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

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ABSTRACT

Our study determined that all 50 sampled children in the Texas foster care program received Medicaid services, and the majority received their most recent required Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) medical examinations. However, the percentage of children receiving their required initial medical and dental screenings was substantially lower, and compliance with guidelines for vision and hearing screenings was undocumented. The Office of Inspector General (OIG) also determined that case plans were not completed within required timeframes for over half of the sampled children, and foster care providers for almost half of the children never received a written medical history for the children in their care. OIG recommends that the Administration for Children and Families (ACF) work with the Texas Department of Protective and Regulatory Services to increase the number of: initial medical and dental screenings that are received within required timeframes; initial case plans that are completed within required timeframes; and, foster care providers who are supplied available medical information for the children in their care, as required by Federal regulations. OIG recommends that the Centers for Medicare & Medicaid Services (CMS) work with the Texas Department of Health to evaluate the need for documentation to ensure compliance with routine EPSDT vision and hearing screening guidelines. ACF noted that it is working with the State to accomplish goals established in a Program Improvement Plan (PIP) developed as a result of a Child and Family Services Review. One of the goals of the PIP focuses on the health and mental health care of children in the child welfare system. CMS concurs with our recommendations and indicates that they are available to provide technical assistance to the State to promote provider education regarding the frequency schedule requirements and appropriate documentation of vision and hearing screenings.

OBJECTIVE

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

BACKGROUND

Currently, there are an estimated 534,000 children in foster care nationwide, many of whom are reportedly in poor health. Compared with children from the same socioeconomic backgrounds, these children suffer much higher rates of serious physical and psychological problems. Texas 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 children in the Texas foster care program are eligible for Medicaid. Federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines require each State to provide coverage of preventive health care services to Medicaid-eligible individuals under the age of 21, at intervals which meet reasonable standards of medical and dental practice, as outlined in Section 1905(r) of the Social Security Act (the Act). In addition, Section 471(a)(22) of the Act requires States to develop and implement standards to ensure that all children in foster care placements are provided quality services that protect their health.

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 the Texas foster care program; interviews with foster care providers and caseworkers for the children in our sample; and interviews with Texas Department of Protective and Regulatory Services, Department of Health, and other State agency officials. Our analysis focused on a 3-year Medicaid claims history for the period September 1, 1999 through August 31, 2002.

FINDINGS

All sampled children had Medicaid coverage and claims for services

All of the sampled children had Medicaid coverage and at least one Medicaid claim for health care services.

Ninety-four percent of sampled children received their most recent EPSDT medical examinations, and 92 percent received their most recent EPSDT dental examinations, in accordance with State guidelines

Nearly all of the sampled children had received their most recent EPSDT medical and dental examinations at the time of our review. A high percentage of the children who had received their most recent EPSDT medical and dental services, according to the State's frequency guidelines, had a foster care provider that knew the correct EPSDT frequency schedule for the child in its care.

Seventy-five percent of sampled children received initial medical examinations, and 66 percent of sampled children received initial dental examinations, within required timeframes

Substantially fewer sampled children received initial medical and dental examinations within required State timeframes than children who received EPSDT medical and dental examinations that met State frequency guidelines. Data collected by the Office of Inspector General suggest that it may be difficult to quickly locate dental providers for initial visits.

Compliance with State guidelines for vision and hearing screenings was undocumented

Texas requires that a hearing and vision screening be performed during each EPSDT medical examination. Our review of case file documentation provided no evidence of a vision screening for 58 percent (29/50) of the children in our sample, and no evidence of a hearing screening for 66 percent (33/50) of the children in our sample at the time of their most recent EPSDT medical examination. The Centers for Medicare & Medicaid Services (CMS) no longer requires States to submit data on the number of children who received a vision or hearing screening through the State's EPSDT program. Likewise, medical providers in Texas are not required to "itemize" the components of an EPSDT medical examination when billing for reimbursement.

Seventy-six percent of sampled children received Medicaid mental health services

Federal law requires that a case plan be developed for each child in Title IV-E foster care that includes a plan for ensuring that the

child's needs are addressed while s/he is in foster care. Texas requires that a case plan be developed for each child in foster care that includes an assessment of the child's mental health needs. For the 50 children in our sample, 44 percent (22/50) had initial case plans that were completed within the required timeframe (within 45 days of entering care). Seventy-six percent (38/50) of the children in our sample had Medicaid claims for mental health care services. The case plans for the 12 children who did not have Medicaid mental health claims indicated that their mental health needs were assessed, and only 2 indicated a need for services that were not received.

Forty-six percent of foster care providers reported never receiving a medical history for the sampled child in their care

Federal law requires that a child's health records be given to the foster care provider at the time of placement. The provision of this information is important to ensure that appropriate health care services are provided to children in foster care. Foster care providers for 46 percent (23/50) of the sampled children reported never receiving a medical history for the child in their care. However, caseworkers for 19 of these 23 children reported receiving or compiling a medical history for the child. Foster care providers for children assigned a lower level of care (i.e., children with few or no medical and/or mental health problems) were less likely to report receiving a medical history for the child in their care than providers caring for a child assigned a higher level of care (i.e., a child with moderate to severe medical and/or mental health problems).

RECOMMENDATIONS

To ensure that children in foster care receive health care services in accordance with Federal guidelines, we recommend that:

The Administration for Children and Familes (ACF) work with the Texas Department of Protective and Regulatory Services to increase the number of

- Initial medical and dental screenings that are received within required timeframes
- Initial case plans that are completed within required timeframes

- Foster care providers who are supplied available medical information for the children in their care

The Centers for Medicare & Medicaid Services work with the Texas Department of Health to

- Evaluate the need for documentation to ensure compliance with routine EPSDT vision and hearing screening guidelines

AGENCY COMMENTS

ACF indicated that it is working with the Texas Department of Protective and Regulatory Services, to assist the State in accomplishing goals established in a Program Improvement Plan developed as a result of 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. ACF stated that indicators in the Child and Family Services Review specifically track the areas of concern highlighted in this report, and that one of the goals of Texas' Program Improvement Plan focuses on the health and mental health care of children in the child welfare system. Upon completion of this plan in March 2005, ACF will conduct another Child and Family Services Review. The full text of ACF's comments to the draft report is located in Appendix F.

CMS concurs with our recommendation and indicates that it is available to provide technical assistance to the State to promote provider education regarding the periodicity schedule requirements, and appropriate documentation of vision and hearing screenings. The full text of CMS's comments to the draft report is located in Appendix G.

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INTRODUCTION

OBJECTIVE

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

BACKGROUND

Currently, there are an estimated 534,000 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. Texas was selected because of its large size, geographic location, and fee-for-service provision of Medicaid services. Texas had 21,353 children in foster care at the end of the Federal fiscal year 2002, based on the most recent Federal data available.[3] The Administration for Children and Families (ACF) has regulatory oversight of Title IV-E foster care programs, including approval of State plans to ensure State foster care programs are operating within Federal guidelines. The Texas Department of Protective and Regulatory Services manages the State's Title IV-E foster care program.

Compared with children from the same socioeconomic backgrounds, children in foster care suffer much higher rates of serious physical and psychological problems.[4] Vision, hearing, and dental problems are prevalent in the foster care population and physical health

[1]Retrieved December 10, 2003 from http://www.acf.hhs.gov/programs/cb/dis/afcars/publications/afcars.htm. "Currently" refers to children in foster care on September 30, 2002, the most recent available nationwide estimate.

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

[3]Retrieved December 10, 2003 from http://acf.hhs.gov/programs/cb/ddis/tables/entryexit2002.htm. Both Title IV-E eligible and non-Title-IV-E eligible children are included in the total "21,353 children in foster care."

[4]Health Care Issues for Children in Foster Care, March 25, 2002. Retrieved October 17, 2002, from http://www.casey.org/cnc/documents/health_care_issues.pdf.

problems (e.g., delayed growth and development, malnutrition, and asthma) affect 30 to 40 percent of children in the child welfare system.[5]

Children in foster care have greater health care needs,[6] yet many foster care providers report having difficulty finding health care professionals who are willing to care for these children. The health care available for children in foster care is often characterized by lack of access, lack of information sharing among health 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 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 (GAO) 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. Adherence to American Dental Association recommendations for preventive dental care leads to better oral health, and practicing preventive behaviors over the long term produces greater benefits than doing so over the short term.[9]

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[5] Factsheet: The Health of Children in Out-of-Home Care. Child Welfare League of America. Retrieved October 21, 2002 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 October 17, 2002 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

All children in the Texas foster care program are eligible for Medicaid. Sections 472(h) and 1902(a)(10)(A)(i)(I) of the Social Security Act (the Act) require States to provide Medicaid (Title XIX of the Act), or equivalent health insurance coverage, to children eligible to receive Title IV-E foster care program maintenance funds. Within broad national guidelines, each State establishes its own Medicaid eligibility standards; 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] Texas provides Medicaid coverage to all children in foster care, regardless of IV-E eligibility status. In 2000, Medicaid payments for children in foster care nationwide totaled over $3.3 billion.[11] Texas Medicaid expenditures to provide health care services to children in the Texas foster care program totaled approximately $156 million in 2000.[12] The Centers for Medicare & Medicaid Services (CMS) is responsible for Federal oversight of individual State Medicaid programs.

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.[13] State EPSDT programs must provide medical, hearing, vision, and dental screenings, and other necessary health care and treatment at intervals established by the State that meet reasonable standards of practice published by recognized health care organizations. Texas established the Texas Health Steps program to meet Federal EPSDT requirements. The current EPSDT frequency schedule for the Texas Health Steps program requires that medical screenings occur at: birth; 2 weeks; 2, 4, 6, 9, 12, 15

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[10] Retrieved November 1, 2002 from http://cms.hhs.gov/medicaid/mover.htm and http://cms.hhs.gov/medicaid/eligibility/criteria.asp.

[11] Medicaid Statistical Information System (MSIS) Report Fiscal 2000. Retrieved December 10, 2003 from http://www.cms.gov/medicaid/msis/00total.pdf. Fiscal 2001 numbers for all States were not available.

[12] Medicaid Statistical Information System (MSIS) Report Fiscal 2000: Texas. Retrieved December 10, 2003 from http://www.cms.gov/medicaid/msis/00tx.pdf. Fiscal 2001 expenditures for Texas totaled approximately $185 million. Retrieved December 10, 2003 from http://www.cms.gov/medicaid/msis/01tx.pdf.

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

and 18 months of age; 2, 3, 4, 5, 6, 8, and 10 years of age; and annually between the ages of 10 and 20. Vision and hearing screenings are required at each medical checkup, beginning at birth. Dental examinations are required every 6 months beginning at 1 year of age. Dental examinations are conducted separately from medical checkups.

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 are provided quality services that protect their safety and health. Sections 422(b)(10)(B)(ii) and 475(1)(B) of the Act require that a case plan be developed for each child that includes a plan for ensuring that the child's needs are addressed while s/he is in foster care. The case plan must be developed no more than 60 days after the child's removal from home.[14] Sections 422(b)(10)(B)(ii) and 475(5)(D) of the Act require procedures to ensure that a child's health records are 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. In accordance with these Federal laws, the Texas foster care program requires: that each child receive a medical examination within 30 days after the date the child entered State custody, unless the child received a medical examination within 30 days before entering custody, and a dental examination within 90 days after placement;[15] that a case plan (Initial Child's Service Plan), which includes an assessment of a child's mental health needs, be created within 45 days of a child's removal from home;[16] and that the child's medical and dental history be supplied to the foster care provider before, or at the time of, the child's placement.[17]

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[14] 45 CFR § 1356.21 (g)(2).

[15] Texas Department of Protective and Regulatory Services Child Protective Services (CPS) Handbook 6520.

[16] Texas Department of Protective and Regulatory Services CPS Handbook 6411.

[17] Texas Department of Protective and Regulatory Services CPS Handbook 6123.3.

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 what types of services children receive while in foster care, and when they receive services. As such, the experiences reported in this State-specific report will be unique to the sampled children's experiences in Texas.

METHODOLOGY

This inspection focused on the receipt of Medicaid health care, dental, and mental health care services that meet EPSDT guidelines; requirements for initial 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; interviews with caseworkers and foster care providers for each of 50 children in our sample; and interviews with Texas State agency officials.

Reasons for State Selection

Texas was selected due to its large size, geographic location, and fee-for-service payment of Medicaid health care services (Texas does not utilize managed care for children in foster care). The Texas Department of Protective and Regulatory Services is responsible for the welfare of children in State custody. An overview of the administration of child welfare services in Texas is included in Appendix A.

Sample

Children who met the following criteria were included in the study sample: (1) were in foster care on September 30, 2002; (2) resided in Texas; and (3) had been in continuous out-of-home foster care placements for at least 6 months. The Texas Department of Protective and Regulatory Services provided us with a list of the 9,030 children who met these criteria. We selected a simple random sample of 50 children in Texas from the list of children who

met the specified criteria. Appendices B and C provide information on the children included in our sample.

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

Policy Review - We reviewed Federal and Texas State foster care and Medicaid policies. All Texas children in foster care are eligible for Medicaid services, regardless of their Title IV-E foster care or other eligibility status (e.g., Temporary Assistance for Needy Families). Federal law relating to EPSDT requires that States meet reasonable standards of medical and dental practice as determined by the State after consultation with recognized medical and dental organizations. The Texas Health Steps program satisfies the Federal EPSDT requirement. Therefore, we used Texas Health Steps policy guidelines to determine whether children had received their most recent EPSDT examination within required frequency guidelines.

Medicaid Claims Data Review – The Texas Health and Human Services Commission provided us with 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 September 1, 1999 and August 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. We included only those Medicaid claims after the child's most recent entry into foster care and any claims prior to entry that were pertinent in establishing frequency of services (i.e., met Texas Health Steps guidelines).

Case File Documentation Review - We requested and reviewed case file documentation from the Texas Department of Protective and Regulatory Services local offices for all the children in our sample. Information requested included 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. One hundred percent of the foster care providers responsible for the children in our sample responded to our request for an interview. We conducted structured interviews with each child's foster care

provider (10 in-person and 40 by telephone) between December 30, 2002 and February 6, 2003. The interviews with foster care providers focused on Medicaid programs and services available, training related to the health and well-being of children, and their experiences procuring health care services for the children included in our sample.

Caseworker Interviews - We conducted structured telephone interviews with each child's current caseworker between December 16, 2002 and January 7, 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 the children, his/her experience accessing services for the sampled child, and any barriers to health care faced by the child. 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 Texas Department of Protective and Regulatory Services, Texas Health and Human Services Commission, and Texas Department of Health officials who are responsible for the administration of both the foster care and Medicaid programs in Texas. Our discussions covered a wide spectrum of information, including the overall provision of Medicaid services for children in foster care, the State's EPSDT program (Texas Health Steps), 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 services

In Texas, all children in foster care are eligible for Medicaid, which includes EPSDT services. All children in our sample had Medicaid coverage and at least one Medicaid claim for health care services between September 1, 1999 and August 31, 2002. Table 1 (below) details the various types of Medicaid-covered services, and the numbers of claims by type of service for the 50 sampled children.

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

Claim type	Number of children with at least one claim	Total number of claims**
Physican's office	49	782
Dental	47	761
Mental health	38	2,077
Prescription drug	35	283
Optometry/Audiology	34	178
Laboratory test	33	813
Hospital/ASC***	31	852
Diagnostic	24	235
Supplies	23	780
Medication management	22	288
Physical/Occupational therapy	12	833
Transportation	10	128
Case management	8	33
Home nursing	6	2,423
Other	3	4
Total		**10,470**

*Claims for 09/01/99 to 08/31/02, or entry into care to 08/31/02.

**A detailed list of services for each child is located in Appendix C.

***Includes emergency room visits.

Source: OIG analysis of Texas Medicaid claims data

Ninety-four percent of sampled children received their most recent EPSDT medical examinations, and 92 percent received their most recent EPSDT dental examinations, in accordance with State guidelines

Federal law requires that State EPSDT programs provide medical, hearing, vision, and dental screenings, and other necessary health care and treatment at intervals established by the State that meet reasonable standards of practice published by recognized health care organizations. The Texas Health Steps program meets Federal EPSDT requirements. For their most recent EPSDT services, 94 percent (47/50) of the children sampled for this inspection received their most recent EPSDT medical examinations, and 92 percent (45/49) received their most recent EPSDT dental examinations in accordance with Texas Health Steps guidelines.[18]

We analyzed Medicaid claims and interview data in an attempt to identify factors that explain the high (over 90 percent) percentages of children that were receiving EPSDT medical and dental examinations at the time of our review. Although several factors, such as geographical region, caseworker involvement in the child's health care, caseworker caseload size, and child's date of entry into foster care were analyzed, we detected no differences between children who received services within required timeframes and those who did not.[19] Of the 47 children who were receiving EPSDT medical examinations according to the Texas Health Steps guidelines, 77 percent (36/47) of their foster care providers knew the frequency schedule established by Texas Health Steps. For the 45 children who were receiving EPSDT dental examinations according to Texas Health Steps guidelines, 87 percent (39/45) of the providers knew the frequency schedule. While the number of children who were not receiving medical and dental examinations according to Texas Health Steps guidelines was relatively small

[18] Percentage of children receiving dental examinations is based on 49 of the 50 sampled children. One child was medically exempt from receiving dental services and was excluded.

[19] Due to the small size of the groups who did not receive medical and dental examinations according to State guidelines (3 and 4 children, respectively), detecting any statistically significant differences with the larger groups who received medical and dental examinations (47 and 45 children, respectively) is difficult.

(three and four, respectively), we believe it is significant to note that only one of the three foster care providers knew the EPSDT frequency schedule for medical examinations, and two of the four foster care providers knew the EPSDT frequency schedule for dental examinations.

Seventy-five percent of sampled children received initial medical examinations, and 66 percent of sampled children received initial dental examinations, within required timeframes

The Texas foster care program requires that each child in foster care receive a medical examination within 30 days after the date the child entered State custody, if the child had not received an examination within 30 days prior to entering custody, and a dental examination within 90 days after placement. Seventy-five percent (27/36) of the children in our sample received initial medical examinations within 30 days prior to or after entering State custody.[20] Sixty-six percent (23/35) of the children in our sample received initial dental examinations within 90 days after placement.[21] These percentages are substantially lower than the number of children who received current EPSDT medical and dental services that met State frequency guidelines.

We analyzed Medicaid claims and interview data in an attempt to identify factors that would explain the lower percentages of children receiving initial examinations within required timeframes, compared to those receiving current EPSDT medical and dental services that met frequency guidelines. Although several factors, such as geographical region, caseworker involvement in the child's health care, caseworker caseload size, child's age, child's level of care,[22] and child's date of entry into foster care were analyzed, we

[20]The percentage of children receiving initial medical examinations is based on a subset of 36 sampled children. Fourteen sampled children were excluded because they entered foster care outside of the timeframe included in our claims data.

[21]The percentage of children receiving initial dental examinations is based on a subset of 35 sampled children. Fourteen sampled children were excluded because they entered foster care outside of the timeframe included in our claims data, and one child was medically exempt from receiving dental services.

[22]"Level of care" is a category of care assigned by the State based on the child's clinical, psychosocial, and related needs. See Appendix D for an explanation of level of care categories in Texas.

found no evidence of differences between children who received initial medical and dental examinations within required timeframes and those who did not.[23] However, 20 percent (10/50) of foster care providers reported that dentists willing to accept new Medicaid patients were difficult to locate. Data suggest that it may be difficult for foster care providers to quickly locate dental providers for initial examinations, but dentists will continue to see the child once a relationship has been established with the foster care provider. If children in foster care are not receiving required initial medical services, it causes the State to be out of compliance with guidelines established in its State plan, and may delay the discovery of serious health care problems.

Compliance with State guidelines for vision and hearing screenings was undocumented

The Texas Health Steps program requires that a hearing and vision screening be performed during each EPSDT medical examination.

Our review of case file documentation provided no evidence of a vision screening for 58 percent (29/50) of the sampled children, and no evidence of a hearing screening for 66 percent (33/50) of the sampled children at the time of their most recent EPSDT medical examination. In addition to a lack of case file documentation, for 17 of the 29 children in our sample with no evidence of a vision screening in their case files, and for 23 of the 33 children in our sample with no evidence of a hearing screening, there was no indication from the foster care provider that a screening was performed.

Foster care providers indicated that children might receive vision and hearing screenings from various sources: at school, through local Head Start programs, or through Early Childhood Intervention (the State's agency that serves families who have babies or toddlers with disabilities or developmental delays). Foster care providers for 12 of the 29 children lacking evidence of a vision screening reported that the child received a separate vision

[23] Due to the small size of the groups who did not receive initial medical and dental examinations according to State guidelines (nine and twelve children, respectively), detecting any statistically significant differences with the larger groups who received initial medical and dental examinations (27 and 23 children, respectively) is difficult.

screening from the most recent EPSDT medical examination. Foster care providers for 10 of the 33 children lacking evidence of a hearing screening reported the children received a separate hearing screening. Nevertheless, the State's rules require that vision and hearing screenings be conducted as part of every EPSDT medical examination.

Prior to Federal fiscal year (FFY) 1999, CMS required States to report the number of children receiving vision and hearing screenings through the State's EPSDT program as part of the State's annual report to CMS on EPSDT participation (CMS Form 416). However, effective FFY 1999, CMS eliminated the requirement to report vision and hearing screenings on CMS Form 416 in an attempt to clarify and simplify reporting requirements wherever possible. Section 1902(a)(43) of the Social Security Act, which requires the annual reporting of EPSDT participation for each State, does not specifically require the reporting of the number of children receiving vision and hearing screenings. Likewise, medical providers in Texas are not required to "itemize" the individual components of an EPSDT medical examination, such as developmental assessment, unclothed physical inspection, vision screening, hearing screening, etc., when they bill for reimbursement.

The State's Medicaid reimbursement for Texas Health Steps medical screenings is provided with the understanding that the provider is performing all components of an EPSDT examination, which, according to Texas Health Steps guidelines, includes a vision and hearing screening. The lack of documentation of vision and hearing screenings makes it impossible to determine if medical providers are performing all of the services for which they are paid, and if children are receiving all EPSDT services according to Texas Health Steps guidelines.

Seventy-six percent of sampled children received Medicaid mental health services

Federal law requires that a case plan be developed for each child in Title IV-E foster care that includes a plan for ensuring that the child's needs are addressed while s/he is in foster care. The Texas Department of Protective and Regulatory Services requires that a case plan be developed for each child who enters foster care that includes an assessment of the child's mental health needs. Case plans that included an

assessment of the child's mental health needs had been completed for 86 percent (43/50) of the children in our sample, and 76 percent (38/50) of the children in our sample had Medicaid claims for mental health care services.

We reviewed case file documentation for the 12 children who did not have Medicaid mental health claims to determine if mental health care needs for these children were identified. The case plans for these 12 children indicated that their mental health needs were assessed. Eight of the children had no needs identified, two children had mental health needs identified and had scheduled appointments outside the timeframe of our claims data, and two children had mental health needs identified, and no services were received or planned.

The case plan is the only Federal or State requirement for assessing mental health care needs. The Texas Department of Protective and Regulatory Services requires that the child's case plan (Initial Child's Service Plan) be completed within 45 days of the child's removal from home. For the 50 children in our sample, 44 percent (22/50) had initial case plans that were completed within the required timeframe established by the State. It is important that initial case plans be completed within required timeframes so that needed mental health services can be provided.

Forty-six percent of foster care providers reported never receiving a medical history for the sampled children in their care

Federal law requires that a child's health record is reviewed, updated, and supplied to the foster care provider at the time of placement. Foster care providers for 46 percent (23/50) of the children in our sample reported never receiving a medical history for the children in their care. However, caseworkers for 19 of these 23 children reported receiving or compiling a medical history for the children.

Foster care providers for children assigned a lower level of care (1 through 3), as defined in Appendix D, were less likely to report receiving a medical history for the children in their care than those providers caring for a child assigned a higher level of care (4 through 6).[24] Of the 23 foster care providers that reported they did not receive a medical history for the sampled children, 74

[24]The difference between these two groups was statistically significant. See Appendix E.

percent (17/23) were caring for children assigned a level of care 1, 2 or 3, and 26 percent (6/23) of these foster care providers were caring for children assigned a level of 4, 5, or 6. Overall, 59 percent (17/29) of foster care providers for children in a level of care 1 through 3 did not receive a medical history, and 29 percent (6/21) of foster care providers for children in a level of care 4, 5 or 6 did not receive a medical history. Foster care providers and caseworkers may not realize the importance of a medical history for children with few or no medical conditions. The requirement that foster care providers are supplied a medical history for the child in their care helps to ensure that all children receive the most effective care possible, regardless of a child's level of care.

Other conditions explaining why foster care providers may not have received medical histories include the following:

- Foster parents stated they did not know they should have received a medical history for the children in their care.
- Foster parents were unable to obtain medical information because the physician for the children in their care was concerned about patient confidentiality.
- Private foster care agencies allow foster parents to view a child's medical record at the agency office, but will not release the information to the foster parent.

Foster care providers for children in our sample who reported that they did not receive a medical history revealed that not having this information made it difficult for them to effectively care for the children placed in their homes. One foster parent who reported not receiving a medical history indicated that it resulted in the child in her care having to receive multiple immunizations at one time so that he could be enrolled in school. Other foster parents reported that children with histories of serious health problems, such as collapsed lungs, severe malnutrition, and chronic ear infections, had been placed in their care without the foster care providers receiving medical histories.

RECOMMENDATIONS

It is important to conduct initial medical, initial dental, and EPSDT examinations for children in foster care, in accordance with Federal guidelines, in order to detect the health care needs of this vulnerable population. Timely completion of initial case plans and the provision of available medical information to these childrens' foster care providers are also important aspects of their care. Therefore, we recommend that:

ACF work with the Texas Department of Protective and Regulatory Services to increase the number of

- Initial medical and dental screenings that are received within required timeframes
- Initial case plans that are completed within required timeframes
- Foster care providers who are supplied available medical information for the children in their care

In Texas, State regulations require that all EPSDT examinations include vision and hearing screenings. Therefore, we recommend that:

CMS work with the Texas Department of Health to

- Evaluate the need for documentation to ensure compliance with routine EPSDT vision and hearing screening guidelines

AGENCY COMMENTS

ACF indicated that it is working with the Texas Department of Protective and Regulatory Services to assist the State in accomplishing goals established in a Program Improvement Plan developed as a result of a Child and Family Services Review. Child and Family Services Reviews measure individual State's performance related to the health and well-being of children in the child welfare system. ACF stated that indicators in the Child and Family Services Review specifically track the areas of concern highlighted in this report, and that one of the goals of Texas' Program Improvement Plan focuses on the health and mental health care of children in the child welfare system. Upon completion of this plan in March 2005, ACF will conduct another Child and Family Services Review. The full text of ACF's comments to the draft report is located in Appendix F.

CMS concurs with our recommendation and indicates that it is available to provide technical assistance to the State to promote provider education regarding the periodicity schedule requirements, and appropriate documentation of vision and hearing screenings. The full text of CMS's comments to the draft report is located in Appendix G.

APPENDIX ~ A

Texas Foster Care and Medicaid Programs

The Health and Human Services Commission is the State agency with primary responsibility for ensuring the delivery of all State health and human services in Texas. The Health and Human Services Commission's State Medicaid Office is responsible for administering medical assistance programs for all eligible recipients enrolled in the Texas Medicaid program. All children in foster care in Texas are eligible for fee-for-service Medicaid.

The Health and Human Services Commission has oversight responsibility for the Texas Department of Protective and Regulatory Services. This agency is charged with protecting children, elder adults, and persons with disabilities from abuse, neglect, and/or exploitation, and with licensing child-care facilities and child-placing agencies. Within the Department of Protective and Regulatory Services, Child Protective Services manages foster care programs in the State. Texas's foster care system utilizes both public (State-administered) and private (contracted) placement agencies, although final responsibility for each child in the managing conservatorship (custody) of the State lies with Department of Protective and Regulatory Services. Funding for foster care services in Texas can come from a variety of sources, including Federal, State, county, community, and private funds, and there is a great deal of variation in sources of funding and methods of service provision by region.

The Health and Human Services Commission also has oversight responsibility for the Texas Department of Health. This agency administers the Texas Health Steps program. The Texas Health Steps program satisfies the Federal requirement that States establish EPSDT programs that provide coverage for preventive child health services to all Medicaid eligible individuals under the age of 21. All children in foster care in Texas are eligible for Texas Health Steps services.

APPENDIX ~ B

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 the end of February 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	17	Residential	1	24	3	5	1	24
2	F	3	Therapeutic	1	12	2	12	1	11
3	F	15	Therapeutic	1	61	2	54	2	22
4	F	7	Family	1	11	2	7	1	11
5	M	11	Therapeutic	1	53	5	4	3	24
6	M	16	Residential	1	10	5	5	2	4
7	F	11	Residential	2	65	2	60	3	7
8	M	10	Family	3	39	2	39	1	38
9	F	3	Family	1	16	1	16	1	14
10	M	11	Therapeutic	1	38	2	30	2	4
11	F	13	Family	1	54	4	24	4	24
12	M	18	Family	1	29	9	2	2	20
13	M	13	Family	1	40	1	24	4	16
14	F	15	Family	1	11	5	9	2	7
15	M	5	Therapeutic	1	13	2	11	4	13
16	F	9	Family	1	27	3	21	1	25
17	F	15	Therapeutic	1	50	7	1	2	1
18	F	11	Family	1	33	1	33	3	10
19	F	17	Residential	1	23	12	2	4	2
20	F	16	Residential	1	36	11	3	3	12
21	M	15	Therapeutic	1	66	4	18	2	8
22	M	3	Rehabilitation	1	13	1	13	1	12
23	F	3	Rehabilitation	1	13	1	13	1	12
24	M	8	Residential	1	30	4	12	2	30
25	F	14	Therapeutic	1	16	2	13	2	7
26	F	4	Rehabilitation	1	17	2	16	(+)	3
27	M	17	Residential	1	28	7	8	1	28
28	F	8	Residential	1	14	3	10	2	7
29	F	2	Family	1	27	4	13	2	7
30	M	17	Residential	2	12	2	12	1	12
31	M	4	Rehabilitation	1	39	1	39	1	38
32	F	1	Family	1	19	2	15	(+)	6
33	F	17	Residential	1	57	14	1	(+)	15

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)
34	F	18	Residential	1	58	2	15	2	44
35	F	3	Therapeutic	3	16	4	9	2	5
36	F	3	Therapeutic	1	34	1	34	2	6
37	M	6	Family	1	19	1	19	3	9
38	F	17	Family	1	46	2	18	2	42
39	F	18	Residential	1	28	2	19	(+)	3
40	F	18	Therapeutic	1	75	5	4	3	8
41	F	15	Residential	1	47	11	5	3	11
42	M	11	Family	2	14	2	12	3	2
43	M	3	Family	2	30	4	1	2	26
44	F	14	Residential	1	12	3	10	3	3
45	F	3	Family	1	44	2	33	1	43
46	M	2	Rehabilitation	1	21	2	20	2	4
47	F	6	Family	1	43	1	43	2	36
48	F	5	Therapeutic	1	51	1	51	6	6
49	M	11	Family	1	37	5	7	1	37
50	M	1	Therapeutic	1	20	2	17	1	12

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 January 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 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 each "episode" in foster care.

(+) Number of caseworkers since last entry into foster care is unknown.

APPENDIX ~ C

Medicaid Claims for Sampled Children

The table below indicates each child's receipt of required services and total claims for September 1, 1999 to August 31, 2002, or entry into care to August 31, 2002, whichever is shorter.

	Number of Medicaid Claims					Initial Exams		Current EPSDT Exams	
ID	Physician's office	Dental services	Prescription medications	Mental health services	Medical history provided to care provider	Medical	Dental	Medical	Dental
1	9	19	0	80	Y	Y	Y	N*	Y
2	3	2	0	0	Y	N	N	Y	Y
3	5	10	1	1	N			N*	N*
4	2	21	0	13	N	Y	Y	Y	Y
5	23	32	4	97	N			Y	N
6	4	4	0	15	Y	N	N	Y	Y
7	30	23	0	14	N			N*	Y
8	19	25	7	72	N	Y	Y	Y	Y
9	13	2	7	4	Y	Y	N*	Y	Y
10	1	18	0	29	Y	N	N	N	Y
11	33	25	0	28	N			Y	Y
12	9	20	4	67	Y	Y	Y	N*	Y
13	8	21	5	28	N	Y	Y	N*	Y
14	1	14	1	21	Y	Y	Y	Y	Y
15	3	11	9	20	N	N	N	Y	Y
16	16	9	1	53	N	N	Y	Y	Y
17	43	49	1	106	Y			Y	Y
18	11	16	0	62	Y	N*	Y	Y	Y
19	15	12	7	98	Y	Y	Y	Y	N
20	17	39	1	88	Y	N*	N	Y	Y
21	10	28	0	21	N			Y	Y
22	2	2	4	0	N	N*	Y	N*	Y
23	0	2	4	0	N	N*	Y	N*	Y
24	9	10	0	62	N	Y	N	Y	N*
25	3	8	1	60	N	N*	Y	N*	Y
26	11	1	6	0	Y	Y	N*	Y	N*
27	12	22	0	42	Y	Y	Y	Y	Y
28	3	13	0	33	N	Y	Y	Y	Y
29	7	2	3	2	Y	Y	N	Y	Y
30	5	11	0	20	Y	Y	Y	N*	Y
31	76	8	35	0	N	Y	N	N	Y
32	15	0	14	0	Y	Y	N	Y	N
33	16	17	6	101	N			Y	Y

	Number of Medicaid Claims					Initial Exams		Current EPSDT Exams	
ID	Physician's office	Dental services	Prescription medications	Mental health services	Medical history provided to care provider	Medical	Dental	Medical	Dental
34	29	25	21	184	Y			N*	Y
35	8	16	0	26	Y	N	Y	Y	Y
36	10	2	8	0	Y	Y	E	Y	E
37	5	7	7	24	N	Y	Y	N	Y
38	30	17	3	191	Y			Y	Y
39	12	41	4	87	Y	N	Y	N*	N*
40	33	32	2	60	N			Y	Y
41	22	33	8	104	Y			Y	Y
42	1	8	3	13	N	Y	N*	Y	Y
43	21	6	8	3	N	Y	Y	Y	N*
44	12	12	0	34	Y	N*	N	Y	Y
45	31	6	10	0	N			Y	Y
46	16	0	24	0	Y	Y	N	Y	N*
47	7	34	5	0	Y			N*	Y
48	81	4	35	0	Y			Y	Y
49	12	22	7	114	Y	N	Y	Y	Y
50	18	0	17	0	N	N	N	N*	N

KEY

Initial Exams: Medical/Dental: "Y" indicates that initial medical/dental examination was received within required timeframes. "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. "E" indicates child was exempt from the requirements.

Current EPSDT Exams: Medical/Dental: "Y" indicates that an EPSDT medical/dental examination was received according to Texas Health Steps frequency timeframes. "N" indicates examination was not received according to Texas Health Steps 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. "E" indicates child was exempt from the requirements.

APPENDIX ~ D

Level of Care Categories for Texas

The Texas Department of Protective and Regulatory Services contracts with a behavioral health care company, Youth for Tomorrow, to assist in the implementation of the Level of Care (LOC) Service System.[25] Youth For Tomorrow uses LOC definitions to determine a child's level of care service needs. Clinically-trained professionals use these definitions to synthesize their knowledge about a child's psychological and social functioning and then assign a single LOC rating from LOC 1 services to LOC 6 services. The LOC rating is determined in the context of a broad review of the clinical information submitted by the Department of Protective and Regulatory Services caseworker.[26]

Level of Care Definitions for Physical and Mental Health[27]

Level of Care 1 Needs

Medically Fragile and Developmentally Delayed: Medical condition is maintained within the normal structure and supervision of a family type environment. No additional services are necessary.

Mental Health: Adequate functioning in all developmental and or environmental areas. There may be transient difficulties, "every-day" worries, and occasional misbehavior, but would be regarded as a "normal" child; responds to "normal" discipline. The caregiver provides routine home environment with guidance and supervision to meet the needs of the child.

Level of Care 2 Needs

Medically Fragile and Developmentally Delayed: Medical condition is maintained within the normal structure and supervision of a family type environment. No additional services are necessary.

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[25]The Department of Protective and Regulatory Services is currently revising its policies to create a new system to replace the LOC service system. Once the new policies are developed, the LOC system will no longer be used. The information contained in this report reflects policy effective at the time of our review in 2001 and 2002.

[26]Retrieved August 6, 2003, from http://www.yft.org/faq/initial_loc.htm.

[27]Retrieved August 6, 2003, from http://www.yft.org/loc_def.htm.

Mental Health: No more than occasional problems in functioning in any area, some acting-out behavior in response to life stresses, but these are brief and transient; minimally disturbing to others, and not considered deviant by those who know them. The caregiver provides routine home environment with supplemental guidance and discipline to meet the needs of the child.

Level of Care 3 Needs

Medically Fragile and Developmentally Delayed: Limited self-care skills require minimal medical assistance. Follow-up medical services and replacement of medical equipment are routine. The child may be ambulatory with assistance. Verbal skills may be limited to communicating basic needs. The child may have frequent or repetitive minor behavioral problems requiring minimal supervision and no more than a minimal risk to self or others.

Mental Health: Frequent or repetitive minor problems in one or more areas; may engage in non-violent antisocial acts, but is capable of meaningful interpersonal relationships. Requires supervision in structured, supportive setting with counseling available from professional or paraprofessional staff.

Level of Care 4 Needs

Medically Fragile and Developmentally Delayed: Requires ongoing assistance in order to perform essential self-care or independent living skills. Medical involvement requires on-site staff skilled in providing appropriate medical assistance with a nurse available on an on-call basis. Periodic adjustments or replacement of medical equipment may be necessary. The child may be non-ambulatory or limited to nonverbal communications. The child may have substantial behavioral problems that require constant supervision and be no more than a moderate risk to self or others.

Mental Health: Substantial problems; has physical, mental, or social needs and behaviors that may present a moderate risk of causing harm to themselves or others, poor or inappropriate social skills, frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships; requires treatment program in a structured setting with therapeutic counseling available by professional staff.

Level of Care 5 Needs

Medically Fragile and Developmentally Delayed: Requires total care with all essential self-help skills. The child may be non-ambulatory or confined to bed. Medical involvement may

require 24-hour on-site (campus) medical or nursing supervision with continuous medical equipment necessary to sustain life support. The child may have severe behavioral problems that require close 24-hour supervision and is a severe risk to self or others.

Mental Health: Severe problems, unable to function in multiple areas. Sometimes willing to cooperate when prompted or instructed, but may lack motivation or ability to participate in personal care or social activities or is severely impaired in reality testing or in communications. May exhibit persistent or unpredictable aggression, be markedly withdrawn and isolated due to either mood or thought disturbance, or make suicidal attempts. Presents a moderate to severe risk of causing harm to self or others. Requires 24-hour supervision by multiple staff in limited access setting.

Level of Care 6 Needs

Medically Fragile and Developmentally Delayed: N/A

Mental Health: Very severe impairment(s), disabilities or needs, consistently unable or unwilling to cooperate in own care. May be severely aggressive or exhibit self-destructive behavior or grossly impaired in reality testing, communication, cognition, affect, or personal hygiene. May present severe to critical risk of causing serious harm to self or others. Needs constant supervision (24-hour care) with maximum staffing, in a highly structured setting.

APPENDIX ~ E

Analysis of Medical History and Level of Care

Level of Care/ Received Medical History	Did Receive History	Did Not Receive History	Total
Level of care 1-3	12	17	29
Level of care 4-6	15	6	21
Total	27	23	50

$p = 0.0354$ (degrees of freedom = 1; chi-square = 4.4275)

APPENDIX ~ F

Agency Comments - ACF

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

OCT 14 2003

TO: Dara Corrigan
Acting Principal Deputy
Inspector General

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

SUBJECT: Office of Inspector General (OIG) Draft Report, "Children's Use of Health Care Services While in Foster Care: Texas," OEI-07-00-00641

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

Should you have questions or need additional information, 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 (OIG) DRAFT REPORT: "CHILDREN'S USE OF HEALTH CARE SERVICES WHILE IN FOSTER CARE: TEXAS," OEI-07-00-00641

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

OIG Recommendations

To ensure that children in foster care receive health care services in accordance with federal guidelines, OIG recommends that:

ACF work with the Texas Department of Protective and Regulatory Services to increase the number of

- Initial medical and dental screenings that children receive within required timeframes
- Initial case plans that are completed within required timeframes
- Foster care providers who are supplied available medical information for the [foster] children in their care.

ACF Comments

ACF finalized a Program Improvement Plan (PIP) with the Texas Department of Protective and Regulatory Services on May 30, 2003, in response to a Child and Family Services (CFS) review. One of the goals of the PIP is to increase by 13.1 percent the number of cases that are found to be in substantial conformity with the well-being measures related to health and mental health care for children in the child welfare system. This goal is to be achieved by March 2005.

In the 2002 Texas CFS review, 72.9 percent of the cases reviewed were rated as having substantially achieved this outcome. Ninety percent is required for an overall rating of substantial conformity. States are allowed to negotiate a reasonable objective to work toward the goal in the PIP. ACF is providing guidance to assist Texas in accomplishing the plans laid out in the PIP. Additionally, ACF monitors the State's efforts to assess its follow-through on a quarterly basis. Indicators in the CFS review specifically track the above areas of concern recommended in the OIG report. Once Texas completes the required PIP, another CFS review will be performed to assess the State's progress.

APPENDIX ~ G

Agency Comments - CMS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: DEC - 5 2003

TO: Dara Corrigan
Acting Principal Deputy Inspector General

FROM: Thomas A. Scully
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Children's Use of Health Care Services While in Foster Care: Texas* (OEI-07-00-00641)

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

OIG Recommendation

The CMS should work with the Texas Department of Health to evaluate the need for documentation to ensure compliance with routine EPSDT vision and hearing screening guidelines.

CMS Response

We concur. The CMS Dallas Regional Office (RO) staff can work with the Texas Department of Health to ensure that Medicaid-eligible children are receiving appropriate vision and hearing services. While there are no Federal documentation requirements, the RO staff can work with the State to ensure that providers are knowledgeable of the required periodicity schedule of vision and hearing screens and to provide technical assistance if necessary regarding the appropriate documentation of EPSDT screenings.

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:

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