

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NOT ALL CHILDREN IN
FOSTER CARE WHO WERE
ENROLLED IN MEDICAID
RECEIVED REQUIRED HEALTH
SCREENINGS**



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EXECUTIVE SUMMARY: NOT ALL CHILDREN IN FOSTER CARE WHO WERE ENROLLED IN MEDICAID RECEIVED REQUIRED HEALTH SCREENINGS

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WHY WE DID THIS STUDY

Children in foster care often experience chronic medical, developmental, and mental health issues. States' ability to ensure that foster children receive needed health services is critical to these children's well-being. The Social Security Act requires each State to develop a plan for ongoing oversight and coordination of health services for children in foster care, which includes establishing a schedule for initial and periodic screenings. Screenings may include medical, dental, hearing, vision, mental health, and other (e.g., developmental) assessments. Furthermore, the Administration for Children and Families (ACF) is responsible for monitoring States' foster care programs, including States' oversight and coordination of health services for children. One method by which ACF monitors States is periodic reviews of States' child welfare systems, known as Child and Family Services Reviews. This report describes whether children in foster care receive required initial and periodic health screenings according to their States' schedules.

HOW WE DID THIS STUDY

We selected four States with large foster care populations (California, Illinois, New York, and Texas) to determine whether children in foster care received initial and periodic health screenings as established in each State's plan. Nearly all children in foster care are eligible for Medicaid; therefore, Medicaid pays for many of the health care services that these children receive. Therefore, from each of the 4 States, we selected a simple random sample of 100 children who were in foster care and were enrolled in Medicaid between July 1, 2011, and June 30, 2012. We also conducted a structured interview with staff from ACF to determine whether ACF ensures that children in foster care receive the required screenings.

WHAT WE FOUND

Nearly a third of children in foster care who were enrolled in Medicaid did not receive at least one required health screening. Furthermore, just over a quarter of children in foster care who were enrolled in Medicaid received at least one required screening late. Moreover, ACF's reviews do not ensure that children in foster care receive the required screenings according to State schedules.

WHAT WE RECOMMEND

We recommend that ACF expand the scope of its Child and Family Services Reviews to determine whether children in foster care receive required screenings according to the timeframes specified in States' plans. ACF stated that it would consider this recommendation. We also recommend that ACF identify and disseminate State strategies to ensure that all children in foster care receive required screenings. We encourage ACF to work with States to (1) identify the barriers that prevent children in foster care from receiving required screenings and (2) identify, disseminate, and implement strategies for overcoming those barriers.

Such strategies might include developing educational materials for foster parents that discuss the benefits of screenings and providing incentives to families and children in foster care to encourage participation in required screenings. ACF concurred with this recommendation.

TABLE OF CONTENTS

Objectives	1
Background	1
Methodology	5
Findings.....	7
Nearly a third of children in foster care who were enrolled in Medicaid did not receive at least one required health screening	7
Over a quarter of children in foster care who were enrolled in Medicaid received at least one required health screening late.....	7
ACF’s reviews do not ensure that children in foster care receive required health screenings according to State schedules	8
Conclusion and Recommendations.....	9
Agency Comments and Office of Inspector General Response.....	11
Appendixes	12
A: Required Elements for Health Services Oversight and Coordination Plans.....	12
B: Four Selected States’ Schedules for Periodic Health Screenings	13
C: Detailed Methodology.....	16
D: Point Estimates, Sample Sizes, and Confidence Intervals	18
E: Agency Comments	19
Acknowledgments.....	21

OBJECTIVES

1. To determine for four selected States the extent to which children in foster care who were enrolled in Medicaid received required health screenings as established in States' health services oversight and coordination plans.
2. To determine the extent to which the Administration for Children and Family Services (ACF) ensured that children in foster care receive required health screenings.

BACKGROUND

Foster Care

Federal regulations define foster care as “24-hour substitute care for children placed away from their parents or guardians...”¹ A child may be placed in foster care for reasons such as abuse, neglect, or abandonment.² Children in foster care are placed in a variety of settings that may include nonrelative foster homes, relative foster homes, group homes, and preadoptive homes.³ On September 30, 2013, there were approximately 402,000 children in foster care nationwide.⁴

Children in foster care experience a high rate of chronic medical, developmental, and mental health issues.⁵ The health care that children receive while in foster care is often affected by lack of access to and coordination of care.⁶ States' ability to ensure that needed health services are received is critical to the well-being of children in foster care.

¹ 45 CFR § 1355.20.

² American Academy of Child & Adolescent Psychiatry, *Facts for Families: Foster Care*. No. 64, May 2005.

³ ACF, *The Adoption and Foster Care Analysis and Reporting System (AFCARS) FY [Fiscal Year] 2012 Data: Preliminary FY 2012 Estimates as of November 2013*.

⁴ ACF, *Numbers of Children in Foster Care on September 30th, by State FY 2004-FY 2013*. Accessed at http://www.acf.hhs.gov/sites/default/files/cb/children_in_care_2013.pdf on January 29, 2015.

⁵ American Academy of Pediatrics. *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2nd Edition.

⁶ American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Dependent Care. “Health Care of Young Children in Foster Care,” *Pediatrics*, Vol. 109, No. 3, March 2002, pp. 536–541.

Health Services Oversight and Coordination Plans and Schedules for Required Health Screenings

Pursuant to section 422(b)(15)(A) of the Social Security Act (the Act), each State must develop a plan for ongoing oversight and coordination of health services for children in foster care.⁷ Each State's foster care agency must coordinate with its State Medicaid agency, health care experts (e.g., pediatricians, general practitioners, and specialists), and child welfare experts in developing the State plan.⁸ Each State is required to submit its plan to ACF every 5 years.⁹ Each State plan must include seven elements, one of which is a schedule for initial and periodic screenings that meets reasonable standards of medical practice.¹⁰ See Appendix A for a complete list of the seven required elements.¹¹

States must establish schedules for initial and periodic health screenings similar to existing standards of care. According to ACF guidance, State schedules for initial and periodic health screenings “should mirror or incorporate elements of existing professional guidelines for physical, mental, and dental health screenings and standards of care.”¹² Examples of existing professional guidelines include, but are not limited to, the American Academy of Pediatrics' *Recommendations for Preventative Pediatric Health* and State Medicaid agencies' Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)¹³ schedules.

⁷ Section 422(b)(15)(A) of the Act has been revised by three separate Public Laws: the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. No. 110-351 § 205, enacted on October 7, 2008); the Patient Protection and Affordable Care Act (P.L. No. 111-148, § 2955, enacted on March 23, 2010); and the Child and Family Services Improvement and Innovation Act (P.L. No. 112-34 § 101(b), enacted September 30, 2011). The Patient Protection and Affordable Care Act was amended by the Health Care and Education Reconciliation Act of 2010 (P.L. No. 111-152, enacted on March 30, 2010). Together, these laws are referred to as the Affordable Care Act.

⁸ Section 422(b)(15)(A) of the Act.

⁹ Each State is required to submit the health services oversight and coordination plan as part of its Child and Family Services Plan (CFSP) to ACF every 5 years (45 CFR § 1357.15). States were required to submit their CFSPs for FYs 2010 to 2014 by June 30, 2009.

¹⁰ Section 422(b)(15)(A) of the Act. Screenings may include medical, dental, hearing, vision, mental health, and other (e.g., developmental) assessments.

¹¹ This evaluation focuses on receipt of required health screenings according to schedules established in States' plans.

¹² ACF, *Program Instruction: Guidance on Fostering Connections to Success and Increasing Adoptions Act of 2008*, July 2010. Section 422(b)(15)(A) of the Act does not stipulate how States must define their schedules for initial and periodic health screenings. Thus, States have flexibility in establishing their schedules for such screenings.

¹³ EPSDT is a Medicaid benefit that provides comprehensive and preventive health care services for children under age 21. EPSDT screenings must be provided at intervals that meet reasonable standards of medical practice.

ACF guidance does not stipulate which professional guidelines State foster care agencies should adopt or incorporate into the plans for their States.

Selected States' Health Screening Schedules

Four States with large foster care populations were selected for inclusion in this evaluation: California, Illinois, New York, and Texas. These four States constitute 31 percent of the national population of children in foster care.¹⁴

Each of the four States has a schedule for initial and periodic health screenings in its plan. Each of the four States requires that children entering foster care receive an initial health screening within a specific timeframe. The States' timeframes vary from within 24 hours of foster care placement to within 30 days of placement. See Table 1 for each State's timeframe.

Table 1: State Timeframes for Initial Health Screenings

State	Timeframe Within Which Initial Health Screening Must Be Received
California	24 hours
Illinois	24 hours; a second comprehensive medical screening within 21 days
New York	24 hours
Texas	30 days

Source: OIG analysis of State plans and survey responses, 2014.

Each of the four States requires that children in foster care receive periodic screenings at specified intervals throughout their foster care placement. All four States' intervals are based on the age of the child, and these intervals vary from State to State. Generally, the four States require more frequent periodic screenings for children under age 3 than for those 3 and older. The screenings for children under age 3 are required at specified monthly intervals (e.g., every 2 months, every 6 months). Once children reach age 3, the States require less frequent periodic screenings (e.g., annually or biennially). See Appendix B for the four States' schedules.

Each of the four States has incorporated elements of its EPSDT schedule into its schedule for health screenings for children in foster care.

¹⁴ These four States constitute 31 percent of the national population of children in foster care. ACF, *Foster Care FY2003–2012 Entries, Exits, and In Care on the Last Day of Each Federal Fiscal Year*. Accessed at www.acf.hhs.gov/sites/default/files/cb/entryexit2012.xlsx on May 28, 2014.

For Texas, the two are the same; Texas adopted the State EPSDT schedule as its schedule for screenings for children in foster care. For the other three States, the schedules are similar to the EPSDT schedules, but require more frequent screenings.

Medicaid for Children in Foster Care

In all States, nearly all children in foster care are eligible for Medicaid services.¹⁵ Medicaid pays for many of the health care services that children in foster care receive. In FY 2011, Medicaid paid over \$5.3 billion for more than 865,000 children in foster care nationwide.¹⁶

ACF Oversight

Within ACF, the Children's Bureau is responsible for providing Federal funding to States' foster care programs and for overseeing those programs. As part of its oversight responsibilities, the Children's Bureau reviews and approves States' Child and Family Services Plans (CFSPs), which include the health services oversight and coordination plans and Annual Progress and Services Reports. The Children's Bureau issues annual program instructions outlining the information that States must report to receive annual Federal funding, including information pertaining to the health services oversight and coordination plans. The Children's Bureau also conducts periodic reviews of each State's child welfare system, known as Child and Family Services Reviews.

Related Reports

A 2010 Office of Inspector General (OIG) report found that for children enrolled in Medicaid in nine States, three out of four children did not receive all required medical, vision, and hearing screenings.¹⁷ The report also found that nearly 60 percent of children who received EPSDT medical screenings lacked at least one component of a complete medical screening.¹⁸

¹⁵ According to section 1902(a)(10)(A)(i)(I) of 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 under Title IV-E might qualify for Medicaid through other eligibility categories established by each State.

¹⁶ This information represents 46 States and is the most complete and current data available. Medicaid Statistical Information System Data Mart 2011 Quarterly Cube, filtered for basis of eligibility value "Foster Care Children." Accessed at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MSIS-Mart-Home.html> on June 4, 2014.

¹⁷ OIG, *Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services*, OEI-05-08-00520, May 2010.

¹⁸ Ibid.

From 2003 through 2005, OIG published a series of reports on the use of Medicaid services by children in foster care in eight selected States.¹⁹ Those reports found a variety of issues, including that foster care providers and caregivers were not receiving medical histories for children in their care and that not all children in foster care were receiving appropriate health care services.²⁰

A 2009 Government Accountability Office (GAO) report described how 10 States identified health care needs for children in foster care, ensured delivery of health services for these children, and documented and monitored their care.²¹ GAO found that the 10 States generally adopted policies specifying the timing and scope of children's health assessments and that most States adopted practices to facilitate access, coordinate care, and review medications for children in foster care. GAO also found that several States shared data across State programs and employed quality assurance measures to track receipt of services.²²

METHODOLOGY

From each of the 4 States, we selected a simple random sample of 100 children in foster care enrolled in Medicaid between July 1, 2011, and June 30, 2012.²³ Because of inaccuracies in the population data that States provided, a total of seven children who were not in foster care during the review period were selected; these children were not eligible to be in the sample. Eliminating the 7 ineligible children brought the total sample size to 393 eligible children. See Table 2 below regarding the population and sample size for the four States.

¹⁹ OIG, *Foster Care Children's Use of Medicaid Services in New Jersey*, OEI-02-00-00360, July 2003; OIG, *Children's Use of Health Care Services While in Foster Care: Kansas*, OEI-07-00-00640, August 2003; OIG, *Children's Use of Health Care Services While in Foster Care: Texas*, OEI-07-00-00641, February 2004; OIG, *Children's Use of Health Care Services While in Foster Care: Illinois*, OEI-07-00-00642, February 2004; OIG, *Foster Care Children's Use of Medicaid Services in Oregon*, OEI-02-00-00363, June 2004; OIG, *Children's Use of Health Care Services While in Foster Care: North Dakota*, OEI-07-00-00643, August 2004; OIG, *Children's Use of Health Care Services While in Foster Care: Georgia*, OEI-07-00-00644, January 2005; and OIG, *Children's Use of Health Care Services While in Foster Care: New York*, OEI-02-00-00362, June 2005.

²⁰ Ibid.

²¹ GAO, *Foster Care: State Practices for Assessing Health Needs, Facilitating Service Delivery, and Monitoring Children's Care* (GAO-09-26), February 2009. GAO's review included the following States: California, Delaware, Florida, Illinois, Massachusetts, New York, Oklahoma, Texas, Utah, and Washington.

²² Ibid.

²³ This timeframe was the most recent complete year of Medicaid claims data available at the start of our data collection.

Table 2: Population of Children in Foster Care Enrolled in Medicaid at Any Time Between July 1, 2011, and June 30, 2012 and Sample Sizes

State	Population Size	Sample Size	Eligible Sampled Children
Texas	46,353	100	100
New York	35,874	100	96
California	26,397	100	100
Illinois	9,438	100	97
Total	118,062	400	393

Source: OIG analysis of State-submitted foster care enrollment and Medicaid claims data, 2013.

We requested case file documentation and Medicaid claims data representing health care services received by the sampled children in the review period. The States were unable to locate the requested case file documents for five sampled children, which brought the overall weighted response rate to 99 percent (388 sampled cases). We received Medicaid claims data for all of the 388 sampled cases. The results of this review are projected to only the four selected States at the 95-percent confidence level.

We interviewed Children’s Bureau staff regarding the extent to which ACF ensures that children in foster care receive required health screenings consistent with State schedules. See Appendix C for a detailed description of our methodology.

Limitations

Although Medicaid is the primary source of health care coverage for most children in foster care, it is also possible for children in foster care to receive health care from other sources, such as schools, free health clinics, or a parent’s private insurance coverage. It is possible that some children in our sample received health care services that were not paid for by Medicaid; therefore, these children’s receipt of required health screenings may be underestimated.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Nearly a third of children in foster care who were enrolled in Medicaid did not receive at least one required health screening

Twenty-nine percent of children in foster care who were enrolled in Medicaid who were required to receive at least one health screening during the review period did not receive one or more of those screenings.²⁴ Of the children who did not receive at least one required screening, 12 percent did not receive their initial screening and 17 percent did not receive one or more periodic screenings. Table 3 below shows the percentages of children who did not receive initial and periodic screenings. See Appendix D for all estimates and 95-percent confidence intervals for projections.

Table 3: Percentages of Children in Foster Care Who Did Not Receive at Least One Required Health Screening

Type of Missing Screening	Percentage of Children in Foster Care Who Did Not Receive the Screening
Initial screening	12%
At least one required periodic screening	17%
Total missing the initial screening or at least one required periodic screening	29%

Source: OIG analysis of State case files and Medicaid claims for children in foster care, 2014.

Over a quarter of children in foster care who were enrolled in Medicaid received at least one required health screening late

Twenty-eight percent of children in foster care who were required to receive at least one health screening received some screenings late.²⁵ Of the children who received at least one required screening late, 17 percent received their initial screenings late and 10 percent received at least one periodic screening late. Table 4 below shows the percentages of children who received initial and periodic screenings late.

²⁴ In the four States, 69 percent of all children in foster care should have received at least one screening between July 1, 2011, and June 30, 2012. The remaining children were not required to have a screening during the review period. The sampled children were required to receive between one and six screenings during the review period.

²⁵ We cannot provide projections of how many days late the late screenings occurred. The number of children with at least one late screening was too low in some States to produce a statistically valid estimate.

Table 4: Percentages of Children in Foster Care Who Received Required Screenings Late

Type of Late Screening	Percentage of Children in Foster Care Who Received Required Screening Late
Initial screening	17%
At least one required periodic screening	10%
Total receiving initial screening late or at least one required periodic screening late*	28%

Source: OIG analysis of State case files and Medicaid claims for children in foster care, 2014.

* Because of rounding, the percentages for late initial and periodic screenings do not total 28 percent.

ACF’s reviews do not ensure that children in foster care receive required health screenings according to State schedules

Children’s Bureau staff reported that they review a sample of children’s case records in each State as part of the Child and Family Services Reviews. These reviews determine whether the State has appropriately assessed a child’s health (i.e., physical and dental health) and mental health needs and whether the State identified and managed those needs by providing necessary services. These determinations are based on information collected from the child’s case record and through interviews with individuals participating in the child’s case, such as the child, biological parents, foster parents, and case workers.

Children’s Bureau staff reported that the case record reviews performed as part of the Child and Family Services Reviews assess whether each child received initial and periodic screenings. Specifically, staff reported that they assess whether the State is providing screenings when the child first enters foster care and on an ongoing basis while the child is in foster care. However, their reviews do not determine whether children in foster care received required screenings according to the time intervals specified in each State’s schedule.

CONCLUSION AND RECOMMENDATIONS

Nearly a third of children in foster care who were enrolled in Medicaid in four States did not receive at least one health screening as required by their respective States' plans for health services oversight and coordination, and 28 percent of children in foster care received a required screening late.

Previous OIG work regarding all children enrolled in Medicaid in nine States revealed issues with children's receipt of required preventive health screenings. OIG found that three out of four children enrolled in Medicaid did not receive all required medical, vision, and hearing screenings. OIG also found that nearly 60 percent of children who received medical screenings lacked at least one component of a complete medical screening. That report recommended that the Centers for Medicare & Medicaid Services collaborate with States and providers to develop effective strategies to encourage children's participation in preventive health screenings and identify and disseminate promising State practices for increasing children's participation in screenings and providers' delivery of complete medical screenings.

Our findings and previous OIG work suggest that issues with children's receipt of required screenings remain. Missing or late screenings may prevent children's mental health needs, physical health needs, and developmental needs from being identified and treated.

ACF and States should do more to ensure that children in foster care receive required screenings. Therefore, we recommend that ACF:

Expand the scope of the Child and Family Services Reviews to determine whether children in foster care receive required health screenings according to the timeframes specified in States' plans

Although ACF assesses through the Child and Family Services Reviews whether States are providing health screenings when a child first enters foster care and on an ongoing basis, the reviews do not assess whether the screenings were received according to the timeframes specified in State plans. ACF should expand its Child and Family Services Reviews to ensure that children in foster care receive screenings according to the timeframes specified in States' plans.

Identify and disseminate State strategies to ensure that all children in foster care receive required health screenings

We encourage ACF to work with States to identify the barriers that prevent children in foster care from receiving required screenings. Once those

barriers are identified, ACF should work with States to identify, disseminate, and implement strategies for overcoming those barriers. Possible strategies include developing educational materials for foster parents that discuss the benefits of health screenings and providing incentives to families and children in foster care to encourage participation in required screenings. ACF could develop technical assistance and resources for States to assist them with implementing identified strategies.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

ACF stated that it would consider the first recommendation and concurred with the second.

In responding to our first recommendation, ACF stated that it would consider implementing the recommendation in future Child and Family Service Reviews. ACF stated that the initial round of Child and Family Service Reviews did determine whether children in foster care received health screenings according to the timeframes specified in States' plans. However, ACF reported challenges with making these determinations, such as obtaining documentation needed to support that children in foster care received required screenings according to States' timeframes. As a result, ACF chose to focus on whether children's individual health needs were met in subsequent reviews. ACF will assess whether reviewing receipt of required screenings according to State timeframes can be included in future reviews.

In responding to our second recommendation, ACF stated that it currently provides training and technical assistance to States that is intended to facilitate implementation of Federal requirements and support program improvement. ACF will work with its technical assistance providers to assist States with identifying strategies that ensure that all children in foster care receive required health screenings.

We support ACF's efforts to address these issues and encourage continued progress, including expanding the Child and Family Services reviews to determine whether children in foster care receive required health screenings according to timeframes specified in States' plans. For the full text of ACF's comments, see Appendix E.

APPENIDX A

Required Elements for Health Services Oversight and Coordination Plans

Section 422(b)(15)(A) of the Act requires that each State plan include the following elements, which are quoted verbatim:

- a schedule for initial and followup health screenings that meet reasonable standards of medical practice;
- a description of how health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child’s maltreatment and removal from home;
- a description of how medical information for children in care will be updated and appropriately shared, which may include the development and implementation of an electronic health record;
- steps to ensure continuity of health care services, which may include the establishment of a medical home for every child in care;²⁶
- oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications;
- how the State actively consults and involves health care experts and other professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children; and
- for children aging out of foster care, steps to ensure that the components of the transition plan development process required under section 475(5)(H) of the Act related to health care needs, including the requirements to include options for health insurance; to include information about a health care power of attorney, health care proxy, or other similar document recognized under State law; and to provide the child with the option to execute such a document, are followed.

²⁶ A medical home is an approach to providing comprehensive primary care, in which a primary care provider works in partnership with a child and family to ensure that all of the medical and nonmedical needs of the patient are met. American Academy of Pediatrics, National Center for Medical Home Implementation. “What is a Family-Centered Medical Home?” Accessed at <http://www.medicalhomeinfo.org> on December 15, 2014.

APPENDIX B

Four Selected States' Schedules for Periodic Health Screenings

California's schedule for periodic health screenings is as follows:

- for newborns, a screening by 1 month old;
- for children aged 1–6 months, a screening every 2 months;
- for children aged 7–15 months, a screening every 3 months;
- for children aged 16–23 months, a screening every 6 months;
- for children aged 2 and 3 years old, an annual screening;
- for children aged 4–5 years old, a screening every 2 years;
- for children aged 6–8 years old, a screening every 3 years; and
- for children aged 9–19 years old, a screening every 4 years.

Illinois' schedule for periodic health screenings is as follows:

- For children aged 0–1 year, a screening occurs:
 - at birth,
 - between 3–5 days old,
 - at 1 month old,
 - at 2 months old,
 - at 4 months old,
 - at 6 months old, and
 - at 9 months old.
- For children aged 1–3 years, a screening occurs:
 - at 12 months old,
 - at 15 months old,
 - at 18 months old,
 - at 24 months old, and
 - at 30 months old.
- For children aged 3 years and older, a screening occurs annually.

New York's schedule for periodic health screenings is as follows:

- For children aged 0–1 year, a screening occurs:
 - between 2–4 weeks old,
 - between 2–3 months old,
 - between 4–5 months old,
 - between 6–7 months old, and
 - between 9–10 months old.
- For children aged 1–6 years, a screening occurs:
 - between 12–13 months old,
 - between 14–15 months old,
 - between 16–19 months old,
 - between 23–25 months old, and
 - annually for ages 3–5.
- For children aged 6–21 years, a screening occurs:
 - at 6 years old,
 - between 8–9 years old,
 - between 10–11 years old,
 - between 12–13 years old,
 - between 14–15 years old,
 - between 16–17 years old,
 - between 18–19 years old, and
 - at 20 years old.

Texas's schedule for periodic health screenings is as follows:

- For children aged 0–1 year, a screening occurs:
 - at birth,
 - between 3–5 days old,
 - at 2 weeks old,
 - at 2 months old,
 - at 4 months old,
 - at 6 months old, and

- at 9 months old.
- For children aged 1–3 years, a screening occurs:
 - at 12 months old,
 - at 15 months old,
 - at 18 months old,
 - at 24 months old, and
 - at 30 months old.
- For children aged 3 years and older, a screening occurs annually.

APPENDIX C

Detailed Methodology

State Selection. As shown in Table C-1, children from the four States constituted approximately 31 percent of the total population of children in foster care as of September 30, 2012.²⁷

Table C-1: Selected States for Data Collection

State	Number of Children in Foster Care as of September 30, 2012	Percentage of Children in Foster Care in the United States
California	54,288	13.7%
Texas	29,613	7.5%
New York	23,924	6.0%
Illinois	16,637	4.2%
Total:	124,462	31.4%

Source: OIG analysis of child welfare outcomes report data for children in foster care, 2014.

Response Rates. Table C-2 below provides detailed information regarding the population, sample size, and response rates for the four States.

Table C-2: Population of Children in Foster Care Enrolled in Medicaid at Any Time Between July 1, 2011, and July 30, 2012, Sample Sizes, and Response Rates by State*

State	Population	Estimated Eligible Population	Estimated Eligible Respondent Population	Total Sampled Children	Eligible Sampled Children	Responses Received	Weighted Response Rates
Texas	46,353	46,353	46,353	100	100	100	100%
New York	35,874	34,439	34,439	100	96	96	100%
California	26,397	26,397	25,869	100	100	98	98%
Illinois	9,438	9,249	8,972	100	97	94	97%
Total	118,062	116,438	115,633	400	393	388	99%

Source: OIG analysis of State-submitted foster care enrollment and Medicaid claims data, 2014.

* The differences in the State populations between tables C-1 and C-2 are due to the nature of the data on which the numbers are based. Table C-1 is based on child welfare data collected by ACF; it reflects the number of children who were in foster care on a single day, September 30, 2012. Table C-2 is based on foster care enrollment data that the selected States provided to us and reflects all children in foster care enrolled in Medicaid at any time between July 1, 2011, and June 30, 2012.

Case File Documentation and Medicaid Claims Data Review. We reviewed the foster care case file documentation provided by the four States to determine whether it supported the sampled child's receipt of

²⁷ ACF, *Foster Care FY2003–2012 Entries, Exits, and In Care on the Last Day of Each Federal Fiscal Year*. Accessed at www.acf.hhs.gov/sites/default/files/cb/entryexit2012.xlsx on May 28, 2014.

initial and periodic health screenings according to State schedules.²⁸ To identify support for the receipt of a required initial or periodic screening, we looked for at least the date of the screening and a brief description of the screening.

We reviewed Medicaid claims data for all health care services that each sampled child received between July 1, 2011, and June 30, 2012. We identified the health care services received by each child that fell within the timeframes for the child's respective State's required initial and periodic screenings and determined whether any of those services represented a required screening.

Analysis of Results. Using the foster care case file documentation and Medicaid claims data, we assessed each child's receipt of health screenings according to the appropriate State's schedule. For example, if a child in our sample entered foster care on May 1, 2012, and his State required an initial screening within 72 hours of foster care placement, his initial screening must have occurred between May 1, 2012, and May 4, 2012, to satisfy the requirement. If either the foster care case file documentation or the Medicaid claims data supported receipt of the required screenings for a sampled child, we counted those screenings as received. If neither the foster care case file documentation nor the Medicaid claims supported receipt of a particular required screening by a sampled child, that screening was counted as not received.

We assessed whether each child received health screenings timely. If either the foster care case file documentation or Medicaid claims data supported receipt of the required screenings for a sampled child, but showed that the screening was received after the specified timeframe or time interval, we counted that screening as late.²⁹

We followed up with foster care program officials in the four States regarding every child for whom we determined one or more screenings were missing. State officials either provided additional documentation showing that the child did receive the screening(s) in question, or confirmed that the screening(s) were not received. If additional

²⁸ Some children in our sample were not required to have a periodic screening within the review period, on the basis of their ages and the relevant State's screening schedule. Additionally, some children in our sample were not required to have an initial screening within the review period. These children entered foster care before the beginning of the review period and their initial screenings should have occurred before the beginning of the review period.

²⁹ We cannot provide projections of how many days late the late screenings occurred. The number of children with at least one late screening was too low in some States to produce a statistically valid estimate.

documentation was provided showing that the screenings were received, we did not count those screenings as not received.

APPENDIX D

Table D-1: Point Estimates, Sample Sizes, and Confidence Intervals

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of children in foster care who did not receive one or more required health screenings in the review period	284	29.3%	23.6%–35.7%
Percentage of children in foster care who should have received at least one screening in the review period	388	68.8%	64.8%–72.5%
Percentage of children in foster care who did not receive an initial screening	284	12.1%	8.5%–16.9%
Percentage of children in foster care who did not receive at least one periodic screening	284	17.2%	12.6%–23.0%
Percentage of children in foster care who received at least one required screening late	284	27.7%	22.8%–33.1%
Percentage of children in foster care who received their initial screening late	284	17.4%	14.2%–21.3%
Percentage of children in foster care who received at least one of their periodic screenings late	284	10.2%	6.7%–15.2%

Source: OIG analysis of State case files and Medicaid claims for children in foster care, 2014.

APPENDIX E

Agency Comments



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

The Honorable Daniel R. Levinson
Inspector General
U.S. Department of Health and Human Services
330 Independence Avenue, SW
Washington, D.C. 20201

JAN 09 2015

Dear Inspector General Levinson:

I am writing to you concerning the Administration for Children and Families' (ACF) response to the recommendations for ACF found in the draft report entitled, *Not All Children in Foster Care Enrolled in Medicaid Received Required Health Screenings*. ACF appreciates the work that the Office of Inspector General (OIG) performed in this area. A discussion of our response to each recommendation follows below.

Recommendation: Expand Child & Family Services Reviews to determine whether children in foster care receive required health screenings consistent with the timeframes specified in States' plans.

Response: ACF will consider implementing this recommendation in future Child and Family Service Reviews (CFSR) as the Children's Bureau completes the third round of the CFSR and plans the fourth round of the CFSR.

As part of the CFSR, the Children's Bureau works with states to gain insight into the practices the state is engaged in that support the proper assessment and identification of health needs for children in foster care and whether the state provides services to meet those needs. In doing so, the Children's Bureau considers whether the state is screening children for health and dental needs when the children first enter foster care and on an ongoing basis while the children remain in foster care, including whether the children have received health and dental screenings. In their evaluation, the Children's Bureau considers the child's individual health needs and factor in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) guidelines that are consistent across the states. By doing this, the Children's Bureau can consider whether the child welfare agency is appropriately individualizing its attention to a child's health issues regardless of state timeframes that can vary widely.

When states are not assessing children's health needs sufficiently, the Children's Bureau engages states in developing an improvement plan that considers the practice, programmatic, and policy context that exists in the state, including whether the state has

appropriate screening timeframes in its policies and/or a successful approach to implementing them in light of child outcomes.

During the initial round of the Child and Family Services Reviews, we employed the approach that the OIG recommends. That approach presented a number of challenges with locating documentation as well as assessing the adequacy of states' responsiveness to children's health care needs. We, therefore, abandoned that approach in favor of the one described above for second round and now third round. Notwithstanding some of the challenges with comparing OIG's data with the second round results, we note that OIG's findings are very similar to those from the second round.

As the Children's Bureau has already begun implementation of the CFSTRs for the third round, we are unable to modify our approach at this time. We will specifically monitor state performance in this area in order to assess whether returning to our earlier approach, and the OIG's recommendation, of monitoring state timeframes in conjunction with our approach to ensuring states are individualizing its attention to a child's health issues is appropriate for fourth round.

Recommendation: Identify and disseminate State strategies to ensure that all children in foster care receive required health screenings.

Response: ACF concurs with this recommendation.

The Children's Bureau currently provides training and technical assistance to states that is intended to facilitate implementation of federal policies and requirements and support program improvement. We will work with our newly awarded technical assistance providers in fiscal year 2015 to plan and develop strategies for communicating health screening standards to states and create resources to assist them with implementation.

ACF appreciates the opportunity to provide comments on the draft report and welcomes any further questions that the OIG may have regarding these issues. Please direct any follow-up inquiries to our Office of Legislative Affairs and Budget OIG liaison, Scott Logan, at (202) 401-4529.

Sincerely,

/S/

Mark H. Greenberg
Acting Assistant Secretary
for Children and Families

ACKNOWLEDGMENTS

This report was prepared under the direction of Brian T. Whitley, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office.

Rae Hutchison served as the lead analyst for this study. Other Office of Evaluation and Inspections staff from the Kansas City regional office who conducted the study include Jordan R. Clementi, Dennis Tharp, and Michala Walker. Central office staff who provided support include Kevin Farber, Christine Moritz, and Sherri Weinstein.

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