

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**FOSTER CARE CHILDREN'S USE OF
MEDICAID SERVICES IN
NEW JERSEY**



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EXECUTIVE SUMMARY

OBJECTIVE

To determine whether sampled foster care children are receiving Medicaid health care services in New Jersey.

BACKGROUND

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

This inspection focuses on the state of New Jersey and is one of eight states being evaluated.

FINDINGS

Foster care children are deemed eligible for Medicaid services in New Jersey. However, our analysis of 2 years of Medicaid claims for 50 foster children in New Jersey show that few of these children are receiving Medicaid services, particularly Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. In addition, interviews with the caseworker and caregiver for each of the 50 children reveal that caseworkers and caregivers are not informed about the Medicaid program and they have received very little training in Medicaid services for foster children. Also, most caseworkers and caregivers did not receive their foster child's medical information, and they report difficulty finding Medicaid providers.

Claims Data Indicate That Only Half the Children in our Sample are Receiving Medicaid Services Despite Every Child Having Coverage

Although all 50 children in the sample have Medicaid coverage, New Jersey Medicaid claims data show that only 24 of the 50 children have had a health care claim between April 1999 and April 2001. Only 11 children have claims for mandated EPSDT services.

Sampled Caseworkers and Caregivers Are Not Informed About the Medicaid Program, Do Not Have Their Foster Child’s Medical Information, and Have Difficulty Finding Medicaid Providers

Just one of the caseworkers reports having received any training in Medicaid services for foster children. In addition, few caregivers have been given the tools necessary to negotiate the Medicaid system, such as a list of Medicaid providers and a schedule of appointments that children need. Although the Centers for Medicare and Medicaid Services (CMS) requires that state Medicaid agencies inform eligible individuals about the EPSDT program, few caregivers and caseworkers have heard of EPSDT. In New Jersey, enrollment in Medicaid managed care is voluntary for foster care children, yet 76 percent of the caregivers interviewed are not aware of the managed care option. Also, most caseworkers and caregivers report difficulty finding Medicaid providers.

Caseworkers for half the children in our sample say they either did not receive the child’s medical records or they received only partial records. Caregivers for 34 children also report that they did not receive a medical history or that the information they received was incomplete. According to New Jersey state law, the Division of Youth and Family Services is responsible for establishing and maintaining a foster child’s health care record.

CONCLUSION

This inspection identifies several shortcomings in New Jersey’s child welfare and Medicaid systems that cause concern. We documented that, although all the children in our sample are covered by Medicaid, less than half have Medicaid claims and less than a quarter show EPSDT claims for preventive health care. Caseworkers and caregivers are not informed about the Medicaid system. They also do not have complete medical information about the children, perhaps compromising the children’s health care needs. The lack of training for both caseworkers and caregivers, the lack of effort to promote Medicaid managed care despite caseworker and caregiver concerns about access to Medicaid providers, and the lack of communication and coordination between the Division of Youth and Family Services and New Jersey Medicaid reveal that New Jersey may not be making reasonable efforts to assure that foster care children are receiving appropriate and necessary health care.

RECOMMENDATIONS

We believe that the Administration for Children and Families (ACF), CMS, and the State of New Jersey need to address the shortcomings in New Jersey’s child welfare and

Medicaid systems. Accordingly, to help ensure that all eligible foster care children receive their entitled health care services, we recommend that:

- ACF work with New Jersey to provide more training to caseworkers and caregivers on the Medicaid program, EPSDT, and managed care to help them better negotiate these health care systems. Two possible vehicles through which ACF may bring about such a change are the Child and Family Service Reviews and the annual Joint Planning Process; and
- ACF and CMS work with the State of New Jersey to address the concerns of caseworkers and caregivers regarding the lack of access to Medicaid providers. They should also work together to promote communication between New Jersey Medicaid and the Division of Youth and Family Services so that the Division and caseworkers have better information about the health care that foster children are receiving.

COMMENTS

We received comments from ACF, CMS, and the State of New Jersey. Both ACF and CMS agree with our recommendations. The ACF, through the Child and Family Services Plans, will address the need for New Jersey to provide training to caseworkers and caregivers to ensure a greater level of service for foster children from Medicaid providers. The Child and Family Services Review for New Jersey in 2004 will determine if the efforts to improve training have led to improved medical health outcomes for foster children.

The CMS agrees that New Jersey Medicaid should work with the Division of Youth and Family Services to provide information on the availability of Medicaid providers. The CMS offers to provide technical assistance to the state to promote this process.

Both ACF and CMS made a number of technical comments that we incorporated into the inspection report, when appropriate. The full text of the comments received from ACF and CMS are included in Appendix D.

The State of New Jersey indicated that, subsequent to our field work, several projects intended to impact the health care needs of foster children were initiated. The full text of those comments can also be found in Appendix D.

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INTRODUCTION

OBJECTIVE

To determine whether sampled foster care children are receiving Medicaid health care services in New Jersey.

BACKGROUND

Currently, there are over half a million children in foster care nationwide, many of whom are reportedly in poor health. Compared with children from the same socioeconomic background, foster children suffer much higher rates of serious emotional and behavioral problems, chronic physical disabilities, birth defects, developmental delays, and educational difficulties.¹ 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.² A General Accounting Office (GAO) report reviewed foster care populations from California, New York, and Pennsylvania in 1986 and 1991. Compared to the 1986 population, the 1991 foster care children had more health-related problems, were at a higher risk for problems due to prenatal drug exposure, and entered foster care to a greater extent due to some form of neglect.³ In addition to the needs they share with other children, such as immunizations, routine well-child examinations, and treatment of childhood diseases, foster children clearly have a greater need for specialized health care services.

Despite their need, it appears that many foster 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

¹Chernoff, R. et. al., *Assessing the Health Status of Children Entering Foster Care*, Pediatrics, 93:2, 1994.

²*Ensuring the Healthy Development of Foster Children*, New York State Permanent Judicial Commission on Justice for Children, 1999.

³*Foster Care: Parental Drug Abuse Has Alarming Impact on Young Children*, General Accounting Office, GAO/HEHS-94-89, 1994.

those children receive mental health services.⁴ A second 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 children did not receive critical health-related services in the three locations 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, Diagnostic and Treatment (EPSDT) services⁶, a federal entitlement to comprehensive medical services for Medicaid-eligible children under the age of 21.

Medicaid for Foster Children

The Medicaid program provides health care to low income persons and long term care to the disabled and low income elderly. It is administered by the Centers for Medicare and 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. In 1999, Medicaid payments for foster care children nationwide approached \$2.9 billion.⁷

According to Section 1902 (a)(10)(A)(i)(I) of the Social Security Act, foster children covered under Title IV-E of the Social Security Act are eligible for Medicaid. Foster children who are not eligible for Title IV-E usually qualify for Medicaid through other eligibility categories set forth by each state.

New Jersey

New Jersey’s foster care system is centrally managed. The New Jersey Department of Human Services is responsible for all the children in foster care within the state. At the time of this inspection, the state had just over 9,500 children in foster care. Within the Department, the Division of Youth and Family Services (the Division) handles the state’s family and child welfare services. New Jersey has five regional offices, 32 district offices and six adoption resource centers. Regional offices supervise district offices and adoption resource centers and provide administrative and support services. Caseworkers in district offices are responsible for placement, supervision, and coordination of services

⁴Factsheet: The Health of children in Out-of-Home Care. Child Welfare League of America. Retrieved 3/14/03 from: <http://www.cwla.org/programs/health/healthcarecwfact.htm>.

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

⁶*Healthy Needs of Many Young Children are Unknown and Unmet*, General Accounting Office, GAO/HEHS-95-114, 1995. p 5.

⁷HCFA-2082 Report for Fiscal 1999: <http://cms.hhs.gov/medicaid/msis/99total.pdf>.

for children; those in adoption resource centers have the added responsibility of preparing cases for parental rights termination court actions. See Appendix A for a more detailed description of New Jersey foster care.

Also within the New Jersey Department of Human Services is the Division of Medicaid Assistance and Health Services. It administers the Medicaid program in New Jersey and is responsible for the Medicaid claims data. We refer to this division as “New Jersey Medicaid.”

METHODOLOGY

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

Reasons for State Selection

This inspection focuses on the State of New Jersey and is one of eight states being evaluated. New Jersey was selected because of its size, centralized child welfare system, and geographic proximity to the OIG regional office in New York City.

Sample

We constructed a two-stage sample of foster children. First, we randomly selected five Division of Youth and Family Services district offices in New Jersey. Second, we randomly selected 10 children from each office. This sample was pulled from all the children in those district offices who had been in continuous foster care placement for at least 6 months prior to April 2001. Because of our sample design, we do not generalize our findings to the universe of all New Jersey foster care children.

We grouped placement types into two categories: 1) family care, in which a child lives in a family setting with non-relatives or relatives; and 2) residential care, in which a child is placed in a group home or larger residential facility with paid staff. Of the 50 children, 22 were in residential care and 28 were in family care at the time of data collection. We included the one case of an 18-year-old child living independently in the residential care category because a caseworker, not a foster parent, is responsible for the child.

Review of Medicaid Claims Data and State Laws and Policy

Medicaid Claims Data. New Jersey Medicaid provided a paid claims history for 2 years for the children in our sample. The data include claims paid between April 1999 and April 2001. New Jersey Medicaid also provided encounter data. The vast majority of foster children in New Jersey are not in managed care and none of the children in our sample showed encounter data for our inspection period. As mentioned above, all the children in our sample had been in continuous care for at least 6 months prior to April 2001. Half the children were in continuous foster care the entire 2-year period. The other half of the children were in foster care for shorter lengths of time or were in and out of care over the 2-year period. We determined the periods of time the child was in foster care based on information given by the caseworkers and caregivers.

In reviewing the Medicaid claims, we paid particular attention to the types of services, dates of service, settings, and diagnoses, where available. We excluded claims that were not health care-related, such as those for administrative or transportation costs. We also excluded claims with a service date for a time our data clearly show that the child was not in foster care or for a time after the study period. If it was not clear that the child was in foster care during a certain period of time, we included Medicaid claims corresponding to that period in our analysis.

Several children in the sample have more than one Medicaid number. When a child enters foster care in New Jersey he or she receives a Medicaid number. If that child already has a Medicaid number through some other program, such as Temporary Assistance for Needy Families or Supplemental Security Income, the child will then have two Medicaid numbers. The Division of Youth and Family Services and New Jersey Medicaid program staff report that these numbers should be reconciled to leave a child with one Medicaid number, but in some instances the reconciliation does not occur. In these instances, Medicaid services could be billed under each of that child's Medicaid numbers. New Jersey Medicaid program staff took this situation into account when compiling the claims data.

In addition, New Jersey's Department of Human Services provided a list of services paid by the Division of Youth and Family Services for children in the sample. The same methods used to analyze the Medicaid claims were used to analyze these health care payments.

State Law and Policy Reviews. We reviewed state laws pertaining to the health care of foster children. We also collected and reviewed licensing requirements for foster homes and residential facilities, the current and proposed revisions of the foster parent handbook, and state-issued EPSDT-related information.

Interviews

Caseworker Interviews. We interviewed each child’s caseworker either in person or by telephone. Some children had the same caseworker, giving us a total of 34 caseworkers for the 50 children in our sample. Each interview focused on the caseworker’s understanding of and training in Medicaid, their experience accessing services for foster children, and any barriers to health care faced by foster children in general. Each caseworker spoke specifically about the sample child’s case and generally about his or her own experiences working in foster care.

Caregiver Interviews. We interviewed the foster parents of the 28 children in family care and residential facility staff for the 22 children in residential care. We use the term “caregiver” to refer to a foster parent or a staff member of a residential facility who is responsible for the child. Like the caseworker interviews, our interviews with caregivers focused on training, Medicaid, and procuring health care services for the child. We analyzed the responses and compared them to those of the caseworkers, noting any consensus or disagreement within and between the two groups.

State Agency Officials. We held several meetings, both in person and by telephone, with officials from the Division of Youth and Family Services and New Jersey Medicaid. 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

Foster care children are deemed eligible for Medicaid services in New Jersey. However, our analysis of 2 years of Medicaid claims for 50 foster children in New Jersey show that few of these children are receiving Medicaid services, particularly EPSDT services. In addition, interviews with the caseworker and caregiver for each of the 50 children reveal that caseworkers and caregivers are not informed about the Medicaid program and they have received very little training in Medicaid services for foster children. Also, most caseworkers and caregivers did not receive their foster child's medical information, and they report difficulty finding Medicaid providers.

Claims Data Indicate That Only Half the Children in our Sample are Receiving Medicaid Services Despite Every Child Having Coverage

Federal law requires that foster children covered under Title IV-E of the Social Security Act be deemed eligible for Medicaid (see § 1902 (a)(10)(A)(i) of the Social Security Act). In New Jersey, foster children who are not covered under Title IV-E are eligible for Medicaid under New Jersey state law (Appendix B). Every child in the sample had a valid Medicaid number at the time of this inspection.

Although all 50 children in the sample have Medicaid coverage, New Jersey Medicaid claims data show that only 24 of the 50 children have had a health care claim between April 1999 and April 2001. This number is far lower than expected in light of two facts: 1) New Jersey state law requires the Division of Youth and Family Services to make every reasonable effort to assure that foster children receive appropriate and necessary health care⁸ and 2) foster care children generally have more medical problems than both children outside of foster care and children in the general Medicaid population.

The 24 children have a total of 1,701 paid health care claims over a 2-year period. Prescription medication is the most common type of claim: Twenty children have a total of 550 prescription claims. See Table 1 below for other frequent claims. The children with claims have an average of six different types of services. The 26 children without Medicaid claims appear to have the same characteristics as those children with Medicaid claims.

⁸NJ AC 10:122D-2.5(a)

Table 1
Health Care Claims

Number of Children	Claim Type	Number of Claims
21	Office Visits	105
21	Diagnostic/Laboratory	262
12	Dental Services	126
3	Hospital Visits	172

Source: New Jersey Medicaid Claims Data, 2001

There are circumstances where a child may receive some type of health care service that is not billed through New Jersey Medicaid. A child in residential care, for instance, may get a health care service through the facility that is not billed to Medicaid because residential facilities often have providers on staff or under contract. At the time of data collection, 22 of the 50 children were in residential facilities. Eleven of these 22 have a Medicaid claim. Mental health professionals work with 14 of the facilities. Doctors and nurses work with 11 facilities and dentists work with six facilities.

Also, a New Jersey foster child can be placed in foster care in another state. In those cases, Medicaid claim information is usually included in the child's placement state's data, not in New Jersey's data. Our records show that five children were in out-of-state placements at the time of data collection. That does not mean, however, that they were out of New Jersey for the entire study period. Our data show that two of the five were in foster care in another state during the entire study period. Interestingly, one of these two has a New Jersey Medicaid claim.

Only 22 Percent of Children Have Claims for Screening Services

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. Specifically, these services cover screening, vision, dental, and hearing services.⁹ Optional services include case management, physical therapy, rehabilitative services, and private-duty nursing. Diagnostic services are covered whenever there is a medical need to conduct further examination. Treatment or medical care must be provided for any physical or mental conditions discovered by the screening services.

⁹Social Security Act §1905 (r)

New Jersey has set its own EPSDT periodicity schedule, based in large part on the one developed by the American Academy of Pediatrics. New Jersey's schedule can be found in Appendix C.¹⁰ New Jersey law requires that the Division of Youth and Family Services ensure that foster children receive medical and dental examinations at least annually after the initial medical examination performed at the time of placement. The type and frequency of the exam shall be based on the foster child's age and medical needs.

However, only 11 of the children have an EPSDT claim. Of these children, eight have a dental EPSDT claim, two have a preventive EPSDT claim, and one child has both types.

This finding is further supported by CMS data that show New Jersey has had low EPSDT participation rates. The latest year of available data from CMS, 1998, show 35 percent of all New Jersey children who were eligible for both Medicaid and EPSDT services participated in EPSDT.¹¹ In 1995, New Jersey's EPSDT participation rate was 32 percent, 12 percent in 1996, and 4 percent in 1997.¹² In January 2001, New Jersey began distributing \$10 incentive payments to providers to increase reporting of EPSDT visits.

State Funds for Services Not Covered by Medicaid are Also Used, But Few Children Receive These Services

The caseworkers report that they turn to the Division of Youth and Family Services for assistance when they feel a foster child needs a service that is not covered by Medicaid. The Division will sometimes pay for a health care service that is not covered by Medicaid, such as replacement eyeglasses. It appears that there may be as many as three pools of funds that caseworkers can access for foster children's health care needs. One is at the headquarters level, one is at the district offices, and one is through a cost-reimbursement contract in which a contracted agency provides services.

The Division provided data on payments it made for health care services dated between April 1999 and April 2001. These data show that the Division paid for health care services for 11 of the 50 children in our sample. The most common types of paid service are assessment and evaluation and maternity home care. In only one instance is the service a medical examination. Six of the 11 children who had health-related services paid by the Division do not have any Medicaid claims.

¹⁰AAP Policy Statement Volume 105, Number 03, March 2000, pp 645 "Recommendations for Preventive Pediatric Health Care (RE9939)."

¹¹<http://cms.hhs.gov/medicaid/epsdt/ep1998.pdf>, July 7, 2002.

¹²<http://cms.hhs.gov/medicaid/epsdt/ep1995.pdf>, <http://cms.hhs.gov/medicaid/epsdt/ep1996.pdf>, <http://cms.hhs.gov/medicaid/epsdt/ep1997.pdf>, January 9, 2003.

Most caseworkers and caregivers say that their foster child had the Division mandated comprehensive medical evaluation upon first entering foster care. But caseworkers point out that this exam is often performed by a nurse from a district office of the Division of Youth and Family Services, and one caseworker indicates that this is a quick check and not comprehensive.

Sampled Caseworkers and Caregivers Are Not Informed About the Medicaid Program, Do Not Have Their Foster Child’s Medical Information, and Have Difficulty Finding Medicaid Providers

Caseworkers and Caregivers Report Very Little Medicaid Training

Just one of the caseworkers reports having received any training in Medicaid services for foster children. This caseworker is responsible for four children in our sample. The lack of training is significant, given the important role that the caseworker plays in the health care of foster children and how frequently caregivers rely on caseworkers. The caseworker is the main source of information and assistance for caregivers. Caregivers turn to their caseworker when they need help accessing services or seek information regarding Medicaid cards or Medicaid providers.

In addition, few caregivers have been given the tools necessary to negotiate the Medicaid system. Only eight of the caregivers say someone explained to them which services might not be covered under Medicaid. Sixteen report they were given a list of health care professionals who accept Medicaid. Twenty mention they were given a schedule of appointments that children need. Just five caregivers say they were given all three of these tools.

Among caregivers, foster parents report that they do not receive general Medicaid training. Some say they learn about Medicaid informally from their caseworker, while other foster parents say they teach themselves. We examined the package given to foster parents at their general training and found that it does not address Medicaid. In correspondence with the Office of Inspector General, the Division of Youth and Family Services reported that another handbook is supposed to be distributed to all foster families, usually at the time of the home study or at the time of approval. The handbook briefly describes Medicaid and EPSDT. It also includes recommended medical appointment schedules. Our inspection did not determine whether or not foster parents received this handbook.

Foster parents receive little training related to the health care of a foster child. Most of the 28 foster parents say they have not received any training in regard to the health care of foster children. Six parents report that they have received some training. This training

ranges from a first aid course to simply receiving some information regarding Medicaid or getting checkup schedules. In contrast, residential facilities often have trained health care professionals on staff.

Few Caregivers and Caseworkers Have Heard of EPSDT

The CMS requires that state Medicaid agencies must “provide for a combination of written and oral methods designed to inform effectively all EPSDT eligible individuals (or their families) about the EPSDT program.”¹³ Only 15 of the caregivers, however, say they have heard of EPSDT and even fewer of the caseworkers have heard of it. For all 50 children, fewer than half have a caseworker or caregiver who has heard of EPSDT. Of the caregivers, residential facilities report knowing about EPSDT more often than foster parents.

New Jersey Medicaid program staff report having problems mailing EPSDT forms and reminders to caregivers due to difficulty in obtaining foster children’s correct address from the Division of Youth and Family Services.

Seventy-six Percent of the Caregivers are Not Aware of Managed Care Option

Most states enroll Medicaid populations in managed care.¹⁴ A managed care organization offers third-party financing of necessary medical care and provides coverage for a defined set of medical and health benefits. Managed care also describes a system in which an individual primary care provider coordinates all care, including referrals to specialty services. Certain Medicaid populations, such as foster care children, may be “carved out” (not included) of the state managed care contract.

In New Jersey, enrollment in Medicaid managed care is voluntary for foster care children. There are five managed care organizations in New Jersey, two of which operate throughout all 21 counties. Caregivers may choose one of these managed care organizations and pick a primary care physician for the child. The primary-care provider performs routine checkups, provides general care and refers to a specialist, if necessary. It appears very few foster children are enrolled in managed care in New Jersey. Foster children not in Medicaid managed care are covered by Medicaid fee-for-service.

¹³42 CFR §441.50; 42 CFR §441.56

¹⁴Summary Statistics: Medicaid Managed Care Enrollment Report, June 2000, <http://www.hcfa.gov/medicaid/omchmpg.htm>.

Forty-one caregivers say their child is not in managed care. Of these, only three say that someone explained to them that their child could be enrolled in Medicaid managed care. According to the Division of Youth and Family Services and New Jersey Medicaid program staff, the Division does not actively encourage caregivers to enroll their foster children in managed care. Division staff feel that foster children would not benefit from managed care because they move often and would frequently have to change their primary care physician. Another reason given is that one home or facility may have children in different managed care organizations and would not be able to take all of the children in that placement to the same provider.

We note that there is some confusion regarding managed care. The Division of Youth and Family Services tells us that one child in the sample was enrolled in managed care at the time of this study. New Jersey Medicaid program staff, however, report that none of the children in our sample was enrolled in managed care at the time of the study. Adding to the confusion, the caregivers for four children report that the children are in managed care, but the caseworkers for those four children say they are not. Caseworkers for two other children mention that the children are in managed care, but the caregivers say the children are not. Other caseworkers report that they simply do not know whether their foster child is in managed care or not.

Most Caseworkers and Caregivers Do Not Have Complete Information About their Foster Child's Medical History

According to New Jersey state law, the Division of Youth and Family Services is responsible for establishing and maintaining a foster child's health care record. The Division needs to update and provide this record to the foster parent. The Division must also share health care information about the child with the child's parents and foster parents (Appendix B).

Caseworkers for half the children in our sample say they either did not receive the child's medical records or they received only partial records. For example, the child's immunization history can be missing or outdated. Caregivers for 34 of the children in our sample report that they did not receive a medical history on their foster child or that they did receive some information, but that it was incomplete. We found that the caseworkers and caregivers are not always aware of certain health problems that their child may have because they do not have enough information about their child's medical history. In only four of the 22 cases in our sample where the child is identified by their caregiver as having a chronic medical condition, does the caregiver mention that he or she learned of the condition from the medical history. It is important to note that the primary source for a foster child's medical history is the biological parents, and they may not be available or cooperative.

The consequences of not knowing a child's medical background could be serious. Because information about the child's medical background is limited or unavailable, a child could arrive at a placement with a medical problem that goes unnoticed. Food allergies could be missing from the background, as was the case for a foster mother we interviewed during our pre-inspection process. She says she discovered that her foster child, who is not in our sample, was allergic to peanuts only after the child had eaten some.

Most Caseworkers and Caregivers Report Difficulty Finding Medicaid Providers

Most caseworkers report that finding providers is a problem. They cite the distant location of dentists and mental health professionals as barriers to getting care. Caregivers, too, report difficulty finding providers. Almost half of the caregivers say that the lack of Medicaid providers is a problem for foster children. Among the caregivers, residential facilities, more often than foster parents, complain about a lack of Medicaid providers, despite the connections that facilities have with health care providers. Half of the facilities cite problems with finding a provider, while 18 percent of foster parents cite problems. Caregivers also mention trouble either finding a dentist or making a timely appointment.

CONCLUSION

This inspection identifies several shortcomings in New Jersey's child welfare and Medicaid systems that cause concern. We documented that, although all the children in our sample are covered by Medicaid, less than half have Medicaid claims and less than a quarter show EPSDT claims for preventive health care. Caseworkers and caregivers are not informed about the Medicaid system. They also do not have complete medical information about the children, perhaps compromising the children's health care needs. The lack of training for both caseworkers and caregivers, the lack of effort to promote Medicaid managed care, despite caseworker and caregiver concerns about access to Medicaid providers, and the lack of communication and coordination between the Division of Youth and Family Services and New Jersey Medicaid reveal that New Jersey may not be making reasonable efforts to assure that foster care children are receiving appropriate and necessary health care.

RECOMMENDATIONS

We believe that the Administration for Children and Families (ACF), CMS, and the State of New Jersey need to address the shortcomings in New Jersey's child welfare and Medicaid systems. Accordingly, to help ensure that all eligible foster care children receive their entitled health care services, we recommend that:

- ACF work with New Jersey to provide more training to caseworkers and caregivers on the Medicaid program, EPSDT, and managed care to help them better negotiate these health care systems. Two possible vehicles through which ACF may bring about such a change are the Child and Family Service Reviews and the annual Joint Planning Process; and
- ACF and CMS work with the State of New Jersey to address the concerns of caseworkers and caregivers regarding the lack of access to Medicaid providers. They should also work together to promote communication between New Jersey Medicaid and the Division of Youth and Family Services so that the Division and caseworkers have better information about the health care that foster children are receiving.

COMMENTS

We received comments from ACF, CMS, and the State of New Jersey. Both ACF and CMS agree with our recommendations. The ACF, through the Child and Family Services Plans, will address the need for New Jersey to provide training to caseworkers and caregivers to ensure a greater level of service for foster children from Medicaid providers. The Child and Family Services Review for New Jersey in 2004 will determine if the efforts to improve training have led to improved medical health outcomes for foster children.

The CMS agrees that New Jersey Medicaid should work with the Division of Youth and Family Services to provide information on the availability of Medicaid providers. The CMS offers to provide technical assistance to the state to promote this process.

Both ACF and CMS made a number of technical comments that we incorporated into the inspection report, when appropriate. The full text of the comments received from ACF and CMS are included in Appendix D.

The State of New Jersey indicated that, subsequent to our field work, several projects intended to impact the health care needs of foster children were initiated. The full text of those comments can also be found in Appendix D.

It is noteworthy that the State of New Jersey reached a settlement in a class-action lawsuit regarding their foster care system. The Settlement Agreement establishes an oversight panel, 6 areas for emergency action, and 11 outcome measures for children in the foster care system. With the increased oversight and funding and an outcome measure focused on service needs, we are optimistic that concerns raised in this report will be addressed.

New Jersey Foster Care

The New Jersey Department of Human Services is responsible for all the children in foster care within the state. Within the Department, the Division of Youth and Family Services handles the state's family and child welfare services. The Division has over 3,000 employees whose tasks include investigating reports of abuse and neglect, providing protective and foster care services, licensing families and facilities that care for children, and supervising public/private contracts.¹⁵ Within this Division is the Child Health Unit, which focuses on the health of foster children. The responsibilities of the Child Health Unit range from reviewing relevant agency policies and procedures to providing consultative services to caseworkers.

The Division of Youth and Family Services employs 28 pediatric nurses throughout the state, located in district offices and adoption resource centers. Their job is to provide direct services for caseworkers, caregivers, and community agencies, such as performing assessments of children, training and answering health-related questions. According to a recent study, child health nurses completed 346 pre-placement assessments and provided over 1,000 training sessions to caregivers, Division staff, and community agencies.¹⁶ The Child Health Program Planner, located in the Division's central office, serves as a liaison between the Division and the Child Health Program, taking on initiatives such as increasing health assessments for children entering foster care in certain district offices.¹⁷

The Division cites its involvement with several programs addressing the health care needs of foster children. These programs include case management, placement, and many other services for medically fragile children. The Division also lists several services, such as assessment, for child abuse and neglect cases. In addition, the State of New Jersey is currently piloting a new project in select counties called "Children's System of Care Initiative." Its goal is to help children and adolescents with emotional and behavioral disturbances and their families across child-serving systems.¹⁸

¹⁵<http://www.state.nj.us/humanservices/dhsabout.html>, June 28, 2002.

¹⁶Ryan, Constance M. and Storm, Deborah., *Child Health Program Year One Evaluation*, New Jersey. Francois-Xavier Bagnoud Center, University of Medicine & Dentistry of New Jersey, January 2002.

¹⁷*Ibid.*, p11.

¹⁸<http://www.njkidsoc.org>, June 28, 2002.

New Jersey State Laws and Regulations

Medicaid Eligibility

The New Jersey Administrative Code provides that persons eligible under the New Jersey Medicaid program include: "Persons for whom adoption assistance agreements are in effect pursuant to Section 473 of the Social Security Act (42 U.S.C. 673) or for whom foster or adoption assistance is paid under Title IV-E of the Act." N.J.A.C. 10:49-2.2(b)8.

The regulations do not explicitly address foster children not eligible under Title IV-E of the Social Security Act. However, it appears that any child in foster care in New Jersey is eligible for Medicaid. Under New Jersey law:

"an individual under 21 years old who, without regard to resources, would be except for dependent child requirements, eligible for the aid to families with dependent children program under the State Plan for Title IV-A of the Federal Social Security Act as of July 16, 1996, or groups of such individuals, including but not limited to, children in foster placement under supervision of the Division of Youth and Family Services whose maintenance is being paid in whole or in part from public funds, children placed in foster home or institution by a private adoption agency in New Jersey or children in intermediate care facilities, including developmental centers for the developmentally disabled or in psychiatric hospitals." N.J. ST 30-40-3(6).

The official state web site for the New Jersey foster care program also states that the costs of health care for "foster children are covered by Medicaid, which covers all necessary care and treatment." See www.njfostercare.org/faq.html

State's Responsibilities for the Health of Children in Foster Care

The New Jersey Administrative Code at 10:122D-2.5, *et. seq.* delineates basic health care services for children in foster care as follows:

"(a) The Division shall make every reasonable effort to assure that each child in foster home placement receives appropriate and necessary health care, including mental health services.

(b) For each child initially entering foster home placement, the Division shall obtain a medical examination at the time of placement. The Division shall establish a health care record for each child and shall provide the foster parent with a health care record which documents health information concerning the foster child, including, but not limited to:

1. The names and addresses of the foster child's health care providers;
2. A record of the foster child's immunizations;
3. The foster child's known medical problems, if any;
4. The foster child's medications, if any; and
5. The foster child's allergies, if any.

(c) The Division shall maintain a health care record for each child. The Division shall review and update the foster child's health record at the time of each placement into a foster home and shall provide the updated record to the foster parent.

(d) The Division shall assure that the foster child receives a medical and dental examination at least annually after the initial medical examination performed at the time of placement. The type and frequency of the exam shall be based on the foster child's age and medical needs.

(e) The foster parent shall be responsible for arranging and providing care to meet the foster child's health needs, including, but not limited to, medical and dental examinations as agreed to with the Division, and shall provide the Division with information concerning the foster child's health care and needs.

(f) The Division shall share health care information concerning the foster care child with the foster child's parents and foster parents.”

New Jersey EPSDT Schedule

The EPSDT recommended health checkup schedule for children is an initial exam at birth followed by one well-child exam:

Age 6 weeks to 3 months
3 months to 5 months
5 months to 11 months
11 months to 14 months
14 months to 17 months
17 months to 20 months
between 20 and 24 months

After 2 years of age, the child should be examined once a year through the age of 20.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES
Office of the Assistant Secretary, Suite 51
370 L'Enfant Promenade, S.W.
Washington, D.C. 20447

FEB 6 2003

TO: Janet Rehnquist
Inspector General

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

SUBJECT: Comments on the OIG Draft Report, "Foster Care Children's Use of Medicaid Services in New Jersey", OEI-02-00-00360

Attached are the Administration for Children and Families' comments on the OIG Draft Report, "Foster Care Children's Use of Medicaid Services in New Jersey", OEI-02-00-00360.

Should you have questions regarding our comments, please contact Patsy Buida, Administration on Children, Youth and Families at (202) 205-8769.

Attachment

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**COMMENTS OF THE ADMINISTRATION FOR CHILDREN AND FAMILIES ON
OFFICE OF INSPECTOR GENERAL'S DRAFT REPORT, "FOSTER CARE
CHILDREN'S USE OF MEDICAID SERVICES IN NEW JERSEY"**

The Administration for Children and Families appreciates this opportunity to review and comment on the above captioned report. Coordination and cooperation within our agency on projects such as this increase the usefulness of the products.

OIG Recommendation:

We believe that the Administration for Children and Families (ACF), CMS and the State of New Jersey need to address the shortcomings in New Jersey's child welfare and Medicaid systems. Accordingly, to help ensure that all eligible foster care children receive their entitled health care services, we recommend that:

- ACF work with New Jersey to provide more training to caseworkers and caregivers on the Medicaid program, HPST, and managed care to help them better negotiate these health care systems. Two possible vehicles through which ACF may bring about such a change are the Child and Family Service Reviews and the annual Joint Planning Process; and
- ACF and CMS work with the State of New Jersey to address the concerns of caseworkers and caregivers regarding the lack of access to Medicaid providers. They should also work together to promote communication between New Jersey Medicaid and the Division of Youth and Family Services so that the Division and caseworkers have better information about the health care that foster children are receiving. One form that this communication could take is the sharing of Medicaid claims data.

Agency Comment:

By June 30 of each year, States are required to review and update their comprehensive 5-year Child and Family Services Plans (CFSP) to address newly identified areas needing improvement through the re-directing of resources to those areas. A primary component of the CFSP is the title IV-B training plan. States are required to outline the training efforts for the upcoming year that they will be financing with title IV-B and title IV-E (of the Social Security Act) funds. The joint planning process is initiated by States and done in collaboration with State and local stakeholders, and is conducted in conjunction with the ACF Regional Office. Given the findings of this report, ACF will involve the State in discussions about its need to provide training to caregivers and caseworkers for the purpose of ensuring a greater level of service for foster children in need of medical and mental health services from Medicaid providers.

The Child and Family Services Reviews (CFSR) are structured by Federal regulation to follow a specific process to identify strengths and weaknesses in States' child welfare programs. New Jersey is scheduled to be reviewed in 2004. ACF and New Jersey will begin discussion of caseworker and caregiver training needs before the CFSR takes place by using the CFSP process described above. The CFSR will provide a valuable follow-up to determine if efforts made to

improve caseworker and caregiver knowledge actually improved medical health outcomes for children in foster care.

ACF looks forward to coordinating with CMS related to access to Medicaid providers and the communication between New Jersey Medicaid and the Division of Youth and Family Services.

TECHNICAL COMMENTS:

General comments:

- The background provided in the report was useful in giving a perspective of the problem.
- In the findings on page 6 and in the first complete paragraph on page 12, it is mentioned that caseworkers did not receive the child's complete medical records. In most States it is the caseworker's role to locate and obtain the medical records of children coming into care. Generally, the caseworker asks the parents for names of doctors so the caseworker can request the child's medical records directly from the medical provider. If there is a separate group in New Jersey with responsibility for collecting medical records for children entering foster care, please identify who has that responsibility. If the caseworkers do not understand their role in locating the children's medical records, then the finding should focus on their lack of knowledge.
- On page 7, an alternative mechanism for the provision of health care services is described for the children in residential care. This description leaves the reader with several questions:
 - Of the 22 children placed in facilities, how many received services from the mental health professionals that work with 14 of the facilities?
 - Of the 22 children placed in residential facilities, how many were in the 11 facilities that have doctors and nurses on staff or under contract?
 - Did these children receive screening, assessment and ongoing treatment from these doctors rather than from Medicaid?
 - Are any of the services provided by facility mental health professionals and doctors included in the description of "State funds for services not covered by Medicaid" on pages 8 and 9?

Since the provision of mental health and medical services (or lack thereof) to the 22 children in residential care is not clear, it leaves the reader questioning if the half of the children not receiving Medicaid services are simply receiving medical services through a different mechanism.

- The section on pages 7 and 8 related to the percentage of children with claims for EPSDT screening services was clearly documented, providing an excellent summary of the concerns in this area.

- The first paragraph on page 9 mentions that the most frequent types of service paid by State funds include assessment and evaluation. Since it is mentioned that only one of the payments was for a medical examination, it may be useful to include information about the types of assessment and evaluation for which payment was made.
- The concerns related to caseworker and caregiver training were well documented on pages 9 and 10.
- The concerns related to caregivers not receiving complete medical information on children were well documented on page 12.

Specific Comments:

Page 7, the first reference to "facilities" should be singular rather than plural.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

DATE: APR - 3 2003
TO: Janet Rehnquist
 Inspector General
FROM: Thomas A. Scully
 Administrator
SUBJECT: Office of Inspector General (OIG) Draft Report: *Foster Care Children's Use of Medicaid Services in New Jersey* (OEI-02-00-00360)

- IG
- EAIG
- FDIG
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- DIG-EI
- DIG-OI
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Administrator
Washington, DC 20201

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Tom Scully

Thank you for the opportunity to review and comment on the above-referenced draft report. The Centers for Medicare & Medicaid Services (CMS) appreciates the effort that went into this report and the opportunity to review and comment on the issues it raises. We look forward to working with OIG on this and other issues pertinent to foster care children's use of Medicaid services. Our responses to the recommendations are discussed below.

OIG Recommendation

The Administration for Children and Families (ACF) should work with New Jersey to provide more training to caseworkers and caregivers on the Medicaid program, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), and managed care to help them better negotiate these health care systems. Two possible vehicles through which ACF may bring about such a change are the Child and Family Service Reviews and the annual Joint Planning Process.

CMS Response

We concur. The CMS suggests that ACF and the New Jersey Division of Youth and Family Services (DYFS) work with the New Jersey state Medicaid agency to obtain information on the programs for the caseworkers and caregivers.

OIG Recommendation

The ACF and CMS should work with the state of New Jersey to address the concerns of caseworkers and caregivers regarding the lack of access to Medicaid providers. They should also work together to promote communication between New Jersey Medicaid and the DYFS so that the division and caseworkers have better information about the health care that foster children are receiving. One form that this communication could take is the sharing of Medicaid claims data.

Page 2 – Janet Rehnquist

CMS Response

We concur, in part, with this recommendation. The second sentence is unclear, since it does not explain what role, if any, that ACF and CMS have in the communication between New Jersey Medicaid and the New Jersey DYFS. However, CMS agrees that the New Jersey state Medicaid agency should work with the DYFS, both of which are located within the New Jersey Department of Human Services, to provide information on the availability of Medicaid providers. This may include providing lists of Medicaid providers to the DYFS or information on managed care organizations available to enroll and provide services to these Medicaid-eligible foster children. The CMS is available to provide technical assistance to the State to promote this process.

However, while we agree that communication between the State agencies needs to be improved, we do not concur with the portion of this recommendation that suggests the sharing of Medicaid claims data.

Section 1902(a)(7) of the Social Security Act (codified in 42 CFR 431.300) requires that a state plan must provide safeguards that restrict the use or disclosure of information concerning applicants and recipients to "purposes directly connected with the administration of the plan." These "purposes" are described in 42 CFR 431.302. Since the disclosure of this information is not directly connected with the administration of the plan, the Medicaid agency should not be directed to share Medicaid claims data with the DYFS.

Another method should be developed to prompt caseworkers and foster parents to seek health care, such as the training described in the first recommendation of this report.

Attachment

Page 3 – Janet Rehrquist

Technical Comments

- Page ii – Under the Recommendations section, we recommend changing the phrase, “receive their entitled” to “receive medically necessary” in order to avoid issues about the nature of the entitlement.
- Page 1 – The first paragraph on the Medicaid program does not clearly distinguish between the Federal and state roles. Furthermore, the first two sentences describe the program as a Federal program and incorrectly suggest that the program directly furnishes services. We recommend replacing these two sentences with this suggested text:

“Medicaid is a Federal-state cooperative program under which the Federal Government partially funds state programs that pay for health care to specified groups of needy individuals. The CMS has been delegated Federal responsibility over the program.”
- Page 1, 3rd sentence – We recommend replacing the phrase, “its own Medicaid program” with “its own State Medicaid program.”
- Page 6 – The first sentence exceeds the actual legal requirements set forth in the appendix. We recommend changing the phrase, “require that foster care children receive necessary” to “provide for Medicaid payment for medically necessary health care for foster care children and require the State DYFS to make reasonable efforts to assure that foster care children receive such care.”
- Page 7 – The first sentence under the subheading at the bottom of the page is also too strong; the phrase, “provide a package of” should be revised to read, “provide coverage for.”
- Page 8 – The report notes that only 11 children had EPSDT claims. However, the chart on page 7 indicates that 21 children had claims for office visits. While we are concerned at the low number of foster children who appear to have received services during the review period, we believe the number of EPSDT claims may be misleading. There is no specific Federal EPSDT code for reporting EPSDT screening visits. States are allowed to use various national CPT codes for reporting these services. Therefore, it is possible that at least some of the 21 children who had office visits did receive the required EPSDT services.
- Page 10 – Under the first subheading, the first sentence refers to Medicaid obligations to inform “EPSDT eligible individuals (or their families)” but the following sentences concern caseworkers and caregivers. The obligation discussed in the first sentence does not necessarily extend to caseworkers and foster care caregivers, to the extent that these individuals are not within the meaning of the “family” of the eligible individual.
- Page 14 – In the introduction to the Recommendations section, we recommend changing the phrase, “receive their entitled” to “receive medically necessary” in order to avoid issues about the nature of the entitlement.



State of New Jersey
DEPARTMENT OF HUMAN SERVICES
PO Box 700
Columbus NJ 08622-0700

JAMES E. MCGHEE
Governor

GWENDOLYN L. HARR
Commissioner

February 4, 2003

Jack Molnar, Regional Inspector General
Office of the Inspector General
Office of Evaluations and Inspections
26 Federal Plaza - Room 41-106
New York, NY 10278

Dear Mr. Molnar:

Thank you for providing our Department the opportunity to review and offer comments regarding the Office of the Inspector General (OIG) draft report, "Foster Care Children's Use of Medicaid Services in New Jersey," dated December 2002.

The Department has concerns regarding the statement "health care of foster children is not a priority for New Jersey" found on pages ii and 13 of the draft. The health and well-being of our foster children are indeed high priorities in New Jersey. We recognize the importance of coordinating program participation with the Division of Youth and Family Services (DYFS), for foster-care services, and the Division of Medical Assistance and Health Services (DMAHS), which administers the Medicaid program, to ensure that all foster families understand the health care options available in New Jersey and how best to access these services.

I understand findings contained in the draft report were based on a review of Medicaid claims paid on behalf of 50 children in foster care. As were our concerns in July 2002, findings for these 50 children may not necessarily represent the experiences of all New Jersey children in foster care, which number approximately 11,000.

We were pleased to read the statement "Because of our sample design, we do not generalize our findings to the universe of all New Jersey foster care children" on page three of the draft report. However, it appears further revisions within the report are necessary to ensure that this statement is understood throughout the document. As examples, both the title and Executive Summary Objective should be amended to reflect sample size.

The Department is concerned about statements such as "Seventy-six percent of the caregivers are not aware of the managed care option." The Department would appreciate this statement being amended to reflect the fact that this finding was based on a sample of caregivers for 50 children in foster care. The Department also has similar concerns regarding other statements that may not acknowledge the sample size.

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Jack Molnar
 February 4, 2003
 Page 2

The Department and its Divisions have implemented educational strategies to ensure that DYFS staff and foster parents are fully aware of health care opportunities for children in foster care and resources available for access to be successful. It has been almost two years since the start of this OIG review. At that time, New Jersey outlined for the OIG several special projects and programs that impacted the health care needs of children in foster care.

The Department is requesting that the draft report be amended to include not only the special projects and programs discussed earlier with OIG, but also the additional special projects and programs discussed below. Some of these projects were initiated in response to feedback received by the Department during the course of the review.

During 2002, the Department and its Divisions initiated an educational program addressing EPSDT services, including prevention and testing for lead poisoning. The DYFS Bureau of Licensing and DYFS contracted nurses were provided comprehensive EPSDT and lead screening training. It is the Department's goal to complete training of all DYFS Field Offices and Adoption Resource Centers by May 1, 2003. Please note that we have enclosed a copy of the New Jersey EPSDT periodicity schedule for health checkups.

- In the fall of 2002, information on EPSDT and other health services were incorporated into the DYFS Intranet site for staff. This site provides additional information and resources for staff.
- Reminder letters regarding EPSDT services and lead screening were sent to all foster families from the Division of Medical Assistance and Health Services. The mailing included DMAHS' health promotion flyer, discussing preventive health care services, and a listing of DMAHS' Medical Assistance Customer Centers (MACCs), including their county location and phone numbers. The MACCs are the local Medicaid field offices that provide health information to beneficiaries, including available physicians, prior authorization of services and any additional information that the beneficiary may require to access necessary services.
- DYFS contracts with the non-profit agency, Foster and Adoptive Family Services (FAFS), to provide a variety of support services to foster families. FAFS continues to include EPSDT and lead prevention promotional materials in mailings to newly approved foster families.
- DYFS caseworkers provide new foster parents with placement kits when a child is placed in their home. Kits provide foster parents with EPSDT and lead screening information and a listing of MACC offices and their telephone numbers. The kit also includes a cover letter from the DYFS Director advising foster parents of EPSDT and its components.

Jack Molnar
February 4, 2003
Page 3

- DYFS is working with its training unit to incorporate information on child health and EPSDT into the training curriculum for new DYFS case workers.
- The Department is also concerned about the health care needs of young adults transitioning away from the child welfare system. New Jersey was one of the first states to provide Medicaid services to aging-out youth under the Chafee legislation. In 2002, DYFS conducted an all-day health fair for approximately 100 youth.
- The Department is aware of the need for ongoing training. As noted in Appendix A of the report, DYFS contracted nurses provided over 1,000 training sessions on child health related issues to caregivers, staff, and community agencies in the first year of the contract and this training is continuing. Also, in 2002, DYFS contracted nurses provided an all-day conference for DYFS staff in the Central Region and this will occur again in 2003.
- FAFS provides 24 home correspondence courses to foster families that focus on a variety of physical and mental health issues. FAFS provides an additional four (4) teleconferences per year on health related issues. During 2002, DYFS began to work collaboratively with several hospitals throughout New Jersey to provide in-service training to foster parents. This has been a particularly encouraging initiative as a means to provide community-based training to foster parents on a wide variety of topics using health care professionals throughout the State. Further expansion is planned for 2003.

It should be noted that contact with Medicaid beneficiaries relating to EPSDT in the form of computerized outreach letters is an ongoing process. A comprehensive informational letter about EPSDT is sent to all beneficiaries who have not participated during the previous 11 months. Additionally, other outreach and reminder letters are sent on an annual basis.

During late 2002, both DYFS and DMAHS focused resources to promote Medicaid managed care for children in foster care. An educational campaign was initiated, first at the Central Region Adoption Resource Center, with staff of the DMAHS Office of Managed Health Care and the DYFS Child Health Unit. Further sessions with other Adoption Resource Centers and other field staff are planned for early 2003. Other components of the campaign will include a multi-faceted statewide approach to educate staff, foster families, and community resources regarding the benefits of Medicaid managed care and to increase enrollment for children in foster care.

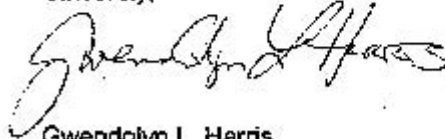
The Department considers Medicaid managed care to be an important opportunity for children in foster care to gain access to health care. The Medicaid managed care initiative in New Jersey is responsible for making managed care a viable option for foster families and the children in their care. In fact, DMAHS hosted a round table session with Medicaid HMOs for DYFS administrators, in late 2002, to update HMOs regarding the special needs of children in foster care. The HMO enrollment process is

Jack Molnar
February 4, 2003
Page 4

already underway, starting first with the more stable adoption segment of this population.

The Department is committed to meeting the health care needs of all children. This includes assuring the delivery of an integrated service package for all children within the Department's programs, especially those children within the foster care system. New Jersey looks forward to working with the Department of Health and Human Services and the Administration for Children and Families to make further progress in providing access to quality health care. If you have any questions concerning our comments, please contact me or Doris Jones, Acting Director, Division of Youth and Family Services, at (609) 292-6920.

Sincerely,



Gwendolyn L. Harris
Commissioner

GLH:2:11
Enclosure
c: Doris Jones

NJ's - EPSDT
Periodicity Schedule

One visit at each age listed below

✓ Under 6 weeks	✓ 15 months
✓ 2 months	✓ 18 months
✓ 4 months	✓ 24 months
✓ 6 months	✓ Annually thereafter
✓ 9 months	to the age of 21
✓ 12 months	years.

3

ACKNOWLEDGMENTS

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

Nancy Harrison, *Project Leader*

Natasha Besch, *Lead Analyst*

Nicole Gillette, *Program Analyst*

Laura Torres, *Program Analyst*

Linda Hall, *Program Specialist*

Barbara Tedesco, *Statistician*