Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

-

Inspector General

FEBRUARY 2004
OEI-07-00-00642

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, by Public Law 100-504, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

ABSTRACT

Our study determined that all 50 sampled children in the Illinois foster care program received Medicaid services, and nearly all received their most recent required Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) medical and dental examinations and initial health examination upon entry into foster care. In contrast, less than half of the sampled children received a comprehensive health care evaluation and mental health screen. Less than half of case files contained a copy of the medical history, which is required by State and Federal regulations and designed to ensure that children are provided with needed health care services. As a result, several children received duplicate services. The Office of Inspector General (OIG) recommended that the Administration for Children and Families (ACF) work with the Illinois Department of Children and Family Services (DCFS) to increase the number of comprehensive health evaluations and mental health screenings conducted within required time frames; and that health information for children in foster care is updated on an ongoing basis, provided to foster care providers, and maintained in the case file. OIG also recommends that the Centers for Medicare & Medicaid Services (CMS) work with the Illinois Department of Public Aid to prevent potentially unnecessary costs to the Medicaid program resulting from duplicate services. ACF responded that it is working with DCFS to improve the provision of health and mental health services to children in foster care and that the provision of these services will be addressed in Illinois' Program Improvement Plan in response to a Child and Family Services review. CMS agrees in part with our recommendation, recognizing the concern about the potential for Federal and State funds being unnecessarily expended for duplicate Medicaid services; however, CMS believes DCFS should work to better inform foster care parents and providers of the availability of services and the State requirements under the Healthworks and Passport program.

OBJECTIVE

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

BACKGROUND

Currently, there are an estimated 565,000 children in foster care nationwide, many of whom are reportedly in poor health. Compared with children from the same socioeconomic backgrounds, children in foster care experience much higher rates of serious physical and psychological problems. Illinois 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 Illinois 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, at intervals which meet reasonable standards of medical and dental practice, as outlined in Sections 1902(a)(43) and 1905(r) of the Social Security Act (the Act). In addition, Sections 472(h) and 1902(a)(10)(A)(i)(I) of the Act require States to provide Medicaid, or equivalent health insurance coverage, to children eligible to receive Title IV-E funds.

This inspection is based on information gathered from multiple sources: reviews of Federal and State policies; analysis of child-specific Medicaid claims data and case file documentation for 50 randomly-sampled children in foster care; interviews with foster care providers (e.g. foster parents and residential facility staff) and caseworkers for the children in our sample; and interviews with the Illinois Department of Children and Family Services (DCFS), Illinois Department of Public Aid, and other State agency officials. Our analysis focused on a 3-year Medicaid claims period for children in foster care ending on December 31, 2002.

FINDINGS

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

In accordance with Federal and State regulations, all of the sampled children had Medicaid coverage. All 50 children had at least one Medicaid claim for health care services.

All sampled children received their most recent EPSDT medical examinations, and 76 percent received their most recent EPSDT dental examinations, in accordance with State guidelines

Almost all of the sampled children who received their most recent dental examination within required timeframes had a foster care provider who was aware of the availability of Medicaid services, whereas half of the children who did not receive their most recent dental examination within required timeframes had a foster care provider who was unaware of the Medicaid services available.

Ninety-seven percent of sampled children received their Initial Health Screening within required timeframes

Illinois requires that each child entering State custody receive an Initial Health Screening within 24 hours to identify and document acute medical problems and/or 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 which makes access available 24 hours a day, 7 days a week.

Only 42 percent of sampled children received Comprehensive Health Evaluations within required timeframes

Illinois requires that children entering State custody receive a Comprehensive Health Evaluation within 21 days that includes an in-depth physical examination and comprehensive medical and psychosocial history. These examinations are usually performed by a primary care physician during regular business hours and scheduled by the child's foster care provider.

Only 1 of 14 sampled children required to receive a Mental Health Screen had one completed within required timeframes

Illinois requires a Mental Health Screen to be performed within 21 days of entering State custody for all children aged 5 or older. Mental health screens are performed in conjunction with Comprehensive Health Evaluations, and are usually performed by a primary care physician limiting access to regular business hours.

Forty-eight percent of case files had a Health Passport

Federal law requires that a child's health records be provided to the foster care provider at the time of the child's placement. This information is important so that appropriate health care services may be provided to children in foster care. Foster care providers and caseworkers indicated that a child's medical history (i.e. Health Passport) is provided at the time of placement in a majority of cases. However, only 48 percent (24/50) of the case files contained copies of the Health Passport, and only 8 of these Health Passports contained complete, accurate, and up-to-date medical information. Because of missing or incomplete Health Passports, which would have indicated the immunizations that had been received, some children received duplicate immunizations.

RECOMMENDATIONS

We recommend that the:

Administration for Children and Families (ACF) work with the Illinois DCFS to increase the number of:

- Comprehensive Health Evaluations and Mental Health Screens conducted within required timeframes
- Health Passports that are (1) updated on an ongoing basis, (2) reviewed for accuracy and completeness during the Administrative Case Review, and (3) copied each time the health information is updated, so that a copy of the most recent Health Passport is maintained in the case file and provided to the foster care provider

Centers for Medicare & Medicaid Services (CMS) work with ACF and the Illinois Department of Public Aid to:

- Prevent potentially unnecessary costs to the Medicaid program resulting from duplicate services

AGENCY COMMENTS

ACF indicated the background provided a useful perspective of the problem and the addition of the case file documentation and analysis of claims data were also informative. ACF noted that it is working with DCFS to improve the provision of health and mental health services to children in foster care and that the provision of these services will be addressed in Illinois' Program Improvement Plan in response to a Child and Family Services Review. Child and Family Services Reviews measure individual States' performance related to the health and well-being of children in the child welfare system.

CMS agrees in part with our recommendation, recognizing the concern about the potential for Federal and State funds being unnecessarily expended for duplicate Medicaid services; however, CMS believes State foster care agency should work to better inform foster care parents and providers of the availability of services and the State requirements under the EPSDT program.

TABLE OF CONTENTS

INTRODUCTION

OBJECTIVE

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

BACKGROUND

Currently, there are an estimated 565,000 children in foster care nationwide,[1] many of whom are 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. Illinois was selected because of its large size, geographic location, and fee-for-service provision of Medicaid services. Illinois had 33,125 children in foster care at the end of the Federal fiscal year 2000, based on the most recent Federal data available.[3] 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 that State foster care programs are operating within Federal guidelines.

Compared with children from the same socioeconomic backgrounds, children in foster care experience much higher rates of serious physical and psychological problems.[4] Dental problems are prevalent in the foster care population and physical health problems (e.g. delayed growth and development, malnutrition, and

[1] Retrieved November 1, 2002 from http://www.acf.dhhs.gov/programs/cb/dis/afcars/cwstats.html.

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

[3] FY 2000 Foster Care Entries, Exits, and In Care on the Last Day. Retrieved December 12, 2003 from http://www.acf.hhs.gov/programs/cb/dis/tables/entryexit.htm.

[4] Health Care Issues for Children in Foster Care, March 25, 2002. Retrieved December 12, 2003 from http://www.casey.org/cnc/documents/health_care_issues.pdf.

asthma) affect 30 to 40 percent of children in the child welfare system.[5]

Children in foster care have greater health care needs, yet many foster care providers (e.g. foster parents and residential care facility staff) report having difficulty finding health care professionals who are willing to care for these children.[6] The health care available for children in foster care is often characterized by lack of access; lack of information sharing among health care providers, child welfare workers, and foster care providers; and long delays in obtaining services.[7] Furthermore, studies have shown that low percentages of children in foster care are actually receiving health care services. 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 age 21 that might otherwise go undetected or untreated. However, a General Accounting Office report released in July 2001 states that available data from short-range studies show that the percentage of children in the general population receiving EPSDT services is very low.[8]

Preventive dental care is also included as part of EPSDT. A journal article reports that adherence to the American Dental Association recommendations for preventive dental care leads to improved oral health and practicing preventive behaviors over the long term yields greater benefits than doing so over the short term.[9]

---

[5] Fact sheet: The Health of Children in Out-of-Home Care. Child Welfare League of America. Retrieved December 12, 2003 from http://www.cwla.org/programs/health/healthcarecwfact.htm.

[6] Chernoff, R. et. al., Assessing the Health Status of Children Entering Foster Care, Pediatrics, 93:2, 1994.

[7] Health Care of Young Children in Foster Care. Pediatrics, 109:3, 2002. Retrieved December 12, 2003 from http://www.aap.org/policy/re0054.html.

[8] Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services. General Accounting Office, GAO-01-749, July 2001.

[9] Journal of Dental Research, March 2003; 82 (3): 223-7.

Medicaid for Children in Foster Care

Illinois provides Medicaid coverage to all children in the Title IV-E foster care program, as well as other eligible children. Sections 472(h) and 1902(a)(10)(A)(i)(I) of the Social Security Act (the Act) require States to provide Medicaid, or equivalent health insurance coverage, to children eligible to receive Title IV-E foster care program maintenance funds. Federal EPSDT guidelines require each State to make comprehensive and preventive child health services available to Medicaid-eligible individuals under the age of 21, at intervals which meet reasonable standards of medical and dental practice, as outlined in Sections 1902(a)(43) and 1905(r) of the Act. Within broad national guidelines, each State establishes its own eligibility standards for the Medicaid program; determines the type, amount, duration, and scope of Medicaid services; sets the rate of payment for services to Medicaid patients; and administers its own Medicaid program.[10] In fiscal year (FY) 2000, Medicaid payments for children in foster care nationwide totalled over $3.3 billion.[11] Illinois Medicaid expenditures to provide health care services to children in foster care totalled approximately $281 million in FY 2000.[12] The Centers for Medicare & Medicaid Services (CMS) is responsible for Federal oversight of individual State Medicaid programs.

Illinois

The Illinois foster care program is State-administered and divided into regional networks. The Illinois Department of Children and Family Services (DCFS) manages foster care in Illinois. DCFS may place children with public or private agencies. The Illinois Department of Public Aid manages the State Medicaid program. The management of the Illinois foster care program changed substantially in 1993 due to implemented changes brought about by the B.H. Consent Decree. One significant change was the introduction of the Healthworks program.

---

[10]Retrieved May 20, 2003 from http://cms.hhs.gov/medicaid/eligibility/criteria.asp.

[11]Medicaid Statistical Information System (MSIS) Report Fiscal 2000. Retrieved December 12, 2003 from http://www.cms.hhs.gov/medicaid/msis/00total.pdf.

[12]Medicaid Statistical Information System (MSIS) Report Fiscal 2000: Illinois. Retrieved December 12, 2003 from http://www.cms.gov/medicaid/msis/00il.pdf.

B.H. Consent Decree

The B.H. Consent Decree[13] was the result of a class action lawsuit brought by the American Civil Liberties Union (ACLU) on behalf of children in the custody of the Illinois DCFS in 1988. ACLU alleged violations of the Fourteenth Amendment to the United States Constitution and the Adoption Assistance and Child Welfare Act of 1980, 42 U.S.C. §§ 620-68, 670-79(a), which requires States to make reasonable efforts to prevent the unnecessary removal of children from their homes and the unnecessary placement of children in foster care. Specifically, child welfare caseloads approached 100 cases-per-worker, work was being duplicated, cases were scattered to such a degree that monitoring was difficult, there was a general lack of emphasis on prevention and primary care, and documentation of medical information was sporadic.[14] In 1991, DCFS reached an agreement in the B.H. Consent Decree on 9 areas to improve the responsiveness of the Illinois foster care program to meet the needs of children in custody and improve accountability within the child welfare system. One of those nine areas was related to the comprehensive health care of children in DCFS custody. Illinois's solution was the implementation of the Healthworks program.

Program Variation

Each State establishes eligibility standards, determines services, sets payment rates, and administers its own foster care and Medicaid programs in accordance with general Federal guidelines. The resulting diversity produces variations in when and what types of services children receive in foster care. As such, the experiences reported in this State-specific report will be unique to the sampled children's experiences in Illinois.

Illinois Healthworks

The Healthworks program is a comprehensive program coordinating the activities of foster care providers, caseworkers, State program administrators, community-based agencies, physicians, and medical case managers in providing health services to children in foster care.

---

[13] B.H. stands for the initials of the first child named in the lawsuit.

[14] Illinois DCFS Promotion of Quality and Accountability. Retrieved on May 20, 2003 from http://www.State.il.us/dcfs/budproqual.htm.

Section 471(a)(22) of the Act requires States to develop a State plan that includes standards to ensure that children in foster care placements in public and private agencies are provided quality services that protect their safety and health. Sections 422(b)(10)(B)(ii) and 475(5)(D) of the Act require procedures to ensure that a foster child's health records be reviewed, updated, and supplied to the foster care provider at the time of placement. According to Section 475(1)(C) of the Act, health records should include, to the extent available and accessible, the names and addresses of the child's health providers, a record of the child's immunizations, the child's known medical problems, the child's medications, and any other relevant health information concerning the child determined to be appropriate by the State agency.

The aspects of the Illinois Healthworks that we addressed include the following:

(1) Initial Health Screenings: The DCFS investigator or caseworker is responsible for ensuring that Initial Health Screenings are conducted within 24 hours of a child's entry into State custody to treat acute medical needs, document possible medical problems and abuse, and provide the caseworker with appropriate medical information necessary for placement.

(2) Comprehensive Health Evaluations: Foster care providers are generally responsible for ensuring that all children receive a Comprehensive Health Evaluation within 21 days of entering foster care, which includes an in-depth physical examination, comprehensive medical history, and, for children 5 years of age and older, a Mental Health Screen. These thorough evaluations are important to identify problems early on, especially for children who may not have received medical care prior to DCFS custody.

(3) Health Passports: A Health Passport is initiated during the Comprehensive Health Evaluation. Physicians receive an incentive of $15 to initiate Health Passports as part of the Comprehensive Health Evaluation. The Health Passport is a manila booklet containing pertinent medical information relating to immunizations, family health history, child health visits, child health information, and a list of previous and current health care providers. The Health Passport is provided to and kept by the child's current foster care provider and is to follow the child through subsequent placements and providers to ensure continuity of care. A copy is required to be kept in the child's case file.

A previous study revealed that foster care providers and caseworkers are inconsistent in updating the Health Passports for the children in their care,[15] although the semiannual Administrative Case Review[16] requires it.

EPSDT Guildelines

States establish EPSDT guidelines in accordance with Federal requirements to provide coverage for preventive child health services to all Medicaid-eligible individuals under the age of 21.[17] State EPSDT programs must provide medical, dental, hearing, and vision 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.

In addition to the Initial Health Screening and Comprehensive Health Evaluation, Illinois DCFS also requires that children receive EPSDT medical screenings consistent with Federal EPSDT criteria.

The current EPSDT frequency schedule for the Healthworks program requires that medical screenings occur at:
birth; 1, 2, 4, 6, 9, 12, 15, and 18 months of age; and annually between the ages of 2 and 21. Dental examinations are required every year beginning at 2 years of age.[18] Dental examinations are conducted separately from medical examinations.

---

[15]Georgetown University, Child Development Center. (2000). *Meeting the Health Care Needs of Children in the Foster Care System, Site Visit Report: Healthworks of Illinois*. Retrieved December 12, 2003 from http://gucdc.georgetown.edu/foster.html.

[16]Administrative Case Reviews are reviews conducted every 6 months with the caseworker, foster care provider, and other pertinent staff, to incorporate the child's health information into the service plan, to review and update the Health Passport, assess the status of the child's health care, and develop plans for unmet health issues. DCFS Foundation Training for New Caseworkers.

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

[18]Handbook for Providers of Medical Services, Chapter 100 General Policy and Procedures, Illinois Department of Public Aid.

METHODOLOGY

This inspection focused on the receipt of medical and dental health care services within EPSDT guidelines; requirements for initial and comprehensive health screenings and mental health assessments upon entry into foster care; and the provision of medical information to foster care providers. This study did not address 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: reviews of Federal and State policies; child-specific Medicaid claims data and case file documentation for 50 randomly-sampled children in foster care; interviews with caseworkers for each of the 50 children in our sample; interviews with foster care providers for 46 children in our sample; and interviews with Illinois State agency officials.

Reasons for State Selection

Illinois was selected due to its large size, geographic location, and fee-for-service payment of Medicaid health care services. The Illinois DCFS is responsible for the welfare of children in State custody.

Sample

Children who met the following criteria were included in the study population: (1) were in foster care on December 1, 2002; (2) resided in Illinois; (3) were Title IV-E eligible, and (4) had been in continuous out-of-home foster care placements for at least 6 months. DCFS provided us with a list of the 17,153 children who met these criteria. We selected a simple random sample of 50 children in Illinois from the list of children who met the specified criteria. Appendices A and B provide information on the children included in our sample, and the services they received.

Review of State Policy, Medicaid Data, and Case File Documentation

Policy Review - We reviewed Federal and Illinois State foster care and Medicaid policies. All Illinois children eligible for the Title IV-E foster care program are eligible for Medicaid services. Federal law relating to EPSDT requires that States meet reasonable standards of medical and dental practices as determined by the State after consultation with recognized medical and dental organizations. The Healthworks program satisfies the Federal EPSDT requirement. Therefore, we used Healthworks guidelines

to determine whether children in foster care had received their most recent EPSDT examination within required frequency guidelines.

Medicaid Claims Data Review - The Illinois Department of Public Aid and Illinois DCFS provided us with up to 3 years of Medicaid claims histories for each of the children in our sample. The data included claims for physician, dental, pharmaceutical, and mental health services paid between January 1, 2000 and December 31, 2002. We paid particular attention to the types of health and mental health services provided, dates of service, where the services were provided, and diagnoses, where available. Our review included only Medicaid claims for services provided on or after the date of the foster child's most recent entry into foster care. We defined examinations as current based on whether the most recent examination was within State frequency guidelines.

Case File Documentation Review - We requested and reviewed case file documentation from local DCFS offices for all the children in our sample. Information requested included the following: case notes, documentation of medical and mental health services provided, the child's initial and most recent case plan, duration of the child's stay in foster care, and information regarding the child's general well-being.

Interviews

Foster Care Provider Interviews - We use the term "foster care provider" to refer to a foster parent or a staff member of a residential facility who is responsible for the child. We conducted structured interviews with 46 of the foster care providers responsible for the children in our sample between March 21, 2003 and April 11, 2003 (9 in person and 37 by telephone). We were unable to speak with four of the foster care providers despite many attempts to reach them. The interviews with foster care providers focused on Medicaid programs and services available, training the foster care provider received related to the health and well-being of children, and their experiences accessing health care services for the children included in our sample.

Caseworker Interviews - We conducted structured telephone interviews with each child's caseworker between March 18, 2003 and April 11, 2003. Each of these interviews focused on the caseworker's understanding of the Medicaid program and services available, training related to the health and well-being

of children, their experiences accessing services, and any barriers to 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 representatives from DCFS and the Illinois Department of Public Aid. Our discussions covered a wide spectrum of information, including the overall provision of Medicaid services for children in foster care, Medicaid claims, the State's Healthworks program, the structure of the State's foster care service organization, and Medicaid claims for children in foster care.

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

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

In Illinois, all children eligible for the foster care program are eligible for Medicaid. Our review of Medicaid claims and interview data indicated that all 50 children in our sample had Medicaid coverage. Our analysis of claims data revealed that each sampled child had at least one Medicaid claim during the period of our review. Table 1 (below) details the total number of sampled children who received various types of Medicaid-covered services. The claims totals for each of the sampled children are provided in Appendix B.

Table 1: Number and Type of Medicaid Claims for 50 Children in the Sample*

Claim type	Number of children with at least one claim	Total number of claims
Physician office	49	990
Prescription drug	40	1028
Laboratory	38	396
Dental	38	357
Hospital/ASC**	30	173
Optometry/Audiology	20	65
Mental health	18	1579
Diagnostic	16	56
Physical/Occupational therapy	12	942
Supplies	12	126
Transportation	11	231
Primary care provider fee	11	163
Social work services	9	66
Early intervention	6	112
Case management	5	197
Total		**6,481**

* Claims period: 01/01/00 to 12/31/02, or entry into care to 12/31/02
**includes emergency room visits
Source: OIG analysis of Illinois Medicaid claims data

All sampled children received their most recent EPSDT medical examinations, and 76 percent received their most recent EPSDT dental examinations, in accordance with State guidelines

Medical Examinations

All sampled children received their most recent EPSDT medical examination in accordance with State guidelines and only one foster care provider reported having difficulty finding a physician to perform an annual EPSDT medical examination. Foster care providers' apparent ease in finding physicians to perform annual medical examinations may be due to the fact that Illinois implemented a 13-percent higher reimbursement, on average, for physicians who treat children in State custody, to encourage physician enrollment and participation in the Healthworks program.[19]

Overall, 70 percent (32/46) of foster care providers reported they were familiar with the Illinois Healthworks program, and 65 percent (30/46) of foster care providers knew the frequency schedule of EPSDT medical examinations. Ninety-six percent (48/50) of caseworkers knew of the Healthworks program, and 86 percent (43/50) knew the frequency of required medical examinations. We found no association between caseworker tenure and knowledge of the frequency guidelines.

The Illinois DCFS monitors well-child examination compliance rates through the biannual Administrative Case Reviews required for all children in foster care and publishes monthly reports on their findings. As of December 2002, the State found that 62.4 percent of the 23,332 cases reviewed were in compliance with the annual examination requirement. Our finding of a 100-percent compliance rate may be due to our analysis of both medical claims data and case file documentation, while the State relies on the case files alone. Also, if the foster care provider is unable to attend the Administrative Case Review, information on recent medical examinations is less likely to be updated in the case file.

[19] Georgetown University, Child Development Center. (2000). *Meeting the Health Care Needs of Children in the Foster Care System, Site Visit Report: Healthworks of Illinois*. Retrieved December 12, 2003 from http://gucdc.georgetown.edu/foster.html.

Dental Examinations

We found that 76 percent (31/41) of sampled children received their most recent EPSDT dental examinations in accordance with State guidelines.[20]

We analyzed Medicaid claims and interview data in an attempt to identify factors that may explain the difference between the children who were current on their dental examination and those who were not. Of the 10 children who were past due on their dental examination, 5 of the foster care providers stated they were unaware of the availability of Medicaid services, whereas only 3 of 27 foster care providers whose children were current on their dental examination were unaware of the availability of Medicaid services. Furthermore, 43 percent (16/37) of the foster care providers with whom we spoke mentioned some difficulty in finding dental providers who accept Medicaid.[21]

Overall, 70 percent (32/46) of foster care providers reported they were familiar with the Illinois Healthworks program, and 65 percent (30/46) of foster care providers knew the frequency schedule of EPSDT dental examinations. Ninety-six percent (48/50) of caseworkers knew of the Healthworks program, and 86 percent (43/50) knew the frequency of required dental examinations. We did not find any association between caseworker tenure and knowledge of the frequency guidelines.

We detected no differences between the children receiving dental examinations and those who did not when analyzing the following variables: geographical region, caseworker involvement in the child's health care, caseworker caseload size, child's date of entry into foster care, total number of placements, total number of caseworkers, number of placements per entry, number of caseworkers per entry, age of the child, or foster care provider's and caseworker's knowledge of EPSDT frequency requirements.

[20] Percentage of children receiving dental examinations is based on 41 of the 50 sampled children. Nine children were not included because of their age.

[21] Although 41 children were eligible for dental examinations, we were unable to speak with 4 foster care providers.

Ninety-seven percent of sampled children received Initial Health Screenings within required timeframes

Illinois DCFS requires that all children entering DCFS custody must receive an Initial Health Screening within 24 hours of entering DCFS custody in order to document possible acute medical problems and abuse and to provide the caseworker with appropriate medical information necessary for placement. The caseworker is responsible for ensuring that the child receives the Initial Health Screening. If the child is discharged from a hospital into DCFS custody, the hospital discharge summary substitutes for the Initial Health Screening.

While only 2 children had paid Medicaid claims for an Initial Health Screening, our case file review showed that 97 percent (30/31)[22] of the sampled children entering State custody received their Initial Health Screening or were discharged from the hospital into DCFS custody.

During the course of the interviews, no caseworkers reported having knowledge of problems obtaining Initial Health Screenings. The Initial Health Screening can take place at a hospital or clinic 24 hours a day, 7 days a week, or at a physician's office during business hours. The ability to take a child to a medical provider at any time of the day, coupled with the fact that the Initial Health Screening is one of the first medically-related tasks a caseworker must provide when a child enters State custody, may explain the high percentage of sampled children receiving this service.

Only 42 percent of sampled children received Comprehensive Health Evaluations within required timeframes

Illinois DCFS requires that all children entering DCFS custody receive a Comprehensive Health Evaluation within 21 days of entering State custody, which includes an in-depth physical examination and comprehensive medical and psychosocial history. The medical professional conducting the Comprehensive Health Evaluation also initiates the Health Passport during the visit. The foster care provider is generally

[22] Because our Medicaid claims data ranged from January 1, 2000 to December 31, 2002, we only reviewed the 31 children for this service who entered State custody on or after January 1, 2000.

responsible for scheduling and taking the child to the Comprehensive Health Evaluation.

We found that 42 percent (13/31)[23] of the sampled children entering DCFS custody received their Comprehensive Health Evaluation within required timeframes. Our review of claims data and case files revealed that an additional 42 percent (13/31) of the sampled children in foster care had their Comprehensive Health Evaluation outside the required timeframe, ranging from 22 days to 266 days. We could not find any evidence for a Comprehensive Health Evaluation for five children. Only one child had a Medicaid claim for a Comprehensive Health Evaluation. None of the caseworkers or foster care providers indicated problems obtaining Comprehensive Health Evaluations for the sampled children.

A possible explanation of why sampled children in compliance with the Comprehensive Health Evaluation requirement is lower than the percentage in compliance with the Initial Health Screening requirement may be that access to Comprehensive Health Evaluation providers is more limited. While the Initial Health Screening is available 24 hours a day, the Comprehensive Health Evaluation is available only during regular business hours with a preference toward selected primary care providers. Also, foster care providers are generally responsible for obtaining the Comprehensive Health Evaluations after a child is placed with them, whereas caseworkers are responsible for obtaining an Initial Health Screening within 24 hours of custody.

Only 1 of 14 sampled children received a Mental Health Screen within required timeframes

Illinois DCFS requires that all children 5 years of age or older entering DCFS custody receive a Mental Health Screen within 21 days of entry. The medical professional conducting the Comprehensive Health Evaluation also conducts the Mental Health Screen during the same visit.

Fourteen sampled children were at least 5 years of age when entering DCFS custody. Of these 14 children, only 1 child received a Mental Health Screen within required timeframes. Our review of

[23] Because our Medicaid claims data ranged from January 1, 2000, to December 31, 2002, we reviewed case files for the receipt of a Comprehensive Health Evaluation for only the 31 children who entered State custody on or after January 1, 2000.

case files demonstrated that an additional 2 children had their Mental Health Screen, but beyond the required timeframes ranging from 33 days to 84 days. None of the caseworkers indicated they were aware of problems obtaining Mental Health Screens at the Comprehensive Health Evaluation.

Because the Mental Health Screen occurs at the same time as the Comprehensive Health Evaluation, we expected the sampled children would have received a Mental Health Screen at the same rate they received Comprehensive Health Evaluations. We could not identify a reason why the Mental Health Screens were not conducted.

Only 18 children had a Medicaid claim for mental health related services and 86 percent (1352/1579) of the mental health claims were for the 5 children in residential facility placements.[24] There were two children diagnosed with Attention Deficit and Hyperactivity Disorder and Post Traumatic Stress Disorder with no Medicaid mental health claims. All other children with a diagnosed mental health disorder had at least one Medicaid mental health claim, and three children with no mental health disorders also received mental health services as evidenced by claims data. We did not evaluate the adequacy of the mental health services provided.

Medicaid funds allocated to Healthworks do not include specific payments for mental health services, and Medicaid funds to provide mental health services for children in State custody are managed separately by DCFS. The provision of mental health services through private agencies is included as part of its contracted payment from DCFS. Thus, mental health services provided by these agencies would not necessarily be billed to Medicaid.

[24] One child was recently transferred from a residential facility to a foster home and the most recent placement is reflected in Appendix A.

Health Passports are in only 48 percent of case files and are not updated at the Administrative Case Review

The Illinois Health Passport satisfies the Federal requirement that a child's health record be reviewed, updated, and supplied to the foster care provider when they are placed in foster care. The Health Passport also is required to be reviewed and updated at each Administrative Case Review.

Seventy-four percent (34/46) of the foster care providers interviewed stated they received a medical history at the time of placement, and 87 percent (40/46) of their caseworkers reported having a medical history available. Thirty-eight caseworkers indicated that they provided the foster care provider with the sampled child's medical history, and 34 foster care providers indicated they received it, demonstrating that the initial transfer of medical history information is occurring in 85 percent (34/40) of the cases where the information is available.

Upon our review, however, we identified copies of the Health Passport in only 48 percent (24/50) of the case files. Only eight of these copies were up-to-date and only two copies contained all the required medical information.[25] A vulnerability to losing parts of a child's medical history is created if information is not recorded timely in the Health Passport, or if the Health Passport is never initiated. In some instances, the sample child's Health Passport was missing information even though the required medical information was available in other case file documentation. One caseworker reported that they did not have the Health Passport because the foster parent had lost it. These situations raise the possibility that children might receive duplicate services or that needed services may be delayed or not obtained.

Only 54 percent (27/50) of case files contained documentation that a 6-month Administrative Case Review had been conducted within the last 6-month period. The Health Passports are to be reviewed and updated at the time of each Administrative Case Review, but this appears not to be occurring in all cases. Of the Administrative Case Reviews completed for our sample, 44 percent (12/27) had no documentation indicating that the child's health passport was

[25] Required information includes, if available: immunizations, illnesses, allergies, medications, medical conditions, dental examinations, vision and hearing screenings, medical examinations, and other pertinent information.

reviewed and updated as required. An additional 15 percent (4/27) of the case files indicated a review had taken place but contained no Health Passport or plan for remediation.

Six foster care providers reported that the lack of medical history adversely affected the health of the child. Specifically, foster care providers stated the lack of medical history made it difficult to care effectively for the children placed with them, made it difficult to answer basic questions about the child's past medical care, and caused other problems, such as subjecting the child to repeated immunizations because records of previous immunizations were unavailable.

RECOMMENDATIONS

The EPSDT program is intended to detect various health needs. However, if children do not receive required health care services or medical information is not updated and given to the foster care providers, children's health may be negatively affected. Therefore, we recommend that:

ACF work with the Illinois DCFS to increase the number of:

- Comprehensive Health Evaluations and Mental Health Screens received within required timeframes
- Health Passports that are (1) updated on an ongoing basis, (2) reviewed for accuracy and completeness during the Administrative Case Review, and (3) copied each time the health information is updated, so that a copy of the most recent health passport is maintained in the case file and provided to the foster care provider

CMS work with ACF and the Illinois Department of Public Aid to:

- Prevent potentially unnecessary costs to the Medicaid program resulting from duplicate services provided as the result of incomplete and outdated Health Passports

AGENCY COMMENTS

ACF indicated the background information included in this report provided a useful perspective of the problem and the case file documentation and analysis of claims data were informative.

ACF noted that it is working with DCFS to improve the provision of health and mental health services to children in foster care and that the provision of these services will be addressed in Illinois' Program Improvement Plan in response to a Child and Family Services Review. Child and Family Services Reviews measure individual States' performance related to the health and well-being of children in the child welfare system.

CMS agrees in part with our recommendation, recognizing the concern about the potential for Federal and State funds being unnecessarily expended for duplicate Medicaid services; however, CMS believes DCFS should work to better inform foster care parents and providers of the availability of services and the State requirements under the Healthworks and Passport program.

APPENDIX ~ A

Sampled Children

The table below is merely descriptive in nature and describes the demographic characteristics of each sampled child and his or her foster care placement history at completion of our interviews in April 2003.

ID	Sex	Age (years)	Placement setting	Entries into foster care (1)	Months since last entry (2)	Placements since last entry (3)	Months since last placement (2)	Caseworkers since last entry	Months caseworker with case (2)
1	F	10	Kinship	1	17	2	7	3	2
2	M	3	Kinship	1	21	1	21	1	21
3	M	3	Family	1	27	3	17	4	3
4	M	1	Family	1	16	1	16	2	1
5	F	9	No Interview	1	104	2	102	3	16
6	F	11	Family	1	9	3	9	1	9
7	F	1	Kinship	1	20	1	20	3	2
8	F	4	Family	1	16	4	2	3	6
9	M	4	Family	1	47	1	47	3	9
10	F	11	Family	1	71	4	26	8	23
11	M	10	Family	1	88	5	28	3	4
12	M	10	Family	1	17	3	2	1	17
13	M	12	Kinship	1	46	4	15	3	17
14	F	4	Family	1	32	4	19	2	5
15	M	9	Kinship	1	14	1	14	1	14
16	M	7	Family	2	24	2	6	1	24
17	M	4	Family	1	28	3	15	2	8
18	F	17	Family	1	61	6	19	2	16
19	M	13	Kinship	1	58	1	58	3	1
20	F	8	No Interview	1	68	2	26	3	23
21	F	1	Family	1	16	1	16	2	4
22	M	8	Family	1	58	1	58	1	58
23	M	13	Kinship	1	81	2	72	5	1
24	M	8	Kinship	1	50	2	17	2	35
25	F	17	Kinship	2	85	5	13	5	24
26	M	17	Family	1	35	5	10	3	2
27	F	4	Family	1	15	2	8	2	6
28	F	7	Family	2	26	3	15	2	25
29	F	8	Family	1	12	2	11	1	12
30	M	16	Residential	1	29	3	19	1	29
31	F	15	Family	1	30	2	28	3	15
32	M	8	Kinship	1	95	3	15	2	1

ID	Sex	Age (years)	Placement setting	Entries into foster care (1)	Months since last entry (2)	Placements since last entry (3)	Months since last placement (2)	Caseworkers since last entry	Months caseworker with case (2)
33	M	2	Family	1	27	1	27	2	23
34	F	15	Residential	1	20	3	14	4	6
35	F	5	Family	1	29	2	25	2	24
36	M	1	Family	1	16	1	16	1	16
37	M	5	Family	1	38	2	12	4	5
38	F	12	Residential	1	28	2	14	1	28
39	M	2	Family	1	25	1	25	2	21
40	M	5	No Interview	1	23	2	23	2	6
41	F	13	Residential	1	17	9	13	3	4
42	M	3	Family	1	36	1	36	1	36
43	M	12	Family	1	82	2	59	3	3
44	M	5	Kinship	1	60	2	48	3	10
45	M	10	Kinship	1	116	2	75	2	8
46	F	12	Family	2	33	3	9	3	14
47	F	18	No Interview	1	73	1	73	4	4
48	F	6	Family	2	16	1	16	2	16
49	M	3	Family	1	39	1	39	2	22
50	F	15	Family	1	15	3	10	1	15

KEY

(1) "Entries into foster care" refers to the number of times a child has entered State custody (i.e., number of foster care "episodes").

(2) "Months since last entry" is the length of time from the date of the child's most recent entry into State custody until April 2003, which coincides with the period of interviews with caseworkers and foster care providers. "Months since last placement" is the length of time from the date of the most recent placement to the date the foster care provider was interviewed. "Months caseworker with case" is the length of time from the date the caseworker initially took over the foster child's case until the date the caseworker was interviewed.

(3) "Placements since last entry" refers to the number of placement settings (e.g. Foster Home A, Foster Home B, Metro Residential Facility) a child has experienced during the most recent entry into foster care.

APPENDIX ~ B

Medicaid Claims for Sampled Children

The table below indicates each child's receipt of required services and total claims for January 1, 2000 to December 31, 2002, or entry into care to December 31, 2002, whichever is shorter.

	Number of Medicaid Claims					Initial Examinations (4)			Current EPSDT	
ID	Physician's office	Dental services	Prescription medications	Mental health services	Health Passport in case file	IHS(1)	CHE(2)	MHS(3)	Medical	Dental
1	9	0	2	0	N	N*	N	N	Y	N
2	32	0	192	0	N	N*	N		Y	
3	14	1	72	87	N	N*	N*		Y	Y
4	41	0	6	0	N	N*	Y		Y	
5	11	20	2	0	Y				Y	Y
6	5	6	3	2	N	N*	N	N	Y	Y
7	25	0	9	0	Y	N*	N		Y	
8	3	3	0	0	Y	N*	N*		N*	Y
9	12	0	16	0	Y				Y	N*
10	12	12	1	0	N				Y	Y
11	5	14	5	0	Y				Y	Y
12	11	16	9	0	N	N*	N	N	Y	Y
13	3	5	0	20	Y				N*	N*
14	39	5	5	0	Y	N*	N*		Y	Y
15	3	3	0	0	N	N*	N	N	N*	Y
16	22	12	0	2	N	N*	N*	N	Y	Y
17	9	4	2	0	Y	N*	N		Y	Y
18	16	18	22	0	Y				N*	Y
19	19	0	0	0	Y				Y	N
20	41	4	35	18	N				Y	Y
21	16	0	20	0	Y	N*	N*		N*	
22	28	6	57	2	N				Y	Y
23	4	10	0	0	Y				Y	Y
24	21	6	26	0	Y				Y	Y
25	13	9	11	8	Y				N*	N
26	19	6	89	455	Y	N*	N	N	Y	N
27	28	5	5	0	N	N*	N*		Y	Y
28	9	5	2	8	N				Y	N
29	4	4	6	0	Y	N*	N	N	N*	Y
30	8	14	9	369	N	N*	N*	N	Y	N
31	9	15	0	0	Y	N*	N*	N*	Y	Y
32	38	17	60	0	N				Y	Y
33	53	0	34	0	N	Y	N*		Y	
34	6	14	6	90	N	Y	N	N	N*	Y

	Number of Medicaid Claims					Initial Examinations (4)			Current EPSDT	
ID	Physician's office	Dental services	Prescription medications	Mental health services	Health Passport in case file	IHS(1)	CHE(2)	MHS(3)	Medical	Dental
35	31	7	25	0	N	N*	N		Y	N
36	3	0	12	0	Y	N	N		N*	
37	27	3	42	17	N	N*	N		Y	N*
38	15	9	7	9	N	N*	N	N	Y	N
39	87	0	21	0	N	N*	N		N*	
40	34	3	4	2	Y	N*	N*		Y	Y
41	56	7	89	429	Y	N*	N	N	Y	Y
42	0	6	22	0	Y	N*	N*		N*	
43	9	13	0	0	Y				Y	N
44	42	0	10	2	N				Y	N
45	17	13	67	57	N				N*	Y
46	4	4	0	2	N	N*	N	N	Y	Y
47	33	14	1	0	N				Y	Y
48	29	38	6	0	N	N*	N*	N	Y	Y
49	5	0	0	0	Y	N*	N		Y	
50	10	6	16	0	Y				Y	Y

KEY

(1) IHS (Initial Health Screening; required within 24 hours of custody)

(2) CHE (Comprehensive Health Evaluation; required within 21 days of custody)

(3) MHS (Mental Health Screen; required within 21 days of custody for children in foster care aged 5 years and above)

(4) Initial Examinations: "Y" indicates that initial medical/dental examination was received within required timeframes, as evidenced by a Medicaid claim. "N" indicates examination was not received within required timeframes. "N*" indicates that Medicaid claims data did not support a positive finding, but evidence was found in the case file to support the positive finding. Shaded areas indicate children who were not eligible for the service due to age or date of entry into the system, which was outside the scope of claims data.

Current EPSDT Examinations: Medical/Dental: "Y" indicates that an EPSDT medical/dental examination was received according to Illinois Healthworks frequency timeframes, as evidenced by a Medicaid claim. "N" indicates examination was not received

according to Illinois Healthworks frequency timeframes. "N*" indicates that Medicaid claims data did not support a positive finding, but evidence was found in the case file to support the positive finding. Shaded areas indicate children who were not eligible for the service due to age or date of entry into the system, which was outside the scope of claims data.

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

DATE: OCT 16 2003

TO: Dara Corrigan
Acting Principal Deputy
Inspector General

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

SUBJECT: Comments on the OIG Draft Report, "Children's Use of Health Care Services While in Foster Care: Illinois" (OEI-07-00-00642)

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

Should you have questions regarding our comments, please contact Dr. Susan Orr, Associate Commissioner, Children's Bureau, Administration on Children, Youth and Families, at (202) 205-8618.

Attachment

COMMENTS OF THE ADMINISTRATION FOR CHILDREN AND FAMILIES (ACF) ON THE OFFICE OF INSPECTOR GENERAL'S (OIG) DRAFT REPORT, "CHILDREN'S USE OF HEALTH CARE SERVICES WHILE IN FOSTER CARE: ILLINOIS" (OEI-07-00-00642)

We appreciate the opportunity to comment on the OIG recommendations directed to the Administration for Children and Families (ACF).

OIG Recommendations:

Because children in the Illinois foster care program are not receiving certain health care services within required timeframes, and because a lack of medical history could negatively affect a child's health, the OIG recommends that the:

ACF work with the Illinois Department of Children and Family Services (DCFS) to increase the number of:

- Comprehensive Health Evaluations and Mental Health Screens conducted within required timeframes

- Health Passports that are (1) updated on an ongoing basis, (2) reviewed for accuracy and completeness during the Administrative Case Review, and (3) copied each time the health information is updated so that a copy of the most recent health passport is maintained in the case file and provided to the foster care provider.

ACF Comments:

ACF is actively working with DCFS to improve services to children and families being served by the child welfare system. One aspect of this effort includes improvement of the provision of health and mental health services to children in foster care. The specific action steps and benchmarks related to improving health care services will be included in a Program Improvement Plan (PIP) developed in response to a Child and Family Services (CFS) review in Illinois.

In addition to the federal regulations cited in the report, the CFS review was authorized by the 1994 amendments to the Social Security Act (SSA) and is administered by the Children's Bureau. The CFS review is a major mechanism for working with States about practice issues that impact the well-being of children and families.

The CFS review consists of two phases. In Illinois, as in other states, the first phase consisted of a State Data Profile, derived from data provided by the State. This profile highlighted key performance indicators relating to safety and permanency for children coming into the child welfare system. Using this profile and other sources of information, Illinois completed a statewide assessment which assessed the process, procedures, and policies of its child welfare system, including foster care and adoption. This assessment also focused on the systemic factors in place which enable the State to carry out the process, procedures and policies of the program.

The second phase of the process involved an on-site review during the week of September 15, 2003. The purpose of the on-site review included an examination of 50 cases for outcome achievement and interviews with community stakeholders to evaluate the systemic factors under review. The cases reviewed on-site were assessed in relation to child-specific performance indicators. Through a combination of aggregate data reported on the statewide assessment and case-specific information gathered on-site, the review team was able to evaluate the outcome achievement within programs and to identify areas where technical assistance is needed to make improvements.

45 CFR 1355.34(b)(3) defines the components of determining a state to be in substantial conformity for the purposes of the CFS review. Outcomes from the case review portion of the CFS review must be rated as "substantially achieved" in 95 percent of the cases examined (90 percent of the cases for a state's initial review) as one component of finding a state in substantial conformity with federal requirements. Information from various sources (case records, interviews) is examined for each outcome and a determination made as to the degree to which each outcome has been achieved for each case reviewed.

Based on the CFS review, the ACF regional office and the State will enter into a PIP to address areas of non-conformity with federal requirements found during the Illinois review. The PIP will have specific action steps and benchmarks related to meeting the health and mental health needs of children. The ACF regional office will monitor progress on the plan quarterly during the two-year period of the PIP. Once Illinois completes the required PIP, another CFS review will be performed to assess the State's progress.

Other Comments:

◦ The background provided in the report is useful in giving a perspective of the problem.

◦ The review of children's medical services received based on documentation in case files is a good addition to the Illinois report. This allowed an understanding of health care services provided beyond those that could be tracked by Medicaid claims. It would be good to provide this level of discussion in all similar future reports.

◦ The analysis of the claims data in the Findings section of the report was informative.

◦The discussion of the presence or absence of case planning around health and mental health care was also informative.

◦ The identification of the higher payment to physicians who treat children in the State's custody will be particularly useful to other states reviewing this report.

APPENDIX ~ D

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

IG
EAIG

7500 Security Boulevard
Baltimore, MD 21244-1850

DATE: NOV 15 2003

TO: Dara Corrigan
Acting Principal Deputy Inspector General
Office of Inspector General

FROM: Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: *"Children's Use of Health Care Services While in Foster Care: Illinois,"* (OEI-07-00-00642)

Thank you for the opportunity to review and comment on the above-referenced OIG draft report. The Centers for Medicare & Medicaid Services' (CMS) comments to the OIG's recommendation are outlined below.

Recommendation

The CMS should work with the Administration for Children and Families and the Illinois Department of Public Aid to prevent potentially unnecessary costs to the Medicaid program resulting from duplicate services provided as the result of incomplete and outdated Health Passports.

Response

The CMS agrees and is concerned about the potential of Federal and State funds being unnecessarily expended for duplicate Medicaid services. However, we believe the State foster care agency should work to better inform foster care parents and providers of the availability of services and the State requirements under the Healthworks and Passport programs to provide and keep up-to-date medical information on foster care children in order to avoid duplication of services.

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 who contributed include:

Deborah Walden, *Team Leader*

Brian T. Whitley, *Lead Analyst*

Zula Crutchfield, *Program Analyst*

Tricia Fields, *Program Analyst*

Steven Milas, *Program Analyst*

Linda Paddock, *Program Analyst*

Elander Phillips, *Program Analyst*

Dennis Tharp, *Program Analyst*

Michala Walker, *Program Analyst*

Linda Hall, *Program Specialist* (Washington, D.C.)

Barbara Tedesco, *Mathematical Statistician* (Baltimore)