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OFFICE OF INSPECTOR GENERAL

FOSTER CARE CHILDREN'S USE OF MEDICAID SERVICES IN OREGON

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUN - 8 2004

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

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: George F. Grob
Acting Deputy Inspector General
for Evaluation and Inspections

SUBJECT: OIG Final Report: "Foster Care Children's Use of Medicaid Services in Oregon," OEI-02-00-00363

Attached for your review is a final report that assesses whether sampled Oregon foster care children are receiving Medicaid health care services. We conducted this inspection in response to concerns about the health care that foster care children are receiving. Oregon is one of eight States being evaluated.

Our analysis of 2 years of Medicaid claims for a random sample of 50 Oregon foster care children and interviews with their caseworkers and caregivers reveal that the children in the sample have Medicaid coverage and access to services. Targeted case management is the most common and most costly Medicaid claim for children in our sample. Yet, we found that recipients do not receive any extra, or even ordinary, health care as a result of targeted case management. Twenty of the 50 sampled foster care children do not have preventive care claims during the study period. This lack of preventive care may be due, in part, to the belief of some Oregon officials that Oregon is not bound by any Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements. In fact, Oregon is bound by EPSDT requirements and is relieved only from its obligation to pay for services required to treat a condition identified during an EPSDT screening that are beyond the scope of the benefits package available to an individual receiving Medicaid. For some foster care children in the sample, caregivers have difficulty obtaining medical records and accessing dental and mental health services. In addition, sampled children placed out-of-State experience problems obtaining medical coverage.

We believe that the Administration for Children and Families (ACF) and the Centers for Medicare & Medicaid Services (CMS) should work with the State of Oregon to ensure that all eligible foster care children receive appropriate health care services. Accordingly, we recommend that CMS review the use of targeted case management for foster care

children in Oregon to ensure that it is consistent with State plan provisions and current CMS requirements for this service. CMS may want to review the use of targeted case management for foster care children in other States to determine the nature and cost of this service. Also, CMS should work with Oregon to clarify the intent of Oregon's 1115 waiver and the State's obligations under EPSDT. ACF and CMS should work with Oregon to promote preventive health care that is consistent with EPSDT guidelines. Finally, ACF should work with Oregon and involved parties, such as the State child welfare administrators and the administrators of the Interstate Compact on the Placement of Children, to address the health care needs of foster care children placed across State lines.

In response to our recommendations, CMS is completing a policy letter to the State Medicaid Directors that will define targeted case management activities that can be claimed for Federal financial participation from the Medicaid program; adding two authorities to Oregon's waiver list that will clarify the intent; and working with the State to promote preventive health care that is consistent with EPSDT guidelines. ACF reports that it is actively working with Oregon in the areas of managed care, training, and follow-up care. ACF plans to form a panel of State child welfare administrators, State foster care managers, State adoption managers, and Interstate Compact on the Placement of Children administrators to address the issues of placing foster care children across State lines. We also received comments from the State of Oregon. Oregon stated that they plan to continue to work with ACF and CMS to clarify current policies and practices and to improve future program delivery.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me or one of your staff may contact Elise Stein, Director, Public Health and Human Services Branch, at (202) 619-2686 or through e-mail (Elise.Stein@oig.hhs.gov). To facilitate identification, please refer to report number OEI-02-00-00363 in all correspondence.

Attachment

ABSTRACT

We reviewed a random sample of 50 children in foster care and found that they have Medicaid coverage and access to services. Targeted case management is the most common and most costly Medicaid claim for children in our sample. Yet, we found that recipients do not receive any extra, or even ordinary, health care as a result of receiving targeted case management. Twenty of the 50 sampled foster care children did not have preventive care claims during the study period. This lack of preventive care may be due, in part, to the belief of some Oregon officials that Oregon is not bound by any Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements. In fact, Oregon must comply with EPSDT requirements and pay for preventive care unless the EPSDT screening identifies a condition that is beyond the scope of the benefits package available to an individual. For some foster care children in the sample, caregivers have difficulty obtaining medical records and accessing dental and mental health services. In addition, sampled children placed out-of-State experience problems obtaining medical coverage. The Centers for Medicare & Medicaid Services (CMS) and the Administration for Children and Families (ACF) concurred with OIG recommendations that: CMS review the use of targeted case management; CMS clarify the intent of the EPSDT portion of Oregon's 1115 waiver; ACF and CMS remind Oregon to cover and pay for preventive health care consistent with EPSDT; and ACF address the health care needs of foster care children placed across State lines.

OBJECTIVE

To determine whether Oregon's foster care children are receiving Medicaid health care services.

BACKGROUND

Currently, there are an estimated 534,000 children in foster care nationwide, and many of them are reportedly in poor health. Compared with children from the same socioeconomic background, foster care children suffer much higher rates of serious emotional and behavioral problems, chronic physical disabilities, birth defects, and developmental delays. Despite their need, it appears that many foster care children are not receiving adequate health care.

This inspection focuses on the State of Oregon and is part of a larger body of work in which eight States are being evaluated. The analysis includes 2 years of Medicaid claims for 50 Oregon foster care children and interviews with their caseworkers and caregivers.

FINDINGS

Forty-nine of 50 foster care children in the sample have Medicaid coverage and access to services

The foster care children in the sample in Oregon have medical coverage and are accessing health care services. During the 2-year inspection period, the vast majority of children in the sample (49 out of 50) have at least 1 Medicaid claim for the time they were in foster care. Overall, the number of Medicaid claims per child in the sample ranges from 0 to 472. The majority of caseworkers and caregivers report that their foster care children have access to needed medical care.

Targeted case management is the most common and most costly Medicaid claim for Oregon foster care children in the sample

Representatives of Oregon Medicaid define targeted case management services as assisting an individual in gaining access to additional services. Targeted case management claims account for 75 percent of all Medicaid health care payments for

the sample Oregon foster care children. Over the study period, Oregon's State Office for Services to Children and Families collected approximately $604 to $800 per month, per foster care child from Medicaid for targeted case management. These payments total $710,420 for our sample. We estimate the total payments for targeted case management for our sample universe to be approximately $71 million over the study period. It appears that recipients do not receive any extra, or even ordinary, health care as a result of receiving targeted case management.

Twenty of the 50 foster care children in the sample do not have preventive care claims

Twenty children in the sample show no preventive claims at all over 2 years. Eighteen of these 20 have been in continuous foster care for a year or more. None of the 50 children have Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) claims. The lack of preventive care claims may be due to Oregon's lack of a clear periodicity schedule for preventive care and the belief of some State officials that Oregon is not bound by any EPSDT requirements. In addition, we found that confusion exists regarding the EPSDT portion of the State's Section 1115 waiver, which relieves Oregon only from its obligation to pay for services required to treat a condition identified during an EPSDT screening that are beyond the scope of the benefits package available to an individual receiving Medicaid.

Some children face problems due to incomplete medical records, access to certain health care services, and out-of-State medical coverage

Medical records for children in the sample are often incomplete, and it appears that caseworkers may not be transferring the medical history to caregivers. Foster care children also face difficulties accessing dental and mental health services, although most children are able to get needed care eventually. Problems include wait time for appointments, lack of Medicaid providers, dissatisfaction with quality of care, and trouble determining which dentists in the area are Medicaid providers. In addition, foster care children placed out-of-State have difficulty obtaining medical coverage in their new State.

RECOMMENDATIONS

We believe that the Administration for Children and Families (ACF) and the Centers for Medicare & Medicaid Services (CMS) should work with the State of Oregon to ensure that all eligible foster care children receive appropriate health care services. Accordingly, we recommend that:

- CMS review the use of targeted case management for foster care children in Oregon to ensure that it is consistent with State plan provisions and current CMS requirements for this service. CMS may also want to consider reviewing the use of targeted case management for foster care children in other States to determine the nature and the cost of this service.
- CMS work with Oregon to clarify the State's waiver and the State's obligations under EPSDT. CMS should also revise the incorrect citation in the EPSDT portion of Oregon's 1115 waiver.
- ACF and CMS work with Oregon to promote preventive health care that is consistent with EPSDT guidelines.
- ACF work with Oregon and involved parties, such as the State child welfare administrators and the administrators of the Interstate Compact on the Placement of Children (ICPC), to address the health care needs of foster care children placed across State lines.

Agency Comments

We received comments from CMS and ACF. The full text of the comments are included in Appendix G. CMS concurs with our recommendations. In regard to targeted case management (TCM), CMS notes that it is "completing a major policy letter to the State Medicaid Directors that will define TCM activities that can be claimed for Federal financial participation from the Medicaid program." We encourage CMS to issue this policy letter as soon as possible and to share it with all State child welfare agencies as well as the State Medicaid Directors.

We are pleased that CMS is adding two authorities to the list of waived statutory provisions for Oregon that will clarify the terms of the waiver. CMS will also work with Oregon to ensure

the State understands that Oregon has obligations under the EPSDT program.

CMS agrees to work with the State to promote preventive health care that is consistent with EPSDT guidelines. It is our hope that these efforts will include the formulation of a clear periodicity schedule, as required by the EPSDT program.

In its comments, ACF notes that it is actively working with Oregon in the areas of managed care, training, and follow-up care. We encourage ACF to continue its current efforts. We also encourage ACF to address actively the issue of preventive care for foster care children, possibly through the Oregon Program Improvement Plan. The Oregon Program Improvement Plan was developed as a result of an ACF Child and Family Services Review, which measures individual States' performance related to the health and well being of children in the child welfare system. Action Step 23.2.3 in the Oregon Program Improvement Plan calls for a clear policy for children receiving adequate, timely, necessary and culturally-competent mental health, medical and dental services. We believe preventive care should be thoroughly addressed in this policy.

ACF plans to form a panel of State child welfare administrators, State foster care managers, State adoption managers, and ICPC administrators. This panel will "identify barriers, issues and suggested resolutions related to placing children across State lines." We encourage the timely formation of this panel and look forward to receiving the panel's findings.

We also received comments from the State of Oregon. The full text of these comments can be found in Appendix G. The State responded that a medical chart review would have given a more accurate assessment of the services provided. The State believes that the text of the EPSDT portion of the 1115 waiver is correct and that the State carefully administers the targeted case management program. Oregon commented that the medical service problem in interstate placements needs to be addressed at the national level. Oregon plans to continue to work with ACF and CMS to clarify current policies and practices and to improve future program delivery.

TABLE OF CONTENTS

INTRODUCTION

OBJECTIVE

To determine whether Oregon's foster care children are receiving Medicaid health care services.

BACKGROUND

Currently, there are an estimated 534,000 children in foster care nationwide,[1] and many of them are reportedly in poor health. Compared with children from the same socioeconomic background, foster care children suffer much higher rates of serious emotional and behavioral problems, chronic physical disabilities, birth defects, developmental delays, and educational difficulties.[2] According to one source, half of all children in the child welfare system suffer from developmental delays or mental health problems that are serious enough to need clinical intervention.[3] In addition to the needs they share with other children, such as immunizations, routine well-child examinations, and treatment of childhood diseases, foster care children clearly have a greater need for specialized health care services.

Despite their need, it appears that many foster care children are not receiving adequate health care. Many foster parents report difficulty in finding health care professionals who are willing to care for their children. It is estimated that 60 percent of all children in out-of-home care have moderate to severe mental health problems, yet less than one-third of those children receive mental health services.[4] A General Accounting Office (GAO) report issued in May 1995, entitled *Health Needs of Many Young Children are Unknown and Unmet*, found that a significant proportion of young foster care children did not receive critical health-related services in the three locations

[1] Retrieved from http://www.acf.dhhs.gov/programs/cb/dis/afcars/cwstats.html on 1/27/04

[2] *Health Care of Young Children in Foster Care*, Committee on Early Childhood, Adoption and Dependent Care, American Academy of Pediatrics, Pediatrics, Volume 109, Number 3. March 2002, pp 536-541

[3] Pamphlet on "Ensuring the Healthy Development of Foster Care Children", New York State Permanent Judicial Commission on Justice for Children, 1999, page 4

[4] Factsheet: The Health Of Children In Out-Of-Home Care. Child Welfare League of America. Retrieved 3/14/2003 from: http://www.cwla.org/programs/health/healthcarecwfact.htm

studied (Los Angeles County, New York City, and Philadelphia County).[5] In fact, GAO estimated that only 1 percent of these children received Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

Medicaid for Foster Care Children

The Medicaid program provides health care to specified groups of needy individuals. It is administered by the Centers for Medicare & Medicaid Services (CMS) and jointly funded by the Federal and State Governments. Within broad national guidelines, each of the States does the following: establishes its own Medicaid eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own State Medicaid program.[6]

Almost all foster care children are eligible for Medicaid services. According to section 1902 (a)(10)(A)(i)(I) of the Social Security Act, foster care children covered under Title IV-E of the Social Security Act are eligible for Medicaid. Foster care children who are not eligible for Title IV-E usually qualify for Medicaid through other eligibility categories set forth by each State. In fiscal year 2000, Medicaid payments for foster care children nationwide were over $3.3 billion.[7]

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

EPSDT is a Federal entitlement to comprehensive medical services for Medicaid-eligible children under the age of 21. While States have the flexibility to design their own Medicaid programs, the EPSDT program requires each State to provide coverage for comprehensive and preventive child health services to Medicaid-eligible individuals under the age of 21. In general, EPSDT treatment services include all mandatory and optional services available under the Medicaid program. Diagnostic services are covered whenever there is a medical need to conduct further examination. Treatment or medical care must be

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[5] *Healthy Needs of Many Young Children are Unknown and Unmet*, General Accounting Office, GAO/HEHS-95-114, 1995, pages 2 and 5

[6] Retrieved 3/14/2003 from: http://www.cms.hhs.gov/medicaid/mover.asp

[7] *Medicaid Expenditures for Federal Fiscal Year 2000, By Type of Service for Maintenance Assistance Status and Basis of Eligibility All States*; MSIS Report for Federal fiscal year 2000. National Total for Foster Care children, page 3. Retrieved from CMS website on 3/13/03: http://www.cms.gov/medicaid/msis/00total.pdf

provided for any physical or mental conditions discovered by the screening services.

Under EPSDT, States must set distinct periodicity schedules for screening, dental, vision and hearing services, and services must be provided at intervals that meet reasonable standards of medical practice. States must consult with recognized medical organizations involved in child health care, such as the American Academy of Pediatrics, in developing reasonable standards.[8]

Oregon

Child Welfare - Oregon's foster care system is centrally managed. At the time of this inspection, the State had just fewer than 7,400 children in foster care.[9] Also, at that time, the Oregon State Office for Services to Children and Families was responsible for administering child welfare programs, including foster care and adoptions. Since the inspection was conducted, Oregon has reorganized its social service system. The Children, Adults and Families group within the Department of Human Services is currently responsible for administering child welfare programs. During our study period, Oregon had 16 districts with 42 child welfare offices and employed about 949 child welfare caseworkers. Caseworkers in child welfare offices are responsible for the placement, monitoring, and coordination of services for foster care children.

Oregon Medicaid - The Office of Medical Assistance Programs (OMAP) is also within the Department of Human Services. OMAP administers the Medicaid program in Oregon and is responsible for the Medicaid claims data.

In Oregon, Medicaid is administered through the Oregon Health Plan (OHP). OHP offers three types of basic medical coverage: a fee-for-service plan; a managed care plan; and a primary care case management plan.

Oregon Administrative Rules state that foster care children have the right to "ordinary medical, dental, psychiatric, psychological, and hygienic care and treatment when the child's

[8] Retrieved from CMS Website 3/28/03: http://www.cms.gov/medicaid/epsdt/

[9] Child Welfare Outcomes 1999: Annual Report, Section IV-C, State data pages, Oregon (from AFCARS database, FY 99) http://www.acf.dhhs.gov/programs/cb/publications/cwo99/statedata/or.htm

condition requires it."[10] Also under Oregon Administrative Rules, all foster care children in the care and custody of the Department of Human Services receive the State's medical plan benefits. A small number of these children have too much income, such as survivor benefits, to be eligible for Medicaid under Title XIX. In these cases, health benefits are paid with State funds.[11]

Waivers - Under section 1115 of the Social Security Act, which provides the Secretary of the Department of Health and Human Services (HHS) with authority to authorize experimental, pilot, or demonstration projects that are likely to assist in promoting the objectives of the Medicaid statute, HHS approved waivers for the OHP Demonstration Project.

HHS granted Oregon a partial waiver of the EPSDT requirement in 1995. The Section 1115 waiver allows Oregon to eliminate certain health care services in order to extend Medicaid coverage to more people. The text of the waiver states that Oregon is no longer obligated to pay for services required to treat a condition identified during an EPSDT screening that are beyond the scope of the benefit package available to an individual receiving Medicaid.

Oregon now offers a benefits package under the OHP that is based on a list of primary and acute medical and mental illness conditions and services ranked by the Health Services Commission in Oregon.[12] It is called the prioritized list of services and is approved by CMS.

METHODOLOGY

This inspection is based on information gathered from multiple sources: Medicaid claims data; a review of Federal and State laws, regulations, and policies; and interviews with State agency officials, caseworkers, and caregivers.

[10] See Appendix A, Oregon Administrative Rules (OAR): 413-010-0180

[11] See Appendix A, OAR 416-610-0140

[12] From Centers for Medicare & Medicaid Services website, retrieved 3/18/2003: http://www.cms.gov/medicaid/1115/default.asp; http://www.cms.gov/medicaid/1115/orfact.asp

Reasons for State Selection

This inspection focuses on the State of Oregon and is part of a larger body of work in which eight States are being evaluated. Oregon was selected because of its size, centralized child welfare system, and geographic location.

Sample

Our population consisted of 5,004 Oregon children in continuous foster care placement for at least 6 months prior to July 2002. From this population, a simple random sample of 50 children was selected. See Appendices B through D for a comparison of the children in the sample to the population and a more detailed description of children in the sample.

The size of the sample limits our ability to estimate the population from the sample. However, in the case of the amount spent for targeted case management claims, the variability of these amounts was relatively small (either $674 or $800, depending on what month the claim was submitted). Since the variability was small, we were able to produce an estimate of the amount spent on targeted case management claims in the population using standard statistical formulas for a simple random sample.

Review of Medicaid Claims Data and State Laws and Policy

Medicaid Claims Data - Oregon Medicaid provided a claims history for 2 years for all of the children in our sample. The data include claims with service dates between July 2000 and July 2002. Encounter data for children in managed care are also included in these data. We refer to all fee-for-service claims and managed care encounters as "claims," unless otherwise specified.

In reviewing the Medicaid claims, we paid particular attention to the types of services, dates of service, and settings, where available. Medicaid claims data are organized into broad categories for analysis. We excluded claims that were not health care related, such as those for transportation and photocopying of medical records. We determined the periods of time the child was in foster care, based on information given by the State Medicaid office and caseworkers. We excluded claims with a service date for a time our data clearly show that the child was not in foster

care during a certain period of time, we included Medicaid claims corresponding to that time in our analysis.

Law and Policy Reviews - We reviewed Federal and State laws and policies pertaining to the health care of foster care children.

Interviews

Caseworker Interviews - We interviewed caseworkers for the children in the sample either in person or by telephone. We spoke with 45 caseworkers, representing 47 children. (Two caseworkers were responsible for more than one child in the sample). Three caseworkers refused to cooperate, despite our repeated attempts to interview them and our repeated attempts to enlist the State's help in encouraging caseworker cooperation. The caseworkers we spoke with were the ones responsible for the children at the time the sample was pulled. Each interview focused on the caseworker's understanding of Medicaid, his or her experience accessing services for the sampled foster care children, and any barriers faced by foster care children in general for the time period of our inspection. Caseworkers also provided a written placement history for each child.

Caregiver Interviews - We interviewed caregivers for 44 of the 50 children in our sample. We were unable to reach and gain the cooperation of six caregivers. We use the term "caregiver" to refer to a foster parent or staff member of a residential facility who is responsible for the child. The caregivers we spoke with were the ones responsible for the children at the time the sample was pulled. Like the caseworker interviews, our interviews with caregivers focused on training, Medicaid, and procuring health services for the child for the time period of our inspection.

State Agency Officials - We held several meetings, both in person and by telephone, with officials from the Oregon State Department of Human Services, State Office for Children and Family Services (now Children, Adults and Families group). Our discussions covered a wide spectrum of information to help us understand how the State's foster care and Medicaid systems are organized.

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

FINDINGS

Forty-nine of 50 foster care children in the sample have Medicaid coverage and access to services

The children in the sample in Oregon have medical coverage, which is required by Federal and State laws. Forty-nine out of 50 foster care children in the sample have at least 1 Medicaid claim between July 2000 and July 2002. Caseworkers and/or caregivers reported that 47 of the children in the sample had Medicaid coverage in Oregon at the time of the interview. The caseworkers and caregivers for the remaining children could not confirm Medicaid coverage.

Most children in the sample have access to Medicaid services

An analysis of Medicaid claims shows that the children in the sample are accessing health care services. As seen in Table 1, the majority of children in the sample (44 out of 50) have at least 1 office visit claim in a 2-year period while they were in foster care. The children in the sample with an office visit claim have an average of over six office visits each. In addition, 80 percent of the children in the sample have a labwork or diagnostic claim.

Overall, the number of Medicaid claims per child in the sample ranges from 0 to 472. The majority of caseworkers and caregivers believe that their foster care children have access to needed medical care. Eighty-seven percent of the caseworkers and 82 percent of the caregivers interviewed report that their child receives needed medical care.

Further, despite reported barriers to access that will be discussed later, foster care children seem to be accessing mental health services in addition to other medical services. Thirty-three children in the sample (66 percent) have 2,079 mental health claims over the 2-year inspection period.

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
Targeted case management	49	962
Office visit	44	295
Labwork/Diagnostic	40	374
Mental health	33	2079
Prescription drug	31	683
Immunization	30	199
Preventive	30	59
Dental	28	314
Emergency Room	23	59
Supplies	22	86
School-based services	19	54
Vision	18	99
Physical/Occupational therapy	8	138
Hospital	7	29
Clinic	7	24
Hearing/Speech	6	27
Other	4	10
Home visit	3	5
Total		**5,496**

Source: OIG Analysis of Oregon Medicaid Claims Data

The foster care children in the sample have a variety of reported conditions. According to caseworkers and caregivers, 82 percent (41 out of 50) of the children in our sample have a medical or mental health problem. These problems include asthma, seizures, depression, anxiety, developmental delays, and abuse. See Appendix D for a description of reported medical and mental health problems of children in the sample.

Foster care children in Oregon sometimes receive health care services outside of Medicaid

According to caregivers and caseworkers, 19 children receive health care services paid for by a source other than Medicaid. These other services are paid for by foster parents, branch funds, or by schools or non-profit organizations. Branch offices have State funds available to them to be used for services not covered by Medicaid. Most of the additional services received were related to mental health treatments or prescription drugs.

Targeted case management is the most common and most costly Medicaid claim for Oregon foster care children in our sample

Case management is allowable under Medicaid (section 1905(a)(19) of the Social Security Act), and defined in section 1915(g)(2) as services which will assist an individual eligible under the State plan in gaining access to needed medical, social, educational and other services. Representatives of Oregon Medicaid define targeted case management services as assisting an individual in gaining access to additional services.

Targeted case management claims account for the majority of Medicaid payments for Oregon foster care children. Forty-nine out of 50 foster care children in our sample have a Medicaid claim for targeted case management services paid to Oregon's State Office for Services to Children and Families. These targeted case management payments occur virtually every month the children are in care during the 2-year study period. This includes children in fee-for-service and managed care plans.

Oregon's State Office for Services to Children and Families collected approximately $604 to $800 per month per foster child for targeted case management over the study period. By way of comparison, Medicaid pays $101 for Medicaid managed care per month per foster child in Oregon. In total, the State collected $710,420 from Medicaid for targeted case management for the 50 children over the 2-year study period. (See Appendix E.) This amount represents an estimated 75 percent of all Medicaid health care payments for these children over this period.

We estimate targeted case management payments for our sample population to be $71 million over the study period (plus

or minus $7 million at the 95 percent confidence level). Our population is a subgroup of all Oregon children in foster care (5,004 out of 7,400).

The State collects the same amount for each child each month the child is in foster care. For instance, all targeted case management claims in November 2000 are $800 each. All targeted case management claims in December 2001 are $674 each. The type and degree of physical and mental health impairments among children showing these targeted case management claims vary widely. While some children appear to have complex medical and emotional problems, others appear to have none. In fact, six children have no reported physical or mental health impairments at all; yet, they each have a targeted case management claim every month along with the rest of the sample.

It appears that recipients do not receive any extra, or even ordinary, health care as a result of receiving targeted case management. As noted earlier, Oregon Medicaid representatives define targeted case management services as assisting an individual in gaining access to additional services. Yet, some children show repeated targeted case management claims during long stretches of time without any other Medicaid services. For example, 1 child has a targeted case management claim every month for 21 consecutive months with only 1 other Medicaid claim for that entire time period. This child's caseworker and caregiver report that the child does not receive other health care services outside of Medicaid. In addition, 17 children in the sample show no preventive care claims but have targeted case management claims for virtually every month that they were in foster care.

Twenty of the 50 foster care children in the sample do not have preventive care claims

Sampled children lack EPSDT claims andpreventive care

The children in the sample may not be receiving an appropriate level of preventive care even though preventive care is covered under the Oregon Health Plan. The Medicaid data show no claims at all for EPSDT services for the children in our sample. Twenty children also show no preventive care claims over the 2-year study period. Eighteen of these children have been in continuous foster care for a year or more. Table 2 provides the ages for these 18 children.

Table 2: Number of Children in Continuous Foster Care for At Least One Year with No Preventive Claims

Age	Number of Children Without Preventive Claims
4	2
6	3
7	2
10	1
12	2
13	1
15	1
16	4
17	2
Total	**18**

Source: OIG Analysis of Oregon Medicaid Data

The EPSDT program requires that each State establish a periodicity schedule at intervals that meet reasonable standards of medical practice. Oregon's prioritized list of Medicaid services includes preventive care, but it does not provide a specific schedule for these services, nor does it provide recipients or providers with a clear periodicity schedule for preventive care.

Confusion exists regarding the EPSDT portion of the State's waiver and implementation

There appears to be confusion regarding the breadth of the EPSDT portion of the 1115 waiver. We learned during interviews that some State representatives are under the impression that Oregon is waived from all EPSDT requirements, which, in fact, it is not. Since EPSDT requires periodic health screenings of children, the belief that Oregon is not bound by EPSDT may contribute to the lack of preventive care we see in the sample children.

The EPSDT portion of Oregon's Section 1115 waiver eliminates the requirement that the State must pay for services to treat a condition identified during an EPSDT screening that are beyond the scope of the benefit package available to the individual. (The benefit package is Oregon's Health Services Commission Prioritized List of Health Services.) However, the waiver approval incorrectly cites the section of the Social Security Act that is being waived as section 1902(a)(43)(A). Section 1902(a)(43)(A) is the requirement that States must inform Medicaid-eligible children of the EPSDT benefits available to them. (Appendix F includes the full text of the EPSDT portion of the waiver and the Social Security Act citation.)

Oregon's Department of Human Services has recently commented that the "State believes that the text of the waiver is correct and that the State is waived from payments of conditions identified during an EPSDT screening." The State's comments do not address other EPSDT requirements. CMS, also in recent comments, explains Oregon's responsibilities. CMS states that the intent of the waiver was that "Oregon would not pay for treatment of conditions identified as part of an EPSDT screening if the treatment of that condition was not covered on the Prioritized List of Health Care Services. When granting this waiver, CMS intended that Oregon would be required to comply with all other requirements of the entire EPSDT program."

Some children face problems due to incomplete medical records, access to certain health care services, and out-of-State medical coverage

Medical records are often incomplete

Caregivers may not be able to meet their legal obligation if they do not receive available medical records. Oregon requires caregivers to maintain a health care record for the child, including medical history and immunization records for a period of 3 years. If a child moves, records must be transferred to the child's new home. (See Appendix A, OAR 309-046-0190 (11).)

Caseworkers may not be transferring medical histories to caregivers. Nineteen of the 44 caregivers interviewed say they did not receive any of their foster child's medical history at all. Yet, 46 out of the 47 caseworkers interviewed indicate that they had received at least some medical history on the foster child in the sample.

Some children encounter problems accessing dental and mental health services

Difficulties accessing dental and mental health services are reported, although most children are able to get needed care eventually. Caregivers for 16 children report a problem accessing needed dental care. Problems include wait time for appointments, lack of Medicaid providers, dissatisfaction with quality of care, and trouble determining which dentists in the area were Medicaid providers. Twelve of the 16 children who experienced a problem report eventually being able to get the care they needed. For example, some caseworkers find alternative sources of funding in the community for braces or other cosmetic dental procedures. When asked about all foster care children, not just children in our sample, nearly half the caseworkers interviewed mention that foster care children in general have problems accessing dental care.

Of the 35 children in the sample with a reported mental health problem, caregivers of 14 complain about mental health services. Specifically, the caregivers of seven of these children feel that the treatment that their child receives is inadequate. The caregivers of the remaining children encounter problems or barriers accessing mental health services, such as wait time for appointments, lack of Medicaid providers, lack of services/coverage, and difficulty finding good quality of care.

Caseworkers, too, cite problems with mental health services. Caseworkers for 16 children feel that foster care children in general, not just those in the sample, experience barriers accessing mental health services.

Caregivers and caseworkers also report problems accessing prescription medications. Nine children in the sample experience problems getting needed prescriptions. Eight of the nine children are eventually able to get the prescriptions they need.

Foster care children placed out-of-State experience problems accessing care

Our data show that five children in the sample were placed out-of-State for at least some portion of the 2-year inspection period. One of the 5 was out of State for 22 months of the inspection period. The other four were out of State for less than 1 year.

It appears from the claims data that all five out-of-State children had Medicaid coverage in Oregon while they were living in Oregon. Yet, only one of them seems to have Medicaid coverage in the other State in which they were placed. Three of the five caregivers cite problems getting a Medicaid card as a barrier to the child's access to health care.

All 50 States, including Oregon, are members of the Interstate Compact on the Placement of Children (ICPC), which requires that a foster child placed over State lines receive adequate protections and support services. It establishes procedures for placement and compels the placing agency, sometimes called the "sending agency," to maintain responsibility for the child. The language of the ICPC, however, does not specifically require that a foster child placed over State lines receive a Medicaid card in his/her new State. According to Oregon's Department of Human Services Client Services Manual, the sending agency is responsible for arranging for medical coverage for the child before the child is placed in another State.

Caseworker involvement with the five out-of-State children in our sample varies. Two caseworkers say that they do not know if their child has a Medicaid card. The caregivers for these children report that their Oregon caseworker is not involved in their child's health care. Two other caseworkers are more involved. For example, one caseworker says she knows that the

child does not have Medicaid coverage, and it is her responsibility to get it, but she has not been successful yet. The child has been without coverage for over a year, and the caregiver is paying for all of the child's medical care out-of-pocket. A second caseworker reports difficulties in getting a Medicaid card in the new State and directing the child to the right place to get care. The caseworker for the remaining child, according to the caregiver, is involved in the child's health care, although the child does not yet have a Medicaid card in the new State.

Despite a lack of medical coverage, all five caregivers of the out-of-State children say that their foster care child has received a well-child exam while in their care. In some cases, the caregiver pays out-of-pocket for this care. These services are not captured in Medicaid claims data.

We believe that the Administration for Children and Families (ACF) and CMS should work with the State of Oregon to ensure that all eligible foster care children receive appropriate health care services. Accordingly, we recommend that:

- CMS review the use of targeted case management for foster care children in Oregon to ensure that it is consistent with State plan provisions and current CMS requirements for this service. CMS may also want to consider reviewing the use of targeted case management for foster care children in other States to determine the nature and the cost of this service.
- CMS work with Oregon to clarify the State's waiver and the State's obligations under EPSDT. CMS should also revise the incorrect citation in the EPSDT portion of Oregon's 1115 waiver.
- ACF and CMS work with Oregon to promote preventive health care that is consistent with EPSDT guidelines.
- ACF work with Oregon and involved parties, such as the State child welfare administrators and the administrators of ICPC, to address the health care needs of foster care children placed across State lines.

Agency Comments

We received comments from CMS and ACF. The full text of the comments are included in Appendix G. CMS concurs with our recommendations. In regard to targeted case management (TCM), CMS notes that it is "completing a major policy letter to the State Medicaid Directors that will define TCM activities that can be claimed for Federal financial participation from the Medicaid program which are integral and inseparable functions of the foster care and child welfare programs, and the social service block grant (Social Security Act (the Act) titles IVB, IVE and XX)." We encourage CMS to issue this policy letter as soon as possible and to share it with all State child welfare agencies as well as the State Medicaid Directors.

We are pleased that CMS is adding two authorities to the list of waived statutory provisions for Oregon that will clarify the terms of the waiver. CMS will also "work with Oregon to ensure the State recognizes that the current waiver…is not a waiver of the requirements of the entire EPSDT program, but rather for

the payment of treatment for conditions identified as part of an EPSDT screening, if such conditions are not covered by the Prioritized List."

CMS agrees to work with the State to promote preventive health care that is consistent with EPSDT guidelines. It is our hope that these efforts will include the formulation of a clear periodicity schedule, as required by the EPSDT program.

In its comments, ACF notes that it is actively working with Oregon in the areas of managed care, training, and follow-up services. The action steps for these efforts are included in the Oregon Program Improvement Plan, developed in response to an ACF Child and Family Services Review. These reviews measure individual States' performance related to the health and well-being of children in the child welfare system. We encourage ACF to continue its current efforts. We also encourage ACF to address actively the issue of preventive care for foster care children. Action Step 23.2.3 in the Oregon Program Improvement Plan calls for a clear policy for children receiving adequate, timely, necessary and culturally competent mental health, medical and dental services. We believe preventive care should be thoroughly addressed in this policy.

ACF plans to form a panel of State child welfare administrators, State foster care managers, State adoption managers, and ICPC administrators. This panel will "identify barriers, issues and suggested resolutions related to placing children across State lines." We encourage the timely formation of this panel and look forward to receiving the panel's findings.

We also received comments from the State of Oregon. The full text of these comments is included in Appendix G. Oregon states that a file review would give a more accurate assessment of services provided. Oregon believes that the text of the EPSDT portion of the 1115 waiver is correct and that the State carefully administers the targeted case management program. Oregon commented that the medical service problem in interstate placements needs to be addressed at the national level. Oregon plans to continue to work with ACF and CMS to clarify current policies and practices and to improve future program delivery.

APPENDIX ~ A

Oregon Administrative Rules (OAR)

413-010-0180 Basic Rights of Children in the State Office for Services to Children and Families's (SOSCF's) Custody.
Each child placed in the legal custody of SOSCF has the following rights:

(1) To be physically placed in the least restrictive environment that can appropriately meet the child's needs;

(2) To be provided basic needs such as adequate food, clothing, and shelter;

(3) To receive care, supervision, and discipline, and to be taught to act responsibly and respect the rights of others;

(4) To be provided ordinary medical, dental, psychiatric, psychological, and hygienic care and treatment when the child's condition requires it;

(5) To be provided with free and appropriate education;

(6) To be protected from physical and sexual abuse, emotional abuse and exploitation;

(7) To be provided services which will reunite the child with his or her own family except when there is clear evidence that the family will not protect the child's welfare;

(8) To be provided services to develop a safe, permanent alternative to the child's own family, when suitable family resources are not available;

(9) To be accorded the least restrictive legal status that is consistent with the child's need for protection or the protection of the community, and to receive advocacy and/or legal representation, when needed, to assure that the child's best interests are presented to the court;

(10) To receive respect and be nurtured in accordance with his or her background, religious heritage, race and culture;

(11) To visit and communicate with members of his or her family within reasonable guidelines as set by the service plan and by the court;

(12) To be involved, in accordance with his or her age and ability and with the law, in making major decisions that affect his or her life;

(13) To receive encouragement and be afforded reasonable opportunities to participate in sports, youth activities in school and neighborhood, and other enrichment programs;

(14) To earn and keep his or her own money and to receive guidance in managing resources to prepare him or her for independence.

416-610-0140 GA Medical Policy

All children in paid substitute care who do not meet the eligibility requirements for Title XIX, will be eligible for General Assistance (GA) medical through OMAP.

309-046-0190 Standards and Practices for Care and Services:

(11) Child Records. A record shall be developed, kept current and available on the premises for each child admitted to the foster home:

(a) General Information. The provider shall maintain a record for each child in the home. The record must include:

(A) The child's name, date of entry into the foster home, date of birth, gender, religious preference, and guardianship status;

(B) The name, addresses, and telephone number of the child's guardian, family, advocate, or other significant person;

(C) The name, address, and telephone number of the child's preferred primary health provider, designated back up health care provider and/or clinic, dentist, preferred hospital, medical card number and any private insurance information, and Oregon Health Plan choice;

(D) The name, address, and telephone number of the child's school program; and

(E) The name, address, and telephone number of the CMHP case manager and representatives of other agencies providing services to the child.

(b) Child records shall be available to representatives of the Division and SOSCF conducting inspections or investigations, as well as to the child, if appropriate, and the guardian, or other legally authorized persons.

(c) Child records shall be kept for a period of three years. If a child moves or the foster home closes, copies of pertinent information shall be transferred to the child's new home.

(d) Medical Information shall include:

(A) History of physical, emotional and medical problems, accidents, illnesses or mental status that may be pertinent to current care;

(B) Current orders for medications, treatments, therapies, use of restraints, special diets and any known food or medication allergies;

(C) Completed Medication Administration Records (MAR) from previous months;

(D) Pertinent medical information such as hospitalizations, accidents, immunization records including Hepatitis B status and previous TB tests, incidents or injuries affecting the health, safety or emotional well-being of the child; and

(E) Documentation or other notation of guardian consent for medical treatment that is not routine, including surgery and anesthesia.

(e) Individual Support Plan. The child's ISP is prepared by the ISP team, and addresses each child's behavior, medical and support needs. The ISP shall be developed within 60 days of placement and updated annually or whenever the child's needs change. The ISP shall describe the child's behavior, medical, support needs and capabilities, and will include by whom, when, and how often care and services will be provided.

(f) Financial records:

(A) A separate financial record must be maintained for each child if the provider manages or handles the child's money.

(B) Each child's financial record shall document the receipt of the room and board fee that is paid to the provider at the beginning of each month.

(C) Any single item over $50 purchased with the child's personal funds, unless otherwise indicated in the child's ISP, will be documented including receipts, in the child's financial record.

(D) The child's ISP team will address how the child's personal spending money will be managed and documented.

(E) If the child has a separate commercial bank account, records from that account must be maintained with the financial record.

APPENDIX ~ B

Comparison of Children in Sample to Universe of Oregon Foster Care Children in Continuous Care for 6 Months

As shown in the table below, gender and ages of the children in the sample are similar to that of the universe of all Oregon foster care children in continuous care for 6 months prior to sample selection. Slightly more than half of the sample and universe are male. Thirty percent of both the sample and universe are age 5 or under, roughly 34 percent are between the ages of 6 and 12, about 36 percent are age 13 or over.

Comparison of Children in Sample to Universe

	50 Children in Sample		Universe	
GENDER	**Count**	**% of Total**	**Count**	**% of Total**
Male	27	54%	2619	52%
Female	23	46%	2385	48%
Total	**50**	**100%**	**5004***	**100%**
AGE				
0-2	10	20%	647	13%
3-5	5	10%	859	17%
6-9	10	20%	981	20%
10-12	7	14%	861	17%
13-17	18	36%	1484	30%
18+	0	0%	172	3%
Total	**50**	**100%**	**5004***	**100%**

Source: Oregon Medicaid Data

* The universe of foster care children in continuous foster care for 6 months prior to sample selection was 5,004 children. The total number of foster care children in care at the time of sample selection was approximately 7,400.

APPENDIX ~ C

Demographics

The table below shows demographic and health characteristics of each of 50 sampled children, including the amount of time they were in foster care during our 2-year study period. Placement setting refers to the type of foster care placement the child was in at the time our sample was pulled in July 2002.

ID	Sex	Age (years)	Placement Setting	Caseworker or Caregiver Reported Medical Problem(s)	Caseworker or Caregiver Reported Mental Health Problem(s)	Amount of Time in Care (Months)
1	M	15	Residential	Y	Y	24
2	M	12	Family	N	Y	19
3	M	15	Family	Y	Y	24
4	M	11	Family	N	Y	24
5	F	6	Family	N	N	23
6	M	16	No Information	Y	Y	24
7	M	13	Family	Y	Y	24
8	M	4	Kinship	Y	N	24
9	F	13	Kinship	N	Y	24
10	M	2	Family	Y	N	24
11	F	14	No Information	N	Y	24
12	M	17	Family	Y	Y	23
13	M	9	Kinship	N	Y	22
14	F	5	Family	Y	Y	24
15	F	12	Family	N	Y	24
16	F	5	Family	N	N	21
17	M	10	No Information	Y	Y	24
18	M	14	Residential	N	Y	24
19	M	16	Family	Y	Y	24
20	F	17	Family	Y	Y	24
21	M	10	Family	N	Y	24
22	M	17	Family	N	Y	24
23	M	2	Family	N	N	24
24	M	6	Family	Y	N	24
25	F	2	No Information	N	N	24
26	M	6	Kinship	Y	Y	10
27	F	7	Family	Y	Y	24
28	M	13	Residential	Y	Y	23
29	M	13	Residential	N	Y	10

ID	Sex	Age (years)	Placement Setting	Caseworker or Caregiver Reported Medical Problem(s)	Caseworker or Caregiver Reported Mental Health Problem(s)	Amount of Time in Care (Months)
30	F	7	Family	Y	Y	22
31	M	16	Kinship	Y	Y	24
32	F	6	Kinship	N	Y	22
33	F	1	Kinship	N	Y	22
34	F	7	Family	N	Y	24
35	M	0	Family	N	N	9
36	F	1	Family	N	N	10
37	M	0	Family	Y	N	10
38	F	1	Family	Y	Y	11
39	F	7	Family	N	Y	24
40	M	1	Kinship	N	N	16
41	F	5	Kinship	Y	N	24
42	F	2	Family	Y	Y	23
43	F	4	No Information	No Information	No Information	24
44	F	13	Family	N	Y	24
45	M	9	Family	Y	Y	24
46	M	11	Family	Y	Y	19
47	F	16	Family	Y	N	24
48	F	11	Kinship	Y	Y	17
49	M	15	Family	N	Y	24
50	F	15	Family	N	N	24

Source: Oregon Medicaid Data, OIG analysis of interview data.

Description of 50 Oregon Foster Care Children in Sample

Medical problems

Caseworkers or caregivers report that approximately 50 percent of the children in our sample have at least one medical problem. Medical problems included acne, asthma, cerebral palsy, drug affected, vision problems, obesity, seizures, allergies, heart problems, and genetic disorders. Caseworkers or caregivers also report that at least 70 percent of the children in our sample have a minimum of 1 mental health problem. The most common mental health problems are related to depression, anxiety, or emotional disorders. Caregivers, in particular, note many problems with anger or behavioral issues. A number of children also suffer from attention-deficit or attention-deficit-hyperactivity disorder and/or post-traumatic stress disorder. Still other children have developmental delays, learning disabilities, and suffer from some form of abuse or neglect.

Types of Medicaid enrollment

Foster care children sometimes have several different placements or go in and out of foster care, so they often participate in a few plans. Most children in our sample were enrolled in more than one type of plan under the Oregon Health Plan during our inspection period. Forty-two children were enrolled in a managed care plan for at least some portion of our study period. Thirty-three were enrolled in a fee-for-service plan, and three were enrolled in a primary care case management plan at some point. In addition, some children were enrolled in one type of plan for medical coverage and another type of plan for dental and/or mental health services. For example, a child might have a fee-for-service medical plan but be enrolled in a dental health maintenance organization plan.

APPENDIX ~ E

Number and Amount of Fee-for-Service and Managed Care Claims for 50 Children in Sample During the 2-year Inspection Period:

Claim Type					
Targeted case management	962	962	$710,420	0	**
Office visit	295	109	$4,934	186	**
Labwork/Diagnostic	374	158	$3,693	216	**
Mental health	2079	517	$57,136	1562	**
Prescription drug	683	666	$55,711	17	**
Immunization	199	74	$8,914	125	**
Preventive	59	34	$2,108	25	**
Dental	314	19	$669	295	**
Emergency Room	59	25	$1,751	34	**
Supplies	86	18	$1,486	68	**
School-based services	54	54	$5,386	0	**
Vision	99	22	$565	77	**
Physical/Occupational therapy	138	44	$2,500	94	**
Hospital	29	7	$1,398	22	**
Clinic	24	3	$433	21	**
Hearing/Speech	27	10	$342	17	**
Other	10	9	$1,886	1	**
Home visit	5	0	0	5	**
TOTAL					

Source: OIG Analysis of Oregon Medicaid Data

** Medicaid pays an average capitated rate of $101.22 per child per month for managed care services.[13] Children in the sample were in managed care a total of 731 out of 1101 months.

[13] http://www.dhs.state.or.us/healthplan/data_pubs/archives/caprates01-02.pdf PricewaterhouseCoopers LLP report on Oregon Health Plan Medicaid Demonstration, Capitation Rate Development, Federal Fiscal Year 2002; 9/25/01, page 18, Exhibit 2, Statewide Capitation Rate for Fiscal Year 2002

APPENDIX ~ F

EPSDT Portion of Oregon's Section 1115 Waiver
(Excerpt from October 15, 2002, Approval Letter from CMS)

"Under the authority of section 1115(a)(1) of the Act, the following waivers of Medicaid and SCHIP State plan requirements contained in section 1902 and 2103 of the Act are granted to enable Oregon to carry out the Oregon Health Plan 2 demonstration through this period:

7. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Section 1902(a)(43)(A)

To waive the requirement that States must pay for services required to treat a condition identified during an EPSDT screening that are beyond the scope of the benefit package available to the individual."

Excerpt from Social Security Act: Section 1902 (a)(43)(A)

"SEC. 1902. [42 U.S.C. 1396a] (a) A State plan for medical assistance must--

(43) provide for--

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1905(a)(4)(B), of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1905(r) and the need for age-appropriate immunizations against vaccine-preventable diseases,"

APPENDIX ~ G

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

DATE: NOV 15 2003

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OCIG
ExecSec
Date Sent 11-18

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OFFICE OF INSPECTOR GENERAL
RECEIVED

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

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

SUBJECT: Office of the Inspector General (OIG) Draft Report: "*Foster Care Children's Use of Medicaid Services in Oregon,*" (OEI-02-00-00363)

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

Recommendation

The CMS should review the use of targeted case management (TCM) for Oregon foster children to ensure that it is consistent with current CMS State plan amendment criteria for this service.

Response

We concur. The CMS agrees to review the use of TCM for Oregon foster children to ensure that it is consistent with current CMS State plan amendment criteria for this service.

The CMS further agrees that it is necessary to ensure that state Medicaid agencies have policies and procedures in place to assure compliance with Federal policy regarding the provision of TCM to children in foster care. The CMS is currently in the process of completing a major policy letter to the State Medicaid Directors that will define TCM activities that can be claimed for Federal financial participation from the Medicaid program which are integral and inseparable functions of the foster care and child welfare programs, and the social service block grant (Social Security Act (the Act) titles IVB, IVE and XX).

Recommendation

The CMS should work with Oregon to resolve the apparent error in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) waiver.

Response

We concur. When CMS granted the current waiver authority, we waived §1902(a)(43)(A) of the Act (the requirement that states must pay for services required to treat a condition identified during an EPSDT screening that are beyond the scope of the benefit package available to the individual). The intent was that Oregon would not pay for treatment of conditions identified as part of an EPSDT screening if the treatment of that condition was not covered on the Prioritized List of Health Care Services. When granting this waiver, CMS intended that Oregon would be required to comply with all other requirements of the entire EPSDT program.

The CMS agrees that adding two additional authorities to Oregon's waiver list would make the intent clearer. Specifically, we will add waivers of §1902(a)(10)(A) and §1902(a)(43)(C) of the Act. The first, that Oregon does not have to make care available to all individuals under title XIX if that care would be for treatment of a condition not covered on the Prioritized List; and the second, providing that Oregon does not have to arrange for the corrective treatment of conditions identified as part of an EPSDT screening if such conditions are not covered on the Prioritized List.

Recommendation

The Administration for Children and Families and CMS work with Oregon to promote preventive health care that is consistent with EPSDT guidelines.

Response

We concur. The CMS will continue to work with Oregon to ensure the State recognizes that the current waiver of §1902(a)(43)(A) of the Act is not a waiver of the requirements of the entire EPSDT program, but rather for the payment of treatment for conditions identified as part of an EPSDT screening, if such conditions are not covered by the Prioritized List. We will work with the State to promote preventive health care that is consistent with EPSDT guidelines.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

DATE: NOV 20 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: "Foster Care Children's Use of Medicaid Services in Oregon," OEI-02-00-00363

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

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

Attachment

IG
EAIG
PDIG ✓
DIG-AS
DIG-EI ✓
DIG-OI
DIG-MP
OCIG
ExecSec ✓
Date Sent 12-2

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OFFICE OF INSPECTOR GENERAL

COMMENTS OF THE ADMINISTRATION FOR CHILDREN AND FAMILIES (ACF) ON THE OFFICE OF INSPECTOR GENERAL (OIG) DRAFT REPORT: "FOSTER CARE CHILDREN'S USE OF MEDICAID SERVICES IN OREGON," OEI-02-00-00363

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

OIG Recommendations:

The issues raised in this inspection are so common that, despite the small sample size, we suspect they are widespread. We believe that the Administration for Children and Families (ACF) and the Centers for Medicare & Medicaid Services (CMS) should work with the State of Oregon to address these potential problems. Accordingly, to help ensure that all eligible foster care children receive appropriate health care services, we recommend that:

- CMS review the use of targeted case management for Oregon foster care children to ensure that it is consistent with current CMS state plan amendment criteria for this service;
- CMS work with Oregon to resolve the apparent error in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) waiver;
- ACF and CMS work with Oregon to promote preventive health care that is consistent with the EPSDT guidelines; and,
- ACF work with Oregon and the state administrators of the Interstate Compact on the Placement of Children to address the health care needs of foster care children placed in other states.

Agency Comments:

ACF is actively working with Oregon on:

- increasing the percent of children enrolled in managed care,
- providing training to foster parents and Department of Human Services staff on how to access health care services, and
- following up on recommendations for mental health treatment.

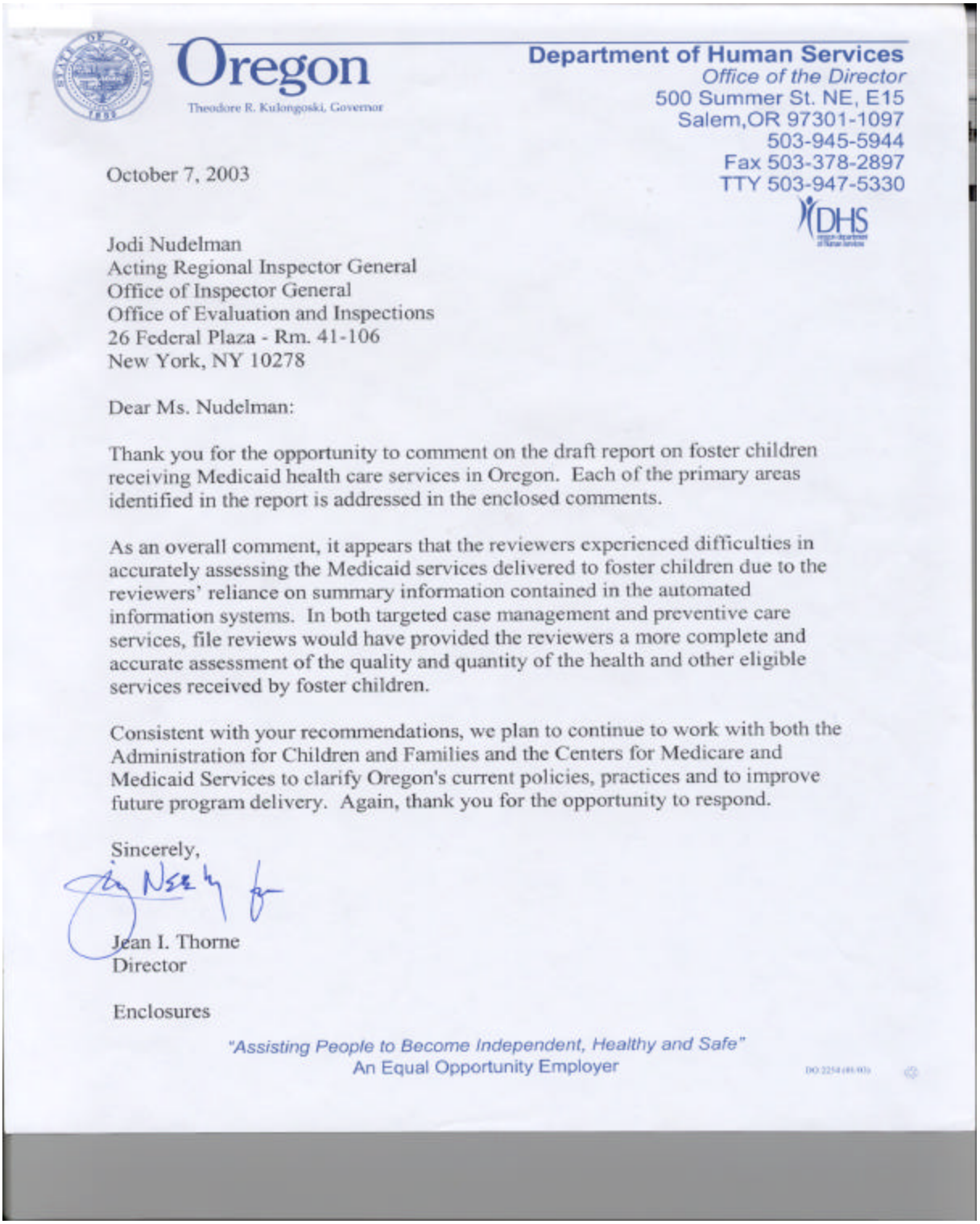
The specific action steps and benchmarks related to these action steps are included in a Program Improvement Plan (PIP) developed in response to a Child and Family Services (CFS) review in Oregon (see attached).

In relation to the last recommendation, the Interstate Compact on the Placement of Children (ICPC) administrators do not have authority over medical services provided to children. The

ICPC does not provide the direction and specificity for providing health care services to children placed across state lines that the Interstate Compact on Adoption and Medical Assistance provides related to Medicaid services provided to children placed in adoption across state lines.

The child welfare directors may be a more appropriate group for ACF to coordinate with related to the medical care needs of children placed out of state. ACF has a work plan during the coming year to develop a panel of state child welfare administrators, state foster care managers, state adoption managers and administrators of the ICPC to identify barriers, issues and suggested resolutions related to placing children across state lines. The concerns about access to medical care for children who are placed across state lines will be brought to the panel's attention.

ACF looks forward to coordinating with CMS related to promoting preventive health care for children who are in foster care in Oregon.



Oregon
Theodore R. Kulongoski, Governor

Department of Human Services
Office of the Director
500 Summer St. NE, E15
Salem,OR 97301-1097
503-945-5944
Fax 503-378-2897
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DHS

October 7, 2003

Jodi Nudelman
Acting Regional Inspector General
Office of Inspector General
Office of Evaluation and Inspections
26 Federal Plaza - Rm. 41-106
New York, NY 10278

Dear Ms. Nudelman:

Thank you for the opportunity to comment on the draft report on foster children receiving Medicaid health care services in Oregon. Each of the primary areas identified in the report is addressed in the enclosed comments.

As an overall comment, it appears that the reviewers experienced difficulties in accurately assessing the Medicaid services delivered to foster children due to the reviewers' reliance on summary information contained in the automated information systems. In both targeted case management and preventive care services, file reviews would have provided the reviewers a more complete and accurate assessment of the quality and quantity of the health and other eligible services received by foster children.

Consistent with your recommendations, we plan to continue to work with both the Administration for Children and Families and the Centers for Medicare and Medicaid Services to clarify Oregon's current policies, practices and to improve future program delivery. Again, thank you for the opportunity to respond.

Sincerely,

Jean I. Thorne
Director

Enclosures

"Assisting People to Become Independent, Healthy and Safe"
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DETAILED COMMENTS
Note: Remarks made by DHHS Office of Inspector General are bold and in quotation marks.

"The link between the targeted case management payment and the child's need was unclear in that several cases had no reported physical or mental health needs, yet there was a targeted case management claim every month."

The definition of targeted case management (TCM) was clarified in a letter issued by CMS, in January 2001. "Sections 1905(a)(19) and 1915(g)(2) of the Social Security Act (the Act) define case management as services which will assist an individual eligible under the State plan in gaining access to needed medical, social, educational, and other services. DHS-Child Welfare TCM is not limited to linking children in foster care to medical, dental or mental health services only. Our training guide for TCM states: "TCM services are **ONLY** those services which **LINK** the **CHILD** to a **RESOURCE** which meets an identified need for medical, social, educational, counseling or other services (see Attachment A).

Our State plan amendment divides case management services into five categories. These categories all include **linking the child to any needed medical, social, educational, or other services.**

1. Assessment - case manager makes preliminary decisions about needed medical, social, educational, or other services and level of agency intervention. They identify any available resource (i.e., community, extended family or professional).
2. Case Planning - case manager develops a case plan, in conjunction with the client and family, to identify goals and objectives which are designed to resolve the issues of concern identified through the assessment process.
3. Case Plan Implementation - case manager will link the client and family with appropriate agencies and medical, social, educational or other services through calling or visiting these resources.
4. Case Plan Coordination - after linkages have been completed, the case manager coordination includes, but is not limited to, personal, mail and telephone contacts with providers, as well as meetings with client and family to assure that services are being provided and used as agreed.
5. Case Plan Reassessment - case manager will continue to determine whether or not medical, social, educational or other services continue to be adequate to meet the goals and objectives identified in the case plan.

To provide quality service to the children in the Oregon's child welfare population, these services are not only eligible, but are essential to meeting the needs of these vulnerable clients. In our on-going efforts to improve child and family outcomes, we expect to see an increase in the frequency of these services.

"Ensure that Oregon's use of targeted case management is consistent with the current CMS State plan amendment criteria for this service."

Oregon carefully administers the TCM program, closely adhering to the state's Medicaid and Cost Allocation plans. We utilize the random moment sample process to allocate case management administrative activities as separate costs, distinct from TCM services. The billing system assures that duplicate payments are not made for more than one TCM provider for the same client in any month. The monthly rate is derived through a formula which calculates the average TCM cost per client served by the state child welfare program.

"Foster care children in the sample may not be receiving preventive care at an appropriate level."

"Sampled children lack preventive care and EPSDT claims."

Medicaid fee-for-service and encounter claims indicate that foster care children in the sample did receive medical services. Medical providers often bill with a medical diagnosis and an appropriate evaluation and management code if a child is being seen for preventive care and a medical issue. The only way to determine if adequate preventive services were performed would be through a medical chart review process.

In reviewing the American Academy of Pediatrics website, information was found recommending that comprehensive screening for children ages 2-20 should occur once every year and that the actual interval rate should be established by state medical consultants. (see: Understanding EPSDT at www.medicalhomeinfo.org/resources/state/Downloads/COInfo/A Physician's Guide to Understanding EPDST.ppt)

The Department of Human Services does not publish a preventive periodicity schedule for our providers. The Health Services Commission Prioritized List of Health Services includes comprehensive Prevention Tables developed by the U.S. Preventive Services task force of recommended services, by age groups, to be included in a preventive examination. The tables include recommended schedules

for individual interventions. The Prevention Tables are included as Attachment One.

We rely on the providers to exercise their best judgement in providing preventive care that is appropriate for the age of the patient and is compliant with the guidelines published by the associations representing their respective disciplines. Our payment system will accept and pay for one preventive exam per year for all Medicaid children.

Oregon does submit EPSDT participation rates annually to CMS. This data is gathered using the ICD-9 codes and the CPT codes for prevention. The reporting interval is one exam every other year. The reporting criteria was established in 2000 using input from the Medicaid Medical Director, the federal guidelines in place at the time and information from other states. Although the reporting criteria reflect one exam every other year, the payment system would accept and pay for an exam every year.

"Confusion exists regarding the EPSDT portion of the State's waiver and implementation."

The State believes that the text of the waiver is correct and the state is waived from payment of conditions identified during an EPSDT screening. This waiver was granted because Oregon used the Health Services Commission Prioritized List of Health Services to determine services that are eligible for payment. Preventive services are covered on the 2001-2003 prioritized list on line 146 for children ages birth through 10 and line 185 for ages above 10. Services are currently covered through line 558.

The Health Services Commission Prioritized List of Health Services includes Prevention Tables by age group. The Prevention Tables were developed by the U.S. Preventive Services Task force and include recommendations for specific age appropriate interventions for both the general population and high-risk groups. The tables also include recommended schedules for these services.

"Foster care children in the sample face some problems."

"Some children encounter problems accessing dental and mental health services."

Dental access is an issue for all Oregonians, not just Medicaid recipients, as Oregon is experiencing a shortage of licensed dentists. Medicaid recipients enrolled in Dental Care Organization often have better access to services than people being served through the fee-for-service network.

The State Medicaid program would never cover costs for cosmetic dental procedures or braces, as they would not be above the payment line on the Health Services Commission's Prioritized List of Health Services.

Every county in Oregon has child mental health capacity. In rural and frontier parts of the state it can be challenging to get specific expertise such as trauma, eating disorder or child psychiatry. In the frontier areas of the state the counties have created a regional structure that employees expertise for specialty consultation.

Oregon's Medicaid Managed Care contracts for mental health services require the contractor to coordinate with allied agencies such as Child Welfare in order to develop methods of serving their members that meet the needs of the agency. The state interviews representatives of allied agencies when performing routine site reviews.

Oregon participated in a national technical assistance initiative aimed at increasing collaboration between Medicaid, child welfare and mental health and increasing access to comprehensive assessments as required by federal regulations. Now that initial pilot projects have been conducted, state-wide planning is underway to increase access to mental health assessments.

Oregon has a method of tracking utilization rates by service type, location and eligibility types. These data are used to identify patterns and trends and avoid over reacting to anecdotal information.

Oregon's Office of Mental Health and Addiction Services staff regularly collaborate with Child Welfare staff at the state, regional and local levels on access, quality and effectiveness and cost of services for children in protective services. In the absence of chart reviews or collecting specific clinical information it is difficult to respond to general statements about concerns related to quality or appropriateness.

Each county service system is subject to a biennial review. State review teams include child/adolescent mental health specialists who interview staff, allied agencies and families and review clinical records. The state team uses the

information gathered for a variety of purposes ranging from technical assistance to formal findings and required actions.

Specialized intensive services such as Psychiatric Residential Treatment are subject to external review by a Professional Review Organization under contract with the state.

Specific Child and Adolescent Intensive Treatment Service Pilot Projects have been implemented that are expanding the availability of flexible community based approaches to serving children with severe emotional/behavioral disorders.

Prescription medications are available for children enrolled in managed care and children served through the fee-for-service delivery system. The fee-for-service system pays for all Medicaid eligible drugs prescribed for diagnoses above the Health Services Commission's Prioritized List of Health Services funding line that meet existing prior authorization requirements. A 96-hour emergency supply will be approved and dispensed if the medical need for the drug is immediate while the request for a prior authorization is being processed (OAR 410-121-0060).

Most managed care organizations have a formulary, restricting the drugs available within each drug class. Prior authorization of non-formulary drugs must be completed within 24 hours and a 72-hour emergency supply must be approved and dispensed if the medical need for the drug is immediate (OAR 410-141-0420).

"Foster care children placed out of State experience problems accessing care."

The Interstate Compact on the Placement of Children requires the sending state to be responsible for the child's financial and medical needs. The caseworker should be exploring, during the home study process, if Medicaid is available to the child in the receiving state. If the child is non-IV-E, the worker should discuss what other medical card options there are in the receiving state, if any. If there isn't any other program option, are there any providers in the receiving state that accept the Oregon medical card? If not, the caseworker needs to carefully consider if this resource is viable for placement. If the placement is adoptive and the receiving state is an ICAMA/reciprocal state, then adoption subsidy can be put into place on the date of placement and ICAMA can issue the medical card. The medical service difficulty can be a significant barrier to the interstate placement of children and needs to be addressed at the national level through a parallel structure to ICAMA (an interstate compact that provides medical benefits for adoptive children moving between member states).

PREVENTION TABLES

Birth to 10 Years

Interventions Considered and Recommended for the Periodic Health Examination

Leading Causes of Death
Conditions originating in perinatal period
Congenital anomalies
Sudden infant death syndrome (SIDS)
Unintentional injuries (non-motor vehicle)
Motor vehicle injuries

Interventions for the General Population

SCREENING
Height and weight [*Ch 21*]
Blood pressure [*Ch 3*]
Vision screen (3-4 yr) [*Ch 33*]
Hemoglobinopathy screen (birth)[1] [*Ch 43*]
Phenylalanine level (birth)[2] [*Ch 44*]
T_4 and/or TSH (birth)[3] [*Ch 45*]
Effects of STDs
FAS, FAE, drug affected infants[4]
Infant motor, hearing, developmental screens
Learning and attention disorders[5]
Signs of child abuse, neglect, family violence

COUNSELING
Injury Prevention [*Ch 57, 58*]
Child safety car seats (age <5 yr)
Lap-shoulder belts (age >5 yr)
Bicycle helmet; avoid bicycling near traffic
Smoke detector, flame retardant sleepwear
Hot water heater temperature <120-130°F
Window/stair guards, pool fence, walkers
Safe storage of drugs, toxic substances, firearms & matches
Syrup of ipecac, poison control phone number
CPR training for parents/caretakers
Infant sleeping position

Diet and Exercise
Breast-feeding, iron-enriched formula and foods (infants & toddlers) [*Ch 22, 56*]
Limit fat & cholesterol; maintain caloric balance; emphasize grains, fruits, vegetables (age >2 yr) [*Ch 56*]
Regular physical activity* [*Ch 55*]

Substance User [*Ch 54*]
Effects of passive smoking*
Anti-tobacco message*

Dental Health [*Ch 61*]
Regular visits to dental care provider*
Floss, brush with fluoride toothpaste daily*
Advice about baby bottle tooth decay*

Mental Health/Chemical Dependency
Parent education regarding:
- Child development
- Attachment/bonding
- Behavior management
- Effects of excess TV watching
- Special needs of child and family due to:
  - Familial stress or disruption
  - Health problems
  - Temperamental incongruence with parent
  - Environmental stressors such as community violence or disaster, immigration, minority status, homelessness
- Referral for MHCD and other family support services as indicated

[1]Whether screening should be universal or targeted to high-risk groups will depend on the proportion of high-risk individuals in the screening area, and other considerations (See Ch 43). [2]If done during first 24 hr of life, repeat by age 2 wk. [3]Optimally between day 2 and 6, but in all cases before newborn nursery discharge. [4]Parents with alcohol and/or drug use. Children with history of intrauterine addiction. Physical and behavioral indicators: hypertension, gastritis, esophagitis, hematological disorders, poor nutritional status, cardiac arrhythmias, neurological disorders, intrauterine growth retardation, mood swings, difficulty concentrating, inappropriateness, irritability or agitation, depression, bizarre behavior, abuse and neglect, behavior problems. [5]Consider screening with full DSM-IV criteria for attention deficit disorder, inattentive or hyperactive types, in children with significant overall academic or behavioral difficulty including academic failure and/or learning difficulty, especially in reading, math or handwriting.

*The ability of clinical counseling to influence this behavior is unproven.

Birth to 10 Years (Cont'd)

Interventions for the General Population (Cont'd)

IMMUNIZATIONS [*Ch 65*]	Hepatitis B[5]
Diphtheria-tetanus-pertussis (DTP)[1]	Varicella[6]
Oral poliovirus (OPV)[2]	
Measles-mumps-rubella (MMR)[3]	**CHEMOPROPHYLAXIS**
H. influenzae type b (Hib) conjugate[4]	Ocular prophylaxis (birth) [*Ch 27*]

[1]2, 4, 6, and 12-18 mo; once between ages 4-6 yr (DTaP may be used at 15 mo and older). [2]2, 4, 6-18 mo; once between ages 4-6 yr. [3]12-15 mo and 4-6 yr. [4]2, 4, 6 and 12-15 mo; no dose needed at 6 mo if PRP-OMP vaccine is used for first 2 doses. [5]Birth, 1 mo, 6 mo; or, 0-2 mo, 1-2 mo later, and 6-18 mo. If not done in infancy: current visit, and 1 and 6 mo later [6]12-18 mo; or any child without history of chickenpox or previous immunization. Include information on risk in adulthood, duration of immunity, and potential need for booster doses.

Interventions for the High-Risk Population

POPULATION	POTENTIAL INTERVENTIONS (See detailed high-risk definitions)
Preterm or low birth	Hemoglobin/hematocrit (HR1)
Infants of mothers at risk for HIV	HIV testing
Low income; immigrants	Hemoglobin/hematocrit (HR1); PPD (HR3)
TB contacts	PPD (HR3)
Native American/Alaska Native	Hemoglobin/hematocrit (HR1); PPD (HR3); hepatitis A vaccine (HR4); pneumococcal vaccine (HR5)
Residents of long-term care facilities	PPD (HR3); hepatitis A vaccine (HR4); influenza vaccine (HR6)
Certain chronic medical conditions	
Increased individual or community lead exposure	Blood lead level (HR7)
Inadequate water fluoridation	Daily fluoride supplement (HR8)
Family h/o skin cancer; nevi; fair skin, eyes, hair	Avoid excess/midday sun, use protective clothing* (HR9)
History of multiple injuries	Screen for child abuse, neurological, mental health conditions
High risk for mental health disorders	Increased well-child visits (HR10)

High Risk Groups

HR1 = Infants age 6-12 mo who are: living in poverty, black, Native American or Alaska Native, immigrants from developing countries, preterm and low birth weight infants, infants whose principal dietary intake is unfortified cow's milk (see Ch. 22).

HR2 = Infants born to high-risk mothers whose HIV status is unknown. Women at high risk include: past or present injection drug use; persons who exchange sex for money or drugs, and their sex partners; injection drug-using, bisexual, or HIV-positive sex partners currently or in past; persons seeking treatment for STDs; blood transfusion during 1978-1985 (see Ch. 28).

HR3 = Persons infected with HIV, close contacts of persons with known or suspected TB, persons with medical risk factors associated with TB, immigrants from countries with high TB prevalence, medically underserved low-income populations (including homeless), residents of long-term care facilities (see Ch. 25). See Ch. 25 for indications for BCG vaccine.

Birth to 10 Years (Cont'd)

HR4 = Persons >2 yr living in areas where the disease is endemic and where periodic outbreaks occur (e.g., certain Alaska Native, Pacific Island, Native American, and religious communities). Consider for institutionalized children aged >2 yr. Clinicians should also consider local epidemiology (see Ch. 65-67).

HR5 = Immunocompetent persons >2 yr with certain medical conditions, including chronic cardiac or pulmonary disease, diabetes mellitus, and anatomic asplenia. Immunocompetent persons >2 yr living in high-risk environments or social settings (e.g., certain Native American and Alaska Native populations) (see Ch. 66).

HR6 = Annual vaccination of children >6 mo who are residents of chronic care facilities or who have chronic cardiopulmonary disorders, metabolic diseases (including diabetes mellitus), hemoglobinopathies, immunosuppression, or renal dysfunction (see Ch. 66). See Ch. 66 for indications for amantadine/rimantadine prophylaxis.

HR7 = Children about age 12 mo who: 1) live in communities in which the prevalence of lead levels requiring individual intervention, including residential lead hazard control or chelation, is high or undefined; 2) live in or frequently visit a home built before 1950 with dilapidated paint or with recent or ongoing renovation or remodeling; 3) have close contact with a person who has an elevated lead level; 4) live near lead industry or heavy traffic; 5) live with someone whose job or hobby involves lead exposure; 6) use lead-based pottery; or 7) take traditional ethnic remedies that contain lead (see Ch. 23).

HR8 = Children living in areas with inadequate water fluoridation (<O.6 ppm) (see Ch. 61).

HR9 = Persons with a family history of skin cancer, a large number of moles, atypical moles, poor tanning ability, or light skin, hair, and eye color (see Ch. 12).

HR10 = Having a: chronically mentally ill parent; substance abusing parent; mother who began parenting as a teen. Living at or below poverty. Having: parents involved in criminal behavior; experienced an out-of-home placement(s), multiple moves, failed adoption(s). Being homeless. Having suffered physical, emotional or sexual abuse, or severe neglect. Having: a chronic health problem in the family; an absence of a family support system. Being substance affected at birth.

Ages 11-24 Years

Interventions Considered and Recommended for the Periodic Health Examination

Leading Causes of Death
Motor vehicle/other unintentional injuries
Homicide
Suicide
Malignant neoplasms
Heart diseases

Interventions for the General Population

SCREENING
Height and weight [*Ch 21*]
Blood pressure[1] [*Ch 3*]
Papanicolaou (Pap) test[2] [*Ch 9*]
Chlamydia screen[3] (females <20 yr) [*Ch 29*]
Rubella serology or vaccination hx[4] (females >12 yr) [*Ch 32*]
Learning and attention disorders[5]
Signs of child abuse, neglect, family violence
Alcohol, inhalant, illicit drug use[6] [*Ch 52*]
Eating disorders[7]
Anxiety and mood disorders[8]
Suicide risk factors[9]

COUNSELING
Injury Prevention [*Ch 57,58*]
Lap/shoulder belts
Bicycle/motorcycle/ATV helmet*
Smoke detector*
Safe storage/removal of firearms* [*Ch 50, 59*]
Smoking near bedding or upholstery

Substance Use
Avoid tobacco use [*Ch 54*]
Avoid underage drinking & illicit drug use* [*Ch 52, 53*]
Avoid alcohol/drug use while driving, swimming, boating, etc.* [*Ch 57, 58*]

Sexual Behavior [*Ch 62, 63*]
STD prevention: abstinence*; avoid high-risk behavior*; condoms/female barrier with spermicide*
Unintended pregnancy: contraception

Diet and Exercise
Limit fat & cholesterol; maintain caloric balance; emphasize grains, fruits, vegetables [*Ch 56*]
Adequate calcium intake (females) [*Ch 56*]
Regular physical activity* [*Ch 55*]

Dental Health [*Ch 61*]
Regular visits to dental care provider*
Floss, brush with fluoride toothpaste daily*

Mental Health/Chemical Dependency
Parent education regarding:
- Adolescent development
- Behavior management
- Effects of excess TV watching
- Special needs of child and family due to:
  - Familial stress or disruption
  - Health problems
  - Temperamental incongruence with parent
  - Environmental stressors such as community violence or disaster, immigration, minority status, homelessness
- Referral for MHCD and other family support services as indicated

[1]Periodic BP for persons aged > 21 yr. [2]If sexually active at present or in the past: q < 3 yr. If sexual history is unreliable, begin Pap test at age 18 yr. [3]If sexually active. [4]Serologic testing, documented vaccination history, and routine vaccination against rubella (preferably with MMR) are equally acceptable alternatives. [5]Consider screening with full DSM-IV criteria for attention deficit disorder, inattentive or hyperactive types, in children with significant overall academic or behavioral difficulty including academic failure and/or learning difficulty, especially in reading, math or handwriting. [6]Persons using alcohol and/or drugs. Physical and behavioral indicators: liver disease, pancreatitis, hypertension, gastritis, esophagitis, hematological disorders, poor nutritional status, cardiac arrhythmias, alcoholic myopathy, ketoacidosis, neurological disorders: smell of alcohol on breath, mood swings, memory lapses or losses, difficulty concentrating, blackouts, inappropriateness, irritability or agitation, depression, slurry speech, staggering gait, bizarre behavior, suicidal indicators, sexual dysfunction, interpersonal conflicts, domestic violence, child abuse and neglect, automobile accidents or citation arrests, scholastic or behavior problems, secretiveness or vagueness about personal or medical history. [7]Persons with a weight >10% below ideal body weight, parotid gland hypertrophy or erosion of tooth enamel. Females with a chemical dependency. [8]In women who are at increased risk, diagnostic evaluation should include an assessment of history of sexual and physical violence, interpersonal difficulties, prescription drug utilization, medical and reproductive history. [9]Recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illness, living alone, homelessness, or recent bereavement.

*The ability of clinical counseling to influence this behavior is unproven

Ages 11-24 Years (Cont'd)

Interventions for the General Population (Cont'd)

IMMUNIZATIONS [*Ch 65, 66*]
Tetanus-diphtheria (Td) boosters (11-16 yr)
Hepatitis B[1]
MMR (11-12 yr)[2]
Varicella (11-12 yr)[3]
Rubella[4] (females >12 yr) [*Ch 32*]

CHEMOPROPHYLAXIS
Multivitamin with folic acid (females planning/ capable of pregnancy) [*Ch 42*]

[1]If not previously immunized: current visit, 1 and 6 mo later. [2]If no previous second dose of MMR. [3]If susceptible to chickenpox. [4]Serologic testing, documented vaccination history, and routine vaccination against rubella (preferably with MMR) are equally acceptable alternatives.

Interventions for the High-Risk Population

POPULATION	POTENTIAL INTERVENTIONS (See detailed high-risk definitions)
High-risk sexual behavior	RPR/VDRL (HR1); screen for gonorrhea (female) (HR2), HIV (HR3), chlamydia (female) (HR4); hepatitis A vaccine (HR5)
Injection or street drug use	RPR/VDRL (HR1); HIV screen (HR3); hepatitis A vaccine (HR5); PPD (HR6); advice to reduce infection risk (HR7)
TB contacts; immigrants; low income	PPD (HR3)
Native American/Alaska Native	Hepatitis A vaccine (HR5); PPD (HR6); pneumococcal vaccine (HR8)
Certain chronic medical conditions	PPD (HR6); pneumococcal vaccine (HR8); influenza vaccine (HR9)
Settings where adolescents and young adults congregate	Second MMR (HR10)
Susceptible to varicella, measles, mumps	Varicella vaccine (HR11); MMR (HR12)
Blood transfusion between 1975-85	HIV screen (HR3)
Institutionalized persons	Hepatitis A vaccine (HR5); PPD (HR6); influenza vaccine (HR9)
Family h/o skin cancer; nevi; fair skin, eyes, hair	Avoid excess/midday sun, use protective clothing* (HR9)
Prior pregnancy with neural tube defect	Folic acid 4.0 mg (HR14)
Inadequate water fluoridation	Daily fluoride supplement (HR8)
History of multiple injuries	Screen for child abuse, neurological, mental health conditions
High risk for mental health disorders	Increased well-child/adolescent visits (HR16)

High Risk Groups

HR1 = Persons who exchange sex for money or drugs, and their sex partners; persons with other STDs (including HIV); and sexual contacts of persons with active syphilis. Clinicians should also consider local epidemiology (see Ch. 26).

HR2 = Females who have: two or more sex partners in the last year; a sex partner with multiple sexual contacts; exchanged sex for money or drugs; or a history of repeated episodes of gonorrhea. Clinicians should also consider local epidemiology (see Ch. 27).

Ages 11-24 Years (Cont'd)

HR3 = Males who had sex with males after 1975; past or present injection drug use; persons who exchange sex for money or drugs, and their sex partners; injection drug-using, bisexual or HIV-positive sex partner currently or in the past; blood transfusion during 1978-85; persons seeking treatment for STDs. Clinicians should also consider local epidemiology (see Ch. 28).

HR4 = Sexually active females with multiple risk factors including: history of prior STD; new or multiple sex partners; age < 25; nonuse or inconsistent use of barrier contraceptives; cervical ectopy. Clinicians should consider local epidemiology of the disease in identifying other high-risk groups (see Ch. 29).

HR5 = Persons living in areas where the disease is endemic and where periodic outbreaks occur (e.g., certain Alaska Native, Pacific Island, Native American, and religious communities); men who have sex with men; injection or street drug users. Vaccine may be considered for institutionalized persons. Clinicians should also consider local epidemiology (see Ch. 66, 67).

HR6 = HIV positive, close contacts of persons with known or suspected TB, persons with medical risk factors associated with TB, immigrants from countries with high TB prevalence, medically underserved low-income populations (including homeless), alcoholics, injection drug users, and residents of long-term facilities (see Ch. 25). See Ch. 25 for indications for BCG vaccine.

HR7 = Persons who continue to inject drugs (see Ch. 53).

HR8 = Immunocompetent persons with certain medical conditions, including chronic cardiopulmonary disorders, diabetes mellitus, and anatomic asplenia. Immunocompetent persons who live in high-risk environments/social settings (e.g., certain Native American and Alaska Native populations) (see Ch. 66).

HR9 = Annual vaccination of: residents of chronic care facilities; persons with chronic cardiopulmonary disorders, metabolic diseases (including diabetes mellitus), hemoglobinopathies, immunosuppression, or renal dysfunction (see Ch. 66). See Ch. 66 for indications for amantadine/rimantadine prophylaxis.

HR10 = Adolescents and young adults in settings where such individuals congregate (e.g., high schools and colleges), if they have not previously received a second dose (see Ch. 65, 66).

HR11 = Healthy persons aged >13 yr without a history of chickenpox or previous immunization. Consider serologic testing for presumed susceptible persons aged >13 yr (see Ch. 65, 66).

HR12 = Persons born after 1956 who lack evidence of immunity to measles or mumps (e.g., documented receipt of live vaccine on or after the first birthday, laboratory evidence of immunity, or a history of physician-diagnosed measles or mumps) (see Ch. 65, 66).

HR13 = Persons with a family or personal history of skin cancer, a large number of moles, atypical moles, poor tanning ability, or light skin, hair, and eye color (see Ch. 12).

HR14 = Women with prior pregnancy affected by neural tube defect planning a pregnancy (see Ch. 42).

HR15 = Persons aged <17 yr living in areas with inadequate water fluoridation (<0.6 ppm) (see Ch. 61).

HR16 = Having a: chronically mentally ill parent; substance abusing parent; mother who began parenting as a teen. Living at or below poverty. Having: parents involved in criminal behavior; experienced an out-of-home placement(s), multiple moves, failed adoption(s). Being homeless. Having suffered physical, emotional or sexual abuse, or severe neglect. Having: a chronic health problem in the family; an absence of a family support system. Being substance affected at birth.

ACKNOWLEDGMENTS

This report was prepared under the direction of John I. Molnar, former Regional Inspector General for Evaluation and Inspections in the New York Regional Office, and Jodi Nudelman, Assistant Regional Inspector General. Other principal Office of Evaluation and Inspections staff who contributed include:

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