

GAO

Report to the Chairman, Subcommittee  
on Income Security and Family Support,  
Committee on Ways and Means, House of  
Representatives

February 2009

## FOSTER CARE

# State Practices for Assessing Health Needs, Facilitating Service Delivery, and Monitoring Children's Care



GAO

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Highlights of [GAO-09-26](#), a report to the Chairman, Subcommittee on Income Security and Family Support, Committee on Ways and Means, House of Representatives

## Why GAO Did This Study

Providing health care services for foster children, who often have significant health care needs, can be challenging. The Administration for Children and Families (ACF) oversees foster care, but state child welfare agencies are responsible for ensuring that these children receive health care services, which are often financed by Medicaid. In light of concerns about the health care needs of foster children, GAO was asked to study states' efforts to improve foster children's receipt of health services. This report has four objectives. It describes specific actions that some states have taken to (1) identify health care needs, (2) ensure delivery of appropriate health services, and (3) document and monitor the health care of children in foster care. It also describes the related technical assistance ACF offers to states.

To address these objectives, GAO selected 10 states and interviewed state officials and reviewed related documentation regarding the nature and results of the states' practices. To describe ACF's technical assistance, GAO interviewed officials and reviewed documents from ACF, states, and relevant technical assistance centers.

## What GAO Recommends

GAO did not make any recommendations in this report. In commenting on this report, Health and Human Services provided additional information on its technical assistance efforts and technical comments which have been incorporated as appropriate.

To view the full product, including the scope and methodology, click on [GAO-09-26](#). For more information, contact K. E. Brown, 202-512-3674, [brownke@gao.gov](mailto:brownke@gao.gov) or C. Bascetta, 202-512-7114, [bascettac@gao.gov](mailto:bascettac@gao.gov).

## FOSTER CARE

### State Practices for Assessing Health Needs, Facilitating Service Delivery, and Monitoring Children's Care

#### What GAO Found

To identify the health needs of children entering foster care, all 10 states we studied have adopted policies that specify the timing and scope of children's health assessments, and some states use designated providers to conduct the assessments. All of the states we selected for study required physical examinations, most states we studied required mental health and developmental screens, and several of them required or recommended substance abuse screens for youth shortly after entry into foster care. Preventive health examinations for foster children were required at regular intervals thereafter, in line with states' Medicaid standards. Limited research has suggested that having assessment policies and using designated providers who have greater experience in the health needs of foster children may permit fuller identification and follow-up of children's health care needs.

To help ensure the delivery of appropriate health care services, states have adopted practices to facilitate access, coordinate care, and review medications for children in foster care. Some states used specialized staff to quickly determine Medicaid eligibility; others issued temporary Medicaid cards to prevent delays in obtaining treatment. In addition, certain states had increased payments to physicians serving children in foster care to encourage more physicians to provide needed care. Nurses or other health care managers were given roles in coordinating care to help ensure that children received necessary health care services. Six states we studied also reported monitoring the use of various medications, including psychotropic medications intended for the treatment of mental health disorders.

To document and monitor children's health care, several states we studied had shared data across state programs and employed quality assurance measures, such as medical audits, to track receipt of services. One state has developed a foster care health "passport" that electronically compiles data from multiple sources, including the state's immunization registry, and this passport can be accessed and updated by responsible parties through a secure Web site. Other states used electronic databases to obtain more complete and timely medical histories than otherwise available but provided more limited access to these and continued to update them through use of paper records.

ACF's network of 25 technical assistance centers is intended to improve state performance in meeting children's needs, including their health care needs, by increasing the capacity of state agencies to ensure safety, wellbeing, and availability of permanent homes for children in their care. According to ACF officials, the centers are not intended to provide medical expertise, but to help state child welfare agencies collaborate with others involved with health programs. One center in ACF's network focuses exclusively on children's mental health and several others have also assisted in identifying some practices to improve the health of children in foster care. Five of the centers are newly funded and are expected to provide long-term help in implementing plans to improve agency performance in meeting children's needs.

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## Abbreviations

AAP	American Academy of Pediatrics
ACF	Administration for Children and Families
AIDS	Acquired immune deficiency syndrome
CBO	Congressional Budget Office
CFSR	Child and Family Services Reviews
CMS	Centers for Medicare & Medicaid Services
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
HHS	Department of Health and Human Services
HIV	Human immunodeficiency virus
HRSA	Health Resources and Services Administration
PIP	Program improvement plan
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIP	State Children's Health Insurance Program

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United States Government Accountability Office  
Washington, DC 20548

February 6, 2009

The Honorable Jim McDermott  
Chairman  
Subcommittee on Income Security and Family Support  
Committee on Ways and Means  
House of Representatives

Dear Mr. Chairman:

Some of our nation's most vulnerable children are those who have been removed from their homes and placed in foster care, often due to abuse or neglect. Of the nearly 500,000 children in foster care at the end of fiscal year 2007, 80 percent are estimated to have significant health care needs, including chronic health conditions, developmental concerns, and mental health needs. Treatment for the health care needs of children in foster care is generally financed through states' Medicaid programs.<sup>1</sup> In addition to the extent of foster children's health care needs, the disruptions associated with foster care—such as having to leave home and experiencing several changes in placement—may increase the challenges of ensuring that these children receive health care services. However, conditions left untreated can impede children's ability to realize their potential or become self-sufficient later in life.

States are responsible for ensuring that children in foster care receive necessary health care services. The Administration for Children and Families (ACF) within the Department of Health and Human Services (HHS) provides funding for state child welfare programs, including foster care. In exchange for this funding, states agree to meet basic federal requirements.<sup>2</sup> However, they also have flexibility in how they design and implement their programs. In its past reviews of state agencies' performance, ACF determined that children under agency supervision, including those in foster care, may not all receive appropriate physical or

<sup>1</sup>Medicaid is a federal-state health financing program established in 1965 to provide health care coverage to certain categories of low-income adults and children.

<sup>2</sup>For example, federal law requires that states have standards to ensure children in foster care are provided quality services to protect their safety and health. In addition, states must maintain case plans for children that include health records, including the most recent information available regarding their immunizations, known medical problems, medications, and their health providers' names and addresses.

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mental health care services. For example, ACF found that about 30 percent of children sampled either did not have their health needs assessed or did not receive treatment during the period reviewed. In these cases, states were required to develop and implement improvement plans, and ACF monitored their implementation.

In October 2008, Congress expanded the federal requirements related to foster children by mandating that states explicitly plan for the ongoing oversight and coordination of health care services for children in foster care.<sup>3</sup> The state practices described in this report, although in use before the expansion of federal requirements, address some of the new requirements and, thus, may be helpful to other states as they consider changes in their plans. Specifically, this report addresses four objectives. It describes practices that selected states have adopted to address the challenges of (1) identifying health care needs, (2) ensuring delivery of appropriate health services, and (3) documenting and monitoring the health care of children in foster care. In addition, the report describes the technical assistance that ACF offers states to help improve their performance in providing for the health care needs of these children.<sup>4</sup>

To address these objectives, we selected 10 states for in-depth study based on the information they provided and the variations they represented in geographic location, foster care caseload, and child welfare administrative structures. The 10 states selected were California, Delaware, Florida, Illinois, Massachusetts, New York, Oklahoma, Texas, Utah, and Washington. (For more information on our state selection, see appendix I.) We conducted site visits in three of these states to describe state practices in context and gather views of multiple stakeholders, such as state child welfare officials, health or Medicaid officials, health care providers, foster parents, and in two cases (Cook County, Illinois and New York City), the views of child welfare personnel in major metropolitan areas. In our interviews with officials of the seven remaining states, conducted by telephone, we focused primarily on interviewing child welfare and Medicaid officials regarding certain practices that state agencies

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<sup>3</sup>Pub. L. No. 110-351 (2008).

<sup>4</sup>Throughout the report, we use the term “health” to refer to both physical and mental health. Physical health includes dental health. Other health areas included are those dealing with children’s development and with substance abuse.

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identified.<sup>5</sup> We cannot generalize the results of our review from the 10 states we selected to all states. Although we did not examine the actual operation of every practice, we reviewed information about states' practices through such means as discussions with researchers, advocates, and other parties who had knowledge of these states' foster care programs and, where available, we also collected and evaluated research, state data, and other information on the effectiveness of the practices adopted. In addition, we reviewed relevant federal laws, policies, and guidance and research literature on the physical and mental health needs and treatment of children in foster care. To obtain information on ACF's provision of technical assistance, we reviewed documents and interviewed officials at ACF and six centers participating in ACF's network of technical assistance providers, including the two centers jointly funded by ACF and HHS's Substance Abuse and Mental Health Services Administration (SAMHSA). Our work was designed to describe specific state and federal practices, not to assess compliance with statutory or regulatory requirements. We conducted our work from November 2007 to January 2009, in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions.

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## Results in Brief

To identify the health needs of children, the states we studied generally reported adopting policies that specified the timing and scope of children's health assessments and, in some cases, also employed designated providers to conduct these assessments. These assessment features were intended to increase the likelihood of more complete identification and follow-up of children's needs. Although ACF had not imposed specific requirements for health assessments, the 10 states we selected for study required that children have a general physical—often referred to as a well-child exam—within 30 days of entering foster care, in line with recommendations from professional associations. Most of these states also required that children's mental health and developmental status be screened after entry, and several of the states we

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<sup>5</sup>As part of our process to select states, we asked all state child welfare agencies to identify some practices that they had adopted and considered noteworthy to screen and assess needs, facilitate and coordinate access to care, or manage data and information. We received 42 responses. While most of the 10 states reported having multiple practices, we did not cover all of these practices adopted by each state.

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selected for study cited screening for substance abuse. The 10 states also required preventive health examinations at regular intervals thereafter, in line with state Medicaid standards. To conduct the assessments, some states used specially selected, trained, or dedicated personnel to increase the likelihood that the children received appropriate health care services. Limited research associates the existence of specific assessment policies or use of specialized personnel with higher rates of screening and referral than occur when policies are not specific or personnel have no specific training. Similarly, some state officials indicated that such assessment policies, including the use of designated providers, have allowed them to provide follow-up treatment more quickly than before these practices were in place.

To ensure the delivery of appropriate health services, most states we studied reported adopting one or more practices to facilitate access to services, coordinate health care, and review medications for children in foster care. These practices were intended to ensure that children's health services were not only delivered in a timely way, but in a consistent and complementary way across each step of the health care delivery process. In one case, a state used specialized staff to ensure that children in foster care were quickly reviewed for Medicaid eligibility. Other efforts included increasing payment rates to physicians for children in foster care to encourage more physicians to provide needed care. With regard to coordination of care, state practices included using nurses or other health care managers to help ensure that children in foster care received necessary health care services. In addition, several of the selected states identified practices related to monitoring the use of psychotropic medications—drugs commonly used for the treatment of mental health disorders—owing to their effects on thought, behavior, or mood. For example, one state requires a review of prescriptions in certain circumstances, such as when multiple psychotropic medications are prescribed at the same time. Officials in this state reported that after the policy took effect, there was a decrease in the number of children in foster care who were prescribed multiple psychotropic medications.

To document and monitor children's health care, some states we studied reported having data management practices that included sharing health care data across programs, and three states and a major city within another state pointed to various quality assurance mechanisms to track receipt of services. Data sharing with Medicaid and other data sources has helped some states we studied develop and maintain health records. In one state, these data sharing efforts include a foster care health "passport" that electronically compiles data on a specific child from multiple data systems, such as immunization records and data on prescription



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medications. This system allows for continuous updating at many points of care and permits access by multiple parties with decision-making responsibility for the child's health. Most state child welfare agencies we contacted reported using a combination of electronic and paper-based data sharing to obtain information other state agencies have compiled on children prior to their entry into foster care to provide more complete and timely medical histories than are otherwise available. However, these states provided more limited access to these data, and updates typically relied on the exchange of paper reports about medical visits and their results among doctors, foster parents, and caseworkers. In addition, the three states we visited and one major city reported having quality assurance activities that could be used to help monitor the receipt of services for children in foster care. For example, officials of some states we studied cited specialized case reviews focusing on children's receipt of health care services as supports in monitoring performance in meeting the health needs of children in their care.

ACF supports a network of 25 technical assistance centers to help state child welfare agencies improve their capacity to meet children's needs, including their health care needs. ACF officials explain that they do not expect the centers to provide technical assistance regarding medical services, but instead to help child welfare agencies carry out their broader mission to ensure the safety, wellbeing, and attainment of permanent homes for children in their care. With respect to the health of children in foster care, ACF officials stated that this may involve helping child welfare agencies work collaboratively with other agencies that provide health care services, including other federally and nonfederally funded public and nonprofit programs. One of ACF's 25 centers focuses exclusively on children's mental health, and several other centers have also assisted in identifying some practices designed to improve the health of children in foster care. Included among ACF's centers are five new centers that are due to become operational in 2009 and are expected to provide in-depth, long-term assistance in implementing plans to improve agency performance in meeting children's needs.

We provided a draft of this report to HHS for its comment. The agency provided some additional information on its technical assistance to state foster care agencies, particularly through collaboration between ACF and SAMHSA in efforts to assist states to address health issues such as mental health and substance abuse that may affect children in foster care. HHS's comments are reprinted in appendix II. HHS also provided technical comments, which we considered and incorporated as appropriate.

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## Background

Children in foster care tend to exhibit more numerous and serious medical conditions than other children, including mental health problems. Foster care begins when children are removed from their parents or guardians and placed under the responsibility of a state child welfare agency. Removal from the home can occur for several reasons. For example, parental violence, substance abuse, severe depression, or incarceration may have led to the children's removal from the home. Other children and youth are referred when their own behaviors or conditions are beyond the control of their families or pose a threat to themselves or the community.

The realities of foster care may further contribute to the challenges in meeting these children's health care needs. Once children are removed from their homes, obtaining information on their health status and health history from their parents or guardians may be challenging. Also, children often move to several different foster homes or treatment facilities during the course of their stay in foster care, which may result in having different health care providers. Changes in placement pose significant challenges for agencies, foster parents, and providers with regard to providing continuity of health care services and maintaining uninterrupted information on children's medical needs and course of treatment.

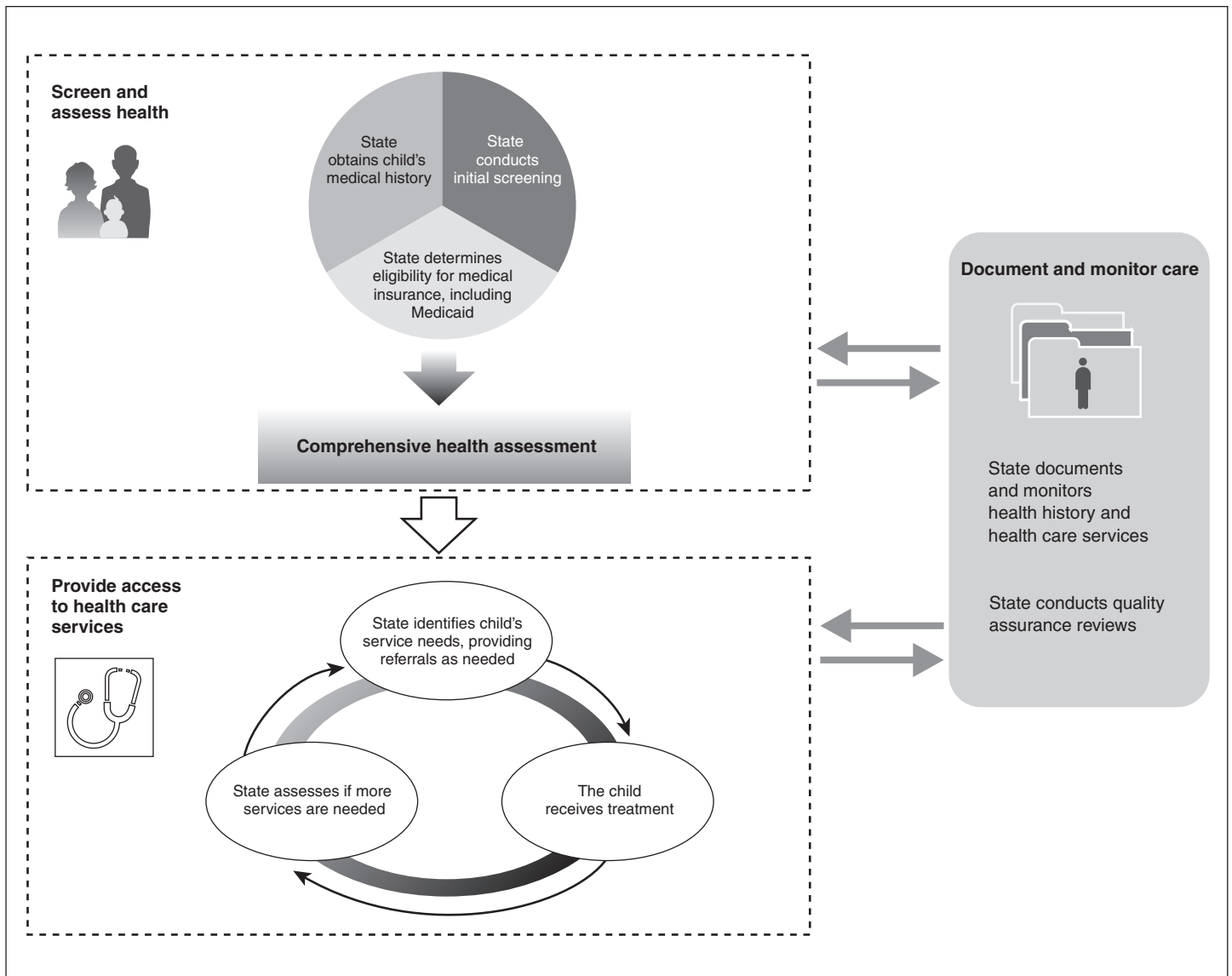
Finally, in addition to specific characteristics or circumstances that complicate their care, children in foster care encounter some health care challenges in common with other health care users. Child welfare agencies generally expect that foster parents or other caregivers will recognize when children need medical attention and obtain the needed health services, but such services may be in short supply or difficult to access because of a lack of providers who serve Medicaid patients—particularly for some specialties or geographic areas. Children entering foster care may lack medical care prior to entry, and children with prior medical care may have experienced disruptions in care, changes in providers, and have missing or incomplete records.

Figure 1 illustrates the steps that are typically involved in addressing health needs of children in foster care.<sup>6</sup>

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<sup>6</sup>While states have primary responsibility for the welfare of children in their care, this responsibility has been delegated to county agencies in about one-fifth of the states, including many of the nation's most populous states such as California, Florida, and New York.

**Figure 1: Steps Typically Involved in Addressing Health Needs of Children in Foster Care**



Sources: GAO analysis; images, Art Explosion (clip art).

## State and Federal Funding for Children in Foster Care

All state child welfare agencies receive federal funds from ACF for children in foster care under two parts of title IV of the Social Security Act. The larger source of federal funds, under title IV-E, provides open-ended reimbursement for a portion of states' foster care expenses for children

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meeting federal eligibility criteria, who represented about 43 percent of children in foster care in 2006.<sup>7</sup> Title IV-E provided \$4.8 billion to states in 2007 for the federal share of the expense of housing and feeding these children.<sup>8</sup> States cover the remaining costs and 100 percent of the costs to house and feed children in foster care who do not meet federal eligibility criteria. State child welfare agencies also receive funds under title IV-B to provide services to children in foster care and to those remaining in their homes for the purpose of preventing conditions leading to the need to remove children from their homes.<sup>9</sup> In 2007, about \$700 million was available under title IV-B. State child welfare agencies cannot use title IV-E or most IV-B funds for the direct provision of health care services. Limited IV-B funds may be used for some health care services but are intended primarily for the support and preservation of families, rather than for children in foster care.<sup>10</sup> Foster children who meet title IV-E eligibility criteria, on the other hand, are explicitly identified as a group that is eligible for coverage under Medicaid.

As a condition of receiving federal funds, state child welfare agencies must agree to meet certain federal requirements, including requirements related to the health of children in foster care. Under both titles IV-B and IV-E, states must submit plans to ACF that contain a number of statutorily required elements. For title IV-E, state agencies must have a written case plan for each child that includes specific health information, such as records of immunizations and medications, to be shared with foster care

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<sup>7</sup>Data for federal fiscal year 2006 were the most recent available. The proportion of children who meet federal eligibility criteria has decreased over the past decade since the income criteria are set at the 1996 income levels under the former Aid to Families with Dependent Children program. See GAO, *Foster Care and Adoption Assistance: Federal Oversight Needed to Safeguard Funds and Ensure Consistent Support for States' Administrative Costs*, [GAO-06-649](#) (Washington, D.C.: June 15, 2006).

<sup>8</sup>Included are IV-E funds available to states to reimburse up to 50 percent of their IV-E administrative costs for child placement, information systems, and other purposes and up to 75 percent of their IV-E training costs. (45 C.F.R. § 1356.60(b) and (c))

<sup>9</sup>States may also use other federal funds, such as the title XX Social Services Block Grant or Temporary Assistance to Needy Families, to provide some child welfare services.

<sup>10</sup>Title IV-B includes two different programs: subpart 1 for general child welfare services and subpart 2 for family preservation, family support, time-limited family reunification, and adoption promotion and support services. Some of the funds available under subpart 2 may be used for health care services, such as counseling, mental health, and substance abuse treatment for foster children or their families, during the 15 months following the children's entry into foster care in order to facilitate the timely, safe reunification of these foster children with their families.

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providers at the time of placement. The agencies must also have standards to ensure that children are provided services to protect their safety and health. Because these standards have not been further defined in statute or regulation, states have some flexibility with respect to their form and content. For safety and health standards, some states have cited standards for licensing foster care facilities, training foster care parents, or credentialing staff.

In recent years, Congress has twice amended title IV-B, subpart 1 to add new state plan requirements related to the health of children served by child welfare agencies. Congress initially required that state plans describe the involvement of physicians and other medical professionals in the assessment and treatment of children in foster care.<sup>11</sup> This requirement was effective with state plans approved by ACF in 2007. In October 2008, as we completed our review, Congress further amended title IV-B, subpart 1 to require state agencies to develop plans for the ongoing oversight and coordination of health care services for children in foster care.<sup>12</sup> This new requirement expanded on the earlier requirement by mandating that the agencies include in their plans schedules for initial and follow-up health screenings that meet reasonable standards of medical practice; steps to ensure continuity of health care services, which may include the establishment of a medical home—a primary health care provider or group—for every child in care; oversight of prescription medications; and information on how children’s needs identified through screenings will be monitored and treated and how their medical information will be updated and appropriately shared—as for example, by using electronic health records. These requirements apply to all children in foster care, regardless of whether or not the children meet federal eligibility criteria.

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## Federal Oversight and Technical Assistance

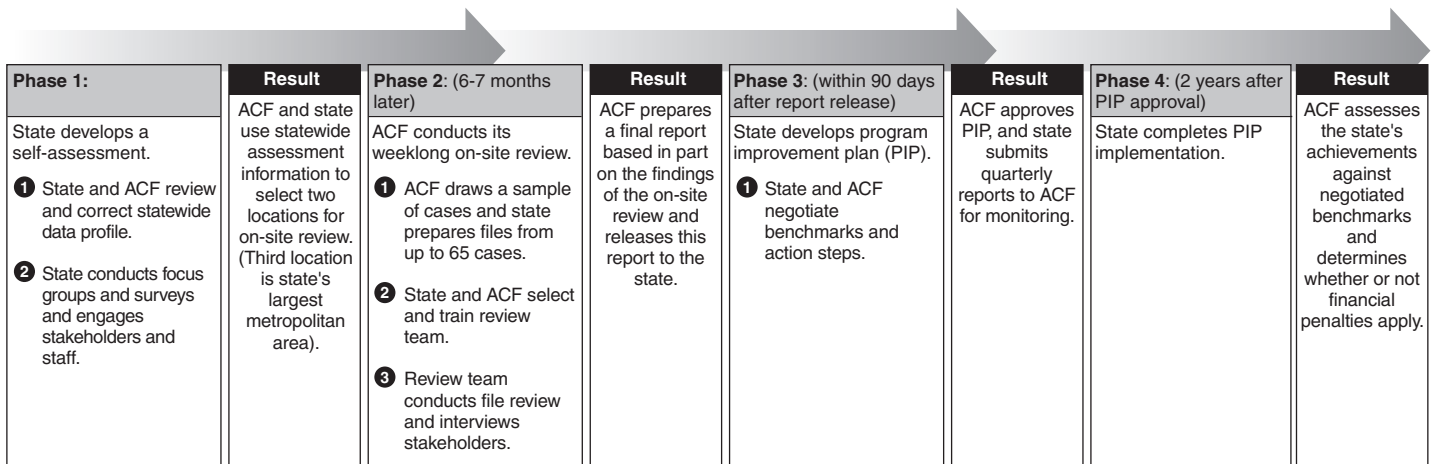
Starting in 2001, ACF took a new, results-oriented approach to its oversight of state child welfare programs, focusing on whether children and their families served by these programs achieved positive outcomes. This oversight effort involved four phases of Child and Family Services Reviews (CFSR), as shown in figure 2. ACF expects to complete the final phase of the initial round of CFSRs in 2009.

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<sup>11</sup>Child and Family Services Improvement Act of 2006, Pub. L. No. 109-288 (2006).

<sup>12</sup>Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351 (2008). ACF alerted states to this new requirement but did not issue further instructions in 2008.

**Figure 2: Four Phases of the Initial Round of the CFSR Process**



Source: GAO analysis.

In the second phase of the initial round of the reviews completed in 2004, ACF identified significant performance challenges, particularly with respect to meeting children’s mental health needs.<sup>13</sup> ACF assessed state child welfare agency performance on 45 indicators across a wide range of areas, such as children’s safety and statewide information systems. On the two health indicators addressing physical and mental health, ACF identified 20 states as showing strengths in providing services to meet children’s physical health needs, and 4 states also showed strengths in meeting the mental health needs of children in foster care and children remaining in their homes under agency supervision.<sup>14</sup> Nearly all states were required to implement program improvement plans because they did not show strengths in physical health, mental health, or both. ACF is required by statute to offer technical assistance, to the extent feasible, to help such states develop and implement plans to improve outcomes for children, including health outcomes. When ACF determines that a state

<sup>13</sup>ACF’s reviews examined a sample of the case records of children served by state agencies; children in foster care, the focus of GAO’s work, were a subset of this sample.

<sup>14</sup>In the initial round of CFSRs, ACF designated a state as showing strength when 85 percent of the up to 65 case records examined in that state indicated that the state had assessed needs and provided treatment as appropriate. Depending on the state, the results varied widely, with the percentage of sampled children who were not assessed or treated ranging from 8 percent to 49 percent. In the next round of reviews, occurring from 2007 through 2010, states will have to assess and treat 90 percent of cases examined in order to show strengths and 95 percent of cases in order to be deemed in substantial conformity.

has not met the jointly developed goals and action steps identified in these plans within 2 years of approval of the improvement plan, ACF regulations specify that it will withhold a portion of the state's grant funds.<sup>15</sup> In the course of its oversight, ACF identified several challenges that states faced in meeting the health needs of children in their care, as summarized in table 1.

**Table 1: Findings of ACF Reviews with Respect to Common Challenges States Faced in Meeting Children's Health Needs**

Physical health	Mental health
Number of physicians and dentists in the state willing to accept Medicaid is not sufficient to meet the need. <sup>a</sup>	There is a lack of mental health services for children in the state.
The state agency is not consistent in conducting adequate, timely health assessments.	The state agency is not consistent in conducting mental health assessments.
The state agency is not consistent in providing children with preventive health or dental services.	

Source: ACF, Summary of the Results of the 2001 - 2004 Child and Family Services Reviews, p.10, <http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/index.htm> (accessed on Nov. 21, 2008).

<sup>a</sup>See GAO, *Medicaid: Extent of Dental Disease in Children Has Not Decreased and Millions Are Estimated to Have Untreated Tooth Decay*, GAO-08-1121 (Washington, D.C.: Sept. 23, 2008).

## Medicaid and Health Care Services for Children in Foster Care

Medicaid is the primary health care funding source for most children in foster care.<sup>16</sup> The Medicaid program is administered at the federal level by the HHS's Centers for Medicare & Medicaid Services (CMS) and is jointly financed by the states and the federal government. All state Medicaid agencies receive federal funds for the Medicaid program under title XIX of the Social Security Act. Within broad parameters set by federal statute and

<sup>15</sup>In November 2008, ACF reported that 39 states had achieved their planned goals and action steps, including those for children's health; that 7 states had missed their planned goals and action steps and were subject to withholding of federal grant funds; and that the actions of 6 states were still being evaluated. ACF withheld grant funds from one state that did not complete the action steps for improving children's health. See 45 C.F.R. § 1355.36 for regulations governing the withholding of grant funds.

<sup>16</sup>In addition to Medicaid, federal funds are available to states for health-related services for a population that may include children in foster care under title V of the Social Security Act for maternal and child health, under title XIX of the Public Health Service Act for community mental health centers, and under the Individuals with Disabilities Education Act.

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regulation, state Medicaid agencies are responsible for determining eligibility and establishing the services and payments offered. Although many coverage, eligibility, and administrative decisions are left to individual states, the federal government sets certain requirements for state Medicaid programs, such as coverage of certain screening and treatment services. Children who meet federal eligibility criteria for IV-E foster care are required to be covered by state Medicaid programs under federal law.<sup>17</sup> In addition, states have chosen to extend Medicaid coverage to other children in foster care.<sup>18</sup> In 2004, Medicaid expenditures for children in foster care exceeded \$5 billion.<sup>19</sup>

Children in foster care who are enrolled in Medicaid may receive services through one of two distinct service delivery and financing systems—managed care and fee-for-service. Under a capitated managed care model, states contract with a managed care organization and prospectively pay the plans a fixed monthly fee per patient to provide or arrange for most health services. Plans, in turn, pay providers. In the traditional fee-for-service delivery system, the Medicaid program reimburses providers directly and on a retrospective basis for each service delivered.<sup>20</sup>

States are required to offer certain screening and treatment services to children enrolled in Medicaid.<sup>21</sup> Termed Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT), these screenings must include, but are not limited to, a comprehensive health and developmental history, a comprehensive unclothed physical exam, appropriate immunizations, laboratory tests, and health education. The required

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<sup>17</sup>See 42 U.S.C. § 1396a(a)(10)(A)(i)(I).

<sup>18</sup>The Urban Institute reports that all states have extended Medicaid coverage to children in foster care. See Rob Geen, Anna Sommers, and Mindy Cohen, The Urban Institute, *Medicaid Spending on Foster Children* (Washington, D.C., 2005). However, some children are excluded, such as noncitizens, those with private health insurance, and children who leave foster care while they are on trial visits to their homes.

<sup>19</sup>This represents federal and state dollars combined for the most recent year available. Expenditures for children in foster care are likely to be underestimated and may exclude expenditures for some children participating in foster care.

<sup>20</sup>Fee-for-service arrangements may also include primary care case management, where primary care providers are paid a monthly, per capita case management fee, usually around \$3, to coordinate care for beneficiaries, in addition to fee-for-service reimbursement for any health care services they provide. Coordination may involve referrals to specialists and other providers.

<sup>21</sup>See 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B).



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services include vision, dental, hearing, and services for other conditions discovered through screenings, regardless of whether these services are typically covered by the state's Medicaid program for other beneficiaries. The state Medicaid agencies establish standards for the timing and frequency of these screening and treatment services and set their own payment rates for fee-for-service providers of these services. Federal regulations require that EPSDT screening services be provided in accordance with reasonable standards of medical and dental practice determined by the state after consultation with recognized medical and dental organizations involved in child health care.<sup>22</sup>

In addition to EPSDT, states may choose to offer optional Medicaid benefits, such as rehabilitative services and targeted case management for children in foster care. States have used the rehabilitative services option for children in foster care who have mental or developmental problems as a means of providing a wide range of services designed to help them achieve their highest level of functioning. States have used targeted case management in order to provide case management services to a defined group of Medicaid-eligible individuals, such as children in foster care.<sup>23</sup> Such case management activities have included assessing a child's needs, developing plans to meet those needs, referring a child to services, monitoring the receipt of such services, and ensuring any necessary follow-up care.

Federal Medicaid funds are available for a portion of case management activities, as long as funds are not available from other programs or from other entities, such as other insurers, that would be legally obligated to pay for such services.<sup>24</sup> However, concerns exist that Medicaid funds have

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<sup>22</sup>See 42 C.F.R. § 441.50 et seq.

<sup>23</sup>For example, The Urban Institute reported that 38 states funded targeted case management under Medicaid for children in foster care. See Rob Geen, Anna Sommers, and Mindy Cohen, The Urban Institute, *Medicaid Spending on Foster Children*, (Washington, D.C., 2005).

<sup>24</sup>See 42 U.S.C. §§ 1396(a)(25), 1396n(g)(4).

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been inappropriately used,<sup>25</sup> and CMS has denied payment for services when funds were available from other programs, such as Title IV-E.<sup>26</sup> In 2007, CMS issued rules—an interim final rule for case management services and a proposed rule on Medicaid program coverage for rehabilitative services—that further defined the use of Medicaid funds for these benefits for children in foster care.<sup>27</sup> However, in 2008, Congress passed and the President signed into law a moratorium on certain aspects of the rules that remains in effect until April 1, 2009.<sup>28</sup>

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## Other HHS Agencies

In addition to ACF and CMS, other agencies within HHS have roles in sustaining the health of foster children through supporting research, providing grants, or offering technical assistance that may assist with providing necessary health care services to children in foster care, as shown below:

- The Agency for Healthcare Research and Quality is responsible for supporting research designed to improve the quality of healthcare, reduce its costs, address patient safety and medical errors, and broaden access to essential services;
- the Health Resources and Services Administration (HRSA) administers programs related to maternal and child health, as well as services specific to particular conditions, such as human immunodeficiency virus and acquired immune deficiency syndrome (HIV and AIDS); and

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<sup>25</sup>We reported that most states have used contingency-fee consultants to help implement a wide range of projects, including rehabilitative and targeted case management services, to maximize federal Medicaid reimbursements. In particular, we found that during fiscal years 1999 through 2003, combined state and federal spending for one category of Medicaid services—targeted case management—increased by 76 percent, from \$1.7 billion to \$3 billion, across all states. See GAO, *Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight*, GAO-05-748 (Washington, D.C.: June 28, 2005).

<sup>26</sup>The Deficit Reduction Act of 2005 amended the Social Security Act provisions concerning Medicaid coverage for case management and targeted case management services effective January 1, 2006. See Pub. L. No. 109-171, §6052, 120 Stat. 4, 93-95.

<sup>27</sup>See *Medicaid Program; Optional State Plan Case Managed Services* (72 Fed. Reg. 68077, December 4, 2007); and *Medicaid Program; Coverage for Rehabilitative Services* (72 Fed. Reg. 45201, August 13, 2007).

<sup>28</sup>Supplemental Appropriations Act, 2008, Pub. L. No. 110-252, §7001(a), 122 Stat. 2323, 2387-88.

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- SAMHSA funds programs and services for individuals—as well as their families and communities—who suffer from or are at risk for substance abuse or mental health disorders.

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## Specific Requirements for Health Assessments—and Using Designated Providers to Conduct Them—Are Employed to Identify Children’s Health Care Needs

To help facilitate the timely identification of foster children’s health care needs, all 10 states we examined had adopted specific policies with regard to the timing and scope of assessments, and 4 of these states also reported using designated providers to conduct the assessments. The policies generally call for assessments shortly after children enter care and take one of two forms: (1) a two-stage assessment comprised of an initial screening followed by a comprehensive assessment or (2) a single comprehensive assessment. Most states we selected for study included a requirement for screening of children’s mental health and developmental needs, and most of the states we studied cited substance abuse screenings. Researchers and state officials have suggested that having designated providers conduct assessments may improve the quality and utility of assessment results. State officials report that these assessment practices have allowed them to make more appropriate and lasting placements of children in foster care and also to provide follow-up treatment more quickly than before these practices were in place. Some research also links specific assessment policies to higher rates of follow-up.

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## Specific Requirements Can Ensure Timely, Appropriate Initial and Comprehensive Assessments

While federal law did not specifically require assessments before fiscal year 2009, the 10 states we reviewed had made assessments of children’s physical health mandatory for all children entering care, as recommended by medical and other professional associations.<sup>29</sup> Because children often enter foster care with serious health conditions and, at times, without easily accessible medical histories, it is important to identify their health needs as quickly as possible. Health or developmental status may be a critical factor in determining the appropriate placement and level of care for children, as in the case of children with HIV or significant behavioral problems. Where there are explicit and comprehensive policies mandating assessments of all children entering care, greater percentages of children are likely to be assessed, according to a survey of a nationally

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<sup>29</sup>Organizations such as the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Child Welfare League of America recommend assessments for children shortly after children enter foster care. However, to avoid undue burden on children and providers, both Delaware and New York consider that assessments made prior to entry into foster care may suffice.

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representative sample of child welfare agencies.<sup>30</sup> Further analysis of these survey data showed that agencies with comprehensive developmental screening policies were more likely to evaluate children, refer them to early intervention agencies, and engage in joint planning of health care services.<sup>31</sup>

Officials from the 10 states we reviewed reported using two general approaches to conducting assessments, but all required some health assessment within 30 days of a child's removal from his or her home. Florida, Illinois, Massachusetts, and New York generally conduct screenings or assessments in two stages: (1) an initial screening within 24 hours to 7 days to check for immediate health needs and (2) a later, fuller assessment within 30 days of entry into foster care.<sup>32</sup> Some state officials expressed the view that waiting a while for the fuller assessment may give children the opportunity to adjust to their changed circumstances and for this reason may offer providers a more accurate picture of the children's health. Additionally, they noted that assessments may be lengthy and require significant time to complete. For example, Florida officials explained that their comprehensive assessment of mental health, development, and substance abuse takes 20 hours to complete, double the amount of time the state previously allotted in order to cover all necessary aspects of care. A second approach to identifying children's health care needs—used by California, Delaware, Oklahoma, Texas, Utah and Washington—invokes a one-stage assessment process mandating that it be completed within 14 to 30 days of entry into foster care depending on the

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<sup>30</sup>Laurel K. Leslie, Michael S. Hurlburt, John Landsverk et al., "Comprehensive Assessments for Children Entering Foster Care: A National Perspective," *Pediatrics*, 112 (1) (2003), pp. 134-142. (Accessible via <http://www.pediatrics.org/cgi/content/full/112/1/134>.) Also see N. Halfon, A. Zepeda, and M. Inkelas (2002), *Mental Health Services for Children in Foster Care* (Policy Brief Number 4). Los Angeles: UCLA Center for Healthier Children, Families and Communities.

<sup>31</sup>A.C. Stahmer, L.K. Leslie, J. A. Landsverk et al., "Developmental Services for Young Children in Foster Care: Assessment and Service Delivery," *Journal of Social Service Research*, 33 (2) (2006), pp. 27-38.

<sup>32</sup>Florida requires the initial screening within 72 hours; New York recommends but does not require that its counties and agencies provide an initial screening.

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state.<sup>33</sup> Utah officials explained that the state dropped its earlier requirement for an initial screening followed by another assessment, in part because the results were duplicative. However, the state expects caseworkers to be alert to urgent health needs and arrange treatment as needed. The state has written guidelines advising caseworkers that if there is any sign of abuse or neglect or if the child is ill, the child should be seen by a health care provider within 24 hours.

Once a child enters foster care and receives an initial assessment, state foster care policies in most of the states we selected for study required that ongoing assessments follow the schedules established by state Medicaid agencies for children's screening, which are based on the children's age or the time between routine checkups.<sup>34</sup> Six of the 10 states we selected for our study called for children in foster care to receive at least annual screening, either under a separate health standard applicable to foster children or because their EPSDT standard for all Medicaid enrollees called for at least annual screenings, consistent with the 2008 American Academy of Pediatrics' recommendation on preventive pediatric care. See table 2 for a summary of the number of EPSDT screens incorporated in the Medicaid EPSDT standard for all children in the Medicaid programs in the 10 states we reviewed.

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<sup>33</sup> California has no policy on initial screenings, but some of its counties conduct examinations that are similar. Texas's contract with its health providers requires that children newborn to age 3 receive an exam within 14 days of enrollment in the health plan and that older children receive an exam within 21 days. A dental exam must be provided within 60 days for children age 1 or older. Providers may be penalized financially if they do not meet these timelines for certain percentages of children. Washington's assessment process must be completed within 30 days of entry into foster care for children who are expected to remain in out-of-home placement longer than 30 days.

<sup>34</sup>Such a policy may involve separate child welfare and Medicaid requirements. For example, Massachusetts officials indicated that the state child welfare agency has a policy specifying that foster parents schedule and support subsequent health care screenings of the foster children in their care. The Massachusetts Medicaid agency requires that Medicaid providers perform ongoing screenings which follow the standards set by the state Medicaid agency for EPSDT screens.

**Table 2: Number of EPSDT Screens for Medicaid-Enrolled Children in Selected Age Groups, by State<sup>a</sup>**

State	Age group				Total
	Less than 1	1-5	6-14	15-20	
California <sup>b</sup>	6	6	3	1	15
Delaware	7	8	9	6	30
Florida <sup>c</sup>	7	7	7 <sup>d</sup>	6	27
Illinois <sup>d</sup>	7	7	5	3	22
Massachusetts	6	7	9	6	28
New York	7	8	9	6	30
Oklahoma	5	7	4	4	20
Texas	5	7	7	6	25
Utah	6	7	7	6	26
Washington <sup>e</sup>	5	6	5	3	19

Source: GAO analysis of states' EPSDT screening requirements.

<sup>a</sup>Because some states used age categories in describing their policies that did not align with those shown here, the distribution of screens across age groups is an approximation, with no screen counted more than once.

<sup>b</sup>California adopted a screening schedule based on an earlier American Academy of Pediatrics screening schedule. According to state officials, California is in the process of updating the state's screening schedule to conform to the most recent American Academy of Pediatrics screening schedule.

<sup>c</sup>Florida follows the 1999 American Academy of Pediatrics schedule, which recommended a total of 27 screens. Florida Medicaid also recommends check-ups at 7 and 9 years of age for "children at risk."

<sup>d</sup>Illinois recommends that health screening be provided to children on a periodicity schedule based on acceptable medical practice standards, such as the schedule recommended by the American Academy of Pediatrics. The schedule above was provided by the Illinois Department of Public Aid, now known as the Illinois Department of Healthcare and Family Services, as a minimum guideline for children in the Medicaid program. The Illinois Department of Children and Family Services requires that children in foster care receive at minimum annual health screenings between the ages of 6 and 21.

<sup>e</sup>The Washington EPSDT standard specifies annual screening for children in foster care between the ages of 2 and 20.

In addition to policies requiring assessments of children's physical health, 8 of the 10 states we studied also reported requiring screening or assessments of children's mental and developmental health shortly after entry into foster care. Research indicates that an estimated 30 to 60 percent of children in foster care may have chronic health conditions, and the proportion estimated to have serious health care needs rises to over 80

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percent when behavioral, emotional, and developmental concerns are included.<sup>35</sup> Guidelines issued by professional associations emphasize the importance of assessing mental health and other behavioral health issues for children in foster care. An analysis of the results of ACF reviews conducted between 2001 and 2004 found no evidence of policies requiring an assessment of children’s mental health in most states; in one state, stakeholders noted that children did not get mental health assessments unless there were problems observed.<sup>36</sup> The ACF reviews have helped focus attention on the mental health needs of children in foster care, however, and we found that most of the 10 states we selected for study had adopted policies to screen or assess the mental health and development of children entering foster care. Most states we studied had also adopted policies requiring or recommending screening youth entering foster care for substance abuse. For example, Delaware officials told us that—since February 2006—its initial health screening has required the inclusion of a component alerting staff to any mental health or substance abuse problems for all children 4 through 17 years of age. Other state policies varied in whether or not they included specific time frames. For example, New York has no mandatory time frame for its required mental health assessment, although it is recommended that this be completed within 30 days of placement. State guidance also varies on the tools used for the assessments. In some states, such as Massachusetts, the steps taken by individual health practitioners as part of either (1) the comprehensive screening within the first 30 days or (2) in later Medicaid screenings are considered sufficient to meet the policy requirements. In other cases, states have adopted or are considering adopting specific screening tools. For example, Utah reported the state had specified the tools to be used in assessing the development of children ages 4 months to 5 years. Officials in both California and Oklahoma reported they were working to identify assessment instruments for the early identification of children with mental health or developmental needs.

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<sup>35</sup>See Administration for Children and Families, Office of Planning, Research, and Evaluation, *National Survey of Child and Adolescent Well-Being Research Brief No. 7: Special Health Care Needs among Children in Child Welfare, Research Brief, Findings from the NSCAW Study* (2008).

<sup>36</sup>See Jan McCarthy and others, National Technical Assistance Center for Children’s Mental Health and Technical Assistance Partnership for Child, and Family Mental Health, *Child and Family Services Reviews 2001-2004—A Mental Health Analysis* (Washington, D.C., August 2007), p. 14.

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## The Use of Designated Providers Can Increase the Thoroughness of Physical and Mental Health Assessments

Four states we studied reported using designated providers to perform certain initial and comprehensive assessments, which some evidence indicates can increase the consistency and thoroughness with which children’s physical and mental health needs are identified. Illinois, for example, requires that children’s initial health evaluations be conducted by a network of hospital emergency rooms and clinics, while subsequent assessments are generally conducted by a network of community- and facility-based physicians, with foster parents permitted to use others on request. We identified two studies that associated use of designated or specialized health care providers for foster children with higher rates of preventive and specialty care.<sup>37</sup>

With regard to physical assessments, states that identified the use of designated providers to perform initial screens and comprehensive assessments reported that these providers functioned as part of a network of providers, as primary providers in specific locations, or both and, in some cases, that the use of such networks had enhanced the numbers receiving assessments. For example, Florida reported that some of its counties have focused on developing a network of trained providers, while Oklahoma and Utah identified specific locations in urban areas—such as clinics or hospitals—where some children could receive assessments. In most cases, these initial providers could serve as medical homes for the children they assessed. (See table 3 for more information on how states use designated providers.) Some state officials commented that the use of a specific network of physicians also facilitated quality improvement efforts. For example, a physician with Cook County’s Healthworks program noted that the quality of health assessments—once a subject of complaint from child welfare field staff—had improved when assessments were channeled to a network of specific providers that could be supported by targeted training efforts. He noted that the health assessment for a child entering foster care requires a more thorough, detailed approach and level of documentation than that involved in a standard EPSDT well-child exam.

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<sup>37</sup>See P. K. Jaudes, L. A. Bilaver, R. M. George and others, “Improving Access to Health Care for Foster Children: The Illinois Model,” *Child Welfare*, 83 (3) (2004), 215-238; and S. M. Horowitz, P. Owens, and M. D. Simms, “Specialized Assessments for Children in Foster Care,” *Pediatrics*, 106 (2000), 59-66 (available at <http://www.pediatrics.org/cgi/content/full/106/1/59>, accessed on November 18, 2008).



**Table 3: Examples of States' Approaches to Using Designated Providers for Physical Health Assessments**

State	Description of approach
Florida	<ul style="list-style-type: none"> <li>Some counties within Florida use a network of physicians to conduct initial screenings for children in foster care.</li> <li>Such networks may serve as a medical home for children throughout and beyond their stay in foster care.</li> </ul>
Illinois	<ul style="list-style-type: none"> <li>Illinois has a network of providers who conduct initial health screenings, comprehensive health evaluations, and ongoing primary care for all children in foster care, and some comprehensive evaluation providers may serve as sources of continuing care.</li> <li>Providers may be located in hospitals or clinics, with hospital emergency rooms or clinics serving as the initial screening location for children.</li> </ul>
Oklahoma	<ul style="list-style-type: none"> <li>Oklahoma uses primary care providers in clinics in Oklahoma City and Tulsa to screen children for physical, mental health, and dental needs, as well as any social needs.</li> <li>The clinic location can serve as a medical home for the child after assessment.</li> </ul>
Utah	<ul style="list-style-type: none"> <li>Children entering custody with a medical home are to be sent to their original provider for the comprehensive health assessment.</li> <li>For children in foster care who do not have an identified medical home, Utah uses providers located in a public health clinic in Salt Lake City to provide initial screening and comprehensive health assessments to local children in foster care.</li> <li>The clinic can serve as a medical home for the child after assessment.</li> </ul>

Source: GAO analysis of state interview responses, as of August 2008.

The states shown in the table as using designated providers elaborated on their practices and, in some instances, noted specific strategies that may contribute to providers' effectiveness:

- Illinois requires that the initial health screening be completed within an hour of the child's arrival at the medical facility. Illinois officials reported that appointments for the screening in Cook County are arranged through a toll-free telephone service called HealthLine, which is staffed around the clock by a child welfare contractor who can obtain priority service for children so they do not experience lengthy waits in hospital emergency rooms. Hospital emergency rooms are used for many initial screenings because they are accessible outside of normal business hours, but the comprehensive health assessments generally take place in physicians' offices because they require more time. Research on children enrolled in the Illinois program has shown that these children experienced higher rates of preventive and necessary specialty care than other children with similar socio-economic characteristics who were not enrolled in the

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program. Although the research did not evaluate the effectiveness of the program itself, the researchers concluded that the increased attention and oversight of the health care for the children enrolled in the program affected their outcomes.<sup>38</sup>

- Oklahoma officials noted that their clinic-based assessment process began with a pediatrician who had experience working with children who had been removed from their homes and placed into shelters. Concerned about the continuity of care for children in these situations, this pediatrician set aside particular times for children in foster care to visit the clinic and see a familiar provider. A second clinic that was opened in another large city is also under the medical direction of a pediatrician familiar with the needs of children in foster care. Officials told us they believe that children's health care benefits when they are served by providers with knowledge of the foster care population.

In addition to using designated providers for physical health screens and comprehensive assessments, a few states reported using a mental health specialist who worked with caseworkers to conduct assessments. The use of specialists to conduct mental health screenings can be an effective means of identifying children's mental health needs. One study that surveyed a nationally representative sample of agencies found that involving mental health specialists in assessments resulted in a greater identification of mental health needs, as well as improved follow-up care, than were received by children whose assessments did not include a mental health specialist.<sup>39</sup>

The mental health assessments used by states we selected varied. In some cases, the assessments were comprehensive social assessments that covered areas such as mental health, emotional health, school, work, and community involvement. In other cases, the focus was narrower, covering specific topics such as indicators of mental illness. Washington officials reported that specialized social workers conducted comprehensive

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<sup>38</sup>P. K. Jaudes and others "Improving Access to Health Care for Foster Children: The Illinois Model," *Child Welfare*, 83 (3) (2004), 215-238.

<sup>39</sup>See L. K. Leslie and others "Comprehensive Assessments for Children Entering Foster Care: A National Perspective", *Pediatrics*, 112 (1)(2003), pp. 134-142. (Accessible via <http://www.pediatrics.org/cgi/content/full/112/1/134>), or S. M. Horowitz, P. Owens, and M.D. Simms, "Specialized Assessments for Children in Foster Care," *Pediatrics*, 106 (2000), 59-66 (available at <http://www.pediatrics.org/cgi/content/full/106/1/59>, accessed on November 18, 2008).

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assessments using standardized tools that assess several aspects of social and mental health needs, including behavioral, developmental, educational, family, and social issues.<sup>40</sup> For physical or mental health concerns identified during the screening that require treatment, state officials indicated that the social workers refer children to appropriate health care professionals.

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## Practices to Enhance Access to Services, Coordinate Care, and Monitor Use of Medications Are among Efforts to Ensure Delivery of Health Care to Foster Children

To address the challenge of ensuring delivery of appropriate health care services to children in foster care, several of the states we selected for review adopted practices designed to facilitate access to care, coordinate services, and review medications for children in foster care. Practices relating to access to care included efforts to hasten determination of Medicaid eligibility, implement financial incentives for providers to serve children in foster care, and enhance access to medical specialists for various subgroups of children. Care coordination practices that the selected states identified employed either nurses or other health care managers to help ensure that children in foster care received necessary health care services. Officials of specific states we contacted said that such care coordination had increased rates of immunization, initial assessment, and well-child visits. Finally, officials from six of the states we studied pointed to policies that they had implemented requiring the review of prescriptions for psychotropic medications commonly used to treat mental health disorders for children in foster care.

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## Practices to Enhance Access to Care Include Streamlined Medicaid Eligibility, Financial Incentives to Providers, and Strategies to Obtain Specialty Care

Among the states we studied that identified a practice state officials believed noteworthy in enhancing access to care, some had identified assigning certain staff—from their Medicaid offices or from their child welfare offices—to ensure that children in foster care were quickly reviewed for Medicaid eligibility. Because the removal of a child from home can change his or her Medicaid eligibility status, some states we contacted had taken steps to save time in certifying Medicaid eligibility and facilitate new foster care beneficiaries' access to providers. For example, Delaware had assigned two Medicaid staff to foster care cases, while Florida, Utah, and Illinois used staff members from the child welfare

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<sup>40</sup>State officials reported that in 2008, the agency funded 45 full-time equivalent social worker positions to assess children, with at least one social worker in each of the state's 44 child welfare offices. Each social worker was responsible for assessing approximately 12 to 14 children each month and entering the results into the state's child welfare case management system.

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offices to determine eligibility for Medicaid. Utah has a written agreement between the state child welfare and Medicaid agencies that specifies that certain staff in Utah's Division of Child and Family Services will determine Medicaid eligibility for children in foster care. The purpose of this arrangement is to enhance services to children and families, simplify administration, improve accuracy, conserve state resources by avoiding duplication, and maximize legitimate Medicaid funding. In Illinois, children coming into foster care are presumed to be eligible for Medicaid. For purposes of formal eligibility determination, Illinois officials reported that using specialized staff members in the state child welfare agency's central office to complete the determination had sped up the process. Specifically, they reported that a process that once took 3 to 4 months could now be completed within 4 weeks of issuance of the temporary medical card. Florida officials also reported that their agreement that staff from the child welfare department determine Medicaid eligibility reduced the amount of time required to make these determinations from 18 days to within 24 hours.

Illinois and Washington are among the states that offer financial incentives to providers who treat children in foster care, since providers may be reluctant to serve children in foster care. In Illinois, physicians serving children in foster care are paid a one-time \$15 fee to initiate a paper health passport to document the health history and ongoing care of the child. Additionally, the state uses an enhanced payment rate for initial health screenings conducted in hospital emergency rooms.<sup>41</sup> Washington officials reported that the state increased its payments in November 2001 for medical providers who conducted well-child examinations for children in foster care. At the time, these rates were about twice the reimbursement rate paid in other cases. State officials reported that since 2001, other Medicaid rates—such as payments for EPSDT services—have also increased, so that rates for foster care children are no longer twice as high. However, the foster care rates remain equal to or substantially greater than the standard Medicaid rates. In April 2008, Washington officials told us that approximately two-thirds of children received well-child examinations, up from about 17 percent before the state increased the rates in 2001.

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<sup>41</sup>For all children covered by Medicaid, not just those in foster care, state officials told us that Illinois also has a performance payment of \$30 per child per year if a required number of visits is met, as well as an expedited payment process that returns payment within 30 days. Additionally, the state was implementing a pay-for-performance bonus for serving a certain number of children.

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Utah, Illinois, and New York have instituted a variety of programs to increase access to medical specialists or subspecialists. Under some circumstances, obtaining specialty care can be difficult for Medicaid-eligible children, and such efforts for children in foster care may be even more difficult if the children have complex health needs or changing placements. These states' efforts typically focused on specific subgroups of children in foster care, such as those in rural areas, those who need mental health services, and those who would otherwise require institutional care.

- *Children in Rural Areas:* Utah and Illinois have efforts focused on children living in rural areas where it may be harder to find a pediatric health specialist or subspecialist. For example, Utah has eight clinics to which multidisciplinary teams travel in order to provide specialty services for children with special health care needs across rural Utah. State officials told us that in some cases, children are seen more quickly in these locations than in Salt Lake City. Illinois officials reported transportation is available and sometimes is used to get rural foster children to providers, including oral dental surgeons, orthodontists, and child psychiatrists. Despite these efforts, state child welfare officials cited a continuing challenge in obtaining mental health and substance abuse services, and especially child psychiatry for children in Medicaid and other publicly-funded medical care, not just those in foster care. As a result, Illinois has also begun to look at the use of telepsychiatry in one of its downstate regions.<sup>42</sup>
- *Children Needing Mental Health Services:* To address children who are experiencing mental health crises, Illinois developed a psychiatric crisis intervention program with a single, statewide 24-hour, 7-day-a-week crisis hotline. When a person calls the crisis line, a mental health provider is expected to reach the child in crisis within 90 minutes of the call to conduct a screening and determine if the child requires psychiatric hospitalization. Following this decision, the mental health provider is to continue to provide treatment and other service interventions for a minimum of 90 days. State officials reported that this program serves about 18,000 children per year, including all children who receive Medicaid or other public funding for medical care (not just those in foster care). Medicaid covers all the services provided by this program, which began in 2004, on a fee-for-service basis.

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<sup>42</sup>Telepsychiatry is a form of video conferencing that can facilitate provision of psychiatric services to patients living in remote locations or otherwise underserved areas.

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- *Children Who Might Otherwise Require Institutional Care:* With respect to difficulty in accessing specialty services, New York launched a program in early 2008 for children in foster care who have developmental disabilities, serious emotional disturbances, and medical problems that are so severe they would otherwise likely be in restrictive and high-cost institutions. By making community-based services available to a fixed number of these children, the state hopes to help them function in family and community settings instead. New York officials reported that when the program is fully implemented after 2011, it will serve approximately 3,000 children in foster care.

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### Public Health Nurses and Other Health Care Managers Coordinate Care to Help Ensure Health Services Are Delivered Appropriately

Several states we studied discussed their development of the role of health care managers with the goal of improving health care and health outcomes for children in foster care. While all children in foster care have caseworkers, they focus on issues related to the child's safety and permanency and do not necessarily have medical expertise. Typically, health care managers are nurses who are colocated with the child welfare agency and work with the child's foster care caseworker. Officials in California told us that the nurses are colocated in the child welfare offices so they can easily talk directly to caseworkers. These nurses may be able to more quickly spot gaps in care than foster care caseworkers because they are trained to understand children's health and developmental needs, they are able to communicate clearly with health care providers, and they can provide medical guidance to both foster care caseworkers and foster and biological parents. In some states—such as California and Utah—each child is assigned a nurse, while in other states—such as Illinois and Massachusetts—only those children with specific or medically complex needs are individually assigned to a nurse. In some states, public health nurses provided the care coordination services for children in foster care, whereas in Illinois, the state child welfare agency or a local contracting agency served as health care manager. Some positive results in achieving health-related goals for children in foster care had been documented for a health care management effort in New York.<sup>43</sup>

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<sup>43</sup>Rebecca Colman and others, *The New York State Care Coordination Pilot Project: Process and Impact Evaluation Study Findings*, a report for the New York State Office of Children and Family Services, March 2007.

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The specific services provided by health care managers varied in the states we contacted, but usually included the development and maintenance of the child's health history, medical case planning—that is, identifying the child's medical needs and arranging for receipt of medical services—and identification of medical professionals available to provide services to children in foster care. For example, state officials in Utah told us that the state has 29 Maternal and Child Health agency nurses serving about 90 children each. The nurses may provide medical, mental health, and dental consultation; identify the child's primary care provider; place the child in the appropriate health plan; gather, evaluate, and document the health history of each child; track ongoing health care; and maintain an up-to-date medical history on each child within an electronic database.<sup>44</sup> Officials in Utah reported that use of public health nurses has reduced errors in transcribing information about medical history and ongoing care into the state's electronic database. Utah officials also reported that they find that biological parents are more comfortable talking openly with the nurse, who they said biological parents tend to view as an advocate rather than an adversary. According to data provided by state officials, another result of the program is that more children are getting their comprehensive assessments completed than before, and more quickly than required. Specifically, Utah officials reported that about 76 percent of children received these assessments in a timely fashion in 2008, compared to 58 percent in 1998, before the program was implemented. They further noted that these assessments are being conducted in 18 days, on average, rather than taking the full 30 days allowed by state requirements.

Health care managers may also provide other services. Caseworkers in Illinois told us that in medically complex situations, families can be assigned to a regional nurse who can provide recommendations and assist a caseworker in communicating with the family on medical needs. Similarly, in Massachusetts, staff told us that nurses in regional offices provide consultation to staff regarding the medical needs of all children and work with children who have difficult or complex medical needs. In Illinois, officials at one of the privately-run case management programs in Chicago became concerned about immunization and well-child exam completion rates. As a result, they implemented a paper-based reminder-

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<sup>44</sup>State officials told us the 2008 budget for the nursing program is approximately \$3.1 million. The majority of costs are personnel costs, with about 46 percent paid for by federal Medicaid funds, 18 percent by state health department funds, and 36 percent by state child welfare department funds. These funds are used to provide services for up to 2,600 children enrolled in foster care on any given day.

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recall system that gives foster parents, providers, and caseworkers information about when and what medical services are needed. Prior to the implementation of the reminder-recall system, officials in one agency that had adopted it told us that 77 percent of children had up-to-date immunizations and 44 percent had received appropriate well-child visits. These officials reported that in 2007, after implementation of this reminder-recall system, 96 percent received appropriate immunizations and 90 percent had received well-child care. We were told that the five community-based medical care management agencies in Cook County used the reminder-recall system.<sup>45</sup> In addition, some counties outside of Cook County have instituted a similar system.

New York conducted a formal evaluation of its health care management project and found that such care coordination had a significant, positive impact on many aspects of care, including the receipt of both initial physical and dental assessments, access to nonpreventative care, and health-related contacts between agency workers and foster parents.<sup>46</sup> However, funding was not available for the state to continue this program when the initial pilot project was completed and the project did not meet nonhealth and well-being related child welfare goals, such as reducing the number of days spent in foster care and increasing the likelihood of leaving foster care for a permanent placement.

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## Policies Governing the Review of Psychotropic Medications Implemented to Help Ensure Children in Foster Care Receive Appropriate Health Care

Officials in six of the states we selected for interview identified specific policies they had adopted to govern the review of psychotropic medications intended for the treatment of mental health disorders.<sup>47</sup> An Illinois official noted that the use of psychotropic medications is uniquely challenging for children in foster care, given that foster children who change placements often do not have a consistent person to plan treatment, offer consent, and provide oversight. Most of the policies states identified require an extra level of review beyond the person prescribing

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<sup>45</sup>The two medical care management agencies in Cook County that do not use the reminder-recall system are local health departments.

<sup>46</sup>Colman et. al., *The New York State Care Coordination Pilot Project: Process and Impact Evaluation Study Findings*, a report for the New York State Office of Children and Family Services, March 2007.

<sup>47</sup>Psychotropic medications may have more than one purpose and may be used to treat other medical conditions. For example, the same drug may be used to control seizures for someone with epilepsy and to reduce mood swings in someone with bipolar disorder.



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the medication, either by state officials or local experts. Concerns have been expressed that psychotropic medications have frequently not been tested for their safety and efficacy with children, and one study of children in foster care found that the most frequently prescribed medication was an antipsychotic drug that had not been tested for use by children and adolescents.<sup>48</sup> Some research has also found that use of psychotropic drugs by children in foster care is three to four times greater than by other low-income children insured by Medicaid.<sup>49</sup> Greater prevalence of use is not, by itself, evidence of inappropriate use; children in foster care may be more likely to have conditions for which the drugs are indicated. However, administrative data from one state associated the introduction of its policy with modest decreases in prescribing psychotropic drugs and declines in specific patterns of prescribing, such as prescribing multiple drugs.

Texas has developed a policy that notes the importance of conducting a health history, psychosocial assessment, mental status exam, and physical exam before prescribing psychotropic medications. The policy suggests that alternative interventions should generally be considered before beginning the use of psychotropic medications and outlines specific circumstances under which a case may require further review.<sup>50</sup> Data examining the percentage of children prescribed a psychotropic medication for at least 60 days, the percentage prescribed two or more medications concurrently from the same drug class, and the percentage prescribed five or more medications concurrently showed decreases from fiscal year 2004, before the new policies were implemented, through fiscal year 2007.<sup>51</sup>

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<sup>48</sup>Diane L. Green, Wesley Hawkins, and Michelle Hawkins, "Medication of Children and Youth in Foster Care," *Disability Issues for Social Workers and Human Services Professionals in the Twenty-First Century*, (New York: Haworth Press, 2005). Also see GAO, *Pediatric Drug Research: Studies Conducted under Best Pharmaceuticals for Children Act*, [GAO-07-557](#) (Washington, D.C.: Mar. 22, 2007).

<sup>49</sup>Julie M. Zito and others, "Psychotropic Medication Patterns Among Youth in Foster Care," *Pediatrics*, vol. 121, no. 1 (2008): e157-e163.

<sup>50</sup>The types of circumstances cited include the absence of a clinical diagnosis, the concurrent use of five or more psychotropic medications, multiple medications being used before trying just one, exceeding the usually recommended dose, and prescribing psychotropic medications for children less than 4 years of age.

<sup>51</sup>See [http://www.hhsc.state.tx.us/medicaid/occ/Psychoactive\\_Medications.html](http://www.hhsc.state.tx.us/medicaid/occ/Psychoactive_Medications.html) (accessed on Sept. 2, 2008).

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Because of concerns raised about the appropriate use of psychotropic medications, California requires judicial approval for their administration to a foster child. The prescribing physician must make the case to a juvenile court judge that the particular medication is appropriate for the given child and that alternatives have been considered. The Judicial Council of California has adopted rules of court to implement this legal requirement. Specifically, these rules require that an application be made to a juvenile court judge requesting the use of psychotropic medication and that the application include the signature of the physician to request the medication's use; the child's diagnosis, the specific medication, and dosage recommended for use; the anticipated benefits and possible side effects of the medication; a list of other medications the child is taking, along with a description of possible drug interactions; a description of other treatment plans; and a statement that the child has been informed of the recommended course of treatment with their responses. The court may grant the application or may delegate that authority to the parent if it is found that the parent poses no danger to the child and that the parent has the capacity to understand the request. In an emergency, the rules allow the administration of psychotropic medications without court approval in accordance with existing law, but court approval must be obtained within 2 days.

Other states have worked with universities and local experts to help with the oversight of psychotropic medication use by children in foster care. For example, Illinois has contracted with a university to provide an independent review of each psychotropic medication request to ensure safe and appropriate usage with children in foster care. The request is forwarded to a board-certified child and adolescent psychiatrist who reviews the information and determines whether to approve, deny, or adjust the request. According to state officials, Florida has also worked with a local university to develop a process whereby caregivers of children in foster care receive a consultation with a physician before psychotropic medications are prescribed. The state also has a mandatory preconsent consultation for all children age 5 and under in foster care. The state then tracks information about the medication, such as the prescribing physician, medication, dosage, number of refills, and its purpose. As a result, the state is able to determine the number of children receiving certain types of medication and can then identify areas where there might be concerns about inappropriate use. Oklahoma and New York also work with experts to review and provide training related to the use of psychotropic medications by children in foster care.

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## Mechanisms for Data Management and Quality Assurance Address Challenges to Documenting and Monitoring Children's Health Care

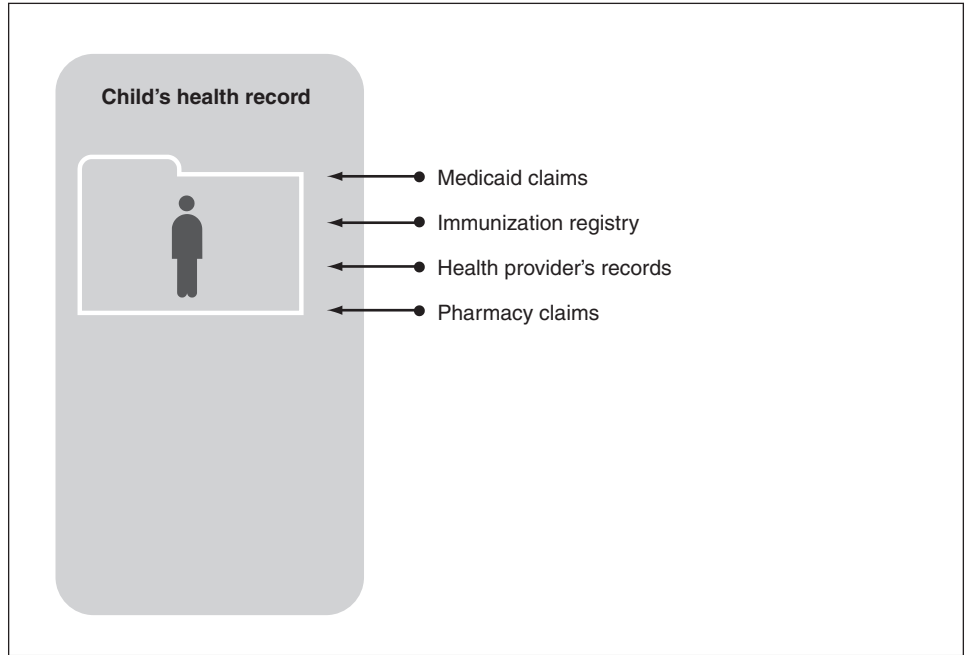
To address the challenges of documenting and monitoring children's health care, some states we studied shared health care data across various state systems to acquire more complete medical histories and used quality assurance mechanisms, such as medical audits or specialized case reviews, to track receipt of services. Efforts to share health care data generally focused on enhancing access to existing health information among parties responsible for the health of children in foster care while meeting requirements for data security and privacy protection. For example, through data sharing with Medicaid and other data sources, Texas has developed an electronic health record—known as the Foster Care Health Passport—that can be viewed by authorized individuals involved in the child's care through a secure Web site. More commonly, states we studied identified initiatives that also combined data from different sources but did not offer electronic access or provide for any updating at the point of care, relying on paper-based transfers of medical histories and providers' updates via the foster parents. Quality assurance activities have also made use of electronic systems as a means of monitoring the receipt of services for children in foster care. These efforts can be important to ensuring that individual children receive the appropriate level of services, avoiding duplication of services such as immunizations, and ensuring the receipt of needed services.

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## Data Sharing with Medicaid and Other Systems May Yield More Complete Medical Information

Some states share data with Medicaid and other state systems, such as immunization registries, in order to obtain more complete medical information than might otherwise be available as a child enters foster care. Basic health information should be included in a written case plan and provided to foster parents before children are placed with them. Obtaining information that is important to a child's health records can be a complex task, which may involve four or more separate systems (see fig. 3). Additionally, information collected from parents and caregivers may also be of assistance in understanding the needs of a child.

**Figure 3: State Data Systems Used by One or More State Child Welfare Agencies to Develop the Health History of Children in Foster Care**



Source: GAO analysis; images, Art Explosion (clip art).

States that pointed to records management systems as a means of developing health history cited the use of an electronic health record—sometimes termed an electronic passport—or other efforts to combine sources of information. Combining these sources of information is important because few children enter foster care with records that accurately identify their health providers, health conditions, or receipt of services. Without these records, their health care may be delayed until records are available, or their care may be compromised. For example, officials in two states told us of cases in which health providers had refused to provide specific treatments to children in foster care because they did not know their histories or did not have medical records available to prevent improper treatment. Similarly, children may miss immunizations, receive duplicate immunizations, or forego necessary medications.

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Web-Based Electronic Passport  
Can Allow Access to  
Comprehensive Health  
Information on Individual  
Children in Foster Care

In April 2008, Texas began implementing an electronic passport to track health data for 29,000 children in foster care.<sup>52</sup> This passport can be updated regularly and is accessed through a secure Web site by foster parents, caseworkers, and health care providers who are responsible for making health decisions on behalf of children.<sup>53</sup> The Foster Care Health Passport is operated by a managed care organization that is under contract with the state Medicaid agency. Texas developed and implemented the Health Passport using funds from the state and CMS. Officials told us that total funding data were not readily available.

When a child enters the Texas foster care system, his or her electronic health record is created by obtaining information from a variety of sources. The Health Passport is initially populated with Medicaid and State Children's Health Insurance Program (SCHIP) claims, including pharmacy claims data from the past 2 years for children previously enrolled in Medicaid or SCHIP. Officials told us that generally, data from these sources are available for a majority, but not all, children who enter foster care. Immunization records are entered through a data sharing arrangement with the state's immunization registry. Once the electronic health record is created, it can be electronically updated with information on any health care services that were delivered by any foster care health provider in the managed care organization's network. Claims data are added when the claim is processed, which state officials indicated could take a few weeks or months, noting that providers have 90 days after a medical visit to submit a claim. Services provided outside of the contractor's network must be added manually through an online form mailed or faxed to the managed care organization. Officials told us that the passport also records behavioral health, dental, and vision services. Finally, officials stated that information in the Health Passport remains accessible statewide, even when the child's placement changes and the child moves to new foster parents, localities, or health providers. When children leave foster care, the electronic health record is printed out for the child or his caregiver.

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<sup>52</sup>The passport covers children in foster care placements, children placed with relatives by the state, children formerly in the foster care program who have returned home but remain in the state's custody, and children who voluntarily entered into the state's care.

<sup>53</sup>See the following Web site for further information:  
[https://www.fostercaretx.com/portal/public/fc/fostercare/health\\_passport/health\\_passport\\_online\\_training\\_tools.com](https://www.fostercaretx.com/portal/public/fc/fostercare/health_passport/health_passport_online_training_tools.com).

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While the Health Passport has not been operational long enough to determine its effectiveness, state officials told us that they are working on baseline measures for several variables, such as well-child outcomes, and have developed measures to assess the contractor's performance.<sup>54</sup>

Officials in several other states we contacted expressed an interest in pursuing the development of an electronic health passport. For example, Illinois uses several data systems to manage Medicaid, foster care, and community health and preventive care for children, but the state is working toward integrating data electronically from the many systems in use, with the ultimate goal being the construction of an electronic passport. Some obstacles to data sharing have included concerns about privacy and security. As states look to sharing individuals' health data to better serve and treat them, they are also implementing standards governing the transmission of data, policies to ensure that only authorized users have access to records, and provisions to protect individuals' privacy. CMS has taken steps to provide assistance to states on issues of security and privacy. Several of the states included in this study cited practices they used to create medical histories and agreements they have to address data security and privacy issues.

### Other Forms of Data Sharing Can Improve Access to Timely Health Information

Other forms of data sharing use and combine existing record-keeping systems, usually through a combination of electronic matches and paper exchange of data among doctors, foster parents, and the Medicaid or the foster care agency, as shown in the examples below.

- Oklahoma officials noted that the state's efforts to obtain medical information for children entering foster care centered on using Medicaid claims data, which it has been doing on a statewide basis since 2007. State officials reported that the project has been particularly successful because over 90 percent of children entering foster care had some prior Medicaid history and over 80 percent were already on Medicaid when they entered the state's care. Officials noted that the Medicaid claims data can provide information on developmental assessments, immunizations, as well as the receipt of both physical and mental health services.

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<sup>54</sup>The Congressional Budget Office recently noted that electronic health records in general might help with the sharing of health information, which in turn might improve the quality of care. See Congressional Budget Office, *Evidence on the Costs and Benefits of Health Information Technology* (May 2008).

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- In Utah and Illinois, nurses enter children’s health information into the state child welfare agency’s database. In Utah, public health nurses who work in collaboration with child welfare workers provide medical care coordination and record visits, diagnoses, and prescriptions for children in foster care. The child welfare agency in Illinois has a memorandum of agreement with its Medicaid agency to share pharmacy claims data for purposes of identifying doctors prescribing psychotropic medications without consent, and it also electronically obtains immunization data on children in foster care from an immunization registry. Both Utah and Illinois state officials told us that they were in the process of creating an integrated system that will store more complete electronic health records for children in foster care. For example, Illinois child welfare officials reported they were working with other state agencies to be able to pull data from Medicaid claims and other sources.
  - Massachusetts uses a combination of paper and electronic records. They exchange medical information with foster parents and health care providers on paper, which they then enter into an electronic database.
  - An official with HHS’s Agency for Healthcare Research and Quality told us that health information exchanges in Colorado and Indiana are being developed with federal demonstration grants that will include foster children along with other patients. The HHS Inspector General reported in August 2007 that at least 27 states are developing at least partially electronic health records for Medicaid with funds from CMS. These efforts may extend to children in foster care but are not focused on them.<sup>55</sup>

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## Quality Assurance Activities Can Help Monitor the Receipt of Services

New York, Utah, Delaware, and Illinois specifically pointed to quality assurance activities relevant to monitoring foster children’s receipt of health care services. Such activities can be used to help track the receipt of services by individual children in foster care, including ensuring that individual children are assessed as required and treated appropriately. Monitoring procedures that aggregate information across foster children can help managers ensure that health policies are consistently implemented and having the intended results.

The four states that discussed their quality assurance activities cited practices that included the use of technology and electronic records to

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<sup>55</sup>Department of Health and Human Services, Office of Inspector General, *State Medicaid Agencies’ Initiatives on Health Information Technology and Health Information Exchange*, OEI-02-06-00270 (Washington, D.C., August 2007).

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collect, analyze, and aggregate health care data, perform medical audits, and conduct evaluations or other checks to ensure the quality of health care services provided to children in foster care. ACF's reviews found that states with identifiable quality assurance systems that conformed to specific criteria had a higher percentage of cases rated as having met the health needs of children in the states' custody. Further, ACF's analysis suggested that states with well-functioning quality assurance systems were more likely to succeed on measures of enhancing a family's capacity to provide for the needs of their children and ensuring that the children's physical and mental health needs were being met.<sup>56</sup>

The states that identified relevant quality assurance activities to us provided examples of two approaches: (1) requiring managed care organizations to track and report individual or aggregate data on foster children in their care and (2) conducting medical audits of health records for children in foster care.

With regard to requiring managed care organizations to track and report certain data, officials in Delaware described a new requirement in its contracts with managed care organizations aimed at ensuring that initial health screenings occur and result in the receipt of necessary services. In 2008, Delaware required that contracts with managed care organizations track and report on services rendered following initial health screenings. According to Delaware Medicaid officials, the reports are intended to provide aggregate data on health screenings provided. The officials told us that no specific concern triggered the 2008 quality check on initial health screenings, but officials noted that the state would like to be able to provide aggregate data on the percentage of children in their foster care program who received an initial health assessment within a set number of days. Utah uses a statewide case management system that can generate detailed data on individual children, as well as aggregate reports. Utah officials explained that these aggregate reports had been used to contact medical providers when the state received alerts from the U.S. Food and Drug Administration on the adverse effects of certain drugs. In this instance, the state sent letters to medical providers urging them to

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<sup>56</sup>See the Department of Health and Human Services, Administration for Children and Families Web site, Summary of the Results of the 2001-2004 Child and Family Services Reviews, *General Findings from The Federal Child and Family Services Review*, p. 17 of 39. This is available at <http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/index.htm> (accessed on Aug. 28, 2008).



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examine specific patients on these medications. Utah officials believed that having a majority of records in electronic form facilitated this effort.

Finally, one city and two states reported the use of medical audits to ensure the receipt and quality of health care provided to children in foster care. For example, New York City uses medical care audits to examine the quality of services provided to the 17,000 children in the city's foster care program.<sup>57</sup> The city reported conducting two types of medical care audits—a routine medical audit conducted every 2 years and a special medical audit for children with HIV, conducted at least annually. These reviews apply an audit tool that is based on local foster care standards for physical and mental health to assess documentation in medical records of the child's medical history, consent for treatments, comprehensive physical examinations, diagnostic screenings, immunization history and status, developmental and behavioral health screenings, and the use of psychotropic medications. Reviewers provide their results to foster care agencies, noting findings that must be addressed immediately, as well as a corrective action plan. The audit score is incorporated into a cumulative score on the agency's performance. Officials in Illinois and Utah also reported the use of medical audits to ensure the delivery of appropriate care.

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## ACF Offers States Health-Related Technical Assistance as Part of Its Broader Efforts to Improve Delivery of Services

Although states are ultimately responsible for meeting the health needs of children in foster care, HHS is required by law to provide technical assistance to the extent feasible to help states develop and implement plans to improve their performance. ACF officials told us that their emphasis is on providing technical assistance that will increase the capacity of state child welfare agencies over the long term to serve the needs of children in their care. ACF officials point out that they do not expect to provide expertise in the area of health care, but instead to help child welfare agencies carry out their mission within the flexibility that states have.

ACF's 25 technical assistance centers—including one center that specializes in children's mental health—offer states a range of assistance, from on-site consultation to Web-based information on promising

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<sup>57</sup> According to New York officials, as of February 2008, New York City's foster care population represented more than 80 percent of all children in the foster care system in the state.

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practices. In some cases, the centers help state child welfare agencies develop strategies to obtain needed services and coordinate their efforts with others involved in health care, such as the agencies responsible for Medicaid, public health, mental health, and substance abuse treatment.<sup>58</sup> These and other agencies are listed among possible stakeholders in ACF's reviews of state child welfare agencies. ACF and center staff also referred to the assistance that is available from nonfederal sources, such as universities and private foundations.<sup>59</sup>

Technical assistance in the form of on-site consultation is provided at state request, and few states have requested on-site consultation specifically to address health care services for children. On-site consultation generally is requested from ACF regions, coordinated through the National Child Welfare Resource Center for Organizational Improvement, and tracked by ACF through a dedicated data system. The centers we contacted generally report that they have not been asked to provide consultants on site, but have provided other forms of assistance related to the health care needs of children in foster care.<sup>60</sup>

Table 4 provides summary information on the centers in ACF's network that either specialize in an aspect of health care or have reported providing some assistance on health care practices through 2008, including one center with funding from HHS's SAMHSA that focuses on

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<sup>58</sup>In commenting on a draft of this report, HHS officials noted that ACF uses an interagency agreement with the Substance Abuse and Mental Health Services Administration to contribute to an additional technical assistance center called the "*National Center on Substance Abuse and Child Welfare*." While GAO's research identified this additional center, the mission of the center focused on substance use in intact families and did not specifically address foster children; therefore, this center was not included in the scope of the GAO study.

<sup>59</sup>Several of the centers include links to the websites of these other organizations. For example, the National Resource Center for Family-Centered Practice and Permanency Planning Center provides a link to The Commonwealth Fund for information on developmental screening.

<sup>60</sup>The centers submit regular reports to ACF on their activities, but they do not have to identify the particular assistance provided individual states. On-site consultation to individual states, however, must be reported by eight centers through the Technical Assistance Tracking Internet System. As GAO has previously reported, ACF has not independently evaluated the centers' effectiveness.

children’s mental health.<sup>61</sup> Examples of some of the work these centers perform in relation to health care are discussed below.

**Table 4: Centers in ACF’s Training and Technical Assistance Network That Have Provided Assistance Related to Foster Children’s Health Care through 2008**

Name of center	Web site address	ACF funds in 2008	SAMHSA funds in 2008
<b>Center specializing in aspects of health care</b>			
National Technical Assistance Center for Children’s Mental Health	<a href="http://gucchd.georgetown.edu/">http://gucchd.georgetown.edu/</a>	\$ 350,000 <sup>a</sup>	\$3,050,000
<b>Centers with other responsibilities that report having assisted with health care practices</b>			
National Resource Center for Family-Centered Practice and Permanency Planning	<a href="http://www.nrcfcppp.org">www.nrcfcppp.org</a>	1,270,000	None
National Child Welfare Resource Center for Organizational Improvement	<a href="http://www.nrcoi.org">www.nrcoi.org</a>	1,750,000	None
National Child Welfare Resource Center for Youth Development	<a href="http://www.nrcys.ou.edu/yd">www.nrcys.ou.edu/yd</a>	1,250,000	None
Child Welfare Information Gateway	<a href="http://www.childwelfare.gov">www.childwelfare.gov</a>	7,982,000	None

Source: GAO analysis of ACF information.

<sup>a</sup>\$200,000 is for assistance to recipients of a discretionary grant to implement systems of care, only some of which are state agencies.

The center that specializes in aspects of children’s health care is the National Technical Assistance Center for Children’s Mental Health, based at Georgetown University, which helps states and other entities build systems to improve access and outcomes for all children with mental health concerns. The center’s focus is on children who have or are at risk of having emotional disorders, including children in foster care. This focus has been extended to include youth facing mental health problems who have also become involved with substance abuse. The center’s services range from the development and dissemination of various publications to consultation on how to increase a state’s capacity to meet children’s

<sup>61</sup>The National Center on Substance Abuse and Child Welfare, operated by the Center for Children and Family Futures, is charged with assisting states and others to improve outcomes for families with substance use disorders who are involved in the child welfare and family court systems.

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mental health needs.<sup>62</sup> Specifically, at state request, center staff and consultants may work for a year or more with mental health leaders in individual states, often along with child welfare directors, to help these states identify and implement strategies to improve services for children. One staff position at the center has been reserved for a consultant with child welfare expertise. According to center staff, the center provides this type of consultation to an average of 8 to 10 states each year and has served 22 states through 2008.<sup>63</sup> To reach more agency personnel, the center holds a training institute every other year for approximately 2,000 to 2,500 attendees that in 2008 offered a series of sessions on partnerships between mental health and child welfare agencies for assessment, early intervention and treatment, support services, and care coordination, among other topics. In carrying out their work, center officials reported coordinating closely with other federally funded centers and organizations, state professional associations, private foundations, and research groups.<sup>64</sup> While currently focused primarily on mental health, the center is also concerned with the integration of primary care and mental health, and prior to implementation of the ACF reviews, received funds from the Maternal and Child Health Bureau of HHS's HRSA to examine promising approaches to providing the full range of health care services for children in foster care. A series of reports were published detailing these approaches that continue to be available through this and other technical centers for use by child welfare agencies in improving their service delivery.<sup>65</sup>

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<sup>62</sup>An example of the center's recent publications is: *Child and Family Services Reviews 2001-2004 - A Mental Health Analysis, 2007*, which reports on mental health service delivery challenges and management trends noted in ACF reviews and state improvement plans.

<sup>63</sup>The 22 states are Alaska, Arizona, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Maryland, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Mexico, Oklahoma, Pennsylvania, South Carolina, Tennessee, Utah, and Vermont.

<sup>64</sup>The center has worked closely with the Technical Assistance Partnership for Child and Family Mental Health operated by the American Institutes for Research with SAMHSA funding, the National Association of State Mental Health Program Directors, The Annie E. Casey Foundation, and the University of South Florida.

<sup>65</sup>See *Meeting the Health Care Needs of Children in the Foster Care System, 2002*, an HRSA-sponsored publication that reported on a 3-year study of promising approaches to meeting the physical, mental, emotional, developmental, and dental health needs of foster children.

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In several other centers, staff described information that they have provided on health care practices, including the following examples:

- Seven audio conferences on topics, such as the use of psychotropic medications, assessing and treating children up through age 3, and other issues concerning the mental health of children in foster care were developed by the National Resource Center for Family-Centered Practice and Permanency Planning at New York's Hunter College School of Social Work. Among many sample areas of technical assistance, the center lists health and mental health issues for children and youth in foster care, and to that end, hosts a Webpage devoted to health care with multiple links to other relevant sites.
- Sessions regarding the role of clinics dedicated to assessing and treating children in foster care and the options for financing mental health care were featured at the 2007 annual conference for child welfare agency staff arranged by the National Child Welfare Resource Center for Organizational Improvement at the University of Maine.
- The sharing of information on the steps states are taking to extend Medicaid coverage to older youth when they leave foster care is a key area of focus for the National Child Welfare Resource Center for Youth Development in Oklahoma. The center connects states that have been successful in this area with states asking for assistance and maintains a list serve for state child welfare agency officials who are responsible for helping youth prepare for independence.

ACF regional and central office staff may also share promising practices that they observe during reviews of state programs. These practices are posted to an ACF Web site and include several related to child and family wellbeing.<sup>66</sup> ACF's Web site notes that the Children's Bureau does not make any representations pertaining to the effectiveness of the posted approaches, and ACF officials stated they had taken no further steps to share them and that they had not evaluated specific state practices. Other practices have been shared among states at regional meetings, as in ACF Region VII, where Kansas shared information on its medical passport. Regional staff may also share information on various practices adopted by states within the regions. For example, ACF reported that regional staff members have shared strategies for meeting children's dental needs, such

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<sup>66</sup>See <http://www.acf.hhs.gov/programs/cb/cwmonitoring/promise/index.htm> (accessed on Nov. 21, 2008).

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as using hygienists in Kansas and using a traveling dental van in Missouri. Florida officials reported that they received assistance from ACF on referrals to early intervention programs. New York and Utah officials also acknowledged the help that they received from regional ACF staff.<sup>67</sup>

To assist in states' efforts to implement improvement strategies, ACF newly funded five centers in fall 2008 that are expected to provide in-depth, long-term consultation and support to states to improve the quality and effectiveness of their child welfare services starting in July 2009. ACF expects the assistance to help build partnerships to deliver a broad array of integrated services that can be individually tailored to meet the diverse needs of children and families served by child welfare agencies, including their physical, mental, and developmental needs as appropriate. As with the older centers, states' identification of needs and potential strategies will determine the assistance provided. Some assistance with aspects of health care may be available from these centers if states request it, according to ACF officials.

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## Agency Comments and Our Evaluation

We provided a draft of this report to the Department of Health and Human Services for comment and received a written response, which is included in this report as appendix II. HHS provided some additional information on its technical assistance to state foster care agencies, particularly through collaboration between ACF and SAMHSA, to assist states in addressing mental health and substance abuse issues among foster children. The agency also provided technical comments, which we have incorporated as appropriate.

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We are sending copies of this report to the Secretary of Health and Human Services, state child welfare agencies, and other interested parties. We will provide copies to others on request. In addition, this report is available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have questions about this report, please contact Kay E. Brown at (202) 512-3674 or [brownke@gao.gov](mailto:brownke@gao.gov) or Cynthia A. Bascetta at (202) 512-7114 or [bascettac@gao.gov](mailto:bascettac@gao.gov). Contact points for our Offices of

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<sup>67</sup>For more information on ACF's technical assistance and states' reactions, see GAO, *Child and Family Services Reviews: Better Use of Data Could Enhance HHS's Oversight of State Performance*, GAO-04-333 (Washington, D.C.: Apr. 20, 2004).

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Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff members who made key contributions to this report are also listed in appendix III.

Sincerely yours,

*Kay C. Brown*

Kay Brown, Director  
Education, Workforce  
and Income Security Issues

*Cynthia A. Bascetta*

Cynthia A. Bascetta, Director  
Health Care Issues

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# Appendix I: Selection of States and Practices for GAO Review

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Our study had four objectives. These included describing practices that selected states have adopted to address the challenges of (1) identifying health care needs, (2) ensuring delivery of appropriate health services, and (3) documenting and monitoring the health care of children in foster care. In addition, we describe technical assistance the Department of Health and Human Services' Administration for Children and Families (ACF) provides to states to help improve their performance in providing for the health care needs of these children.

To gain an initial understanding of the types of practices states have adopted, we reviewed relevant reports and interviewed various experts and researchers. We reviewed information on promising practices listed on ACF's Web site that were identified during ACF's reviews of state performance and a list of state practices that ACF provided to us. We also interviewed several prominent child welfare experts and researchers, including individuals affiliated with the American Academy of Pediatrics, the Center for Health Care Strategies, the Chapin Hall Center for Children, the Georgetown University Child Development Center, and the National Academy for State Health Policy to obtain additional information on practices to improve the delivery of health care to children in foster care.

To update information on practices described in available publications and to obtain additional examples that may not have been reported in publications, we e-mailed requests for information on current practices they believed were noteworthy efforts to address children's health care needs to representatives of child welfare agencies in 50 states and the District of Columbia. To minimize the burden on state representatives, we suggested that they could limit the number of practices they described. We sent our e-mail requests in October 2007, and representatives for 42 of the 51 child welfare agencies provided responses.

To gather more detailed examples of these practices, we selected 10 state child welfare agencies for further review—conducting visits to 3 states and telephone interviews with 7. In selecting states and their practices for further review, we considered descriptions of each state's practices obtained from the states and other research. For practical reasons, in order to collect sufficient examples from each category while limiting the number of distinct states we would contact, we also considered whether a state had more than one practice it considered noteworthy and whether it encompassed practices in at least two of our five broad categories. We also gave some weight to the level of context and information the state had provided about its practices and generally limited our consideration of practices to those that states indicated they had begun to implement. In



In addition, we made efforts to include states that had achieved a strong rating on the ACF reviews for children’s physical and mental health indicators and to achieve some distribution in geographic location and administrative structure.

For 3 of the 10 states selected—Illinois, New York, and Utah—we conducted site visits and interviewed officials of state child welfare agencies and state Medicaid Offices, and when possible, health care providers, interest groups, and foster care parents. For seven states—California, Delaware, Florida, Massachusetts, Oklahoma, Texas, and Washington—we conducted interviews by telephone with officials of each state’s child welfare agency and, in some instances, officials of state Medicaid Offices.

Key characteristics of the selected states are shown in table 5. Collectively, the states we contacted account for 53 percent of federal IV-E funds distributed in fiscal year 2007.

**Table 5: Characteristics of States Contacted for GAO’s Review**

States GAO selected	Foster care caseload Sept. 30, 2007	Federal foster care funds 2007 (IV-E)	State match required for IV E and XIX	Federal child welfare funds 2007 (IV-B1)	Type of child welfare administration	Medicaid included in same State agency as child welfare	Public, maternal & child health in same agency as child welfare	Strength in physical health Per ACF review	Strength in mental health per ACF review
<b>Sites visited</b>									
Ill.	16,000	\$199,758,813	50.00	\$11,343,733	State	No	No	No	No
NY	30,548	370,648,137	50.00	14,424,182	County	No	No	Yes	No
Utah	2,600	19,232,449	29.86	3,368,524	State	No	No	Yes	Yes
<b>Sites contacted by teleconference</b>									
Calif.	78,282	1,302,357,112	50.00	33,565,519	County	Yes	Yes	Yes	No
Del.	970	\$5,737,528	50.00	783,771	State	No	Yes	Yes	Yes
Fla.	26,124	152,407,545	41.24	15,930,592	County	No	No	No	No
Mass.	10,000	64,838,028	50.00	4,094,353	State	Yes	No	No	No
Okla.	12,200	42,892,775	31.26	1,891,061	State	No	No	No	No
Tex.	18,000	216,799,611	39.22	25,115,256	State	Yes	Yes	No	No
Wash.	11,015	84,681,985	49.88	5,313,865	State	Yes	Yes	No	No
<b>Total</b>		<b>\$4,669,165,598</b>							

Source: GAO analysis of federal and state child welfare data.

For our visits and telephone interviews, we developed semistructured interview guides for state and local child welfare agencies, including caseworkers, state Medicaid offices, interest groups, and foster parents. In addition, we obtained from officials of state child welfare agencies detailed information on their identified practices, including the dates of operation; numbers of children served; size of jurisdiction covered; variety of services offered; funding mechanisms used; outcomes, if any, reported; and whether any evaluative studies had been conducted or other documents prepared that discussed the effectiveness of the practice.

We conducted our work from November 2007 to January 2009 in accordance with all sections of GAO's Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions.

# Appendix II: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for  
Washington, DC 20201

**JAN 13 2009**

Kay E. Brown, Director  
Education, Workforce, and  
Income Security Issues  
U.S. Government Accountability Office  
441 G Street NW  
Washington, DC 20548

Dear Ms. Brown:

Enclosed are the Department's comments on the U.S. Government Accountability Office's (GAO) draft report entitled: "Foster Care: State Practices for Assessing Health Needs, Facilitating Service Delivery, and Monitoring Children's Care (GAO-09-26).

The Department appreciates the opportunity to review and comment on this report before its publication.

Sincerely,

*Jennifer R. Luong*  
for Craig Burton  
Acting Assistant Secretary for Legislation

Attachment



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

JAN 09 2009

TO: Vincent J. Ventimiglia, Jr.  
Assistant Secretary for Legislation

FROM: Daniel C. Schneider  
Acting Assistant Secretary  
for Children and Families

SUBJECT: Government Accountability Office (GAO) Draft Report Titled,  
"FOSTER CARE: State Practices for Assessing Health Needs,  
Facilitating Service Delivery, and Monitoring Children's Care"  
(GAO-09-26)

Attached are comments of the Administration for Children and Families and the  
Substance Abuse and Mental Health Services Administration on the above-referenced  
report.

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

Attachment

**COMMENTS OF THE ADMINISTRATION FOR CHILDREN AND FAMILIES AND  
THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION  
ON THE GOVERNMENT ACCOUNTABILITY OFFICE DRAFT REPORT TITLED,  
“FOSTER CARE: STATE PRACTICES FOR ASSESSING HEALTH NEEDS,  
FACILITATING SERVICE DELIVERY, AND MONITORING CHILDREN’S CARE”  
(GAO-09-26)**

The Administration for Children and Families (ACF) and the Substance Abuse and Mental Health Services Administration (SAMHSA) appreciate the opportunity to comment on the Government Accountability Office (GAO) draft report.

**GAO Recommendations**

GAO did not make any recommendations in this report.

In describing the National Technical Assistance Center for Children's Mental Health (Georgetown), GAO did not mention that part of the funding for this center (i.e., \$150,000) comes from an Interagency Agreement with ACF. The report states, “One staff position at the center has been reserved for a consultant with child welfare expertise.” This is accomplished through the Interagency Agreement between SAMHSA and ACF. This should be stated.

There is no mention that the SAMHSA-funded Technical Assistance Partnership also has a staff position for a child welfare consultant that provides assistance to SAMHSA-funded system of care communities that are part of the Comprehensive Community Mental Health for Children and Their Families Program. This staff position is similarly funded through an Interagency Agreement with ACF in the amount of \$200,000, which makes the total Interagency Agreement \$350,000. This position and the relationship established with ACF has allowed SAMHSA to prioritize services and consultation related to child welfare issues.

As a result of the collaboration between SAMHSA and ACF, and the significant mental health needs of foster children, SAMHSA has made the child welfare population a priority in the Request for Application (RFA) used to solicit proposals for the Comprehensive Community Mental Health for Children and Their Families Program. Specifically, page 2 of the RFA states that applicants are encouraged to address children and youth involved with the child welfare system. Creating priority status for children and youth in the child welfare system has resulted in a number of grantees that specifically focus on foster children, which has helped create collaborations and partnerships between mental health and child welfare systems in States and communities across the nation. Of the 59 currently funded system of care grantees, 7 have a primary focus on foster children.

While SAMHSA manages this Center, ACF is a significant fund provider of the Center's activities. Similar to the other technical assistance centers funded by ACF, NCSACW does not provide direct medical services, but provides assistance to agencies supporting positive child welfare outcomes.

NCSACW completed a review of the Round 1 Child and Family Services Reviews (CFSRs) and Program Improvement Plans, managed by ACF, and found that 13 of the States specifically mentioned that services were inadequate to meet the substance abuse treatment needs of adolescents in their caseloads. Although not specifically mentioned in reports from other States, this is likely to be a much more widely experienced problem.

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# Appendix III: GAO Contacts and Staff Acknowledgments

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## GAO Contacts

Kay E. Brown, (202) 512-3674 or [brownke@gao.gov](mailto:brownke@gao.gov)  
Cynthia A. Bascetta, (202) 512-7114 or [bascettac@gao.gov](mailto:bascettac@gao.gov)

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## Staff Acknowledgments

In addition to the contacts named above, Betty Ward-Zukerman and Carolyn L. Yocom (Assistant Directors), Patricia Elston, Carolyn Feis Korman, Jacqueline Harpp, Darryl Joyce, Jasleen Modi, Alexandra Edwards, Alison Goetsch, Kevin Milne, Mimi Nguyen, James Rebbe, Jay Smale, and Charlie Willson made key contributions to this report.

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# Related GAO Products

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*Medicare Physician Payment: Care Coordination Programs Used in Demonstration Show Progress, but Wider Use of Payment Approach May Be Limited.* [GAO-08-65](#). Washington, D.C.: February 15, 2008.

*Department of Health and Human Services, Centers for Medicare and Medicaid Services: Medicaid Program; Elimination of Reimbursement Under Medicaid for School Administration Expenditures and Costs Related to Transportation of School-Age Children Between Home and School.* [GAO-08-394R](#). Washington, D.C.: January 11, 2008.

*Child Welfare: Additional Federal Action Could Help States Address Challenges in Providing Services to Children and Families.* [GAO-07-850T](#). Washington, D.C.: May 15, 2007.

*Medicaid: Concerns Remain about Sufficiency of Data for Oversight of Children's Dental Services.* [GAO-07-826T](#). Washington, D.C.: May 2, 2007.

*Pediatric Drug Research: Studies Conducted Under Best Pharmaceuticals for Children Act.* [GAO-07-557](#). Washington, D.C.: March 22, 2007.

*Children's Health Insurance: States' SCHIP Enrollment and Spending and Considerations for Reauthorization.* [GAO-07-558T](#). Washington, D.C.: March 1, 2007.

*Child Welfare: Improving Social Service Program, Training, and Technical Assistance Information Would Help Address Long-standing Service-Level and Workforce Challenges.* [GAO-07-75](#). Washington, D.C.: October 6, 2006.

*Foster Care and Adoption Assistance: Federal Oversight Needed to Safeguard Funds and Ensure Consistent Support for States' Administrative Costs.* [GAO-06-649](#). Washington, D.C.: June 15, 2006.

*Administrative Expenditures and Federal Matching Rates of Selected Support Programs.* [GAO-05-839R](#). Washington, D.C.: June 30, 2005.

*Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight.* [GAO-05-748](#). Washington, D.C.: June 28, 2005.

*Medicaid: States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight.* [GAO-05-836T](#). Washington, D.C.: June 28, 2005.

*Child And Family Services Reviews: States and HHS Face Challenges in Assessing and Improving State Performance.* [GAO-04-781T](#). Washington, D.C.: May 13, 2004.

*Child And Family Services Reviews: Better Use of Data and Improved Guidance Could Enhance HHS's Oversight of State Performance.* [GAO-04-333](#). Washington, D.C.: April 20, 2004.

*Medicaid and SCHIP: States' Premium and Cost Sharing Requirements for Beneficiaries.* [GAO-04-491](#). Washington, D.C.: March 30, 2004.

*SCHIP: HHS Continues to Approve Waivers That Are Inconsistent with Program Goals.* [GAO-04-166R](#). Washington, D.C.: January 5, 2004.

*Child Welfare: States Face Challenges in Developing Information Systems and Reporting Reliable Child Welfare Data.* [GAO-04-267T](#). Washington, D.C.: November 19, 2003.

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*Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services.* [GAO-03-397](#). Washington, D.C.: April 21, 2003.

*Medicaid and SCHIP: States Use Varying Approaches to Monitor Children's Access to Care.* [GAO-03-222](#). Washington, D.C.: January 14, 2003.

*Mental Health Services: Effectiveness of Insurance Coverage and Federal Programs for Children Who Have Experienced Trauma Largely Unknown.* [GAO-02-813](#). Washington, D.C.: August 22, 2002.

*Medicaid and SCHIP: States' Enrollment and Payment Policies Can Affect Children's Access to Care.* [GAO-01-883](#). Washington, D.C.: September 10, 2001.



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**Related GAO Products**

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*Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services.* [GAO-01-749](#). Washington, D.C.: July 13, 2001.

*Foster Care: Health Needs of Many Young Children Are Unknown And Unmet.* [GAO/HEHS-95-114](#). Washington, D.C.: May 26, 1995.

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