

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**A REVIEW OF HHS CHILDREN'S  
PROGRAMS**



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INSPECTOR GENERAL

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# EXECUTIVE SUMMARY

## **PURPOSE**

The purpose of this report is to consolidate recent Office of Inspector General (OIG) findings on programs of the Department of Health and Human Services (HHS) that protect the health and welfare of children.

## **BACKGROUND**

Children need adequate income, access to health care, positive opportunities for development, and stable family environments. HHS programs touch on all these fundamental needs. Some HHS programs have recently been expanded to provide more services to children, and the Administration for Children and Families (ACF) was created to facilitate coordination and cooperation among children's programs.

While change is underway to improve services for children, more improvements could be made. In the past few years, the OIG has released a number of reports recommending management or policy improvements in the programs of the Department that serve children. Our recommendations were targeted at improving the quality of services and program efficiency and effectiveness. Agency officials have implemented some of these recommendations.

## **SCOPE**

This report has been organized into four broad issue areas that deal with the problems that some children face: income, health care, educational and developmental opportunities, and living environment. In each issue area, we identify how the Department deals with specific aspects of these problems and the findings of OIG reviews.

## **ISSUES**

### ***ADEQUATE INCOME***

Maximizing family economic self-sufficiency through child support

- ▶ *A specific set of practices at the State and local level generally results in establishing paternity, the first step in child support.*
- ▶ *Many opportunities exist for improved child support collections with both AFDC and non-AFDC absent parents.*
- ▶ *Ineffective garnishment systems hamper child support collections.*

- ▶ *Problematic cash management practices weaken the child support program.*

Reducing error and fraud in AFDC

- ▶ *Successful anti-fraud efforts help reduce the AFDC error rate.*

## ***ADEQUATE HEALTH CARE***

Ensuring that States expand their eligibility under existing Medicaid policy for pregnant women and children

- ▶ *Many barriers exist in implementing new Medicaid policies for pregnant women and children.*

Reducing infant mortality and morbidity

- ▶ *Prenatal and perinatal care programs can be improved by special management strategies.*

Ensuring that children have health insurance

- ▶ *Detecting and pursuing available health care for children of absent parents could be greatly improved.*

## ***EDUCATIONAL AND DEVELOPMENTAL OPPORTUNITIES***

Expanding and managing Head Start effectively

- ▶ *The Head Start expansion poses many management challenges.*
- ▶ *Head Start participants from dysfunctional families are more difficult to serve.*

Expanding the monitoring effort of Head Start to ensure program quality

- ▶ *Procedures and tools for monitoring the Head Start program are incomplete.*

Ensuring that children receive high quality child care

- ▶ *State child care regulations vary considerably from State to State.*

## ***STABLE LIVING ENVIRONMENT***

Identifying potential administrative changes in the foster care system to control costs

- ▶ *Administrative costs have risen dramatically, but most of the costs are actually for child placement services.*
- ▶ *Foster care maintenance payments are often made to ineligible children.*

Improving the quality and availability of services in the State child welfare system

- ▶ *Administrative barriers cause excessive delays in freeing children for adoption.*
- ▶ *Placing minority children in adoptive homes often requires special practices.*

Improving access to treatment and support services for drug-exposed and abandoned children

- ▶ *Crack babies have a tremendous impact on the child welfare system.*
- ▶ *Many obstacles exist to placing boarder babies in adoptive homes, but some cities are successful.*

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# INTRODUCTION

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## PURPOSE

The purpose of this report is to consolidate recent Office of Inspector General (OIG) findings on programs of the Department of Health and Human Services (HHS) that protect the health and welfare of children. OIG reports generally examine a specific issue dealing with a specific program, but the range of subject matter the OIG has examined has allowed for coverage of broad issues and the programs related to those issues. By consolidating the main points of these reports, we hope to provide a more comprehensive examination of children's issues and how the Department is dealing with those issues.

## BACKGROUND

Many of today's children face significant hardships--broken families, malnutrition, physical and emotional abuse, disease, and lack of developmental and educational opportunities. These hardships have been compounded by societal problems such as drugs, poverty, homelessness, and AIDS. No single solution exists for the problems that face children today. Children need adequate income, access to health care, positive opportunities for development, and stable family environments.

Programs of HHS touch on all these fundamental needs. Aid to Families with Dependent Children (AFDC) and Child Support Enforcement (CSE) help to ensure income security for families. Medicaid provides health care to children. The Head Start Program provides educational and developmental activities during the formative pre-school years. The Foster Care and Adoption Assistance program works to ensure that vulnerable children live in stable environments. Numerous smaller programs address children's needs as well.

The Secretary has a strong commitment to improving HHS programs for children as evidenced in his Program Directions, a departmental strategic plan for dealing with these issues now and in the near future. Almost all of the Program Directions involve children's programs either directly or indirectly.

Some HHS programs have recently been expanded to provide more services to children. By FY 1991, the Head Start program was projected to expand enrollment by an additional 150,000 children as well as to improve the quality of service provided. The Omnibus Reconciliation Act (OBRA) of 1989 required all States to set a minimum Medicaid income eligibility threshold at 133 percent of the Federal poverty level for both pregnant women and children below age six.<sup>1</sup> OBRA 90 called for States to annually phase in coverage for all children up to age 19 in families with incomes below 100 percent of poverty.<sup>2</sup> Child care legislation was enacted in 1990, and regulations have been developed (although not yet finalized).



Another step forward for children was the creation of the Administration for Children and Families (ACF), which consolidated the Family Support Administration and the Office of Human Development Services. Now, many of the programs that provide services to children are administered by one agency. The consolidation will facilitate coordination and cooperation among children's programs.

While change is underway to improve services for children, more improvements could be made. In the past few years, the OIG has released a number of reports recommending management or policy improvements in the programs of the Department that serve children. Our recommendations were targeted at improving the quality of services and program efficiency and effectiveness. Agency officials have implemented some of these recommendations.

## **SCOPE**

This report has been organized into four broad issue areas that deal with the problems that some children face: income, health care, educational and developmental opportunities, and living environment. In each issue area, we identify how the Department is involved in dealing with specific aspects of these problems and the findings and major recommendations of OIG reviews. The following areas and programs are covered: Child Support Enforcement, Aid to Families with Dependent Children, Medicaid, prenatal care, Head Start, child care, foster care, adoption, and drug-exposed children.

# ISSUES

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## ***ADEQUATE INCOME***

The Department of Health and Human Services administers two primary programs that provide families with income assistance and security--Child Support Enforcement and Aid to Families with Dependent Children. Child support enforcement, in reinforcing the need for individual and parental responsibility and as a method of offsetting the AFDC program, is a strong and important element of the Family Support Act of 1988. The CSE program provides grants to States to enforce obligations of absent parents to support their children by locating absent parents, establishing paternity when necessary, and establishing and enforcing child support orders. All families with an absent parent can receive services from CSE, whether they receive AFDC benefits or not. Since many single-parent families live close to the poverty level, the regular payment of child support may be essential in avoiding welfare dependency.

When child support is not paid or is not sufficient, AFDC becomes the income source of last resort. More specifically, a family unit becomes eligible for AFDC when a dependent child, under 18 years of age, is deprived of parental support as the result of a parent's death, mental or physical incapacity, loss of employment, or most common, absence from the home. With the passage of the Family Support Act of 1988, the AFDC philosophy shifted to assisting needy children and parents in moving from welfare dependency to self-sufficiency.

The Office of Inspector General conducts reviews of the CSE and AFDC programs to ensure that eligible persons are receiving services and benefits, and that the programs run efficiently and effectively. OIG studies have addressed the problem of lack of adequate income for children and families from the perspective of (1) maximizing family economic self-sufficiency through child support and (2) reducing error and fraud in AFDC.

### **Maximizing family economic self-sufficiency through child support**

One of the main steps towards ensuring income security of children and families is to maximize family economic self-sufficiency through child support paid by the absent parent, both for AFDC families and non-AFDC families. Failure to pay child support can have devastating economic effects on the custodial parent and children. In many cases, welfare dependency is the only option.<sup>3</sup> However, even though child support is a tremendous resource, approximately one-third of non-custodial parents do not pay child support and many others do not pay what the court has ordered them to pay.<sup>4</sup>

The crucial first step of child support enforcement is establishing paternity and the OIG examined effective paternity establishment practices. In addition, we have also found ways to increase child support collections through periodically and systematically

reviewing absent parent earnings and through strengthening wage garnishment programs.

- ▶ ***A specific set of practices at the State and local level generally results in establishing paternity, the first step in child support.***

Establishing paternity is the first step towards making certain that child support is paid. Different States have different approaches and practices for paternity establishment. However, some practices are more effective than others. An OIG study found that successful paternity establishment is the result of the following practices: (1) soliciting support for the paternity establishment program, (2) clarifying responsibility for obtaining intake information, (3) promoting improved parental cooperation, (4) streamlining adjudication of paternity establishment, and (5) instituting effective case management controls.<sup>5</sup> These practices can improve the rate of paternity establishment.

- ▶ ***Many opportunities exist for improved child support collections with both AFDC and non-AFDC absent parents.***

We found that while AFDC absent parents may have little or no earnings when AFDC eligibility is initially established, their earnings generally increase over time. Accordingly, child support collections of AFDC parents could be increased significantly if CSE agencies would systematically review the earnings of absent parents.<sup>6</sup> In addition, we found that a logical, systematic review of non-AFDC child support cases would also substantially increase child support collections. Some of the non-AFDC cases did at one time receive AFDC benefits and some arrearages were incurred at that time. We estimated between \$765 and \$850 million could be collected by targeting those parents currently earning over \$10,000, whose cases presumably represent AFDC arrearages still owed. The Federal savings represented by this range would be approximately \$245 to \$270 million.<sup>7</sup>

We recommended that the Office of Child Support Enforcement (OCSE) annually match Social Security Administration (SSA) or Internal Revenue Service (IRS) records, relying on data submitted by the States. The ACF agreed that there is a great deal of potential for increasing child support collections, but ACF did not concur with the recommendation since it goes beyond the review and modification requirements of the Family Support Act of 1988.

A specific group of non-AFDC parents that we examined was Federal employees. We identified more than 65,000 absent parents who work for the Federal Government and who may owe as much as \$284 million in past due child support. We estimated that current annual child support payments could be increased conservatively by \$46.6 million. We recommended that States implement immediate wage withholding. The OCSE agreed with the

recommendation and States were to implement this requirement by November 1990.<sup>8</sup>

► ***Ineffective garnishment systems hamper child support collections.***

Although wage withholding is an effective method of increasing child support collections, employers encounter problems with garnishment systems. We found that Federal and non-Federal employers had systems for processing child support garnishments in compliance with Federal regulations, but that the employers encountered impediments to timely and efficient processing of child support garnishments. These impediments include lack of detailed guidance regarding State and Federal laws for child support garnishments, lack of standardized forms for court orders, State and court requests for data that require departures from their normal pay and disbursement cycles, and lack of electronic funds transfer capability by State withholding agencies and other collection authorities. We determined that only one Federal and one non-Federal employer in our sample collected fees to cover costs of processing child support garnishments.

We proposed that ACF direct State CSE agencies to establish an electronic fund transfer system that has the capability of expediting the payment process. The ACF has moved forward with the Electronic Funds Transfer Pilot Program which will transfer funds electronically to provide a seamless flow of collections and information from the employer to the child support agency.<sup>9</sup>

► ***Problematic cash management practices weaken the child support program.***

Some of the cash management practices in the State CSE programs are problematic. In some CSE programs (1) interest and other income is not offset against child support expenditures, (2) controls are not adequate for handling unidentified payments, (3) collections are deposited untimely and/or in non-interest bearing accounts, and (4) undistributable/unidentified IV-D collections are not adequately allocated between the Federal and State Government to distribute the applicable Federal share. We recommended that OCSE work with the States to improve cash management practices. As a result, OCSE distributed a nationwide bulletin requesting that each State review the totality of their operations for weaknesses in internal control over handling collections.<sup>10</sup>

## **Reducing error and fraud in AFDC**

Limited resources at the State and Federal levels force the AFDC program to avoid payment errors as well as ensure that benefits go to those families who are truly eligible. Error control and fraud control are crucial components of the AFDC system; that is why the OIG has focused on those areas.

► *Successful anti-fraud efforts help reduce the AFDC error rate.*

We identified three reasons some States are more successful than others in reducing AFDC payment errors and determined those factors that prevent most States from meeting their AFDC error rate reduction goals. First, the threat of fiscal disallowances compels States to emphasize AFDC error rate reduction. Second, States successful in error reduction have fostered the attitude that every person in the AFDC network statewide is important and accountable for assuring accurate benefit payments.<sup>11</sup> Third, pre-entitlement fraud screening, as used in the California Welfare Fraud Early Detection and Prevention program, has been effective at reducing AFDC fraud. This program investigates irregularities in applications quickly and efficiently, disallowing applicants who provide misinformation on their application. On the other hand, most traditional law enforcement approaches to reduce AFDC fraud have been ineffective. As a result of the OIG study, ACF revised regulations effective October 1989 to require that States implement a pre-eligibility fraud detection and prevention system as a condition of State plan approval.<sup>12</sup>

### ***ADEQUATE HEALTH CARE***

Medicaid is the major HHS program that helps finance health care for children when they are not covered by private insurance. It provides grants to States for medical care for low-income persons, the majority of which are children and families. Each State administers its own Medicaid program, setting eligibility and coverage standards within broad Federal guidelines. Within Medicaid, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is specifically for children and is designed to assure the availability and accessibility of required health care services as well as help children use services effectively.

Other programs within the Department focus on delivering health care services to children and mothers. These programs include the Maternal and Child Health Care Block Grant and the Community and Migrant Health Centers. Additionally, a special initiative, the Comprehensive Perinatal Care Program, has provided funding to community and migrant health centers, specifically for perinatal care.

In addition to the specific programs that provide health care, the CSE program is required by statute to assure that children of absent parents are covered by the absent parent's health insurance. This requirement has the potential to be the deciding factor in whether a child receives health care.

The OIG reviews whether the health programs are ensuring that their services are accessible to eligible children and families, run in an effective manner, and utilized appropriately. Recent OIG work has examined Medicaid expansions to ensure that States effectively expand their eligibility for pregnant women. Studies have assessed managing and implementing infant mortality programs. The OIG has also reviewed

the CSE program's compliance with the requirement that children be covered by their absent parent's health insurance.

### **Ensuring that States expand their eligibility under existing Medicaid policy for pregnant women and children**

Lack of adequate health care for women and children prompted Congress to enact significant Medicaid eligibility expansions in recent years. The Omnibus Reconciliation Act (OBRA) of 1986 enabled States to expand eligibility for women to receive Medicaid-covered prenatal care.<sup>13</sup> However, we have found problems with these expansions.

- ▶ *Many barriers exist in implementing new Medicaid policies for pregnant women and children.*

We found that problems exist in implementing the new Medicaid expansions. First, some States are not aggressively enrolling pregnant women in Medicaid and do little or no outreach.<sup>14</sup> Next, women are not completing the cumbersome application process due to lengthy, complex forms and multiple application sites and appointments. Lastly, States have difficulty recruiting prenatal care providers because many providers do not accept Medicaid patients. This shortage of obstetricians limits States' capacity to deliver adequate and timely prenatal care.

To address these problems, we recommended that HCFA develop a comprehensive outreach strategy, simplify and streamline the application process, and develop incentives to increase provider participation.<sup>15</sup>

### **Reducing infant mortality and morbidity**

In 1990, the United States ranked 21st among industrialized countries in infant mortality--9.1 deaths per 1000 live births.<sup>16</sup> Although the infant mortality rates in the United States have decreased during the past decade, the rate of decline has slowed in recent years. Infant mortality rates among certain ethnic groups and in certain urban and rural geographic area remain high.<sup>17</sup> Federal, State, and local programs exist to help reduce the infant mortality rate. OIG studies have examined some of these programs.

- ▶ *Prenatal and perinatal care programs can be improved by special management strategies.*

The Comprehensive Perinatal Care Program (CPCP) provides supplemental funds for enhancing perinatal care systems in community and migrant health centers to improve the pregnancy outcomes and health status of women and infants served by these centers. We found that the goals and objectives set forth in CPCP grant proposals approved by the Public Health Service (PHS)

have been in accord with the intended purposes of the program. However, we also found that many areas of the country with high rates of infant mortality have not been receiving CPCP funds. In response to our report, PHS revised the grant approval process to require CPCP grantees to submit both a budget and a narrative report detailing the specific uses of the funds. In addition, PHS reexamined its approach for allocating CPCP funds to assure that these limited funds are targeted to areas of highest need.<sup>18</sup>

On the local level through an in-depth review of the Boston Healthy Baby Program, important insights we gained into how infant mortality programs can be managed to achieve the best results include (1) using vital statistics data to target geographical areas where high risk women reside and developing aggressive outreach networks in those target areas using various neighborhood resources; (2) using a standardized screening process to identify women at high risk within the target area and developing program guidelines for triage purposes; (3) ensuring that contact with program staff occurs at time of screening; (4) placing first level priority on funding for clinical services that are stable and adequate to meet demand and developing formal linkages between prenatal care sites and hospitals to enhance continuity of care for each case; and (5) providing educational and social services to high risk women beginning in the first trimester and using multidisciplinary staff to design service plans based on individual client needs.<sup>19</sup> These implementation strategies can contribute significantly to the success of Federal, State, and local efforts to lower the incidence of infant mortality.

### **Ensuring that children have health insurance**

Children must have health insurance to receive adequate health care. However, the National Commission on Children estimates that 8.3 million children do not have health insurance; one-half of these children live below the poverty line. Medicaid covers only an estimated 59 percent of poor children.<sup>20</sup> Some children lack coverage because the parents' employers do not provide health insurance.<sup>21</sup> However, many children belong to families in which an absent parent may be eligible for health insurance through an employer that could provide coverage for the employee's children. Although required by law, this does not always happen. As a result, the children may remain uninsured, or, if eligible, they may receive Medicaid, thus making Medicaid the primary payer. We have examined this issue of absent parent liability in depth and found significant room for improvement.

- ▶ *Detecting and pursuing available health care for children of absent parents could be greatly improved.*

To ensure health coverage for children, the OIG found that State CSE agencies should petition for including medical support as part of all child support orders. This would allow State Medicaid programs to avoid expenditures for medical services for the children of these covered absent parents and could result in

Medicaid program savings of \$33 million annually.<sup>22 23</sup> We then determined that, as of June 1, 1990, only 46 percent of State CSE programs had criteria developed by State Child Support Enforcement agencies to target cases with high potential for medical support and to identify the most effective criteria and practices, as Federal regulations require. Further, we found that less than half of the 54 States can modify existing court orders for the sole purpose of including medical support.

We recommended that ACF enforce current regulations regarding targeting medical support and place additional emphasis on its importance. As a result, the requirement for States to develop criteria is now being audited for substantial compliance, and the review of targeting criteria is now included in the Program Results Audit Guide. The ACF has also since issued regulations that state that the availability of reasonably priced insurance must be treated as adequate grounds for petitioning for modification of the support order.<sup>24</sup>

Additionally, a loophole exists for some absent parents due to the Employee Retirement Income Security Act of 1974 (ERISA). Because self-insurers are exempt under ERISA from State regulation of insurance, ERISA prevents States from assuring that many AFDC dependent children are covered under their absent parents' group health insurance plans. The pool of self-insurers has grown considerably since passage of ERISA, increasing the significance of this gap in coverage. In 1985, almost half of firms with 100 employees or more were self-insured, doubling the figure from four years earlier. As more and more businesses self-insure, the exposure for the Medicaid program in financing health care for employees and their children grows. We recommended that HCFA and ACF address ERISA preemption problems when drafting a legislative proposal to require States to prohibit discrimination in insurance plans on the basis of residence.<sup>25</sup>

## ***EDUCATIONAL AND DEVELOPMENTAL OPPORTUNITIES***

HHS funds programs that provide developmental and educational activities for children that might not have them otherwise. Foremost of these programs is Head Start, providing comprehensive educational, nutritional, social, health and other services primarily to low income preschool children and their families. It has recently been expanded to include many more children and to strengthen the program.

HHS funds a number of child care programs. The major new program resulted from the passage of the Child Care and Development Block Grant Act of 1990. This block grant will provide financial assistance to low-income families to help them find and pay for quality child care. It will also improve the quality and increase the supply of child care available to all families.<sup>26</sup> Other child care programs include At-Risk Child Care, JOBS Child Care, Transitional Child Care, and many smaller programs such as Comprehensive Child Development Centers, Child Care Licensing Grants, Dependent



## Care Grants, Temporary Child Care and Crisis Nurseries, and Child Development Scholarships.

As with all HHS programs, the Inspector General has oversight authority of the Head Start program. The OIG conducts reviews of the Head Start program to ensure that it provides quality services to eligible children and monitors the effectiveness and efficiency of its management. To that end, we have examined the program's responsiveness to families with many problems, its management and monitoring, and its capacity for expansion. Additionally, with the growing number of child care initiatives and concern over the quality and safety of care, we have also examined enforcing State child care regulations.

### Expanding and managing Head Start effectively

Because of the recognized need for educational and developmental activities, Congress increased funding for the Head Start program from \$1.24 billion in FY 1989 to \$1.95 billion in FY 1991. Total enrollment was expected to increase from 451,000 children to nearly 600,000 children.<sup>27</sup> In recent years, Head Start staff have expressed concern over the growing number of multiproblem families enrolling in the program. Because of the severe nature of the problems in some of the families, they are unable to benefit fully from the Head Start program.<sup>28</sup> Both the rapid expansion and the participants from dysfunctional families pose management challenges for the Head Start program, and we examined these areas to assist ACF in meeting these challenges.

#### ► *The Head Start expansion poses many management challenges.*

We assessed the Head Start system's capacity to successfully manage the rapid enrollment expansion and found that it presents problems. First, grantees are meeting enrollment expansion goals but are experiencing problems in obtaining suitable space. They believe that more lead time for expansion implementation will help resolve this problem. Additionally, grantees express more optimism than Federal staff that enrollment expansion will improve the quality of services. Both regional and headquarters Head Start staff claim a serious lack of resources to assist and assess grantees in upcoming expansions, as well as a lack of timely information on grantee enrollment progress.<sup>29</sup>

In response to the study, ACF added 13 additional staff members to headquarters in FY 1991, and more staff will be added in the regional offices if the budget permits. The ACF also stated that every effort will be made to provide more lead time to grantees, and to track expansion progress, a data collection system is being considered.

As an additional check on the management capacity of Head Start grantees, we analyzed the results of over 1,200 nonfederal audits of individual grantees conducted in the three years prior to the expansion. As a result, we were able

to alert the Head Start program to problems of accountability, grants management, and cash management. We recommended that the ACF reevaluate all important aspects of financial management and accountability, including technical assistance, monitoring, financial reporting, tracking audit reports, and audit resolution. We also recommended financial management capability reviews for new grantees and training and oversight to correct persistent deficiencies.<sup>30</sup>

► *Head Start participants from dysfunctional families are more difficult to serve.*

For many reasons Head Start participants from dysfunctional families are more difficult to serve. Dysfunctional families face serious physical, mental, and social problems. These comprehensive needs of dysfunctional families create special challenges for Head Start grantees, but almost all grantees believe that Head Start is the best program for children from dysfunctional families despite additional demands placed on staff. Income guidelines, performance standards, and lack of resources limit grantees' ability to serve some of the children from dysfunctional families who are not eligible for Federal "safety net" programs. We recommended that Head Start revise its enrollment criteria to provide greater flexibility to enroll children from dysfunctional families and use its discretionary grant authority to develop ways of providing better access to community resources and to develop and test new and better approaches for Head Start grantees to assist dysfunctional families.<sup>31</sup>

### **Expanding monitoring effort of Head Start to ensure program quality**

Program monitoring is essential for a successful Head Start program. Section 651 of the Head Start Act requires ACF to perform periodic evaluations and cost analyses to measure program impact as well as Head Start agencies' ability to perform grant activities.<sup>32</sup>

► *Procedures and tools for monitoring the Head Start program are incomplete.*

We found that monitoring the Head Start program is difficult because ACF has not established or implemented procedures necessary to measure performance of Head Start agencies. Although performance standards have been established, ACF has not developed the needed criteria to determine the extent of an agency's compliance with these standards. Also, ACF has not formalized procedures needed to effectively manage high risk agencies in its program instructions. Because of this, we recommended that ACF establish and implement improved procedures to assure that the extent of an agency's compliance with the performance standards is determined and used as a basis for establishing uniform ratings for agencies.<sup>33</sup> ACF agreed with our recommendation and plans to continue to make improvements in the Head Start monitoring system which is ACF's most important mechanism for assuring program compliance.

Monitoring is also difficult because the data maintained on the management information systems utilized in the Head Start program is incomplete. The incomplete data raise concerns as to their accuracy and usefulness to program officials for evaluating program performance, analyzing operating costs, and assisting in making decisions about program administration.<sup>34</sup> As a result, ACF currently has underway several efforts which will improve information systems.

The statute requires every Head Start grantee to conduct an annual self-assessment of its program, but the regulations do not provide guidance on how self-assessment should be done. Despite the lack of guidance, we found that virtually all grantees are conducting self-assessment annually, as required. Nearly all grantees use the Self Assessment Validation Instrument (SAVI) for conducting self-assessment, but many have concerns about its length, complexity, and comprehensiveness.<sup>35</sup>

### **Ensuring that children receive high quality child care**

As a result of the changing demographics of the work force, more children are placed in day care, and they should receive high quality care that provides developmental opportunities. To that end, the Child Care and Development Block Grant (P.L. 101-508) was enacted on November 5, 1990. States are required to use at least 20 percent of the block grants funds to improve the quality of child care provided. Areas where States may use the funds are monitoring and complying with State and local licensing and regulatory requirements.<sup>36</sup> We examined current State regulatory enforcement efforts in child care as well as effective State enforcement practices.

► ***State child care regulations vary considerably from State to State.***

Regulations regarding child care arrangements varied significantly among the States. Many types of settings were not regulated. Even when a setting was regulated, the nature and force of the regulations varied in such areas as health and safety requirements, child care staff requirements and staff-to-child ratios. Enforcing the regulations that did exist was just as problematic; inspections were time consuming and legal sanctions were difficult to enforce, even in cases of imminent danger.<sup>37</sup>

We also identified effective practices which States should consider adopting to improve their enforcement of existing regulations. These practices included administrative closures, consent agreements, investigative protocols, inspection review techniques, monetary incentives and penalties, and training and technical assistance for providers.<sup>38</sup>

## ***STABLE LIVING ENVIRONMENT***

Many HHS programs seek to promote family preservation and to protect vulnerable children living in unstable environments. Title IV-E of the Social Security Act or Foster Care and Adoption Assistance reimburses States for the cost of maintenance payments and administrative costs associated with running the program. In the adoption assistance portion of Title IV-E, HHS reimburses States for administrative costs incurred in running the program and for adoption subsidies to families who adopt special needs children. The Title IV-B Child Welfare Services Program funds services designed to protect and promote children's welfare, prevent abuse and neglect, promote family preservation, and place children in suitable adoptive homes when family preservation is not possible. The Title XX Social Services Block Grant is another major source of funding for social services that can help create a stable environment for children.

The OIG has focused on the effectiveness, efficiency, and quality of foster care and child welfare services. But we have explored the human aspect as well. One specific population that we have examined is the drug-exposed infant.

### **Identifying potential administrative changes in the foster care system to control costs**

Growing congressional and departmental concern exists over the rapid rate of cost escalation in the foster care program. Before any changes can be made to provide expanded or new services to children, costs must be brought under control in the current program. Two areas of foster care show great potential for cost savings--administrative costs and unallowable maintenance payments--and we have examined these areas in detail.

- ▶ *Administrative costs have risen dramatically, but most of the costs are actually for child placement services.*

Foster care administrative costs rose from \$143 million in FY 85 to \$400 million in FY 88. Two primary reasons have caused the administrative costs to increase: (1) the expanded definition of allowable activities under Title IV-E in P.L. 96-272 and (2) a broad interpretation of that definition by the Departmental Appeals Board (DAB). The DAB ruled that Federal Financial Participation (FFP) was allowable for preplacement and other costs incurred for children not yet determined to be eligible for foster care maintenance payments. Only 20 percent of these administrative costs, however, relate to administering the foster care program. The other 80 percent of the administrative costs are actually child placement services, allowed under P.L. 96-272. Thus, relative to foster care, the term "administrative costs" is a misnomer because it includes activities related to the delivery of social services. The States' practices for maximizing Federal reimbursement have resulted in significant increases in Title IV-E costs. This trend is expected to continue as more States become sophisticated in capturing additional costs. We

recommended that legislative action be taken to limit Federal participation. In FY 1991, Congress enacted requirements to States to separately report placement costs but did not enact cost containment provisions.<sup>39</sup>

► ***Foster care maintenance payments are often made to ineligible children.***

Under Title IV-E, FFP is allowed for foster care maintenance payments to a child when certain conditions are met. We found in New York that 67 percent of maintenance payments--\$141.3 million (\$70.6 million Federal share)--were unallowable for FFP. Further, OIG estimated that at least \$61.4 million (\$30.8 million Federal share) of claimed administrative costs associated with ineligible maintenance payments were also unallowable for FFP.<sup>40</sup> In the District of Columbia, we found that 76 percent of claimed foster care maintenance payments--\$11.8 million (\$5.9 million Federal share) was ineligible for FFP. We attributed this extremely high rate of ineligibility to a widespread disregard of Federal regulations and the District of Columbia's Department of Human Services' own policies and procedures. We recommend that the States reimburse the Federal Government for these unallowable foster care maintenance costs.<sup>41</sup>

**Improving the quality and availability of services in the State child welfare system**

To fully protect children in families that have problems, the services provided by the child welfare system must be improved. When a child cannot be returned to his or her original home, then proceedings begin for adoption. Waiting to be adopted can be difficult for children, but the adoption process can be improved to make it easier for the children, the courts, and the child welfare system. We have identified some problems in the foster care and adoption system.

► ***Administrative barriers cause excessive delays in freeing children for adoption.***

Administrative barriers in the child welfare system cause the most excessive delays in freeing children for adoption. Under P.L. 96-272, a State cannot obtain Federal foster care funds for a child unless reasonable efforts to maintain the child in the family were made. Continued Federal funding is contingent upon a State making reasonable efforts to reunite families. The specific definitions of "reasonable efforts to maintain and to reunite" are left to the State. The primary barrier to implementing permanent plans of adoption was the inability of the child welfare agencies to meet the "reasonable efforts" standard to the satisfaction of State courts in a timely manner. Also, long-term planning is often made after the child has been in care for considerable periods, and limited management commitment and lack of staff and services play a significant role in the failure to make "reasonable efforts."

Many barriers and delays also arise from the legal and judicial systems. Case records do not contain legally acceptable documentation of the "reasonable

hospital delivery, perinatal care, and foster care to just these 8,974 children through age 5 will cost approximately \$500 million. Additional interventions cost considerably more. For example, Florida estimates an annual cost of over \$40,000 per child to get crack babies ready for school. Even costs after age 5 will be substantial because special education, residential treatment, juvenile detention, etc. are all costly.

Not only is care for crack babies costly, but crack baby cases also are more time consuming and more complex than the average child welfare case, requiring extensive tracking and follow-up, interagency coordination, and professional case management. Fifty to 75 percent of identified crack babies go home with their mother or relative, and an estimated 30 to 50 percent go into foster care. Many children may be left with their natural parents because no foster placements are available.<sup>45</sup>

In response to our report, ACF co-sponsored a national conference with the Maternal and Child Health Bureau in PHS on prenatal substance abuse exposure and is developing educational material for child welfare workers. The PHS is conducting a national evaluation of the different approaches utilized to reduce drug abuse. The Office of Substance Abuse Prevention and the Office Maternal and Child Health are jointly funding demonstration grant projects that focus on prevention, education, and treatment of pregnant and postpartum women and their infants. The National Institute on Drug Abuse has funded 10 treatment research demonstration projects which include intensive prenatal outreach, drug treatment for women, and developmental assessment and follow-up for the prenatally drug exposed infants.

- ▶ *Many obstacles exist to placing boarder babies in adoptive homes, but some cities are successful.*

Boarder babies, infants who remain in the hospital even though medically ready for discharge, usually have serious medical problems which are often due to fetal exposure to drugs. Babies also stay in the hospital due to questions about the parents' ability to care for the babies and lack of care alternatives. A number of complex legal obstacles to placement of these babies also exist, such as establishing legal abandonment and terminating parental rights. Some of the 12 cities visited have been successful in making timely placements. Their successes have resulted in significant decreases in hospital overstays and the number of boarder babies.<sup>46</sup>

## ENDNOTES

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