stein@oig.hhs.gov]. To facilitate identification, please refer to report number OEI-07-00-00645 in all correspondence.

Attachment

Children's Use of Health Care Services While in Foster Care:
Common Themes
OEI-07-00-00645

July 2005

Summary

The Office of Inspector General, Office of Evaluation and Inspections, conducted a series of inspections in eight States[1] to determine whether children in foster care in those States were receiving Medicaid and other health care services. Here we offer a summary of the reports of these inspections in hope that this information and the information presented in each of the individual State reports will be useful in all States' efforts to identify the health and mental health services children in foster care are receiving or lacking, and that it will be used to ensure that children in foster care receive the health and mental health services they need.

Our field work varied to address each State's provision of health care services to children in foster care. The field work consisted of a review of State policies, analysis of child-specific Medicaid claims data and case-file documentation for sampled children in foster care, interviews with caseworkers and foster care providers (i.e., foster parents and residential facility staff) for children in our sample, and interviews with staff in the State agencies responsible for administering the foster care and Title XIX Medicaid programs. This mixed-method approach to our data collection allowed us to identify the receipt of more health screenings and examinations than would have been identified using a single data source.

We found that, even though sampled States utilized differing approaches (i.e., fee-for-service or per diem rates) to provide Medicaid services to children in foster care, all of the 400 sampled children included in these studies were covered by their States' Medicaid program and most had made Medicaid claims for health care services. Through our use of mixed methods, in which we reviewed both Medicaid claims and case-file documentation in five of the eight States,[2] we found that the experiences of sampled children varied in the receipt of required services. Mental health screening requirements also varied, ranging from generally requiring that legal custodians provide for the mental health of children in their custody to specifically requiring that a developmental or psychological evaluation be completed within specific timeframes. Many foster care providers (i.e., foster parent or residential care facility staff) interviewed

[1] The eight States (Georgia, Kansas, Illinois, New Jersey, New York, North Dakota, Oregon, and Texas) represented 24 percent of the total foster care population nationwide and a diverse cross section of foster care.

[2] We followed somewhat different methodologies in three of the eight States. We analyzed Medicaid claims data, but not case-file documentation, in New Jersey and Oregon. We analyzed both Medicaid claims data and case-file documentation in New York, but because New York used a per diem approach to pay for Medicaid services that children in foster care received, these sampled children could not be compared to children in the other States. In all three States, we determined the receipt of services beyond those required.

reported not receiving medical histories or other medical information about children in their care.

Not all sampled children received Early and Periodic Screening, Diagnosis, and Treatment examinations or initial examinations required upon entering State custody

The number of sampled children who received required Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) examinations or required initial medical and dental examinations upon entering State custody varied by State. Some services were not received by any of the sampled children. In five States, we analyzed both fee-for-service Medicaid claims data and case-file documentation to determine if sampled children had received required health care services. Thus, we were able to make comparisons for these five States. We did so based primarily on whether they had received their most recent required EPSDT examinations in accordance with State-established frequency guidelines, and whether they had received an initial examination upon entering State custody in the States where initial examinations were required.

EPSDT Examinations. EPSDT examinations are designed to screen for, diagnose, and treat conditions of Medicaid-eligible children that might go otherwise undetected or untreated. State EPSDT programs must provide medical, hearing, vision, and dental screenings and other necessary health care and treatment at intervals established by the State that meet reasonable standards of practice published by recognized health care organizations. The percentage of sampled children in the five States who had received their most recent required EPSDT medical and dental examinations in accordance with State-established frequency guidelines ranged from 60 to 100 percent,[3] as detailed in Table 1.

Table 1: Percentage of Sampled Children Receiving EPSDT Examinations Timely

State	Medical Examinations	Dental Examinations
Georgia	60%	60%
Illinois	100%	76%
Kansas*	90%	82%
North Dakota	70%	79%
Texas	94%	92%

*Kansas is the only sample State that printed notification of upcoming required EPSDT medical and dental examinations on monthly Medicaid cards mailed to foster care providers.

Source: Office of Inspector General, review of case files for sampled children in five States, 2005

[3] Based on their age, the length of time they had been in foster care, individual State-established EPSDT frequency guidelines, and the periods covered by the individual State studies, 233 of the 250 sampled children in the five States were required to receive an EPSDT medical examination and 201 were required to receive a dental examination during the periods covered by these studies.

Initial Examinations. Initial health examinations provide an early assessment of children and their health care needs as they enter the foster care system. Four States where we examined both Medicaid claims and case-file documentation required that children entering foster care receive an initial medical examination within State-established timeframes. (One State recommended but did not require an initial medical examination.) Two States required that children entering foster care receive an initial dental examination within State-established timeframes; three States did not. The percentage of sampled children who received State-required initial medical examinations within established timeframes ranged from 42 to 97 percent. The percentages of children entering foster care who received required dental examinations in the two States where they are required were 29 and 66 percent. The percentages of sampled children in the four States who received the medical and dental examinations required by their State upon entering foster care are detailed in Table 2.

Table 2: Medical and Dental Examinations Required Upon Entering Foster Care and Percentage of Sampled Children Who Received These Examinations Timely

State	Initial Medical Examinations		Initial Dental Examinations	
	Requirement(s)	% Received Timely	Requirement	% Received Timely
Georgia	38 Days	64%	38 Days	29%
Illinois*	24 hrs & 21 Days	97% & 42%	N/A	N/A
Kansas	30 Days	82%	N/A	N/A
Texas	30 Days	75%	90 Days	66%

*Illinois required that children receive an Initial Health Screening within 24 hours of entering State Custody and a separate Comprehensive Health Evaluation within 21 days of entering State custody.

Source: Office of Inspector General, review of case files for sampled children in four States, 2005

Requirements for initial examinations in the four States were as follows:

- The Georgia First Placement, Best Placement (FP/BP) program required that all children entering foster care receive a Comprehensive Child and Family Assessment, which includes a complete medical examination, a dental examination, and a developmental assessment or psychological evaluation within 38 days of entering State custody. The components of these assessments mirrored those required as part of EPSDT examinations. Because children are required to receive Comprehensive Child and Family Assessments separately from the EPSDT examinations, we believe some children may have received one examination and not the other (e.g., FP/BP versus EPSDT), and children receiving both required examinations may have received some duplicated services.

- Illinois required that all children entering foster care receive an Initial Health Screening within 24 hours of entering State custody to identify and document acute medical problems and evidence of abuse, and to provide the caseworker with appropriate medical information to place the child. The Initial Health

Screening is scheduled by the caseworker and can be performed at a hospital, clinic, or physician's office, meaning that screenings can be performed 24 hours a day, 7 days a week. The State also required that children receive a Comprehensive Health Evaluation, which includes an in-depth physical examination and comprehensive medical and psychosocial history, within 21 days of entering State custody. Illinois did not require an initial dental examination upon entering State custody.

- Kansas required that all children entering foster care receive an initial medical examination within 30 days of entering State custody. Kansas did not require an initial dental examination.

- Texas required that all children entering foster care receive an initial medical examination within 30 days of entering State custody and an initial dental examination within 90 days.

Required mental health screenings were not received and mental health needs were undocumented for some sampled children

Research has shown that children often enter foster care after experiencing traumatic life events and suffer much higher rates of serious psychological problems than other children from similar socioeconomic backgrounds.[4] Therefore screening for the mental health needs of children in foster care is essential. States establish their own policies regarding the identification of mental health needs. Mental health screening requirements for children in foster care in the eight States we reviewed ranged from simply requiring that a child's guardian be informed of the availability of mental health services and that legal custodians provide for the mental health of children in custody, to requiring that all children in foster care receive a psychological evaluation or developmental assessment within 38 days of entering State custody. Two of the States reviewed had implemented specific guidelines regarding the provision of mental health services to children in foster care. These required that a licensed therapist, psychologist, or psychiatrist perform a comprehensive psychological examination of children entering foster care. Specifically,

- Georgia required children in foster care to receive a developmental assessment (ages 3 years or younger) or psychological evaluation (ages 4 years and older) within 38 days of entering foster care to assess their mental health needs. However, 22 of the 39 sampled children who entered foster care during the period covered by our study did not receive the required assessments/evaluations within the required timeframes, and four children were not receiving ongoing services for assessed and documented mental health needs.

[4] Casey Family Programs, National Center for Resource Family Support, Health Care Issues for Children in Foster Care, March 25, 2002.

- Illinois required that children in foster care ages 5 and older receive a mental health screening, but only 1 in 14 of the sampled children ages 5 years and older received the screening.

We found that the only mental health screening some sampled children received was provided as part of an EPSDT examination, the results of which were recorded in the physical health assessment forms completed by the screening physicians. These notations were often simply a reflection of the physician's review of reported behavior regarding developmental and emotional observations (i.e., exercise, sleep habits, discipline, school grades and attendance, emotions, and peer interaction). Federal EPSDT guidelines require that Medicaid-eligible children under the age of 21 receive screening services that meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations. However, Federal EPSDT guidelines do not specifically address standards required for mental health screenings. Federal EPSDT guidelines address mental health screenings as part of overall medical screenings and do not require consultation with recognized mental health organizations.

We also found that the identification of a child's mental health needs did not necessarily ensure that foster care providers were aware of those needs, or that the need for or receipt of services received were documented in the case files for the sampled children. For example, in Georgia, the foster care providers for four children were unaware of the identified need for mental health services even though it was noted in the case file, and mental health needs were not documented in the case files for 5 sampled children receiving mental health services in Georgia and for 12 of the 34 sampled children who had received mental health services in North Dakota. In evaluating whether children are receiving adequate services to meet their mental health needs, the Administration for Children and Families (ACF) noted in the Children and Family Services Reviews (CFSR) for seven of the eight States we studied that mental health services were an area needing improvement.

Forty-three percent of foster care providers reported never receiving medical information for the sampled children in their care

Of the foster care providers we interviewed in the eight States, 43 percent (165/384) indicated that they had received no medical history for the sampled child placed in their care. Section 475(5)(D) of the Social Security Act requires that a child's health records be reviewed, updated, and supplied to the foster care provider at the time of each placement.

Foster care providers offered the following examples of negative consequences resulting from the absence of medical information for children in their care:

- They were unaware of severe medical problems the child had suffered in the past (e.g., collapsed lungs, malnutrition) that could affect the child's ongoing health care needs.

- The lack of medical information had subjected the child to repeated immunizations.

- They were unable to provide medical information to physicians treating the sampled children in their care.

Our findings regarding foster care providers who reported not receiving medical information for the sampled children in their care echo the findings of ACF, in that all eight States failed to achieve substantial conformity with the portion of the CFSR addressing the sharing of medical information. Through the CFSRs, ACF explores how State child welfare agencies track the medical needs of and services provided to children in foster care and the provision of medical information to foster care providers. More specifically, whether health records are given to foster care providers is part of the CFSR measure used to determine State performance and substantial conformity with the child and family well-being outcome, which assesses if children in the child welfare system are receiving adequate services to meet their physical and mental health needs.[5] ACF must be able to determine that a State has substantially achieved the outcome in 90 percent of the sample cases selected by ACF for review, and 95 percent of the sample cases selected in all subsequent reviews.

Table 3: Foster Care Providers Who Reported Never Receiving Medical Information for the Sampled Child in Their Care

State	Number of Foster Care Providers		Percentage of Foster Care Providers Who Reported Not Receiving Medical Information
	Interviewed	Reported Not Receiving Medical Information	
Georgia	50	24	48%
Illinois	46	12	26%
Kansas	46	20	43%
New Jersey	50	18	68%
New York	49	20	48%
North Dakota	48	9	19%
Oregon	44	19	43%
Texas	50	23	46%
All States Studied	384	165	43%

Source: Office of Inspector General, review of case files for sampled children in eight States, 2005

The Georgetown University Child Development Center identified the need for exchange of health care information in a 3-year study between 1997 and 2000. The report stressed that

[5] 45 CFR § 1355.34 (b)(1)(iii)(C).

> to ensure a child's safety and well-being, and to enhance his/her opportunity for a permanent placement, parents, caregivers, agencies, courts, schools, and health care providers must have a clear understanding of the child's health care history and needs, as well as the services and supports required to meet those needs.

As such, the report's authors recommended that State child welfare agencies establish a system for gathering and recording needed health care information on children and their families and for sharing it with all involved persons.[6]

To alleviate some of the problems associated with the communication of health information to foster care providers, some States have implemented procedures to collect the information, ensure that foster care providers receive it, and ensure that it is kept up to date. Examples of procedures designed to collect and document medical information included the following:

- In Illinois, physicians were paid a $15 incentive fee to initiate a Health Passport in conjunction with performing the Comprehensive Health Evaluations each child is required to receive within 21 days of entering foster care. The Health Passport is a booklet containing pertinent medical information that is provided to the child's foster care provider and follows the child through subsequent foster care placements. A copy was required to be kept in the child's case file.

- In Kansas, the child welfare agency worked with a local State university to develop a medical report that contains the child's medical history. This report was to be updated on an ongoing basis to reflect all medical examinations and immunizations the child received and was to be given to each foster care provider who cared for the child.

Conclusion

It is our hope that this information and the information presented in each of the individual State reports will be useful in efforts in all States to identify the health and mental health services children in foster care are receiving or lacking. We hope that this information will be used to ensure that children in foster care receive the health and mental health services they need, especially as related to:

- Ensuring the identification of health and mental health needs of children entering foster care;

- Increasing the number of EPSDT and other required examinations received within required timeframes;

[6] Georgetown University, Child Development Center (2000), "Meeting the Health Care Needs of Children in the Foster Care System, Summary of State and Community Efforts: Key Findings."

- Promoting the importance of obtaining medical information for children in foster care and furnishing it to foster care providers;

- Documenting, updating, and managing health and mental health information for children in foster care;

- Enhancing communication between the State agencies responsible for administering the foster care and Medicaid programs; and

- Using multiple sources of information to identify the services children in foster care have received or may be lacking.

Additionally, based on our review of prior related studies, we embarked upon this series of foster care studies expecting to find that many children in foster care were not receiving required or needed health care services. Had we followed common existing research approaches and relied solely on Medicaid claims data or case-file documentation, that would have proven to be true (see Appendix A). However, through our use of mixed methods, in which we reviewed both Medicaid claims data and case-file documentation, we found that most sampled children had received Medicaid health care services. Appendix B offers a detailed description of methods used in our studies for those who might wish to similarly determine receipt of health care services by children in foster care.

Appendix A

Use of Case-File Documentation and Medicaid Claims to Assess EPSDT Participation

Using the mixed methods outlined in Appendix B, we reviewed both Medicaid claims data and case-file documentation. This use of mixed methods revealed that sampled children received more EPSDT health care screenings than a review of either the case files or Medicaid claims histories alone would have shown. The disparity between the receipt of services based solely on case-file documentation or Medicaid claims data was even more striking in our review of EPSDT dental services. We believe possible causes as to why either data source is not complete could include the following: health care providers may not be submitting Medicaid claims for some services, children in foster care may receive some health and dental services from providers who do not participate in the Medicaid program, caseworkers may not be documenting some EPSDT services, communication between caseworkers and foster care providers regarding health care and dental services may be lacking, or difficulty may arise in transferring records from physicians to caseworkers.

In the five States where we assessed the receipt of EPSDT services, each of the 250 sampled children was eligible to receive EPSDT health care and dental examinations. Based on their age, length of time in foster care, and State-established EPSDT guidelines, 233 of the 250 sampled children should have received an EPSDT medical examination and 201 should have received a dental examination during the periods covered by these studies. The table below details the number of children in our sample in five States who were eligible to receive EPSDT medical and dental health care examinations, and the number that would have been counted as having received their most recent EPSDT examinations in accordance with State-established EPSDT frequency guidelines.

Evidence Supporting Receipt of EPSDT Services			
EPSDT Service	Evidence Reviewed		
	Case-File Documentation	Medicaid Claims Data	Case-File Documentation and/or Medicaid Claims Data
Medical	129 (55.4%)	169 (72.5%)	207 (88.8%)
Dental	64 (32.3%)	141 (70.1%)	159 (79.1%)

Source: Office of Inspector General, review of case files for sampled children in five States, 2005

EPSDT Medical Examinations. A review of the case files alone would produce results demonstrating that only 129 of the 233 eligible sampled children received an EPSDT medical examination in accordance with State-established guidelines. A review of claims data alone would demonstrate that 169 of the 233 eligible sampled children received these EPSDT medical examinations timely. However, a review of both case-file

documentation and Medicaid claims data indicated that 207 of the 233 eligible sampled children received their most recent EPSDT medical examination within the State-established timeframes.

EPSDT Dental Examinations. A review of case-file documentation alone would show that only 64 of 201 eligible sampled children received dental services in accordance with State guidelines. A review of Medicaid claims data alone would show that 141 of the 201 eligible sampled children received dental services timely. However, a review of both case-file documentation and Medicaid claims data indicated that 159 of the 201 sampled children received dental services within required timeframes.

Appendix B

Methods Used in Five States to Determine the Health Care Services Sampled Children Received

In five of the eight States, we limited our reviews to the receipt of health and dental services that met State-established EPSDT frequency guidelines, the receipt of State-required initial medical examinations, the receipt and documentation of mental health services required by the States, and the provision of medical information to foster care providers.[7] We did not focus on follow-up care or the appropriateness of ongoing health care in meeting the needs of sampled children. These five inspections were based on information gathered from multiple sources: review of Federal and State policies, child-specific Medicaid claims data and case-file documentation for the sampled children, interviews with caseworkers and foster care providers for sampled children, and interviews with State child welfare and Medicaid agency officials.

Law, Regulations, and Policy Review. We reviewed Federal laws and regulations and State foster care, Medicaid, and EPSDT program policies. We used State-established EPSDT frequency guidelines to determine whether sampled children had received required EPSDT medical examinations and dental services timely. We used State-established guidelines regarding initial examinations required upon entry into foster care. We consulted with State agency officials to enhance our understanding of each State's foster care and Medicaid programs and of individual State policies and requirements developed with regard to Federal EPSDT and child welfare requirements.

Sample Selection. States were selected based on population size, geographic location, rural or metropolitan setting, child welfare program administration (i.e., county-administered or State-administered), and fee-for-service or managed care provision of Medicaid services.

Children who met selected criteria were included in the study populations in each of the five States. The criteria were that the child:

- Was in foster care at the time the study was being conducted,
- Resided within the sample State,
- Was eligible for Title IV-E foster care program maintenance funds, and
- Had been in continuous foster care placements for at least 6 months.

At our request, the child welfare agencies in each of these five States provided us with a list of children who met these criteria. The information provided for each child included the child's name, date of birth, sex, county of residence, foster care entry date,

[7] We followed somewhat different methodologies in three of the eight States. We analyzed Medicaid claims data, but not case-file documentation, in New Jersey and Oregon. We analyzed both Medicaid claims data and case-file documentation in New York, but because New York used a per diem approach to pay for Medicaid services that children in foster care received, these sampled children could not be compared to children in other States. In all three States, we determined the receipt of services beyond those required.

caseworker's name and contact information, child welfare case number, Medicaid number, current placement setting (e.g., family, kinship, therapeutic, or residential foster care), the number of times the child had entered foster care, the number of months since the child's most recent entry into foster care, the number of placements the child had experienced during the most recent entry, and the number of months the child had resided in the most recent placement.

We randomly selected 50 children from the list provided by each State for inclusion in our studies.

Medicaid Claims Review. At our request, the State Medicaid agencies in each of the five States provided us with up to 3 years of Medicaid claims data for 50 sampled children. The 3-year Medicaid claims period was identified based on each State's ability to provide detailed Medicaid claims information (i.e., the 36-month period prior to the most recent date for which the State was able to provide the information).

General Medicaid claims information provided for the sampled children in each State included:

- The child's name, Medicaid identification number, and date of birth;
- Dates Medicaid eligibility and/or Title IV-E eligibility began; and
- Other identified health insurance.

Specific claims data for each Medicaid service provided to the sampled children included:

- Date of service,
- Type of service (procedure code and description),
- Diagnosis code,
- Place of service,
- Provider type,
- Unit of service,
- Amount billed to Medicaid,
- Whether the claim was paid or denied (and reason for denial), and
- Payment amount.

We analyzed the Medicaid claims information provided to determine if the sampled children had received Medicaid services since entering foster care, what Medicaid services they had received, and if the services they received met State-established EPSDT frequency guidelines and State requirements for the receipt of initial medical and dental examinations and mental health care evaluations or assessments. Medicaid claims for the entire 3-year claims period were reviewed for sampled children who entered foster care prior to the beginning of the period. For children who entered foster care after the beginning of the selected Medicaid claims period, we analyzed Medicaid claims data from the date they entered foster care through the end of the Medicaid claims period. Each sampled child's age and length of time in foster care was considered with regard to

State-established EPSDT frequency guidelines and requirements for initial medical, dental, and mental health services in determining whether the child had received the most recent required EPSDT medical and dental examinations and required initial examinations.

Case-File Documentation Review. We worked with child welfare agency staff in each of the five States to determine what case-file documentation was needed to verify the receipt of EPSDT and other required health care services in their State. We then requested that documentation from local child welfare offices. The information requested included supporting documentation of medical, dental, and mental health services provided to the child (e.g., physician notes, medical forms signed by a physician), the child's medical history, the child's case plan, verification of the duration of the child's stay in foster care, and information regarding the child's health and general well-being.

We reviewed the case-file documentation provided as evidence that each sampled child had received medical, dental, or mental health services (e.g., EPSDT form signed by a physician or other health care professional). As in our review of Medicaid claims, we compared each child's age and length of time in foster care to State-established EPSDT frequency guidelines to determine whether sampled children had received their most recent required EPSDT medical and dental examinations and whether they received required initial medical, dental, or mental health services.

Foster Care Provider and Caseworker Interviews. We conducted structured interviews, in person or by telephone, with the foster care providers and caseworkers responsible for most children included in each State sample. These interviews provided us with valuable insights regarding why sampled children had received, or may not have received, required health or mental health care services. The interviews with foster care providers (i.e., foster parent or residential care facility staff) focused on the Medicaid program and the services available, the training they had received related to the health and well-being of children, and their experiences procuring health care services for the sampled children. Interviews with caseworkers focused on their understanding of the Medicaid program and the health and mental health services available, the training they received related to the health and well-being of children, their experiences accessing health care services, and any barriers to obtaining needed health care. Each caseworker spoke specifically about the sampled child's case, and generally about his or her own experiences working in foster care. We compared the caseworkers' responses with the responses of the foster care providers, noting any consensus or disagreement within and between the two groups.