Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

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EXECUTIVE SUMMARY

OBJECTIVE

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

BACKGROUND

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, and developmental delays. Kansas had 6,569 children in foster care at the end of the Federal fiscal year 2000, and utilized a statewide public-private partnership for the delivery of child welfare services. Kansas is one of a series of States chosen to represent a diverse cross-section of foster care nationwide. The Administration for Children and Families (ACF) has regulatory oversight of the Title IV-E foster care programs. The Centers for Medicare & Medicaid Services (CMS) is responsible for oversight of individual State Medicaid programs.

All Title IV-E children in the Kansas foster care program are eligible for Medicaid. Federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines require each State to provide coverage for preventive health care services to Medicaid-eligible individuals under the age of 21, as outlined in Section 1905(r) of the Social Security Act (the Act). In addition, Sections 472(h) and 1902(a)(10)(A)(i)(I) of the Act require States to provide Medicaid, or equivalent health insurance coverage, to children eligible to receive Title IV-E foster care program maintenance funds.

This inspection is based on information gathered from multiple sources: reviews of Federal and State policies; analysis of child-specific Medicaid claims data and case file documentation for 50 randomly-sampled children; interviews with foster care providers (e.g., foster parents and residential care facility staff) and caseworkers for the children in our sample; interviews with Kansas State agency officials; and telephone calls to dental office staff to validate foster care providers' concerns regarding the lack of available Medicaid dental providers. This study did not address follow-up care or the appropriateness of ongoing health care in meeting the needs of foster children.

FINDINGS

All sampled children have Medicaid coverage and claims for services

In accordance with Federal law and State regulations, all of the sampled children have Medicaid coverage. All 50 children had at least one claim for services through Medicaid.

Ninety percent of sampled children received EPSDT Medicaid examinations, and 82 percent received EPSDT dental examinations, in accordance with State guidelines

Ninety percent (45/50) of the sampled children were receiving medical services that met the current EPSDT periodicity time frames. Eighty-two percent (32/39) of children required to receive dental services received a dental examination within established EPSDT guidelines, although foster care providers expressed difficulties locating dentists willing to accept Medicaid patients.

Eighty-two percent of sampled children received initial medical examinations within required timeframes

Of the 39 children in our sample who had initial placements during our study time period, 82 percent (32) had a Medicaid paid claim or case file documentation indicating a medical examination took place within 30 days of placement.

All sampled children received mental health services

The Kansas IV-E foster care program State plan requires that an individual case plan, including an assessment of the child's mental health needs, be developed for each child in foster care within 30 days of their entry into State custody. All children in our sample had a completed case plan and Medicaid claims for mental health services.

Forty-three percent of foster care providers in our sample reported never receiving a medical history for the child in their care

Sections 422(b)(10)(B)(ii) and 475(5)(D) of the Act provide for a case review system and procedures for ensuring that a child's health record is reviewed, updated, and supplied to the foster care provider. Forty-three percent (20/46) of foster care providers interviewed reported never receiving a medical history for the sample child in their care. However, 12 out of 20 caseworkers for these children reported compiling or receiving a medical history.

RECOMMENDATIONS

To ensure that children in foster care have access to and receive the most appropriate health care services, we recommend that:

ACF work with the Kansas Department of Social and Rehabilitation Services to promote the importance of obtaining medical histories for children in foster care and providing this information to foster parents.

CMS work with the Kansas Department of Social and Rehabilitation Services to increase the number of Medicaid health care providers willing to provide services to children in foster care, and provide case workers and foster care providers with current lists of Medicaid providers willing to treat children in foster care.

AGENCY COMMENTS

ACF indicated the background provided in this report was useful. ACF also notes that they are working with the Kansas Department of Social and Rehabilitation Services to promote the importance of obtaining medical histories for children in foster care, and have included steps necessary to gather medical information and provide the information to foster parents. We incorporated suggested terminology changes into this document. The full text of ACF's comments to the draft report is located in Appendix D.

CMS concurs, in part, with our recommendations and points out that the Medicaid program is State-administered within broad Federal guidelines. As such, CMS does not have the ability to directly impact the numbers of providers participating in the

Kansas Medicaid program or the collection, maintenance, and distribution of lists of participating providers. However, CMS indicates they are available to provide technical assistance to the State to promote these processes. The full text of CMS's comments to the draft report is located in Appendix E.

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INTRODUCTION

OBJECTIVE

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

BACKGROUND

Currently, there are an estimated 565,000 children in foster care nationwide,[1] many of whom are reportedly in poor health. To determine if children in foster care are receiving mandated health care services, we selected a series of States for review.[2] The States were chosen to represent a diverse cross-section of foster care nationwide. Kansas was selected because of its child welfare population size, State location, Medicaid fee-for-service coverage for children in foster care, and statewide public-private partnership for child welfare service delivery. Kansas had 6,569 children in foster care at the end of the Federal fiscal year 2000, based on the most recent Federal data available at the time of our review.[3] The Administration for Children and Families (ACF) has regulatory oversight of the Title IV-E foster care program, including State plans to ensure State foster care programs are operating within Federal guidelines.

Compared with children from similar socioeconomic backgrounds, children in foster care suffer much higher rates of serious physical and psychological problems.[4] Dental problems are prevalent in the foster care population and physical health problems (e.g., delayed growth and development, malnutrition, and asthma) affect 30 to 40 percent of children in the child welfare system.[5]

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[1] Retrieved November 1, 2002, from http://www.acf.dhhs.gov/programs/cb/dis/afcars/cwstats.html

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

[3] FY 2000 Foster Care Entries, Exits, and In Care on the Last Day. Retrieved May 20, 2003, from http://www.acf.hhs.gov/programs/cb/dis/talbes/entryexit.htm.

[4] Health Care Issues for Children in Foster Care, March 25, 2002. Retrieved May 20, 2002, from http://www.casey.org/cnc/documents/health_care_issues.pdf.

[5] Fact sheet: The Health of Children in Out-of-Home Care. Child Welfare League of America. Retrieved May 17, 2003, from http://www.cwla.org/programs/health/healthcarecwfact.htm.

Children in foster care have greater health care needs, yet many foster care providers (e.g., foster parents and residential care facility staff) report having difficulty finding health care professionals who are willing to care for these children.[6] The health care available for children in foster care is often characterized by lack of access; lack of information sharing among health care providers; and long delays in obtaining services.[7] Furthermore, studies have shown low percentages of children in foster care are actually receiving services. One report states that less than one-third of children in the child protective system nationwide received mental health services in 1995.[8] A General Accounting Office (GAO) report released in July 2001 states that available data from short-range studies show that the percentage of children in the general population receiving Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services is very low.[9]

The EPSDT program is designed to screen for, diagnose, and treat medical conditions that might otherwise go undetected or untreated. Preventive services for the early detection of disease have been associated with substantial reductions in morbidity and mortality. The benefits of incorporating preventive health care into medical practice have become apparent in recent years, as cases of previously common and debilitating medical conditions have declined in number following the introduction of effective preventive health care services.[10] Preventive dental care is also included as part of EPSDT. A journal article concludes that adherence to American Dental Association recommendations for

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[6] Chernoff, R. et. Al., Assessing the Health Status of Children Entering Foster Care, Pediatrics, 93:2, 1994.

[7] Health Care of Young Children in Foster Care. Pediatrics, 109:3, 2002. Retrieved May 12, 2003, from http://www.aap.org/policy/re0054.html.

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

[9] Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services. General Accounting Office, GAO-01-749, July 2001.

[10] Guide to Clinical Preventive Services, 2nd edition, U.S. Preventive Services Task Force, 1996. Retrieved March 12, 2003 from http://hstat.nlm.nih.gov/hq/Hquest/db/local.gcps.cps/screen/Browse/s/44098/cmd/HF/action/GetText?IHR=CHI.

preventive behaviors over the long-term yields greater benefits than doing so over the short term.[11]

Medicaid for Children in Foster Care

Kansas provides Medicaid coverage to all children in Title IV-E foster care, as well as other eligible children. Sections 472(h) and 1902(a)(10)(A)(i)(I) of the Social Security Act (the Act) require States to provide Medicaid or equivalent health insurance coverage for children eligible to receive Title IV-E foster care maintenance funds. Federal EPSDT guidelines require each State to provide coverage for comprehensive and preventive child health services to Medicaid-eligible individuals under the age of 21, as outlined in Section 1905(r) of the Act. Within broad national guidelines, each State establishes its own eligibility standards for the Medicaid program; determines the type, amount, duration, and scope of Medicaid services; sets the rate of payment for services to Medicaid patients; and administers its own Medicaid program.[12] In 2000, Medicaid payments for children in foster care totaled $3.3 billion nationally.[13] Kansas Medicaid expenditures to provide health care services to children in foster care totaled $10.8 million in 1999. The Centers for Medicare & Medicaid Services (CMS) is responsible for Federal oversight of individual State Medicaid programs.

States design their own Medicaid programs and establish EPSDT guidelines in accordance with Federal requirements to provide coverage for preventive child health services to all Medicaid-eligible individuals under the age of 21.[14] State EPSDT programs must provide medical, hearing, vision, and dental screenings, and other necessary health care and treatment at intervals established by the State that meet reasonable standards of practice published by recognized health care organizations. Kansas established the *Kan Be Healthy* program to meet Federal EPSDT requirements. The current EPSDT periodicity schedule, established in August 2001, for the *Kan Be Healthy* program, requires that medical screenings occur at: birth; 1, 2, 4, 6, 9, 12, 15 and 18 months of age; 2, 3, 4, 5, 6,

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[11] Journal of Dental Research, March 2003; 82 (3): 223-7

[12] Retrieved May 20, 2003 from http://cms.hhs.gov/Medicaid/eligibility/criteria.asp.

[13] Medicaid Statistical Information System (MSIS) Report Fiscal 2000: Illinois. Retrieved May 20, 2003 from http://www.cms.gov/medicaid/msis/00tx.pdf

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

8, and 10 years of age; and annually between the ages of 10 and 21. After age 3, children receiving EPSDT services are required to receive a vision screening every 2 years and a hearing screening every 3 years. Vision and hearing screenings are conducted as part of EPSDT medical screenings. Dental screenings are conducted separately. Under the public-private partnership, foster care contractors are responsible for ensuring that all children in foster care receive EPSDT screenings. Section 6141.02 of the Kansas Medical Services Manual specifies that information provided to program beneficiaries must include information about how *Kan Be Healthy* services can be obtained.

In addition, Section 471(a)(22) of the Act requires States to develop a State plan that includes standards to ensure that all children in foster care placements are provided quality services that protect their safety and health. Sections 422(b)(10)(B)(ii) and 475(5)(D) of the Act require procedures to ensure that a child's health record is reviewed, updated, and supplied to the foster care provider at the time of placement. According to Section 475(1)(C) of the Act, health records should include, to the extent available and accessible, the names and addresses of the child's health providers, a record of the child's immunizations, the child's known medical problems, the child's medications, and any other relevant health information concerning the child, determined to be appropriate by the State agency. The Kansas foster care program policies require that each child receive a medical examination within 30 days of entering State custody and that a case plan be developed for each child within this same 30 days. The case plan must include an assessment of the child's mental health needs and the services required to meet those needs.

METHODOLOGY

This study focused on the receipt of medical and dental health care services within EPSDT guidelines; requirements for initial and comprehensive health screenings upon entry into foster care; case plan assessments of mental health needs and services; and the provision of medical information to foster care providers. This study did not address follow-up care or the appropriateness of ongoing health care in meeting the needs of children in foster care.

This inspection is based on information gathered from multiple sources: reviews of Federal and State policies; analysis of child-specific Medicaid claims data and case file documentation for 50 randomly-sampled children in foster care; interviews with caseworkers and foster care providers for each of the 50 children in our sample; interviews with Kansas State agency officials; and telephone calls to dental office staff to validate foster care providers' concerns regarding the lack of available Medicaid dental providers.

Reasons for State Selection

Kansas was selected due to its small size, centralized child welfare system, geographic location, fee-for-service payment of Medicaid health care services (Kansas does not utilize managed care for children in foster care), and its statewide public-private partnership for provision of child welfare services. The Kansas Department of Social and Rehabilitation Services (SRS) is responsible for the welfare of children in State custody. However, instead of State, county, or local offices providing direct service delivery in child welfare cases, private contractors provide foster care and adoption services. An overview of the Kansas public-private partnership is provided in Appendix A.

Sample

Children who met the following criteria were included in the study population: (1) were in foster care on June 14, 2002; (2) resided in Kansas; and (3) had been in continuous out-of-home foster care placements for at least 6 months. SRS provided us with a list of the 3,766 children (of the 6,569 children in foster care at the end of Federal fiscal year 2000) who met these criteria. We selected a simple random sample of 50 children in foster care in Kansas, based on this defined population, which allowed us to formulate an overview of their use of health care services. Appendices B and C provide information on the children included in our sample.

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

Policy Review - We reviewed Federal and Kansas foster care and Medicaid policies. All children in foster care in Kansas are eligible for Medicaid services, regardless of their Title IV-E foster care or other eligibility status (e.g., Temporary Assistance for Needy Families). Federal law relating to EPSDT requires that States meet reasonable standards of medical and dental practice, as

determined by the State after consultation with recognized medical and dental organizations. Kansas's *Kan Be Healthy* program satisfies the Federal ESPDT requirement. We used *Kan Be Healthy* policy guidelines to determine whether children in foster care received health care services within required time frames.

Medicaid Claims Data Review - SRS provided us with 3 years of Medicaid claims histories for each of the children in our sample. The data included claims for physician, dental, pharmaceutical, and mental health services paid between June 1, 1999, and May 31, 2002. We paid particular attention to the types of health and mental health services, dates of service, settings where the services were provided, and diagnoses, where available. We included only those Medicaid claims after the child's most recent entry into foster care and any claims prior to entry that were pertinent in establishing periodicity for services (i.e., *Kan Be Healthy*).

Case File Documentation Review - We requested and reviewed case file documentation from local offices for all the children in our sample. Information requested included documentation of medical and mental health services provided, duration of the child's stay in foster care, and information regarding the child's general well-being.

Interviews

Foster Care Provider Interviews - We use the term "foster care provider" to refer to a foster parent or a staff member of a residential facility who is responsible for the child. We conducted structured interviews with 46 of the 50 foster care providers (20 in person and 26 by telephone) responsible for the children in our sample between July 31 and August 28, 2002. After repeated attempts, we were unable to interview four foster care providers. The four children, whose foster care providers we were unable to interview, were not included in certain comparative analyses, but were included in our Medicaid claims data analysis. Our interviews with foster care providers focused on Medicaid programs and services available, training related to the health and well-being of children, and procuring health care services for the children included in our sample.

Caseworker Interivews - We conducted structured interviews with each child's caseworker either in person (22) or by telephone (26) between July 29 and September 6, 2002. Two caseworkers were responsible for more than one child, giving us a total of 48 caseworkers for the 50 children in our sample. Each of these interviews focused on the caseworker's understanding of the Medicaid programs and services available, training related to the health and well-being of children, their experience accessing services for the sampled child, and any barriers to health care faced by the child. Each caseworker spoke specifically about the sampled child's case, and generally about his or her own experiences working in foster care. We analyzed the caseworkers' responses and compared them to those of the foster care providers, noting any consensus or disagreement within and between the two groups.

Discussions with State Agency Officials - To enhance our understanding of the State's foster care and Medicaid programs, we consulted, both in person and by telephone, with SRS officials who are responsible for the administration of both programs in the State of Kansas. Our discussions covered a wide spectrum of information, including the overall provision of Medicaid services for children in foster care, the *Kan Be Healthy* (EPSDT) program, Kansas' public-private partnership, and Medicaid claims for children in foster care.

Dental Provider Contacts - During our interviews with foster care providers, they reported difficulty scheduling dental appointments for children in their care. To validate these difficulties, we contacted the offices of dental care providers. At our request, SRS provided us with a list of 26 dental providers whom they believed accepted Medicaid patients in 2 areas of the State where foster care providers and caseworkers reported the most difficulty scheduling dental appointments for children in their care. We called the offices of all 26 dental providers and asked them whether they were accepting new Medicaid patients and, if so, when their first available appointment was for a routine dental examination.

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

FINDINGS

All sampled children have Medicaid coverage and claims for services

Federal law requires States to provide Medicaid or equivalent health insurance coverage to children eligible to receive Title IV-E foster care program maintenance funds. Within broad national guidelines, each State establishes its own Medicaid-eligibility standards. Children in foster care in Kansas are eligible for all health care services provided through the Medicaid program, including EPSDT.

Our review of Medicaid claims and interview data indicates that all 50 children in our sample had Medicaid coverage. Our analysis of the Medicaid claims data revealed that each sampled child had paid health care claims since entering foster care. Overall, foster care providers were aware of the availability of Medicaid services for children in their care and were receiving monthly Medicaid cards for them. The 50 children in our sample had received a total of 5,853 Medicaid health care services while in foster care since June 1, 1999, as outlined in the following chart.

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

Claim type	Number of children with at least one claim	Total number of claims*
Physician office	50	2,126
Mental Health	50	1,916
Prescriptions	49	1,129
Dental	37	675
Hospitalization	5	7
Total		**5,853**

*A detailed list of services for each child is located in Appendix C.
Source: OIG analysis of Kansas Medicaid claims data

Ninety percent of children in the sample received routine physical examinations, and 82 percent received EPSDT dental examinations, in accordance with State guidelines

Federal EPSDT guidelines require each State to provide physical, mental, vision, hearing, and dental screenings, and other necessary health care and treatment, as needed, at

intervals established by the State. These services must meet reasonable standards of practice published by recognized health care organizations and are designed to prevent, diagnose, and treat medical conditions that might otherwise go undetected or untreated. Kansas' *Kan Be Healthy* program fulfills the Federal EPSDT requirements.

Physical Examinations

A review of 3 years of Medicaid claims data and case file documentation showed that 90 percent (45/50) of the children in this study were receiving EPSDT services within the time frames established by Kansas at the time of our review. For the five children in foster care who did not have current EPSDT services, either the caseworker, foster care provider, or both stated that the child did, in fact, receive EPSDT services; however, we were not provided with medical documentation to support receipt of those services.

While it is difficult to pinpoint specific practices that enabled Kansas to meet established guidelines for providing required EPSDT services to many of the sampled children in foster care, evidence collected suggests two factors may be instrumental. First, the Kansas Medicaid program distributes monthly Medicaid cards to each Medicaid client; these cards are printed with the due date of the next required *Kan Be Healthy* (EPSDT) screen. Foster care providers indicated the information printed on the Medicaid card was helpful. Also, caseworkers conduct monthly visits to each foster child's placement, during which they monitor the child's health care and receipt of required services. Caseworkers must complete the form (CFS 3050C) every 6 months that includes a section verifying that the child's most recent *Kan Be Healthy* screening is correct (i.e., received within periodicity guidelines).

Dental Examinations

Kansas EPSDT guidelines require every child in foster care over 3 years of age to have an annual dental examination. Of the 40 children in our sample 3 years of age and older, 98 percent (39/40) had at least 1 oral evaluation since their entry into foster care, and 82 percent (32/39) received an evaluation within the past year. Six children who were overdue for required services had received previous dental services, such as resins and sealants. The

one child with no Medicaid claim for an oral evaluation had no other dental claims, and the child's foster care provider was one of the four non-respondents whom we were unable to interview.

One possible reason that the percentage of children receiving EPSDT dental services is lower than the percentage receiving other EPSDT services is because, according to interview data, foster care providers experience difficulty locating dentists willing to accept Medicaid patients. Foster care providers also reported difficulty scheduling appointments with dental providers participating in the Medicaid program. Of the 31 foster care providers interviewed who had attempted to schedule a dental appointment for the foster child in their care, 12 reported having difficulty locating a dentist who would accept Medicaid patients. Of the 19 foster care providers who indicated they did not have a problem locating a dentist, 6 foster care providers reported having difficulty scheduling an appointment.

Foster care providers reported that participating dentist's offices are often geographically far from the foster care provider's residence and that very few dentists were accepting new Medicaid patients. They reported that the lack of dental providers willing to accept Medicaid patients was acute in two geographic areas of the State - one large and one small community. At our request, the SRS created a list of dental providers that it believed accepted Medicaid patients in these two communities. The list provided by SRS contained the names of 24 dentists in the large community (out of 105 total dentists) and 2 dentists in the small community (out of 7 total dentists).

To validate the problems that foster care providers reported, we called the offices of the 26 dentists listed and asked if the dentist was accepting new Medicaid patients, and if so, when the first available appointment could be scheduled. These contacts revealed that only 6 of the 24 dental providers in the large community were accepting new Medicaid patients. Both listed dentists in the small community were accepting new Medicaid patients. An appointment for a routine dental examination with any of the eight dentists accepting new Medicaid patients could be scheduled within 3 days to 2 months, depending on the provider. Given that only 8 of the dentists who accepted Medicaid (out of 112 dentists total in the

2 communities) were accepting new Medicaid patients, finding a dentist willing to treat a child on Medicaid is problematic.

Eighty-two percent of sampled children received initial medical examinations within required timeframes

Federal law requires States to develop a State plan that includes standards to ensure that children in foster care placements are provided quality services that protect their safety and health. The Kansas foster care program, as outlined in the Kansas IV-E foster care program State plan, requires that children in foster care receive a medical examination within 30 days of entering State custody. Thirty-nine children in our sample had initial placements between June 1999 and November 2001 (the time period covered by our claims data less six months, due to the time it takes to submit and process some claims). Eighty-two percent (32/39) of these children had a Medicaid paid claim or case file documentation indicating a medical examination took place within 30 days of placement.

All sampled children received mental health services

While there are no requirements in Title IV-E of the Act that address the provision of mental health services to children in foster care specifically, Section 471(a)(22) of the Act requires States to develop and implement standards to ensure that all children in foster care placements are provided quality services that protect their safety and health. The Kansas foster care program policies require that a case plan be developed for each foster child within 30 days of a child entering State custody. The case plan requires an assessment of the child's mental health needs and the services required to meet those needs. Assessments for mental health needs are important because children in foster care are more likely to suffer from mental health problems than other children.[15]

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

All children in our sample had a completed case plan that addressed the child's mental health needs, and all children in our sample had at least one Medicaid claim for some type of mental health service. We did not evaluate the adequacy of the mental health assessments or services provided.

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

Federal law requires that a child's health record is reviewed, updated, and supplied to the foster care provider when they are placed in foster care. Twenty of the 46 foster care providers interviewed reported never receiving a medical history for the sampled child in their care. However, caseworkers for 12 out of these 20 foster care providers reported compiling or receiving a medical history. Two out of the 12 foster care providers who did not receive the medical history available to the caseworker reported being unaware of documented mental health problems facing the foster child in their care. A child's health may be compromised if the foster care provider is unaware of the child's family medical history, chronic physical health problems, mental health problems, or other medical needs.

In exploring why medical histories were not shared with foster care providers, several reasons were identified.

- The caseworker was a student intern.
- The child's case changed from foster care to adoption status, and the adoption caseworker had assumed that the foster care caseworker provided a medical history to the foster care providers.
- The caseworker lost the medical record.

The failure to provide a medical history is particularly problematic because the foster care providers whom we questioned indicated that caseworkers are the most important source of information for them regarding the health care needs of children in their care.

Fifty-nine percent (27/46) of foster care providers interviewed indicated that when they have questions about accessing medical services for the foster child, they would ask the child's caseworker

first. Less common cited sources included the child's primary care physician or staff at an SRS or Medicaid office.

RECOMMENDATIONS

To ensure children in foster care have access to and receive the most appropriate health care services, we recommend that:

ACF work with the Kansas Department of Social and Rehabilitation Services to:

- Promote the importance of obtaining medical histories for children in foster care and providing this information to foster parents

CMS work with the Kansas Department of Social and Rehabilitation Services to:

- Increase the number of Medicaid health care providers willing to provide services to children in foster care
- Develop and maintain current and accurate lists of Kansas health care providers participating in the Medicaid program by area or community
- Provide case workers and foster care providers with current lists of Medicaid providers willing to treat children in foster care

AGENCY COMMENTS

ACF indicated the background provided in this report was useful. ACF notes it found that only 78 percent of the children included in the Kansas Children and Family Services Review, conducted in August 2001, received medical services, but that differences in its review and Office of Inspector General findings may be explained by the use of different methodologies. ACF also notes four conclusions resulting from its review. The first two, related to an insufficient number of dental care providers that accept Medicaid and foster parents not always being provided with timely medical information for the children in their care, were similar to our findings. ACF is working with the Kansas Department of Social and Rehabilitation Services to promote the importance of obtaining medical histories for children in foster care and have included steps

necessary to gather medical information and provide the information to foster parents as part of a Program Improvement Plan. The latter two conclusions, related to foster parent reimbursement to transport children for medical care and the need for improvements in the provision of mental health services, focused on issues outside the scope of our study. The full text of ACF's comments to the draft report is located in Appendix D.

The CMS concurs, in part, with our recommendations and points out that the Medicaid program is State-administered within broad Federal guidelines. As such, CMS does not have the ability to directly impact the numbers of providers participating in the Kansas Medicaid program or the collection, maintenance, and distribution of lists of participating providers. However, CMS indicates they are available to provide technical assistance to the Kansas Department of Social and Rehabilitation Services, the State agency responsible for both the Medicaid and Title IV-E foster care programs, to promote efforts to ensure children in foster care have adequate access to health care services. The full text of CMS's comments to the draft report is located in Appendix E.

APPENDIX ~ A

Kansas Foster Care and Medicaid Programs

The Kansas Department of Social and Rehabilitation Services is responsible for all children in State custody in Kansas. Within that Department, the Division of Children and Family Policy is specifically responsible for providing child protective services. The child welfare system is administered through a public-private partnership, in which the State is ultimately responsible for the well-being of children in State custody, but private contractors provide direct services, instead of State or county offices. Kansas has five contracted agencies, one in each region of the State, who in turn subcontract with other agencies to provide services at the community level. Each agency is paid a flat fee, plus an additional amount for each child whom it serves. State contracts with participating agencies are awarded every 4 years and renewed annually.

Health care for Kansas children in foster care is provided primarily through Medicaid, and all Kansas children in foster care are status-eligible for Medicaid. There are no special health guidelines or coverage exceptions for children in foster care; they follow the same rules as the general Medicaid population. Although Medicaid managed care is available in Kansas, managed care programs are not used to provide benefits to children in foster care. Each child in foster care is issued a monthly Medicaid card that must be shown to access benefits, and these cards are printed with the date of the child's most recent *Kan Be Healthy* screening and the date that the child's next screening is due. Other sources of health care funding for children in foster care in Kansas include Head Start, public health clinics, and any private health insurance a child's biological parents might have.

APPENDIX ~ B

Detailed Demographic Data

The table below is merely descriptive in nature and describes the demographic characteristics of each sampled child and his or her foster care placement history (the first 6 columns) at the end of May 2002.

ID	Sex	Age (years)	Placement Setting	Entries into foster care (1)	Months since last entry (2)	Placements since last entry (3)	Months since last placement (2)	Caseworkers since last entry	Months caseworker with case (2)
1	F	1	Family	1	7	1	10	1	10
2	F	4	Family	1	23	1	25	1	3
3	M	14	Family	1	7	1	9	2	4
4	F	17	Kinship	1	37	1	37	2	2
5	F	6	Family	1	44	1	46	2	3
6	F	4	Kinship	1	8	1	11	2	7
7	F	1	Family	1	15	1	17	3	8
8	F	8	Family	1	13	2	8	1	14
9	M	9	Family	1	8	2	9	1	11
10	M	2	Family	1	15	2	7	1	18
11	F	10	Family	1	27	2	26	1	28
12	F	16	Family	1	12	2	13	1	14
13	F	15	Kinship	1	14	2	5	2	16
14	M	3	Family	1	21	2	14	2	4
15	M	4	Family	1	34	2	36	2	13
16	F	2	Family	1	23	2	25	2	5
17	M	1	Residential	1	13	2	13	2	7
18	F	9	Family	2	20	2	10	3	10
19	M	9	Family	1	33	2	36	3	15
20	F	1	Family	1	17	2	3	3	12
21	F	6	Family	1	21	2	24	4	11
22	M	3	Kinship	1	30	2	21	4	21
23	F	11	Family	1	28	3	25	2	25
24	F	3	Family	1	20	3	9	4	18
25	F	17	Kinship	1	15	3	13	5	9
26	F	13	Secure Care	1	7	4	3	1	9
27	M	4	Kinship	1	18	4	18	2	3
28	F	1	Family	1	15	4	15	2	7
29	M	18	Independent	1	16	4	5	3	10
30	M	12	Family	1	56	4	18	3	24
31	M	11	Family	2	13	4	6	3	2
32	F	18	Family	1	29	4	13	3	22
33	M	12	Family	1	20	4	2	4	5
34	M	5	Adoptive	1	50	4	52	8	6
35	F	14	Family	1	38	5	13	1	13
36	M	14	Family	1	29	5	10	2	4
37	F	15	Family	1	22	5	6	5	15

ID	Sex	Age (years)	Placement Setting	Entries into foster care (1)	Months since last entry (2)	Placements since last entry (3)	Months since last placement (2)	Caseworkers since last entry	Months caseworker with case (2)
38	F	14	Kinship	1	15	6	5	2	5
39	M	12	Family	1	28	6	3	3	3
40	M	17	Residential	1	11	6	5	3	1
41	F	5	Family	2	55	6	42	3	8
42	F	17	Family	1	18	7	1	5	20
43	M	15	Family	2	36	9	2	2	9
44	M	6	Adoptive	1	39	9	2	4	20
45	M	7	Family	2	44	10	9	3	6
46	F	17	Family	1	11	11	11	1	15
47	F	11	Residential	1	62	11	23	5	14
48	M	19	Group Home	1	65	14	3	8	16
49	F	14	Family	1	16	16	5	2	3
50	M	15	Residential	1	30	18	8	4	1

(1) "Entries into foster care" refers to the number of times a child has entered State custody (i.e., number of foster care "episodes").
(2) "Months since last entry" is the length of time from the date of the child's most recent entry into State custody until 05/31/02, which coincides with the last date of our claims record. "Months since last placement" is the length of time from the date of the most recent placement to the date the foster care provider was interviewed, and may be up to 4 months greater than "months since last entry" due to rounding. "Months caseworker with case" is the length of time from the date the caseworker initially took over the case until the date the caseworker was interviewed and may be up to 4 months greater than "months since last entry" due to rounding.
(3) "Placements since last entry" refers to the number of placement settings (e.g., Foster Home A, Foster Home B, Metro Residential Facility) a child has experienced during each "episode" in foster care.

APPENDIX ~ C

Detailed Claims Data

The table below describes whether the child received required services, including a tally of services during his or her time in foster care from a period June 1, 1999, to May 30, 2000, or entry to May 30, 2002, whichever is shorter.

ID	EPSDT current (1)	Dental current (1,2)	30-day physical assessment	Medical history provided to care provider	Office visit claims	Mental health-related claims	Prescription claims	Dental claims	Hospital claims
1	YES	N/A	YES	YES	25	20	18	0	0
2	YES	NO	YES	YES	43	25	8	18	0
3	YES	YES	YES	NO	12	8	2	4	0
4	NO	NO	N/A	YES	16	33	5	13	0
5	YES	YES	N/A	YES	8	40	8	53	0
6	YES	YES	YES	NO	13	12	6	12	0
7	YES	N/A	YES	YES	33	24	14	0	1
8	YES	YES	YES	NO	16	51	5	9	0
9	YES	N/A	YES	NO	75	7	29	0	0
10	YES	N/A	YES	NO	50	19	29	0	0
11	YES	YES	YES	NO	101	78	41	22	0
12	YES	YES	YES	YES	15	20	3	2	0
13	YES	YES	YES	YES	9	19	5	17	0
14	YES	N/A	YES	YES	21	24	21	0	0
15	YES	YES	NO	NO	59	32	18	4	0
16	YES	N/A	NO	YES	18	17	4	0	0
17	YES	N/A	YES	NO	25	14	16	0	0
18	YES	YES	YES	YES	14	22	3	22	0
19	YES	YES	YES	NO	22	41	6	20	0
20	YES	N/A	YES	YES	40	20	16	0	0
21	YES	YES	NO	NO	7	37	3	11	0
22	YES	N/A	YES	NO	23	30	15	0	0
23	YES	NO	YES	NO	17	82	5	24	0
24	YES	N/A	YES	YES	30	19	20	3	0
25	NO*	NO	YES	No Interview	22	12	9	0	0
26	YES	NO	YES	NO	27	15	54	0	1
27	YES	YES	YES	YES	15	114	4	23	0

ID	EPSDT current (1)	Dental current (1,2)	30-day physical assessment	Medical history provided to care provider	Office visit claims	Mental health-related claims	Prescription claims	Dental claims	Hospital claims
28	YES	N/A	YES	NO	16	15	3	0	0
29	YES	YES	YES	NO	56	37	2	17	0
30	YES	NO	N/A	YES	62	43	16	17	0
31	YES	YES	YES	YES	8	49	0	5	0
32	NO	YES	YES	YES	179	127	92	39	1
33	YES	YES	YES	YES	6	29	2	7	0
34	YES	NO*	N/A	No Interview	57	32	45	0	0
35	NO	YES	N/A	YES	15	47	2	24	0
36	YES	YES	YES	YES	290	38	45	9	1
37	NO	YES	NO	NO	9	43	11	13	0
38	YES	YES	YES	YES	12	45	22	25	0
39	YES	YES	NO	No Interview	60	60	101	10	3
40	YES	YES	YES	NO	29	10	6	8	0
41	YES	YES	N/A	NO	24	48	13	10	0
42	YES	YES	YES	YES	70	25	54	24	0
43	YES	YES	N/A	YES	60	94	5	52	0
44	YES	YES	N/A	YES	55	73	16	13	0
45	YES	YES	N/A	NO	30	32	13	33	0
46	YES	YES	NO	No Interview	14	12	3	2	0
47	YES	YES	N/A	YES	98	47	147	9	0
48	YES	YES	N/A	NO	20	54	15	14	0
49	YES	YES	YES	YES	72	51	57	31	0
50	YES	YES	NO	YES	128	70	92	56	0

(1) * = No record of screening ever performed

(2) N/A = Under the age of 3 years or child was placed before June 1, 1999

APPENDIX ~ D

Agency Comments - ACF

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

DATE: JUN 3 - 2003

TO: Dennis Duquette
Acting Principal Deputy Inspector General

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

SUBJECT: Comments on the OIG Draft Report: "Foster Children's Use of Medicaid Services in Kansas," OEI-07-00-00640

Attached are the Administration for Children and Families' comments on the OIG Draft Report: "Foster Children's Use of Medicaid Services in Kansas," OEI-07-00-00640.

If you have any 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 (ACF) ON THE OFFICE OF INSPECTOR GENERAL'S DRAFT REPORT: "FOSTER CHILDREN'S USE OF MEDICAID SERVICES IN KANSAS," OEI-07-00-00640

The Administration for Children and Families (ACF) appreciates the opportunity to comment on the Office of Inspector General's (OIG) draft report.

OIG Recommendations

To ensure foster children have access to and receive the most appropriate health care services, OIG recommends that ACF work with the Kansas Department of Social and Rehabilitation Services to:

- promote the importance of obtaining medical histories for foster children, and
- ensure that foster care providers are provided with available medical information for the foster children in their care.

OIG also recommends that the Centers for Medicare & Medicaid Services work with the Kansas Department of Social and Rehabilitation Services to:

- increase the number of Medicaid health care providers willing to provide services to foster children,
- develop and maintain current and accurate lists of Kansas health care providers participating in the Medicaid program by area or community, and
- provide case workers and foster care providers with current lists of Medicaid providers willing to treat foster children.

ACF Comments

The background provided in the report was useful in giving a perspective of the problem. However, OIG should consider using the term "children in foster care" rather than "foster children."

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

In addition to the federal regulations cited in the report, the CFSR was authorized by the 1994 amendments to the Social Security Act (SSA) and is administered by the Children's Bureau (CB).

The CFSR is a major mechanism for working with states about practice issues that impact the well-being of children and families.

The CFSR consists of two phases. In Kansas, as in other states, the first phase consisted of a state data profile, derived from data provided by the state. The profile highlighted key performance indicators relating to safety and permanency for children coming into the child welfare system. Using this profile and other sources of information, Kansas completed a statewide assessment which assessed the process, procedures, and policies of their child welfare system, including foster care and adoption. This assessment also focused on the systemic factors in place which enable the state to carry out the process, procedures and policies of the program.

The second phase of the process involved an on-site review the week of August 6, 2001. The purpose of the on-site review included an examination of a sample of 50 cases for outcome achievement and interviews with community stakeholders to evaluate the systemic factors under review. The cases reviewed on-site examined child-specific performance indicators. Through a combination of aggregate data reported on the statewide assessment and case-specific information gathered on-site, the review team was able to evaluate outcome achievement within programs and to identify areas where technical assistance is needed to make improvements.

The regulation at 45 CFR 1355.34(b)(3) defines the components for determining when a state is in substantial conformity for the purposes of the CFSR. Outcomes from the case review portion of the CFSR must be rated as "substantially achieved" in 95 percent of the cases examined (90 percent of the cases for a state's initial review) as one component of finding a state in substantial conformity with federal requirements. Information from various sources (e.g., case records, interviews, etc.) are examined for each outcome and a determination made as to the degree to which each outcome has been achieved for each case reviewed.

During the on-site portion of the Kansas review, only 78 percent of the cases reviewed to measure whether or not "children receive adequate services to meet their physical and mental health needs" substantially achieved this outcome. While there were a number of strengths identified related to the provision of health and mental health services, the findings of the CFSR identified more concerns than the OIG review of the use of Medicaid by children in foster care within Kansas. The concerns identified during the CFSR are the focus of the PIP mentioned above. The difference in findings from the OIG review may be explained by the fact that the CFSR included a more in-depth review of children's specific needs and services.

There were a number of challenges identified related to health and mental health services during the 2001 CFSR in Kansas. They included:

- Stakeholders stated that there are insufficient numbers of dental care providers that accept Medicaid, especially for orthodontia care.

- In some instances foster parents are not provided with medical information on children placed in their care in a timely manner or at all.

- The mechanism for foster parents to claim reimbursement for travel to take children for medical care was reported to be cumbersome and did not support timely reimbursements.

- Stakeholders and case reviews identified the need for improvement in the provision of mental health services to children and families. While mental health evaluations were being completed for children, follow-up treatment or the specialized services needed were not always provided. There were waiting lists for specialized services. Especially challenging were the children with severe emotional disturbances, described as one to two percent of the children served. Stakeholders indicated that the duration, level, and intensity of appropriate mental health services are not being provided. Mental health services were the most costly and were not being authorized, resulting in unstable placements, children remaining in care for extended periods of time and placement of children in restrictive placements.

Kansas was the twelfth state in the country to participate in the CFSR. In October 2002, the ACF regional office and the State entered into a PIP to address areas of non-conformity with federal requirements found during the Kansas review. The PIP has specific action steps and benchmarks related to gathering medical information and providing it to foster families. The ACF regional office will be monitoring progress on the plan quarterly. Even so, it is beyond the authority of ACF to ensure that individual foster care providers are given available medical information for the foster children in their care.

APPENDIX ~ E

Agency Comments - CMS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Ser

Administrator
Washington, DC 20201

DATE: MAY 23 2003

TO: Janet Rehnquist
Inspector General
Office of Inspector General

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

SUBJECT: Office of Inspector General (OIG) Draft Report: "Foster Children's Use of Medicaid Services in Kansas" (OEI-07-00-00640)

Thank you for the opportunity to review and comment on the above-referenced draft report. We were pleased to learn that, based on the sample used by OIG, children in the Kansas foster care system are receiving the required and necessary medical services to which they are entitled. While access to providers appears to be an issue in some instances, it does not seem to be greatly impeding the delivery of services.

OIG Recommendation

The Centers for Medicare & Medicaid Services (CMS) work with the Kansas Department of Social and Rehabilitation Services to:

- Increase the number of Medicaid health care providers willing to provide services to foster children,
- Develop and maintain current and accurate lists of Kansas health care providers participating in the Medicaid program by area or community, and
- Provide caseworkers and foster care providers with current lists of Medicaid providers willing to treat foster children.

CMS Response

The CMS concurs, in part, with the recommendation. The Medicaid program is a state and Federal partnership whereby states administer their own Medicaid programs within broad Federal guidelines. The CMS does not have the authority or ability to directly impact the number of providers participating in the State's Medicaid program nor to collect and maintain lists of providers of every state and distribute them to foster care providers and caseworkers. These are part of the administrative responsibilities of the State Medicaid agency.

Page 2 - Janet Rehnquist

The Kansas Department of Social and Rehabilitation Services (SRS) appears to be responsible for both the Medicaid program and the foster care system. We recommend that SRS better coordinate these functions within its own agency so that foster care providers and caseworkers receive the information they need to ensure that medical services are available and appropriately provided. The Kansas State Medicaid agency could also work with State provider groups to encourage participation in the Medicaid program so as to ensure adequate access to services.

While CMS cannot play a direct role in the maintenance and distribution of current provider lists, or directly impact an increase in the number of Medicaid providers in the State, we are available to provide technical assistance to the State to promote these processes.

Attachment

ACKNOWLEDGMENTS

This report was prepared under the direction of Brian T. Pattison, Regional Inspector General for Evaluation and Inspections and Gina Maree, Assistant Regional Inspector General for Evaluation and Inspections in Kansas City. Other principal Office of Evaluation and Inspections staff who contributed include:

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