Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

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OBJECTIVE

To determine whether children in New York foster care have Medicaid coverage and are receiving health care services.

BACKGROUND

It is estimated that 532,000 children are in foster care nationwide, and many of them are reportedly in poor health. Compared with children from the same socioeconomic background, children in foster care suffer much higher rates of serious emotional and behavioral problems, chronic physical disabilities, birth defects, developmental delays, and educational difficulties.

Almost all children in foster care are eligible for Medicaid services and for Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Among other things, the EPSDT requires each State to make preventive health care and follow-up services available to Medicaid-eligible individuals under the age of 21.

This inspection focuses on the State of New York and is part of a larger body of work in which eight States are being evaluated. The analysis is based on a review of Medicaid claims and case file records relating to 50 children in New York foster care over a 26-month period, as well as interviews with foster care agency staff and caregivers.

FINDINGS

All children in the sample we reviewed have Medicaid coverage and are receiving health care services. All 50 children have a Medicaid identification number and all had at least 1 Medicaid claim between September 2000 and October 2002.

One reason supporting this finding is that 43 of the 50 sample children benefit from New York's Medicaid payment system called the per diem. In this system, participating agencies receive periodic (usually monthly) fixed payments per child from Medicaid to cover a variety of physician and dental services for the children in the agency's care. This system provides flexibility in that it allows foster care agencies to employ health care providers onsite or to contract with them.

Many caregivers are not informed about the Medicaid program and the EPSDT, and they often do not receive their children's medical histories. Many caregivers say they are not taught how to navigate the Medicaid system. For example, 32 say they did not receive an explanation as to which services are covered by Medicaid and 23 say they did not get a schedule of doctor appointments children need. Twenty-one caregivers have not heard of the EPSDT program. Twenty-four say they have heard of it but only one of them reports that her child receives services under the program.

Further, 20 caregivers say they did not receive any of their children's medical histories. Eight more say they did receive some history, but not all of the important information. Three of these caregivers believe that their children's health care was adversely affected because the information was missing.

RECOMMENDATIONS

The children in our sample are receiving needed services, especially preventive care. We believe that New York's Medicaid payment system likely facilitates the children's access to health care services. Nevertheless, we recommend that the Administration for Children and Families (ACF) and the Centers for Medicare & Medicaid Services (CMS) work with the New York State Office of Children and Family Services and Office of Medicaid Management to further promote access to services by addressing potential obstacles, including caregivers' limited knowledge about the EPSDT and how to navigate the Medicaid system. We also recommend that ACF help the State ensure that the most complete medical histories are shared with the children's caregivers.

Agency Comments

We received comments from ACF and CMS. The full text of the comments is included in Appendix D. ACF reports that it is working with New York on our recommendation to promote the importance of obtaining medical histories for children in foster care. ACF notes that a Program Improvement Plan was developed in response to the New York Child and Family Service Review conducted by ACF. This plan contains action steps that address the gathering of medical information and the physical and mental health needs of children served by New York's child welfare system. ACF says that it monitors progress of the plan with quarterly reports.

CMS concurs with the recommendation that CMS work with New York to further promote access to services. CMS states that regional staff will work with the New York Office of Children and Family Services and Office of Medicaid Management to ensure that New York's foster care staff is educated on Medicaid and the EPSDT program services. CMS also mentions that it is working with ACF to develop interagency multi-state meetings. According to CMS, these meetings will focus on access to Medicaid services for children in foster care and facilitate communication between State Medicaid directors and Child Welfare directors.

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INTRODUCTION

OBJECTIVE

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BACKGROUND

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Despite their need, it appears that many children in foster care are not receiving adequate health care. 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 Government Accountability 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 children in foster care did not receive critical health-related services in the three locations studied (Los Angeles County, New York City, and

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[1] Retrieved on June 23, 2004, from: http://www.acf.hhs.gov/programs/cb/dis/afcars/publications/afcars.htm.

[2] *Health Care of Young Children in Foster Care*, Committee on Early Childhood, Adoption and Dependent Care, American Academy of Pediatrics, Policy Statement, 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] Fact Sheet: The Health of Children in Out-Of-Home Care, Child Welfare League of America, retrieved March 14, 2003, from: http://www.cwla.org/programs/health/healthcarecwfact.htm.

Philadelphia County).[5] In fact, GAO estimated that only 1 percent of these children received Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Medicaid for Children in Foster Care

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

Early and Periodic Screening, Diagnosis, and Treatment

The 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, the EPSDT treatment services include periodic screening, vision, dental, and hearing services and all other services available under the Medicaid program. Treatment or medical care must be provided for any physical or mental conditions discovered by the screening services.

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

[6] Retrieved from CMS Web site on March 14, 2003: 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*; Medicaid Statistical Information System Report for Federal fiscal year 2000. National Total for Foster Care children, page 3, retrieved from CMS Web site on March 13, 2003: http://www.cms.gov/medicaid/msis/00total.pdf.

Under EPSDT, States must set distinct periodicity schedules for screening, dental, vision, and hearing services. 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]

New York

Child Welfare. The New York State Office of Children and Family Services (OCFS) in the Department of Family Assistance is responsible for the State's children in foster care. At the time of this inspection, New York had approximately 57,000 children in foster care. New York's foster care system is decentralized so child welfare programs are State-supervised and county-administered. New York State is divided into 58 local social services districts. One of these districts includes the five boroughs of New York City. Almost one-third of the State's children in foster care reside in New York City. Outside of New York City, each district corresponds to 1 of the 57 counties that make up the remainder of the State.

In each district, children are placed either under the direct care of the local district or under the care of a contracted foster care agency, commonly referred to as a voluntary agency. These agencies provide services under contract with a local district. Nearly 80 percent of the children in foster care are under the care of voluntary agencies statewide. OCFS is responsible for licensing, inspecting, supervising, and monitoring them. In 2002, there were 153 such foster care agencies in New York.

Pursuant to OCFS, each child in foster care has a case planner and a case manager. The case planner has the primary responsibility of providing, arranging, coordinating, and evaluating the provision of services to the child and family. When a child is placed with a voluntary agency, the case planner is a member of the agency's staff. Case managers, on the other hand, are employees of the local social services district. They are responsible for authorizing the provision of services, approving the client eligibility determination, and approving service plans. When the child is placed in the care of the local district, the case manager is also the case planner.

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[8] Retrieved from CMS Web site March 28, 2003: http://www.cms.gov/medicaid/epsdt/.

Medicaid Program. The New York State Department of Health is responsible for the State's Medicaid program. Within this Department, the Office of Medicaid Management manages the Medicaid program, which is administered by local social services office.

As in all States, children in New York foster care who meet Title IV-E requirements are eligible for Medicaid coverage. For children in New York foster care who do not meet IV-E requirements, Medicaid eligibility is determined by State standards and based, in part, on the child's income. Medicaid must be authorized for 12-month periods in all foster care cases that are Medicaid eligible.[9]

In fiscal year 2001, Medicaid expenditures for children in New York foster care were approximately $395 million.

Managed Care. Children placed in the care of voluntary agencies are excluded from participating in managed care.[10] Children under direct care, however, may be eligible for enrollment in a Medicaid managed care plan at the option of each local district. Districts may opt not to enroll children in managed care for a number of reasons, such as distance from providers or the special medical needs of the child. Of the 58 social service districts, 5 enroll children in managed care. The New York City district is not one of the five.

New York's Medicaid Payment System. Voluntary agencies have the option of receiving a Medicaid payment per child, commonly referred to as the per diem, to pay for their children's health care or having the children receive care through Medicaid fee-for-service.

These payments cover many physician and dental services. They also cover most prescription and non-prescription drugs, home health, medical supplies, eye care, and mental health/behavioral health services. Agencies may have medical professionals on staff or contract with local providers to care for the children. In 2002, 96 of the 153 voluntary agencies in New York State chose to receive the per diem.

Agencies use the per diem to pay health care providers directly for rendered services.[11] See Appendix A for services included and not included in the per diem rate. If a child needs services not included

[9] NYS OCFS Eligibility Manual for Child Welfare Programs, June 2003, pp.4-4, 4-5.

[10] New York Social Services Law, Title 11, section 364-j 3(d)(xi).

[11] NYS OCFS Eligibility Manual for Child Welfare Programs, June 2003, p. 4-2.

under the payment system, the child may go to a Medicaid provider. The provider would then bill Medicaid directly for these services.

The per diem rate paid to the agency varies by agency and by the types of programs within the agency. The rate is based on the agency's historic costs of providing medical care, subject to certain ceilings. Each agency receiving a per diem is required to submit a medical services expenditure distribution sheet to the Department of Health annually. It is a summary of all medical costs incurred by the foster care agency. The annual cost is the basis for determining rates for subsequent years. Per diem payments totaled $221,000 for the children in our sample from September 2000 through October 2002. In general, per diem payments were made to agencies monthly for each child in their care. The average per diem payment for the children in the sample was $263 per month.

New York has formed a workgroup to look at standards of care, cost of care, and what services should and should not be included in the per diem rate. The workgroup includes representatives from OCFS, the Division of Budget, the Office of Mental Health, the Office of Alcohol and Substance Abuse Services, the Department of Health, Office of Mental Retardation and Developmental Disabilities, and the Council on Children and Families.

METHODOLOGY

This inspection is based on information gathered from multiple sources: a review of Medicaid claims and case file records relating to 50 children in New York foster care over a 26-month period; a review of Federal and State laws, regulations, and policies; and interviews with Federal and State agency officials, foster care agency staff, and caregivers.

Reasons for State Selection

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

Sample

The 50 children in the sample were randomly selected from a population of 41,232 children in continuous foster care placement for at least 6 months prior to September 30, 2002. See Appendixes B and C for a more detailed description of children in the sample and a comparison of the children in the sample to the population.

It should be noted that, because of our sample size, we do not project our estimates to the universe of all children in New York foster care. Our purpose was to gain an understanding of how children in foster care receive medical care.

Review of Medicaid Claims Data, Case File Information, and Federal and State Laws and Policies

Medicaid Claims Data. New York's Office of Medicaid Management provided a Medicaid claims history of 26 months for each of the 50 children in our sample. The data include claims with service dates from September 2000 through October 2002. None of the children were enrolled in managed care at the time of the sample selection, so the Medicaid histories contain no managed care encounter data. All claims discussed in this report are fee-for-service.

In reviewing the Medicaid claims, we paid particular attention to the types of service, claims coded as EPSDT, dates of service, and settings, where available. Medicaid claims data were organized into broad categories for analysis, such as preventive care, office visits, dental, and mental health. We excluded claims that were not health care related, such as those for transportation. We determined the periods of time the child was in foster care based on information given by the OCFS and the child's foster care agency. Claims for services provided when the child was not in foster care were excluded.

Case File Information. Forty-five of the fifty sampled children were placed in the care of voluntary agencies. These children, unlike the five in the direct care of a local district, could receive medical services paid by the per diem. Services provided under the per diem, along with any other services the child receives, are recorded in the child's case file by the voluntary agency. The children in direct care receive health care services through Medicaid fee-for-service. We did not collect their case files because the services they received are evident from their Medicaid claims histories.

We collected the medical portion of the case file from September 2000 through October 2002 for each of the 45 children placed in the care of a voluntary agency. The case files did not distinguish between Medicaid services and those that are paid for by the State or other non-Medicaid sources, such as Head Start. Therefore, our analysis includes services that may not have been paid by Medicaid.

In the case file review, just as in the Medicaid claims review, we excluded services that were not health care related or were provided

while the child was not in foster care. For each child, the health care services found in the case files were compared to the child's Medicaid claims history. To prevent counting a service more than once, if the same service was found in the claims and the case file, that service was counted in the claims data and not counted in the case file review data.

Law and Policy Reviews. We reviewed Federal and State laws, regulations, and policies pertaining to the provision of health care to children in foster care.

Interviews

Foster Care Agency Interviews. We conducted interviews, either in person or by telephone, with foster care agency staff responsible for each of the 50 children in our sample. We interviewed each child's case planner, who, as previously noted, has the primary responsibility of providing, arranging, coordinating, and evaluating the provision of services to the child and family. In some interviews with voluntary agencies, a member of the agency's health care staff joined the case planner. We use the term "agency" to refer to the case planner and health care staff representing the child.

The interviews focused on agency staff's understanding of Medicaid and experiences accessing health care services for the child in our sample. We also discussed any barriers to health care faced by the child and by children in foster care in general.

Caregiver Interviews. We interviewed the caregivers for 49 of the children in our sample. We were unable to reach one caregiver. We use the term "caregiver" to refer to a foster parent or residential facility staff member who is responsible for the child. Forty of the children were in family care and nine were in residential care. Like the caseworker interviews, our interviews with caregivers focused on training, Medicaid, and procuring health care services for the child in our sample.

Federal and State Agency Officials. We held several meetings, both in person and by telephone, with officials from CMS, the Administration for Children and Families (ACF), New York's OCFS, and New York's Office of Medicaid Management. Our discussions covered a wide spectrum of information to help us understand how the State's foster care and Medicaid systems are organized and administered.

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

All children in the sample have Medicaid coverage and are receiving health care services

All the children in the sample have Medicaid coverage. All 50 children have a Medicaid identification number, and all had at least 1 Medicaid claim filed for a service provided between September 2000 and October 2002.

Forty-seven children in the sample received preventive care services. The EPSDT program requires each State to provide coverage for comprehensive and preventive child health services. Forty-seven of the fifty sampled children received at least one preventive health care service during the study period, according to the Medicaid claims and the case file documentation. The number of preventive care services per child ranged from 1 to 15.

The sampled children received a variety of services in addition to preventive care. Forty-two children received office visit services. These services typically included treatment of an illness or injury. Forty-two children received diagnostic services, such as lab tests. Thirty-six children received all three of these services: preventive, office, and diagnostic. The number of total health care services per child ranged from 5 to 786 over the study period. Table 1 (shown on next page) lists the services received by the children in the sample.

Table 1: Number and Type of Health Care Services

Service Type	Number of Children With at Least One Service	Total Number of Services
Preventive	47	164
Office Visit	42	201
Lab Work/Diagnostic	42	216
Dental	36	153
Mental Health	36	1,835
Hearing/Speech	32	422
Vision	30	74
Immunizations	27	112
Emergency Services	19	82
Other	9	25
Physical/Occupational Therapy	7	756
Case Management	6	30
Hospital Services	5	15
Supplies	3	8

Source: Office of Evaluation and Inspections Medicaid Claims Data and Case File Review.

Caregivers and foster care agencies report their children have access to the health care they seek.

Forty-six of forty-nine caregivers and 46 of 50 agencies interviewed report that the children in foster care receive the health care services they seek. Caregivers also say that finding providers for the children in the sample is not difficult. Forty-five caregivers report no problems finding doctors, dentists, or any other type of health care professionals. Of the four caregivers who report problems, two say finding a dentist who accepts Medicaid is difficult, one reports problems finding a dentist and a doctor, and the fourth reports problems finding a therapist.

In total, caregivers and agencies describe five instances where they could not eventually get the care they sought for their children. In two of these instances, a provider was available but the child refused treatment. In another instance, the provider's waiting list was reportedly too long. The remaining instances involve disagreement over treatment plans or difficulty getting prescription drugs.

Caregivers and agencies report that eight children in the sample receive non-Medicaid health care services in addition to Medicaid services. Caregivers say that they pay for medications, medical care, or mental health care themselves. A few agencies say children in foster care receive counseling at a boys' club, while another agency says the child in its program receives counseling and therapy through school. Several agencies point out that, in general, when a child needs health care services not covered by Medicaid, the foster care agency will pay for the services.

According to caregivers and agencies, nine children in the sample are enrolled in some type of program that improves their access to health care. These programs include early intervention and specialized day care centers, which provide mental health care, speech therapy, or physical or occupational therapy.

Most caregivers and agencies report that they have received training about health problems that often affect children in foster care.

According to the Foster Care Program Placement Agreement, OCFS has the responsibility to provide training opportunities for foster parents and foster parents are responsible for attending training sessions. Thirty-nine of the forty-nine caregivers say they have received training about health issues relevant to children in foster care. This training covers topics such as mental/behavioral health, obtaining certain medical services, HIV/AIDS, and asthma. Thirty-three of the fifty agencies say they have received similar training. Forty-four children in the sample have either a caregiver or agency reporting that they received this training. Twenty-eight children have both a caregiver and an agency reporting that they received training.

According to caregivers and agencies, 36 of the 50 sampled children have a variety of ongoing medical or mental health problems. These problems include asthma, attention deficit disorder, post-traumatic stress disorder, and depression.

Forty-three children in the sample are covered by New York's Medicaid payment system, called the per diem.

As explained in the background section of this report, the per diem is paid to voluntary agencies in New York State for medical services necessary to meet the needs of the children in their care. Forty-three of the fifty children in the sample were covered by the per diem during the study period. Of the remaining seven children, five were in direct care

and therefore excluded from the per diem, and two were placed out-of-State for a time during the study.

New York's Office of Medicaid Management reports that the per diem gives localities the flexibility to provide services within the community. The agencies can have onsite medical staff or contract out, therefore ensuring a sufficient number of providers. All the voluntary agencies representing the children in the sample report that their agency has health professionals on staff. These professionals include nurses, mental health professionals, and physicians who often provide for the children or act as a resource for caregivers. Fifteen agencies and eight caregivers say that having a medical department or doctors onsite improves access to health care services.

Thirty-four of the forty-three children covered by the per diem also had Medicaid fee-for-service health care claims. The remaining nine children covered by the per diem appear to have had all their health care services paid for by the per diem. A child could have fee-for-service claims while under the per diem for a variety of reasons. In addition to the routine care generally paid for by the per diem, the child may need care from a specialist or certain type of facility that is outside the per diem. These services are paid under Medicaid fee-for-service. (See Appendix A for a list of services that are inside or outside the per diem.)

Many caregivers are not informed about the Medicaid program or the EPSDT, and they often do not receive their children's medical information

Caregivers say they are not taught how to navigate the Medicaid system.

Caregivers report that they do not get information about Medicaid that could help them access Medicaid services for their children. For example:

- Thirty-three caregivers say they did not receive telephone numbers to call if they had questions about Medicaid.
- Thirty-two caregivers say they did not receive an explanation as to which services are covered under Medicaid.
- Thirty caregivers say they did not receive a list of doctors who accept Medicaid.
- Twenty-three caregivers say they did not receive a schedule of the doctor appointments children need.

- Fourteen caregivers say they did not receive any of this information. Five caregivers say they received all of this information.

Not all caregivers and agencies know about the EPSDT.
Twenty-one caregivers have not heard of the EPSDT or any of the program's other names in New York, such as Child/Teen Health Plan or Child Health Assurance Program. Twenty-four caregivers say they have heard of the EPSDT (or one of its other names), but only one of them reports that her child receives services under the program. Twenty-seven agencies have not heard of the EPSDT. Twenty-two agencies say they have heard of the program but only six of them report that their children receive services under the program.

Caregivers often do not receive their child's medical history.
Twenty caregivers say they did not receive any of their children's medical histories. Eight more say they did receive some history but not all of the important information. In contrast, one agency reports that it did not receive a medical history. Five agencies say they did not receive all the important information about their children's medical history. According to the Foster Care Program Placement Agreement, OCFS has the responsibility to provide foster parents with all pertinent information concerning youth placed in their home.

Three caregivers believe the missing information adversely affected the health care of their children. One caregiver says that she had no record of her child's immunizations so the child "had to start from scratch." Another caregiver says she would have been better able to care for her child had she known the child came from an abusive home. The third caregiver says it would have been helpful to know that her child was born prematurely.

The children in our sample are receiving needed services, especially preventive care. We believe that New York's Medicaid payment system, the per diem, likely facilitates the children's access to health care services. Nevertheless, we recommend that ACF and CMS work with the New York State OCFS and Office of Medicaid Management to further promote access to services by addressing potential obstacles, including caregivers' limited knowledge about the EPSDT and how to navigate the Medicaid system. We also recommend that ACF help the State ensure that the most complete medical histories are shared with the children's caregivers.

Agency Comments

We received comments from ACF and CMS. The full text of the comments is included in Appendix D. ACF reports that it is working with New York on our recommendation to promote the importance of obtaining medical histories for children in foster care. ACF notes that a Program Improvement Plan was developed in response to the New York Child and Family Service Review conducted by ACF. This plan contains action steps that address the gathering of medical information and the physical and mental health needs of children served by the New York State child welfare system. ACF says that it monitors progress of the plan with quarterly reports.

CMS concurs with the recommendation that CMS work with New York to further promote access to services. CMS states that regional staff will work with the New York OCFS and Office of Medicaid Management to ensure that the New York foster care staff is educated on Medicaid and the EPSDT program services. CMS also mentions that it is working with ACF to develop interagency multistate meetings. Pursuant to CMS, these meetings will address access to Medicaid services for children in foster care and facilitate communication between State Medicaid directors and Child Welfare directors.

Services Inside and Outside the Medicaid Per Diem Rate

Service	
Physician Administrative	In the Rate
Nurses	In the Rate
Physician Specialists	In the Rate
Physicians	In the Rate
Article 28 Freestanding Clinics	In the Rate
Psychiatrists	In the Rate
Psychologists	In the Rate
Certified Social Workers	In the Rate
OMH Licensed Vol Clinics	In the Rate
OMRDD Licensed Vol Clinics	In the Rate
OASAS Licensed Clinics	In the Rate
Dentists	In the Rate
Dental Freestanding Clinics	In the Rate
Prescription Drugs*	In the Rate
Non-Prescription Drugs*	In the Rate
Medical Supplies	In the Rate
Durable Medical Equipment	In the Rate
Home Health PCA/HHA/LPN/RN	In the Rate
Laboratory	In the Rate
X-ray	In the Rate
Transportation	In the Rate
Eye Care	In the Rate
OT/PT Speech and Audiology	In the Rate

Service	
Article 28 Outpatient Departments	Out of Rate
Emergency Room	Out of Rate
School-Based Health Clinics	Out of Rate
Family Planning Clinics	Out of Rate
OMH Partial Hospital	Out of Rate
OMH Day Treatment	Out of Rate
OMH State Clinics	Out of Rate
OMR/OASAS State Operated Clinics	Out of Rate
General Inpatient	Out of Rate
OMH Inpatient	Out of Rate
OMRDD Inpatient	Out of Rate
OASAS Inpatient	Out of Rate
Dental Outpatient Departments	Out of Rate
Early Intervention	Out of Rate
School Supportive Health Services	Out of Rate
Case Management	Out of Rate

*The per diem covers most prescription and non-prescription drugs.

APPENDIX ~ B

Children's Demographic and Health Characteristics

The table below illustrates the demographic and health characteristics of the 50 children in the sample, including the number of months they were in foster care from September 2000 through October 2002. Placement setting refers to the type of foster care placement at the time of the interviews.

ID	Sex	Age (years)	Placement Setting	Agency or Caregiver Reports Child has Medical Problem(s)	Agency or Caregiver Reports Child has Mental Health Problem(s)	Months in Care During Study Period
1	Male	16	Residential	Y	Y	26
2	Female	16	Family	Y	Y	26
3	Male	17	Residential	N	Y	26
4	Male	11	Family	Y	Y	18
5	Female	14	Family	Y	N	12
6	Male	5	Family	N	Y	24
7	Female	4	Family	Y	Y	26
8	Male	7	Family	N	N	26
9	Female	6	Family	N	Y	26
10	Male	8	Family	Y	Y	26
11	Male	15	Residential	N	Y	13
12	Female	5	Family	N	Y	26
13	Male	18	Residential	N	Y	26
14	Male	13	Kinship	N	N	26
15	Female	2	Family	Y	N	23
16	Male	15	Family	Y	Y	26
17	Male	16	Family	Y	Y	10
18	Male	1	Kinship	N	N	10
19	Female	6	Kinship	Y	N	26
20	Male	17	Trial Discharge	Y	Y	26
21	Male	17	Kinship	Y	Y	19
22	Male	6	Family	N	Y	26
23	Male	10	Residential	Y	Y	26
24	Male	8	Residential	Y	Y	10
25	Female	10	Family	N	N	26

Children's Demographic and Health Characteristics (continued)

ID	Sex	Age (years)	Placement Setting	Agency or Caregiver Reports Child has Medical Problem(s)	Agency or Caregiver Reports Child has Mental Health Problem(s)	Months in Care During Study Period
26	Female	17	Family	N	N	26
27	Female	9	Family	N	N	13
28	Male	2	Family	Y	N	26
29	Female	2	Family	Y	N	8
30	Male	19	Residential	N	N	26
31	Female	11	Family	N	Y	26
32	Male	7	Kinship	Y	N	26
33	Female	11	Family	N	N	23
34	Female	4	Family	N	N	26
35	Female	5	Trial Discharge	N	N	12
36	Male	1	Family	Y	N	12
37	Male	8	Kinship	N	N	25
38	Female	4	Kinship	Y	N	26
39	Female	4	Family	Y	N	26
40	Female	20	Family	Y	N	26
41	Male	7	Kinship	Y	Y	26
42	Male	9	Family	Y	Y	26
43	Female	11	Family	N	N	10
44	Male	9	Family	Y	Y	26
45	Male	15	Family	N	N	8
46	Female	18	Kinship	N	Y	25
47	Male	13	Residential	N	Y	8
48	Female	12	Kinship	N	N	26
49	Male	14	Residential	N	Y	10
50	Female	6	Kinship	Y	N	26

Source: New York State Office of Medicaid Management, January 2003

Comparison of Children in Sample to Population

The table shows characteristics of children in the sample and of the population of children in New York foster care for at least 6 continuous months.

Comparison of Children in Sample to Population				
	Sample		**Population**	
	Count	**Percent of Total**	**Count**	**Percent of Total**
GENDER				
Male	28	56%	21,665	53%
Female	22	44%	19,567	47%
Total	**50**	**100%**	**41,232**	**100%**
AGE				
0-2	5	10%	4,730	11%
3-5	7	14%	5,679	14%
6-9	13	26%	7,394	18%
10-13	9	18%	8,343	20%
14-17	12	24%	11,343	28%
18+	4	8%	3,743	9%
Total	**50**	**100%**	**41,232**	**100%**

Source: New York State OCFS, 2002

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES
Office of the Assistant Secretary, Suite 600
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Washington, D.C. 20447

IG
EAIG
PDIG
DIG-AS ✓
DIG-EI
DIG-OI
DIG-MP
OCIG
ExecSec ✓
Date Sent 1-27

DATE: JAN 26 2005

TO: Daniel R. Levinson
Acting Inspector General

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

SUBJECT: Comments on the Office of Inspector General's (OIG) Draft Report: "Children's Use of Health Care Services While in Foster Care: New York," OEI-02-00-00362

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 at (202) 205-8618.

Attachment

COMMENTS OF THE ADMINISTRATION FOR CHILDREN AND FAMILIES ON THE OFFICE OF INSPECTOR GENERAL'S (OIG) DRAFT REPORT: "CHILDREN'S USE OF HEALTH CARE SERVICES WHILE IN FOSTER CARE: NEW YORK," OEI-02-00-00362

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

OIG Recommendations:

OIG recommends that ACF and the Centers for Medicare and Medicaid Services work with the New York State Office of Children and Family Services (OCFS) and Office of Medicaid Management to further promote access to services by addressing potential obstacles, including caregivers' limited knowledge about the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and how to navigate the Medicaid system. OIG also recommends that ACF help the state ensure that the most complete medical histories are shared with the children's caregivers.

ACF Comments

ACF is actively working with New York's OCFS on the recommendations to promote the importance of obtaining medical histories for children in foster care and providing this information to foster care parents. The specific action steps and benchmarks related to gathering medical information and providing it to foster care families are included in the Program Improvement Plan (PIP) developed in response to a Child and Family Services Review (CFSR) in New York.

In addition to the Federal regulations cited in the report, the CFSR was authorized by the 1994 Amendments to the Social Security Act, which are administered by the Children's Bureau (CB). The CFSR is ACF's primary mechanism for working with states on practice issues that impact the well-being of children and families.

During the on-site portion of the New York review, 85.7 percent of the 49 eligible cases reviewed to measure whether or not "children receive adequate services to meet their physical and mental health needs" substantially achieved this outcome. Ninety percent is required for an overall rating of substantial conformity. While there were a number of strengths identified related to the provision of physical health needs of children, the mental health care of children was rated as an area needing improvement. New York did not achieve substantial conformity for this outcome.

ACF finalized a PIP with New York on April 14, 2003. As a result of the CFSR, the state was required to address both physical and mental health improvements in its PIP. The state's PIP has a number of action steps pertaining to improvement of physical and mental health needs of children being served by the child welfare system. Some of the action steps were developed to address both issues. They are all in varying stages of

implementation, but all action steps must be completed by the end of the PIP. The goals are to be achieved by April 2005.

ACF is continuing to monitor the progress of New York's PIP with quarterly reports.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs

200 Independence Avenue SW
Washington, DC 20201

TO: Daniel R. Levinson
Acting Inspector General
Office of Inspector General

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: *"Children's Use of Health Care Services While in Foster Care: New York,"* (OEI-02-00-00362)

Thank you for the opportunity to review and comment on the above-referenced draft report. We appreciate the effort that went into this report and the opportunity to comment on the issues it raises.

In response to a request by the Administration for Children and Families (ACF), the Office of the Inspector General (OIG) has undertaken a review of seven state foster care populations to measure their access and use of Medicaid and other health services. OIG selected states based on varied factors such as number of children in foster care, enrollment in managed care, type of child welfare system, and geographic location. New York is the final state report we have reviewed. We are pleased that all the children selected as part of this study were enrolled in the Medicaid program. While the vast majority of children have been shown to be receiving the health services to which they are entitled, all of the reports have noted areas where improvements are needed. A lack of communication between the state foster care agency, foster parents, and the state Medicaid agency has been the most prevalent finding in all of the reports. In response to the OIG's recommendations in this report, CMS offers the following comments:

Recommendation

The ACF and CMS should work with New York's Office of Children and Family Services (OCFS) and Office of Medicaid Management (OMM) to further promote access to services by addressing potential obstacles, including caregivers' limited knowledge about the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and how to navigate the Medicaid system.

Page 2 – Daniel R. Levinson

Comment
The Centers for Medicare and Medicaid Services (CMS) concurs with this recommendation. The CMS regional office staff will work with the New York OCFS and OMM to ensure that the State's foster care staff is educated on the appropriate provision of Medicaid and Medicaid's EPSDT program services, including the state periodicity schedules for health screenings. In turn, OCFS will then be better able to provide this information to caseworkers and foster care providers. CMS is available to provide any technical assistance to both Agencies as appropriate.

Moreover, CMS is working with ACF to develop their proposed five interagency multi-state meetings. Invitees include central and regional office staff as well as the Office of Child Support Enforcement, Medicaid, SCHIP and Child Welfare Directors from each state. These meetings were planned to discuss the issue of medical support however the agenda is being expanded to include a discussion of access to Medicaid services for foster children. The meeting will facilitate communication between State Medicaid Directors and Child Welfare Directors and put into action the OIG recommendations made in the series of studies "Children's Use of Health Care Services while in Foster Care."

Recommendation
The ACF should help the State ensure that the most complete medical histories are shared with the children's caregivers.

Comment
This recommendation is addressed to ACF. Therefore, CMS defers to ACF for comments on this recommendation.

Thank you for the opportunity to review this final report. The CMS appreciates the efforts that went into this report and the opportunity to review and comment on the issues it raises. We will continue to work with OIG on this and other issues pertinent to foster care children's use of Medicaid services. The CMS is available to provide technical assistance to the State to insure the appropriate provision of Medicaid and EPSDT services to this vulnerable population.

ACKNOWLEDGMENTS

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

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