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CHILDREN'S USE OF HEALTH CARE SERVICES WHILE IN FOSTER CARE: GEORGIA

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EXECUTIVE SUMMARY

OBJECTIVE

To determine whether sampled children in the Georgia foster care program receive health care services.

BACKGROUND

Section 471(a)(22) of the Social Security Act (the Act) requires States to provide children in foster care with quality services that protect their health and safety. Section 472(h)(1) of the Act deems children in foster care eligible for Medicaid health care services. Georgia is the focus of this inspection and is one of a series of eight States chosen to represent a diverse cross section of foster care nationwide. All Title IV-E children in the Georgia foster care program are eligible for Medicaid.

Federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines require each State to make preventive health care services available to Medicaid-eligible individuals under the age of 21. The guidelines also require States to establish intervals for providing EPSDT examinations that meet reasonable standards of medical and dental practice as outlined in sections 1902(a)(43) and 1905(r) of the Act. A unique aspect of the Georgia foster care program is its First Placement, Best Placement (FP/BP) Comprehensive Child and Family Assessment policy, which requires that all children entering foster care receive initial medical and dental examinations and a developmental assessment or psychological evaluation.

This inspection is based on information gathered from multiple sources. We reviewed Federal and State policies; analyzed child-specific Medicaid claims data and case file documentation for 50 randomly sampled children in the Georgia foster care program; and interviewed foster care providers (i.e., foster parents or residential care facility staff), caseworkers for the children in our sample, and relevant Georgia State staff. Our analysis focused on a 3-year claims period for children in foster care ending on March 26, 2003.

FINDINGS

All 50 sampled children had Medicaid coverage, and 49 children had claims for health care services. The 49 children with Medicaid claims had a total of 3,574 claims during our review period.

Thirty of forty-three sampled children required to receive an EPSDT medical examination received their most recent EPSDT medical examination within State-established frequency guidelines. According to State guidelines, 43 sampled children should have received EPSDT services based on their age and length of time in foster care. However, 13 of the 43 children did not receive an EPSDT medical examination within State-established guidelines. Seven of the fifty sampled children had been in foster care less than the time period that would have required an EPSDT examination based on the EPSDT guidelines established by the State.

Twenty-one of thirty-five sampled children required to receive an EPSDT dental examination received their most recent EPSDT dental service within State-established frequency guidelines. The EPSDT frequency guidelines adopted by Georgia required that children 3 years of age or older receive dental services every 6 months. Thirty-five of the sampled children were 3 years of age or older and, therefore, should have received dental services.

Many of the sampled children did not receive First Placement, Best Placement assessments within the State-required timeframe. Georgia State guidelines required that 39 of the 50 sampled children receive FP/BP services upon entry into foster care during the period covered by our Medicaid claims. Fourteen children did not receive required FP/BP medical examinations within the required timeframe. Thirteen of the twenty-four children required to have an FP/BP dental examination did not receive it timely, and 4 of the 16 children required to receive a developmental assessment and 8 of 23 children required to receive a psychological evaluation did not receive it within the required timeframe.

Four sampled children did not receive services to address documented mental health needs, and mental health needs were not documented for five children who received such services. Federal law requires that case plans be developed, and the Georgia Division of Family and Children Services requires that these plans include information regarding the child's current emotional and psychological status. Case plans or State-required FP/BP assessments for four sampled children clearly indicated a need for mental health services. However, no Medicaid claims for mental health services existed, and the caseworkers and foster care providers for these children stated they were not receiving mental health services. Medicaid claims, caseworkers, and foster care providers for five other sampled children

indicated the children received mental health services, but the need for mental health services was not documented in the case plans for these children.

Twenty-four of the fifty foster care providers reported never receiving medical information for the children in their care.

Section 475(5)(D) of the Act requires that the health records of children in foster care be reviewed, updated, and supplied to the foster care providers at the time of placement. Caseworkers for 21 of the 24 children whose foster care providers reported they did not receive medical information stated they had received or compiled some medical information for the sampled children.

RECOMMENDATIONS

The Administration for Children and Families (ACF) and the Centers for Medicare & Medicaid Services (CMS) should work with the Georgia Department of Community Health to ensure that:

- The EPSDT medical examinations and dental services are received timely.

ACF should work with the Georgia Department of Human Resources, Division of Family and Children Services (DFCS) to ensure that:

- Assessments are completed within the required timeframe.
- Foster care providers receive initial and updated medical information for children placed in their care.

In addition, ACF should work with DFCS to ensure that case files contain required documentation, including mental health needs. Further, during the course of this study, we noted that some of the components of the FP/BP Comprehensive Child and Family Assessments mirrored the components required as part of EPSDT. We encourage ACF, CMS, DFCS, and the Georgia Department of Community Health to consider allowing services provided under either program to count for meeting the requirements of both programs, as appropriate.

AGENCY COMMENTS

ACF described actions it is taking that will address our recommendations. The ACF is monitoring the State of Georgia's actions through quarterly reports relative to the State's efforts to ensure that EPSDT medical examinations and dental services are received timely

and to ensure that foster care providers receive appropriate medical information for children placed in their care.

CMS concurred with the Office of Inspector General (OIG) recommendation and will have CMS regional office staff work with the Georgia Department of Community Health to ensure that EPSDT services are provided according to the State-established EPSDT frequency guidelines. CMS also notes that its staff are available to the State and to ACF to provide any necessary technical assistance. Additionally, in response to an OIG suggestion, CMS will not prohibit FP/BP assessments from serving as EPSDT screenings if the screenings are provided in accordance with the State-established EPSDT frequency guidelines and meet the definition of an EPSDT screening, with all age appropriate screens and services being provided.

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INTRODUCTION

OBJECTIVE

To determine whether sampled children in the Georgia foster care program receive health care services.

BACKGROUND

At the time of our review, an estimated 542,000 children were in foster care nationwide,[1] many of whom were reportedly in poor health. To determine if children in foster care are receiving mandated health care services, we selected eight States for review.[2] The States were chosen to represent a diverse cross section of foster care nationwide. Georgia was selected for its medium population size based on Bureau of the Census data when compared to other States.[3] It was also chosen for its southern geographic location, largely rural setting, county-administered child welfare system, and fee-for-service provision of Medicaid services. Georgia had 13,149 children in foster care at the end of fiscal year (FY) 2002, based on the most recent Federal data available at the time of this study.[4] The Administration for Children and Families (ACF) has regulatory oversight of the Title IV-E foster care program, including approval of State plans to ensure State foster care programs are operating within Federal guidelines. Within Georgia, the Department of Human Resources, Division of Family and Children Services (DFCS), manages the Title IV-E foster care program.

Compared with other children from the same socioeconomic backgrounds, children in foster care suffer much higher rates of serious physical and psychological problems.[5] Vision, hearing, and dental problems are prevalent in the foster care population, and physical health problems (e.g., delayed growth and development, malnutrition,

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[1] Department of Health and Human Services, Administration for Children and Families, *Adoption and Foster Care Analysis and Reporting System Report* for the period ending September 30, 2001. Retrieved July 6, 2004 from http://www.acf.hhs.gov/programs/cb/publications/afcars/report8.htm.

[2] Other States selected for review are Illinois, Kansas, New Jersey, New York, North Dakota, Oregon, and Texas.

[3] Bureau of the Census, retrieved January 21, 2004, from http://www.factfinder.census.gov/.

[4] Department of Health and Human Services, Administration for Children and Families, *Foster Care: Entries, Exits, and In Care on the Last Day*. Retrieved on January 13, 2004, from http://www.acf.hhs.gov/programs/cb/dis/tables/entryexit2002.htm.

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

and asthma) affect 30 to 40 percent of children in the child welfare system.[6]

Children in foster care have greater health care needs, yet many foster care providers reported having difficulty finding health care professionals who were willing to care for these children (we use the term "foster care provider" to refer to a foster parent or a residential care facility who is responsible for a child in foster care).[7] The health care available for children in foster care is often characterized by lack of access; lack of information sharing among health care professionals; and long delays in obtaining services.[8] Furthermore, studies have shown that low percentages of children in foster care are actually receiving services.[9] Therefore, concern exists that children with the greatest health care needs may not be receiving needed services.

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is designed to screen for, diagnose, and treat medical conditions in Medicaid-eligible individuals under the age of 21 that might otherwise go undetected or untreated. However, a Government Accountability Office report released in July 2001 stated that available data from short-range studies showed that the percentage of children in the general population receiving EPSDT services is very low.[10]

Periodic dental care (i.e., oral screenings and examinations) is included as part of EPSDT and must be performed by a dentist. Georgia requirements for EPSDT services require that every child receive dental services in accordance with the frequency guidelines developed by the State and at other intervals as medically necessary. The EPSDT dental frequency guidelines must be established after consultation with recognized dental organizations involved in child health care.

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6 Fact Sheet: *The Health of Children in Out-of-Home Care.* Child Welfare League of America. Retrieved October 17, 2002, from http://www.cwla.org/programs/health/healthcarewfact.htm.

7 Chernoff, R. et. al., (1994) *Assessing the Health Status of Children Entering Foster Care*, Pediatrics, 93:2, 594-601.

8 *Health Care of Young Children in Foster Care*, Pediatrics, 109:3, 2002. Retrieved January 14, 2004, from http://www.aap.org/policy/re0054.html.

9 *Ensuring the Healthy Development of Foster Children*, New York State Permanent Judicial Commission on Justice for Children, 1999 and *Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services*, Government Accountability Office, GAO-01-749, July 2001.

10 Medicaid*: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services*. Government Accountability Office, GAO-01-749, July 2001.

Medicaid for Children in Foster Care

All children in the Georgia Title IV-E foster care program are eligible for Medicaid. Section 472(h)(1) of the Social Security Act (the Act) deems children eligible for Medicaid health care services and section 1902(a)(10)(A)(i)(I) of the Act requires that Medicaid services be made available to them. Federal EPSDT guidelines require each State to make comprehensive and preventive child health services available to Medicaid-eligible individuals under the age of 21, as outlined in sections 1902(a)(43) and 1905(r) of the Act. Within a broad framework, each State establishes its own Medicaid eligibility standards; determines the types, amount, duration, and scope of Medicaid services; sets the rate of payment for services to Medicaid patients; and administers its own Medicaid program.[11]

In FY 2000, Medicaid payments for children in foster care nationwide totaled over $3.3 billion.[12] Georgia Medicaid expenditures for this population totaled approximately $36 million in 2000.[13] The Centers for Medicare & Medicaid Services (CMS) is responsible for the Federal oversight of individual State Medicaid programs. The Georgia Department of Community Health manages the State Medicaid program.

Georgia Health Check

In accordance with Federal law, participation in the Medicaid program requires States to establish EPSDT guidelines for all Medicaid-eligible individuals under 21 years of age.[14] 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.[15] Georgia has established the Health Check program to meet Federal EPSDT requirements.

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[11] Retrieved September 12, 2002, from http://cms.hhs.gov/medicaid/eligibility/criteria.asp.

[12] Department of Health and Human Services, *Medicaid Statistical Information System (MSIS) Report Fiscal Year 2000: All States*. Retrieved January 14, 2004, from http://www.cms.gov/medicaid/msis/00ga.pdf.

[13] Department of Health and Human Services, *Medicaid Statistical Information System (MSIS) Report Fiscal Year 2000: Georgia.* Retrieved January 14, 2004, from http://www.cms.gov/medicaid/msis/00ga.pdf.

[14] Section 1905(a) of the Social Security Act.

[15] Section 1905(r) of the Social Security Act.

The current frequency schedule established for the Health Check EPSDT program requires a complete physical examination at birth; 1, 2, 4, 6, 9, 12, 15, and 18 months of age; annually from 2 to 5 years of age; and every other year between 6 and 21 years of age. The frequency schedule requires that vision and hearing screenings be included as part of every Health Check physical screening for all children regardless of their age, if determined necessary based on their medical history. Health Check also requires dental services, separate from the medical examinations, and that all children 3 years of age and older receive dental services every 6 months.[16]

Georgia requires that caseworkers refer all children entering foster care to the Medicaid eligibility office and that caseworkers coordinate with Medicaid-eligibility workers to determine the Title IV-E foster care and Medicaid program eligibility for the children they refer. All children determined eligible for Title IV-E foster care funds in Georgia are automatically eligible for Medicaid health care services.[17]

Further, Georgia requires State child welfare staff (e.g., eligibility specialists and caseworkers) to inform all foster care providers caring for Medicaid-eligible children of the availability of EPSDT services and to document that such services were offered. The foster care caseworker is also responsible for arranging appropriate and timely medical care for children in foster care, obtaining health-related documents for the case record, and making arrangements for the children to receive initial health examinations as soon as possible after placement.[18]

First Placement, Best Placement

Georgia designed the First Placement, Best Placement (FP/BP) program in response to the Adoption and Safe Families Act, Public Law 105-89.[19] This Act requires States to develop case plans for children entering foster care to ensure reasonable efforts are made to reunite them with their families, ensure their health and safety while they are in foster care, and ensure appropriate decisions are made regarding permanency (e.g., reunification with the child's family or adoption).

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[16] Georgia Multihealthnet System, Department of Community Health, Report Specification, *Health Notification Letter-Dental Screening*, May 30, 2002.

[17] Georgia Department of Community Health Manual, Section 2801-1, April 1, 2003.

[18] Georgia Department of Human Resources, Social Services Manual, Chapter 1000, Section 1007.3, May 2000.

[19] The Adoption and Safe Families Act, Administration for Children and Families, Program Instruction, ACYF-CB-PI-98-02, January 8, 1998.

The FP/BP program policy requires that all children entering foster care after July 1999 receive a Comprehensive Child and Family Assessment, which includes (1) the completion of a family assessment detailing the child's family history, a summary of the child's strengths, needs, and functional level,[20] (2) a medical examination, (3) a dental examination, and (4) a developmental assessment for children 3 years of age or younger or a psychological evaluation for children 4 to 21 years of age.[21] Information obtained through the Comprehensive Child and Family Assessments aid child welfare agency staff, juvenile courts, families, and foster care providers in making decisions that will assure the safety and well-being of children in foster care.[22]

All children entering foster care in Georgia must be referred for FP/BP services within 5 working days of the 72-hour detention hearing.[23] The FP/BP caseworkers then have 30 days from the date of the referral to complete the Comprehensive Child and Family Assessment. At the time of our review, DFCS was contracting with 80 private entities to provide FP/BP services, which included the development of a case plan and determination of needed interventions and services for all children entering foster care in Georgia.

Medical and dental examinations to rule out conditions that may impact the child's overall well-being are required each time a child enters foster care.[24] Some of the components required as part of the Comprehensive Child and Family Assessment (e.g., medical and dental examinations and developmental assessments and psychological evaluations) are also required as part of an EPSDT screening, as shown in Appendix A. However, FP/BP examinations and assessments are not used by the State to satisfy the EPSDT frequency guideline requirements.

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[20] First Placement, Best Placement Manual, Section VI, June 2002 requires that a child's functional level be based on the Child and Adolescent Functional Scale, or Preschool and Early Childhood Functional Scale.

[21] First Placement, Best Placement Manual, Introduction Section, June 2002.

[22] Ibid., p. 1.

[23] The 72-hour detention hearing is used to determine if the State should retain custody of the child and maintain them in foster care.

[24] First Placement, Best Placement Manual, Sections III and IV, June 2002.

Initial Case Plan

To meet Federal requirements,[25] Georgia child welfare policy stipulates that caseworkers must develop an initial case plan for each child entering foster care within 30 days of entering State custody.[26] Each child's case plan must include information obtained from his/her FP/BP assessment, information regarding family strengths and resources, and goals established for the child and his/her family. To the extent available, information regarding each child's health (e.g., medical history, known medical problems, medications, immunizations, current health status, and dental status), the names and addresses of the child's health care professionals, and the child's emotional and psychological status are included in the initial case plan. State policy requires that all case plans be reviewed and updated every 6 months.

Section 475(1)(B) of the Act requires States to develop a plan for each child entering foster care to ensure their needs are addressed. Pursuant to section 475(1)(C) of the Act, available and accessible health information about a child is required to be included in the plan. Section 471(a)(15)(A) of the Act provides that the health and safety of children in foster care be considered of paramount concern. Section 475(5)(D) of the Act requires that a child's health record be updated and supplied to the foster care provider with whom the child is placed. Medical information plays a role in ensuring children receive required health care services. In response, Georgia requires caseworkers to discuss with foster care providers the health status and health care needs of each child in their care, and to give foster care providers medical health information about each child placed in their care. Caseworkers are also required to document that the foster care provider received the health information on each child. The information provided to foster care providers should include, at a minimum and where available and accessible, the names and addresses of the child's current health care professionals, a record of the child's immunizations, known medical problems, medications, and any other relevant health information determined appropriate to share with the foster care provider.[27] If any of this information is unknown or unavailable at the time the child is

[25] 45 CFR § 1356.21(g)(2) states that case plans must be developed no later that 60 days from the child's removal from the home.

[26] Georgia Department of Human Resources, Social Services Manual, Chapter 1007.2, p.8, May 2000.

[27] Georgia Department of Human Resources, Social Services Manual, Chapter 1007.2, p. 4, May 2000.

placed with a foster care provider, the caseworker is to provide an explanation regarding the missing information in the initial case plan. Caseworkers are instructed not to leave the medical portion of the case plan blank.[28]

METHODOLOGY

This inspection focused on the receipt of health care and dental services that meet EPSDT guidelines; the receipt of mental health services; and the provision of medical information to foster care providers. This study did not focus on follow-up care or the appropriateness of ongoing health care in meeting the needs of children in foster care. The inspection is based on information gathered from multiple sources: review of Federal and State policies; child-specific Medicaid claims data and case file documentation for 50 sampled children; interviews with caseworkers and foster care providers for the 50 sampled children; and interviews with Georgia State agency officials.

Reasons for State Selection

Georgia was selected for its medium population size based on Bureau of the Census data when compared to other States. It was also chosen for its southern geographic location, largely rural setting, county-administered child welfare system, and fee-for-service provision of Medicaid services.

Sample

Children who met the following criteria were included in the study population: (1) were in foster care on March 26, 2003; (2) resided in Georgia; (3) were eligible for Title IV-E foster care program maintenance funds; and (4) had been in continuous foster care placements for at least 6 months. DFCS provided us with a list of the 9,711 children who met these criteria.[29] Appendix B provides information on the 50 children included in our study.

[28] Georgia Department of Human Resources, Social Services Manual, Chapter 1011.2 (7), p. 4, November 2000.

[29] Based on the *Adoption and Foster Care Analysis and Reporting System* information regarding children in foster care in Georgia, the Atlanta metropolitan area is underrepresented in the universe of children in IV-E foster care. The percentage of children in foster care in the Atlanta region eligible for IV-E foster care maintenance is significantly lower than the remainder of the State.

Review of Law, Regulations, Policies, Medicaid Data, and Case File Documentation

Law, Regulation, and Policy Review—We reviewed Federal laws and regulations and Georgia State foster care, Medicaid, and EPSDT program policies. The Georgia Health Check program meets the Federal EPSDT requirements. Therefore, we used State-established Health Check frequency guidelines to determine whether children in foster care were receiving required EPSDT medical examinations and dental services timely.

Medicaid Claims Review—DFCS provided us with up to 3 years of Medicaid claims data for each of the children in our sample. The data included Medicaid claims for physician, dental, pharmaceutical, and mental health services paid between March 26, 2000, and March 26, 2003. For children entering foster care on or after March 26, 2000, we analyzed Medicaid claims data from the date they entered foster care through March 26, 2003. Appendix C provides the number of Medicaid claims for each child in the sample who received services during the period covered by our review.

Case File Documentation—We requested case file documentation from Georgia DFCS local offices for all of the children in our sample, including documentation of medical, dental and mental health services provided, the child's medical history, the child's case plan, the FP/BP Comprehensive Child and Family Assessment, verification of the duration of the child's stay in foster care, and information regarding the child's health and general well-being. We received case file documentation for all 50 children.

We reviewed case file documentation to determine if each sampled child had been referred for, scheduled for, or had actually received medical, dental, or mental health services (e.g., EPSDT form signed by a physician or other health care professional). Appendix D provides information regarding each sampled child's EPSDT services.

We also reviewed the case file documentation and Medicaid claims data provided to determine if sampled children received FP/BP family assessments, medical and dental examinations, and developmental assessments or psychological evaluations, within the required timeframes. To determine the timeliness of these assessments, we used the dates listed on the copies of the assessment or evaluation reports. Therefore, all children should have received a Comprehensive Child and Family Assessment within 38 days of entering care. The 38 days

included completion of the court hearing required within 72 hours of entering care, 5 days to complete a referral for a FP/BP assessment, and 30 days to complete the FP/BP assessment. We also reviewed Medicaid claims data to identify initial medical examinations provided in outpatient and emergency room settings. Appendix E identifies those children who received FP/BP services and the types of services they received.

Interviews

Foster Care Provider Interviews—We conducted structured interviews with 50 foster care providers responsible for the children in our sample (16 in person and 34 by telephone). 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 received related to the health and well-being of children, and their experiences procuring health care services for the children in our sample.

Caseworker Interviews—We conducted structured telephone interviews with the caseworkers assigned to all 50 sampled children. Each of these interviews focused on the caseworker's 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 analyzed the caseworkers' responses and compared them to those of the foster care providers, noting any consensus or disagreement within and between the two groups.

State Agency Officials—To enhance our understanding of the State's foster care and Medicaid programs, we consulted, both in person and by telephone, with DFCS and the Georgia Department of Community Health staff.

This inspection was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

All 50 sampled children had Medicaid coverage, and 49 had claims for health care services

Federal law requires that all children eligible for the Title IV-E foster care program be provided Medicaid services.[30] In Georgia, all children in Title IV-E foster care are automatically eligible for Medicaid, including EPSDT services.[31] Forty-nine of the fifty sampled children had Medicaid claims for health care services during the 3-year period covered by our study. One of the fifty sampled children, in foster care for over a year, had no Medicaid claims for health care services during the period covered by this study. Table 1 details the various types of Medicaid-covered services and the number of claims by type of service provided for the 49 sampled children with claims for health care services.

Table 1: Number and Type of Medicaid Claims for 49 Sampled Children

Claim Type	Number of Children with at Least One Claim	Total Number of Claims
Case Management*	45	839
Dental	31	121
Diagnostic	14	28
Hospital/Emergency Care	18	43
Laboratory	23	80
Mental Health	37	494
Miscellaneous**	38	121
Optometry/Audiology	19	65
Physical/Occupational Therapy	3	15
Physician Office	44	326
Prescription Drug	46	1,335
Skilled/Residential Care	5	49
Surgical Procedures	4	10
Transportation/Supplies	7	8
Vaccines	22	40
Total		**3,574**

* Case management includes four Medicaid claims for Targeted Case Management. The remaining Case Management claims are for child protective services and residential care services case management.

** Paid claims for which no diagnosis or procedure codes were given. See Appendix C for the number and type of Medicaid claims for the sampled children.

Source: Office of Inspector General, 2004.

[30] Section 1902(a)(10)(A)(i)(I) of the Social Security Act.

[31] Georgia Department of Community Health Manual, Part II-Chapter 700, April 2003.

Thirty of forty-three sampled children required to receive an EPSDT medical examination received their most recent EPSDT medical examination within State-established frequency guidelines

The EPSDT medical examinations are intended to screen for and identify health needs that may not be detected during a medical examination for a specific condition. All age-appropriate EPSDT examinations must be completed in accordance with the State-established EPSDT frequency guidelines. If a child entering foster care has not received the required age-appropriate EPSDT examinations in accordance with the frequency guidelines, the child should receive the needed services at the earliest possible time.[32]

The Georgia DFCS is responsible for arranging appropriate and timely medical care for all children in foster care and arranging for an initial health examination as soon as the child is placed in foster care. Seven of the fifty sampled children had been in foster care less than the time period specified by the EPSDT frequency guidelines for their age group and were not required to receive EPSDT examinations during that time. Of the remaining 43 sampled children, 30 received their most recent required EPSDT medical examinations within State-established guidelines. However, 13 of the 43 sampled children who should have received EPSDT medical examinations did not receive them within the required timeframe. Caseworkers for 9 of these 13 children stated they were familiar with the Health Check program and indicated they had received training regarding EPSDT screenings or understood the required health examination policies for children in foster care.

Twenty-one of thirty-five sampled children required to receive EPSDT dental services received their most recent EPSDT dental service within State-established frequency guidelines

The EPSDT frequency guidelines adopted by Georgia require that all children 3 years of age or older receive dental services every 6 months and allow for all children to be referred for dental services at any time. Thirty-nine of the sampled children were 3 years of age or older. However, we could evaluate receipt of required dental services only for the 35 sampled children with a full 6 months of Medicaid claims during our study period.

[32] Georgia Department of Community Health Manual, Part II, Chapter 900, Section 902, April 2003.

Only 21 of the 35 children required to receive dental services received their most recent required dental service, in accordance with the State-established EPSDT frequency guidelines. We were unable to determine why the remaining 14 children did not receive their most recent required dental services within the required timeframe. Only 1 foster care provider for the 14 children reported experiencing problems finding a dentist that would accept Medicaid and treat the sampled child in his/her care.

Many of the sampled children did not receive First Placement, Best Placement assessments within the State-required timeframe

Section 471(a)(22) of the Act required States to develop and implement standards to ensure the health and safety of children in foster care by January 1, 1999. In response to this statute, Georgia DFCS established the FP/BP program in 1998 beginning with five demonstration counties. They implemented the program statewide in July 1999.[33] Policies governing the FP/BP program require that children entering foster care after July 1999 receive all services required as part of a Comprehensive Child and Family Assessment (i.e., family assessment, medical and dental examinations, and developmental assessment or psychological evaluation) within 30 days from the date the DFCS caseworker makes the referral to the FP/BP agency. In most respects, FP/BP components mirrored those required as part of EPSDT examinations. See Appendix A for a comparison of EPSDT and FP/BP required components.

Forty of the fifty sampled children entered foster care after July 1999 and, therefore, were required to receive a Comprehensive Child and Family Assessment. However, we could determine FP/BP compliance for only 39 of the sampled children because 1 child entered foster care during the period covered by FP/BP policy, but before the beginning of our Medicaid claims window. Not all children received all of the required assessment services, and some services were not received timely.

[33] Georgia Department of Human Resources, Division of Family and Children Services, First Placement/Best Placement Fact Sheet dated February 2003.

Family Assessments are not completed timely.

The goal of a family assessment is to gather information about the child and his/her family. The family assessment includes information about the child's history and aids in identifying services relating to the health and safety of the child and his/her needs while in foster care. Caseworkers provided us with family assessments for 26 of the 39 sampled children covered by FP/BP. Fifteen of the twenty-six assessments were dated, but only 2 of the 15 were completed within the required 30-day timeframe. Eleven of the twenty-six assessments were not dated, and we were unable to determine if they were completed within the required 30-day timeframe. We did not receive family assessments for the remaining 13 sampled children and, therefore, were unable to determine if family assessments for these children were completed or completed timely.

Fourteen of thirty-nine sampled children did not receive FP/BP medical examinations within the State-required timeframe.

The initial medical examination documents the child's medical history upon entering foster care. This information is used by DFCS to assure that the medical needs of children in foster care are addressed. Some of the FP/BP initial medical examination components mirrored those components required as part of EPSDT medical examinations.

Twenty-five of the thirty-nine sampled children required to receive FP/BP services received their initial medical examinations timely. Twelve of these thirty-nine children did not, waiting 46 to 435 days after entering foster care to receive an initial medical examination. Two of the thirty-nine sampled children did not have case file information or Medicaid claims data to indicate they received the required medical examination even though one child had been in foster care 242 days and the other had been in foster care 398 days at the end of the period covered by our Medicaid claims window.

Thirteen of twenty-four sampled children did not receive FP/BP dental examinations within the State-required timeframe.

The initial dental examination, required for children age 3 and older, documents the child's dental history upon coming into foster care. DFCS uses this information to ensure that the dental needs of children in foster care are addressed. Like the initial FP/BP medical examinations, FP/BP dental examination components mirrored those required as part of EPSDT dental services.

Twenty-four of the thirty-nine sampled children were age 3 or older on the date they entered foster care, and were required to have a dental

examination completed within 30 days from the date of referral to FP/BP. However, only 7 of these 24 sampled children received their initial dental examination timely. Thirteen children waited from 43 to 371 days after entering foster care to receive their initial dental examinations, and four children had no Medicaid claims for dental examinations.

Some sampled children did not receive developmental assessments or psychological evaluations within the State-required timeframe.

Developmental Assessments—The initial developmental assessment screens and assesses developmental milestones and characteristics for children 3 years of age or younger when they enter foster care. The information from these assessments is critical in making placement decisions, developing case plans, assuring the safety and well-being of the child, and obtaining services for children who have developmental delays. The EPSDT guidelines do not require that children receive an initial developmental assessment but some of the aspects of the initial assessment meet the EPSDT developmental/behavioral component requirements.

Sixteen of the thirty-nine sampled children referred to FP/BP were 3 years of age or younger when they entered foster care. Two of these sixteen sampled children received their developmental assessment timely. Ten of the sixteen sampled children received their developmental assessments 40 to 885 days after entering foster care. We were unable to document the receipt of the required initial developmental assessment for 4 of the 16 children because there was no Medicaid claim to indicate an assessment had been completed and no developmental assessment report was included in the case file.

Psychological Evaluations—Initial psychological evaluations differ from developmental assessments and are only required for children age 4 and older. These evaluations should include, but are not limited to, the psychological status of the child or adolescent at the time they enter foster care. If a psychological evaluation yields any mental health concerns, the psychological summary and report must provide detailed recommendations and actions to be taken.[34] DFCS uses this information to identify the child's mental health service needs and to assure his/her safety and well-being. The initial psychological evaluation is not required

[34] First Placement, Best Placement Manual, Section IV, June 2002.

by the EPSDT frequency guidelines, but meets some of the EPSDT developmental/behavioral component requirements.

Twenty-three of the thirty-nine sampled children referred to FP/BP were 4 to 21 years of age when they entered foster care. Fifteen of the twenty-three sampled children received their psychological evaluations within required timeframes. Eight of the twenty-three sampled children who received a psychological evaluation did not receive it within the required 30-day timeframe, with receipt ranging from 41 to 461 days after referral.

Four sampled children did not receive services to address documented mental health needs, and mental health needs were not documented for five children who received such services

Section 475(1)(B) of the Act requires a case plan to be developed for each child entering foster care, and that the plan should include steps for assuring that the child receives safe and proper care. Section 475(1)(C) of the Act requires the health records of the child including names and addresses of providers, a record of immunizations, any known medical problems, medications, and any other relevant health information also be included in the plan. The Georgia DFCS further requires that case plans contain information regarding the child's current emotional and psychological status.[35] The Georgia DFCS requires caseworkers to complete case plans within 30 days from the date a child enters foster care, and to update the plans every 6 months.

Discrepancies existed in the documentation and receipt of mental health services for 9 of the 50 sampled children. Four of the nine sampled children had an assessment indicating a need for mental health services. However, these four children received no additional mental health services. The remaining five children had Medicaid claims indicating they received mental health services, and caseworkers and foster care providers for these children acknowledged the children were getting their mental health services needs met, but the need for mental health services was not documented. Documentation is essential to ensure the continuation of needed services.

[35] Georgia Department of Human Resources, Social Services Manual, Chapter 1007.8, p. 19, May 2000.

Twenty-four of the fifty foster care providers reported never receiving medical information for the children in their care

Section 471(a)(15)(A) of the Act provides that the health and safety of children in foster care be considered of paramount concern. Medical information supplies foster care providers with information necessary to ensure that the child in their care receives proper care and that the child's needs are met. Section 475(5)(D) of the Act requires that a child's health records be reviewed and updated and supplied to the foster care provider with whom the child is placed at the time of each placement. Georgia requires all caseworkers to supply the foster care provider with a copy of the health information on the child, and to document that the foster care provider received the health information.[36]

Of the 50 foster care providers we interviewed, 24 stated they received no medical information for the sampled children in their care. However, caseworkers for 21 of these 24 children reported they had received or compiled some medical information for the sampled children. While we were unable to determine the reasons that available medical information was not given to these 21 foster care providers, failure to share this information indicates a problem in the communication of medical information from caseworkers to foster care providers and could result in children's needs not being met.

[36] Georgia Department of Human Resources, Social Services Manual, Chapter 1000, Sections 1011.2, p.4, November 2000.

RECOMMENDATIONS

States are required to ensure that all children in foster care are provided quality health care services that protect their health. States are also required to develop a plan for each child that includes their health care needs and medical information and to supply foster care providers with a child's health record at the time the child is placed with them. Medical information plays a role in ensuring that children receive required health care services. The EPSDT program is intended to detect various health needs. The Georgia FP/BP program requires that each child who enters foster care receive a Comprehensive Child and Family Assessment. However, if children do not receive the required EPSDT services or FP/BP assessments, or do not receive those services timely, their health needs may go undetected and untreated.

ACF and CMS should work with the Georgia Department of Community Health to ensure that:

- The EPSDT medical examinations and dental services are received timely.

ACF should work with the Georgia Department of Human Resources, DFCS to ensure that:

- Assessments are completed within the required timeframe.
- Foster care providers receive initial and updated medical information for children placed in their care.

In addition, ACF should work with DFCS to ensure that case files contain required documentation, including mental health needs. Further, during the course of this study, we noted that some of the components of the FP/BP Comprehensive Child and Family Assessments mirrored the components required as part of EPSDT. We encourage ACF, CMS, DFCS, and the Georgia Department of Community Health to consider allowing services provided under either program to count for meeting the requirements of both programs, as appropriate.

AGENCY COMMENTS

ACF described actions it is taking that will address our recommendations. It is monitoring the State of Georgia through quarterly reports relative to the State's efforts to ensure that EPSDT medical examinations and dental services are received timely and to ensure that foster care providers receive appropriate medical information for children placed in their care.

CMS concurred with the OIG recommendation and will have CMS regional office staff work with the Georgia Department of Community Health to ensure that EPSDT services are provided according to the State-established EPSDT frequency guidelines. CMS also notes that its staff is available to the State and to ACF to provide any necessary technical assistance. Additionally, in response to an OIG suggestion, CMS will not prohibit FP/BP assessments to serve as EPSDT screenings if the screenings are provided in accordance with the State-established EPSDT frequency guidelines and meet the definition of an EPSDT screening, with all age appropriate screens and services being provided.

EPSDT and First Placement, Best Placement Required Components

The table below provides a comparison of EPSDT and FP/BP components.

Screening/Examination Components	EPSDT Required Component	FP/BP Required Component
INITIAL/INTERVAL	Y	Y
MEASUREMENTS		
Height and Weight	Y	Y
Head Circumference	Y	Y
Blood Pressure	Y	Y
SENSORY SCREENING		
Vision	Y	Y
Hearing	Y	Y
MENTAL HEALTH	Y*	Y**
PHYSICAL EXAMINATION	Y	Y
PROCEDURES	Y	Y
Hereditary/Metabolic	Y	Y
Screening (newborn)	Y	Y
Immunization	Y	Y
Tuberculin Test	Y	Y
Hematocrit or Hemoglobin	Y	Y
Urine	Y	Y
Lead Screening	Y	N
ANTICIPATORY GUIDANCE	Y	Y
DENTAL EXAMINATION	Y	Y

*The EPSDT mental health component requires developmental/behavioral assessments be performed by the physician who conducts the EPSDT medical examination.

**The FP/BP mental health component requires developmental assessments and psychological evaluations be performed by trained professionals who specialize in the field of mental health, and are more extensive than those required as part of an EPSDT medical examination.

APPENDIX ~ B

Demographic Charactertics of Sampled Children

The table below provides the demographic characteristics of each of the 50 sampled children and his or her foster care placement history as of June 1, 2003.

OIG ID	Age in Years	Sex	Placement Setting	Entries into Foster Care (1)	Months Since Foster Care Entry (2)	Placements Since Last Entry (3)	Months Since Last Placement (4)	Caseworkers Since Last Entry (5)	Months Caseworker with Case (6)
1	3	M	Family	1	33	1	33	3	24
2	14	F	Family	1	26	2	20	*	7
3	15	M	Residential	2	13	5	4	1	13
4	1	M	Family	1	21	1	21	2	17
5	11	F	Family	1	28	6	18	3	5
6	2	F	Family	*	18	1	18	1	18
7	11	M	Family	1	14	1	14	1	14
8	7	M	Family	1	13	1	13	*	5
9	16	F	Residential	1	40	7	30	4	22
10	3	F	Family	1	21	1	21	2	4
11	5	F	Family	1	25	2	12	3	12
12	2	M	Family	1	12	2	9	1	12
13	13	F	Family	2	14	1	14	4	1
14	17	F	Kinship	1	91	1	91	2	12
15	10	F	Kinship	2	19	4	12	4	1
16	16	F	Family	*	44	3	16	*	24
17	12	F	Family	1	19	2	15	2	12
18	3	M	Family	1	9	1	9	1	9
19	16	F	Residential	2	35	8	7	3	24
20	17	F	Family	1	52	2	9	3	1
21	7	M	Therapeutic	1	29	*	19	5	1
22	3	M	Family	1	22	3	1	1	22
23	12	M	Family	2	11	1	11	*	6
24	8	M	Family	1	20	1	20	3	16
25	16	F	Family	3	20	2	18	3	4
26	9	M	Therapeutic	1	116	6	1	5	12
27	1	M	Family	1	15	2	1	4	12
28	2	F	Family	1	31	1	31	3	2
29	9	F	Family	1	75	3	13	2	12
30	15	M	Residential	1	22	10	2	3	3
31	7	F	Family	1	56	2	6	8	6

A P P E N D I X ~ B

OIG ID	Age in Years	Sex	Placement Setting	Entries into Foster Care (1)	Months Since Foster Care Entry (2)	Placements Since Last Entry (3)	Months Since Last Placement (4)	Caseworkers Since Last Entry (5)	Months Caseworker with Case (6)
32	1	F	Family	1	10	1	10	2	6
33	11	M	Kinship	2	131	*	120	3	5
34	11	`F	Family	2	10	2	8	1	10
35	17	F	Institution	1	102	3	32	5	18
36	8	F	Family	1	26	1	26	*	24
37	3	F	Family	2	36	2	14	3	5
38	1	F	Family	1	10	1	10	1	10
39	2	F	Family	1	24	2	2	3	11
40	2	F	Family	1	30	1	30	2	29
41	17	F	Residential	1	19	1	19	1	19
42	9	F	Kinship	1	37	1	37	2	3
43	1	F	Family	1	9	1	9	1	9
44	17	M	Institution	1	28	5	13	*	27
45	10	M	Family	1	21	3	1	*	13
46	1	M	Family	1	14	2	5	2	12
47	17	M	Therapeutic	1	48	1	48	3	2
48	8	F	Kinship	2	12	2	7	*	10
49	13	F	Family	1	54	*	10	6	16
50	15	M	Residential	1	21	10	3	3	3

KEY

(1) Entries into Foster Care—number of times a child has entered State custody.

(2) Months Since Foster Care Entry—length of time from the date of the child's most recent entry into foster care until June 1, 2003, when interviews were conducted with caseworkers and foster care providers, or the date the child left care if that date precedes June 1, 2003.

(3) Placements Since Last Entry—total number of placements, in all settings (e.g., Foster Home, Residential Care Facility), the child experienced during their most recent entry into foster care.

(4) Months Since Last Placement—length of time from the date of the most recent foster care placement to the date the foster care provider was interviewed.

(5) Caseworkers Since Last Entry—number of caseworkers assigned responsibility for the child since his/her last entry into foster care.

(6) Months Caseworker with Case—number of months the most recent caseworker has been assigned responsibility for the child.

(*) Indicates an unknown value.

Medicaid Claims for Sampled Children

The table below indicates each of the 50 children's paid Medicaid claims for physician visits, dental services, prescription medications, and mental health services from March 26, 2000, to March 26, 2003.

OIG ID	Number of Medicaid Claims*			
	Medical and Physician's Visits	Dental Services	Prescription Medications	Mental Health Services
1	36	0	54	0
2	2	1	11	21
3	2	0	16	11
4	13	0	10	0
5	8	3	80	25
6	10	0	50	1
7	2	2	27	28
8	1	3	12	1
9	6	0	11	62
10	0	0	6	0
11	1	0	8	1
12	0	0	25	0
13	1	3	0	0
14	15	5	30	7
15	2	0	10	4
16	12	10	22	5
17	3	4	34	14
18	6	0	16	1
19	14	3	19	12
20	5	5	4	7
21	8	4	47	26
22	9	0	27	0
23	2	1	27	2
24	4	2	24	8
25	0	5	0	19
26	17	3	54	30
27	0	0	0	0
28	35	1	19	0
29	6	4	19	84
30	4	3	40	10
31	1	1	0	1
32	11	0	5	1
33	1	3	2	18
34	0	2	7	1

OIG ID	Number of Medicaid Claims*			
	Medical and Physician's Visits	Dental Services	Prescription Medications	Mental Health Services
35	7	4	5	28
36	9	6	22	10
37	10	0	9	1
38	5	0	15	0
39	1	0	1	0
40	14	0	27	0
41	1	5	137	1
42	3	13	4	1
43	2	0	1	1
44	13	8	108	1
45	3	7	22	22
46	7	0	13	0
47	7	4	187	0
48	5	1	20	2
49	0	1	31	24
50	2	4	17	3
TOTAL	**326**	**121**	**1335**	**494**

KEY

* Includes only services for which a Medicaid claim was paid. Services documented in the case file for which no Medicaid claims were paid are not included.

APPENDIX ~ D

EPSDT Services for Sampled Children

The table below reflects EPSDT services received by each of the 50 sampled children from March 26, 2000, to March 26, 2003, or from entry into foster care to March 26, 2003, whichever is shorter.

OIG ID	Medical History In Case File (1)	Case Plan Completed In 30 Days (2)	EPSDT Services Current (3)	
			Medical	Dental
1	Y	Y	A	D
2	Y	Y	C	A
3	Y	Y	B	D
4	Y	Y	A	D
5	Y	N	B	A
6	Y	Y	A	D
7	Y	Y	B	C
8	Y	N	B	C
9	Y	NP	D	C
10	Y	Y	C	D
11	Y	Y	C	C
12	Y	NP	C	D
13	Y	Y	B	C
14	Y	NP	B	A
15	Y	Y	B	C
16	Y	Y	B	A
17	Y	NP	D	A
18	Y	N	B	D
19	Y	Y	B	C
20	Y	Y	B	A
21	Y	NP	C	A
22	Y	Y	A	D
23	Y	Y	C	A
24	Y	Y	B	A
25	Y	Y	B	A
26	Y	NP	D	C
27	Y	NP	C	D
28	Y	NP	A	B
29	Y	Y	C	C
30	Y	NP	A	C

OIG ID	Medical History In Case File (1)	Case Plan Completed In 30 Days (2)	EPSDT Services Current (3)	
			Medical	Dental
31	Y	NP	A	A
32	Y	Y	A	D
33	Y	Y	B	A
34	Y	N	C	C
35	Y	NP	D	C
36	Y	Y	A	A
37	Y	NP	C	C
38	Y	NP	C	D
39	Y	NP	C	D
40	Y	Y	A	D
41	Y	Y	A	A
42	Y	Y	D	A
43	Y	N	A	D
44	Y	Y	A	A
45	Y	NP	D	A
46	Y	Y	A	D
47	Y	Y	B	C
48	Y	Y	A	A
49	Y	NP	C	B
50	Y	NP	D	B

KEY

(1) Medical History in Case File—case file documentation provided by the sampled child's caseworker included a medical history

(2) Case Plan Completed in 30 Days—case plan was completed within 30 days after the child entered foster care or was not provided to us.
- Y - Case plan completed within 30 days.
- N - Case plan not completed within 30 days.
- NP - Case plan not provided to us.

(3) EPSDT Services Current—Medical and Dental
- A - Most recent required service was received.
- B - One or more services were received, but the sampled child would not have been considered out of compliance if the service had not been received based on his/her age or the length of time the child had been in foster care at the time of our review.
- C - Most recent required service was not received.
- D - No services were received, but none were required during our claims window (i.e., the length of time the child had been in foster care and the period covered by our claims window did not extend the full length of time covered by the EPSDT frequency guidelines for the child's age, or the child was under 3 years of age and not required to receive dental services).

APPENDIX ~ E

First Placement, Best Placement Assessments

The table below reflects the number of days from the date of entry into foster care to the date child received initial assessment services from a First Placement, Best Placement professional.

OIG ID	Child Entered Care During the Medicaid Claims Window (1)	FP/BP Initial Services Required (2)	Initial Required Services			
			Developmental Assessment (3)	Psychological Evaluation (3)	Medical Examination (4)	Dental Examination (4)
1	Y	Y	X	•	9	•
2	Y	Y	•	27	4	4
3	Y	Y	•	26	3	X
4	Y	Y	42	•	2	•
5	Y	Y	•	33	25	371
6	Y	Y	335	•	46	•
7	Y	Y	•	55	19	145
8	Y	Y	•	84	61	21
9	N	Y				
10	Y	Y	X	•	8	•
11	Y	Y	•	461	1	X
12	Y	Y	X	•	243	•
13	Y	Y	•	37	34	34
14	N	N				
15	Y	Y	•	28	435	X
16	N	N				
17	Y	Y	•	**	49	1
18	Y	Y	21	•	26	•
19	Y	Y	•	35	20	43
20	N	N				
21	Y	Y	•	41	38	216
22	Y	Y	85	•	17	•
23	Y	Y	•	98	148	168
24	Y	Y	•	23	1	123
25	Y	Y	•	15	9	290
26	N	N				
27	Y	Y	90	•	X	•
28	Y	Y	58	•	294	•
29	N	N				
30	Y	Y	•	33	2	23

OIG ID	Child Entered Care During the Medicaid Claims Window (1)	FP/BP Initial Services Required (2)	Initial Required Services			
			Developmental Assessment (3)	Psychological Evaluation (3)	Medical Examination (4)	Dental Examination (4)
31	N	N				
32	Y	Y	40	•	5	•
33	N	N				
34	Y	Y	•	17	X	15
35	N	N				
36	Y	Y	•	25	204	156
37	Y	Y	885	•	158	X
38	Y	Y	X	•	21	•
39	Y	Y	54	•	2	•
40	Y	Y	150	•	7	•
41	Y	Y	•	16	1	13
42	Y	Y	•	73	121	128
43	Y	Y	26	•	9	•
44	Y	Y	•	13	356	213
45	Y	Y	•	41	1	125
46	Y	Y	140	•	4	•
47	N	N				
48	Y	Y	•	13	6	130
49	N	N				
50	Y	Y	•	102	340	349

KEY

(1) Child Entered Care During the Medicaid Claims Window—child entered foster care between March 26, 2000, and March 26, 2003.

(2) FP/BP Initial Services Required—child entered foster care after July 1999, and, therefore, was required to receive FP/BP initial services.

(3) Developmental Assessment or Psychological Evaluation—number of days from the date the sampled child entered foster care and receipt of a developmental assessment or psychological evaluation. We used either the date of the psychological report from the child's case file or the Medicaid claims data date, whichever was closest to the child's foster care entry date.

(4) Medical Examination or Dental Examination—number of days from the date the sampled child entered foster care and receipt of a medical examination or dental services. We used the Medicaid claims data date or medical documentation from the case file, whichever was closest to the child's foster care entry date, to determine when the child received his/her first outpatient, emergency room, or EPSDT medical examination.

X Indicates service not received.

• Indicates that the service was not required based on the sampled child's age at the time of our review.

** Child received a psychological evaluation 125 days before coming into foster care.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES
Office of the Assistant Secretary, Suite 600
370 L'Enfant Promenade, S.W.
Washington, D.C. 20447

OCT 14 2004

TO: Daniel R. Levinson
Acting Inspector General

FROM: Wade F. Horn, Ph.D.
Assistant Secretary
for Children and Families

SUBJECT: Comments on the Office of Inspector General Draft Report: "Children's Use of Health Care Services While in Foster Care: Georgia," OEI-07-00-00644

Attached are the Administration for Children and Families' comments on the above-referenced OIG draft report.

Should you have questions or need additional information, please contact Dr. Susan Orr, Associate Commissioner, Children's Bureau at (202) 205-8618.

Attachment

COMMENTS OF THE ADMINISTRATION FOR CHILDREN AND FAMILIES ON THE OFFICE OF INSPECTOR GENERAL'S DRAFT REPORT: "CHILDREN'S USE OF HEALTH CARE SERVICES WHILE IN FOSTER CARE: GEORGIA," OEI-07-00-00644

The Administration for Children and Families (ACF) appreciates the opportunity to comment on the OIG draft report.

OIG Recommendations

The Administration for Children and Families (ACF) and the Centers for Medicare & Medicaid Services (CMS) should work with the Georgia Department of Community Health to ensure that:

- EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) medical examinations and dental services are received timely.

ACF should work with the Georgia Department of Human Resources, Division of Family and Children Services (DFCS) to ensure that:

- Assessments are completed within the required timeframe.
- Foster care providers receive initial and updated medical information for children placed in their care.

In addition, ACF should work with DFCS to ensure that case files contain required documentation, including mental health needs. Further, during the course of this study, we noted that some of the components of the FP/BP (First Placement, Best Placement) Comprehensive Child and Family Assessments mirrored the components required as part of EPSDT. We encourage ACF, CMS, DFCS, and the Georgia Department of Community Health to consider allowing services provided under either program to count for meeting the requirements of both programs, as appropriate.

ACF Comments

ACF is actively working with the Georgia Department of Human Resources on the recommendations to promote the importance of obtaining medical histories for children in foster care and providing this information to foster parents. The specific action steps and benchmarks related to gathering medical information and providing it to foster families are included in the Program Improvement Plan (PIP) developed in response to a Child and Family Services Review (CFSR) in Georgia.

In addition to the federal regulations cited in the report, the CFSR, which was authorized by the 1994 amendments to the Social Security Act, is administered by the Children's

Bureau. The CFSR is ACF's primary mechanism for working with States on practice issues that impact the well-being of children and families.

During the on-site portion of the Georgia review of the cases reviewed to measure whether or not "children receive adequate services to meet their physical and mental health needs," only 62 percent substantially achieved this outcome. While there were a number of strengths identified related to the provision of health and mental health services, Georgia did not achieve substantial conformity.

ACF finalized a PIP with Georgia on October 1, 2002. As a result of the CFSR, the State was required to address both physical and mental health improvements in its PIP. The State's PIP has a number of action steps pertaining to improvement of physical and mental health needs of children being served by the child welfare system. Some of the action steps were developed to address both issues. They are all in varying stages of implementation, but all action steps must be completed by the end of the PIP. The goals are to be achieved by late October 2004.

Following are some of the key initiatives in the PIP to address improvements for physical and mental health issues:

(1) Conduct multi-disciplinary team meetings within 30-60 days of a child's entry into placement. This includes completion of a comprehensive child and family assessment. This action step has been achieved and the State is now monitoring for effectiveness, including conducting random case reviews. This initiative also includes training and support to county child welfare staff and providers on meeting the needs of children and families, including the use of wrap-around services.

(2) The comprehensive child assessments, as noted in the above action step, include the following: for infants and toddlers - developmental screenings; ages 4-18 - psychological assessments and/or youth/adolescent assessments. Assessments must include medical and dental, mental health, and educational needs.

(3) The State is developing a Statewide database of available child mental health resources.

ACF is continuing to monitor the progress of Georgia's PIP with quarterly reports.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: NOV 17 2004

TO: Daniel R. Levinson
Acting Inspector General

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Children's Use of Health Care Services While in Foster Care: Georgia* (OEI-07-00-00644)

Thank you for the opportunity to review and comment on the above-referenced draft report. This report is one of a series of eight inspections that focus on children's use of health care services while in foster care. We look forward to working with OIG on this and other issues pertinent to Medicaid health care services, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Our response to the audit recommendation follows.

OIG Recommendation

The Administration for Children and Families (ACF) and the Centers for Medicare & Medicaid Services (CMS) should work with the Georgia Department of Community Health to ensure timely receipt of EPSDT medical and dental examinations.

CMS Response

The CMS concurs with this recommendation and our regional office staff will work with the Georgia Department of Community Health to ensure that EPSDT services are provided according to the State's periodicity schedule. We are also available to the State and ACF to provide any necessary technical assistance.

Additionally, while not specified as a recommendation, OIG also encourages ACF, CMS, the Georgia Department of Human Resources' Division of Family and Children Services, and the Georgia Department of Community Health to consider allowing services provided under either program to count for meeting the requirements of both programs, as appropriate. CMS would not prohibit the use of the First Placement/Best Placement assessments as EPSDT screenings if several conditions were met. First, the screenings would have to be due according to the State's periodicity schedule. This would include any make-up screenings a child may be due, but would not include duplicative screenings. Second, the screenings must meet the definition of an EPSDT screening, with all age-appropriate screens and services being provided.

Again, we appreciate the effort that went into this report and the opportunity to review and comment on the issues it raises.

Attachment

ACKNOWLEDGMENTS

This report was prepared under the direction of Brian Pattison, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office, and Gina Maree, Assistant Regional Inspector General. Other principal Office of Evaluation and Inspections staff that contributed include:

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