



April 2014

# FOSTER CHILDREN

## Additional Federal Guidance Could Help States Better Plan for Oversight of Psychotropic Medications Administered by Managed-Care Organizations

# GAO Highlights

Highlights of [GAO-14-362](#), a report to congressional requesters

## Why GAO Did This Study

In December 2011, GAO reported that foster children in selected states were prescribed psychotropic medications at rates higher than nonfoster children in Medicaid in 2008. GAO was asked to further examine instances of foster children being prescribed psychotropic medications.

For the five states included in GAO's 2011 report—Florida, Massachusetts, Michigan, Oregon, and Texas—this report: (1) assesses the extent that documentation supported the usage of psychotropic medication for selected cases; and (2) describes states' policies related to psychotropic medication and assesses HHS actions since GAO's 2011 report.

GAO contracted with two child psychiatrists who conduct mental-health research and work on issues related to foster care, to provide clinical evaluations of 24 cases that GAO selected from the population of foster children prescribed psychotropic drugs in GAO's 2011 report. The case selections were based, in part, on potential health risk indicators, and the findings are not generalizable. GAO obtained medical and child-welfare documentation spanning children's time in foster care, and redacted personally identifiable information prior to experts' review of cases. GAO also analyzed federal guidance and selected states' policies and interviewed federal and state officials.

## What GAO Recommends

GAO recommends that HHS issue guidance to states regarding oversight of psychotropic medications prescribed to children in foster care through MCOs. HHS agreed with GAO's recommendation.

View [GAO-14-362](#). For more information, contact Stephen M. Lord at (202) 512-6722 or [lords@gao.gov](mailto:lords@gao.gov).

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## FOSTER CHILDREN

### Additional Federal Guidance Could Help States Better Plan for Oversight of Psychotropic Medications Administered by Managed-Care Organizations

## What GAO Found

Two experts GAO contracted with reviewed foster and medical records for 24 cases in five selected states and found varying quality in the documentation supporting the use of psychotropic medications for children in foster care. Experts examined documentation related to several categories, such as (1) screening, assessment, and treatment planning; and (2) medication monitoring.

- **Screening, Assessment, and Treatment Planning.** Experts' evaluation of this category included whether medical pediatric exams and evidence-based therapies—which are interventions shown to produce measureable improvements—were provided as needed, according to records. Experts found in 22 of 24 cases that medical pediatric exams were mostly supported by documentation. For example, in one case with mostly supporting documentation, experts found that a child with a history of behavioral and emotional problems had records documenting a medical pediatric exam and thorough psychological assessments, with comprehensive discussions of diagnostic issues and medication rationale. With regard to evidence-based therapies, experts found that 3 of 15 children who may have benefitted from such therapies were mostly provided such services, while 11 of 15 cases were scored as partial in this category, and in 1 of 15 cases there was no documentation that evidence-based therapies were provided.
- **Medication Monitoring.** Experts' evaluation of this category included the appropriateness of medication dosage and the rationale for concurrent use of multiple medications, according to records. Experts found appropriateness of medication dosages was mostly supported by documentation in 13 of 24 cases and partially supported in the other 11 cases. The rationale for concurrent use of multiple medications was mostly supported in 5 of the 20 cases where multiple medications were used, but 14 of 20 cases included documentation that partially supported concurrent use, and 1 case did not include documentation to support concurrent use. For example, experts found for one case that a child was prescribed four psychotropic drugs concurrently, when nonmedication interventions could have been considered. The rationale for the actions taken was partially supported by documentation.

All of the five selected states—two of which pay health care providers directly through fee-for-service, and three of which use or are transitioning to a third-party managed-care organization (MCO) for prescription-drug benefits to some extent—have policies intended to address oversight of psychotropic medications for foster children. According to state officials, all five of the states require medical examinations for children in foster care. Since GAO's 2011 report, the Department of Health and Human Services' (HHS) Administration for Children and Families (ACF) has, among other things, worked with other federal agencies to provide informational webinars and technical guidance for states to improve oversight of psychotropic medications, but this guidance does not address third-party MCOs administering medications. Officials from two of the three states relying on MCOs described limited state planning for MCOs to monitor psychotropic medications. Because there are indications MCO use is increasing, additional HHS guidance that helps states implement oversight strategies within the context of a managed-care environment could help ensure appropriate monitoring of psychotropic medications prescribed to children in foster care.

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**Abbreviations**

AACAP	American Academy of Child and Adolescent Psychiatry
ACF	Administration for Children and Families
ADHD	attention deficit hyperactivity disorder
APSR	Annual Progress and Services Report
CANS	Child and Adolescent Needs and Strengths
CHIP	State Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FDA	Food and Drug Administration
HHS	Department of Health and Human Services
MCO	managed-care organization
OIG	Office of Inspector General
PTSD	post-traumatic stress disorder
SAMHSA	Substance Abuse and Mental Health Services Administration

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April 28, 2014

Congressional Requesters

Children in foster care with mental-health conditions are among the country's most vulnerable populations, and there are concerns about whether they have access to the most appropriate care for their conditions.<sup>1</sup> Early detection and treatment of emotional and behavioral disturbances can improve a child's symptoms and reduce potentially detrimental effects on a child, such as difficulties with relationships, dropping out of school, and involvement with the juvenile justice system. Children with mental-health conditions, such as attention deficit hyperactivity disorder (ADHD) or depression, can be treated with psychosocial therapies (sessions with a provider designed to reduce symptoms and improve functioning); psychotropic medication (medications that affect mood, thought, or behavior); or a combination of both.

Child mental-health advocates, providers, and researchers have expressed concern about the increase in the prescription of psychotropic medications to children, due in part to limited evidence available regarding short- and long-term safety and efficacy for some types of medications, particularly when used in combination. Some state Medicaid and mental-health officials have expressed concern about the relatively high rates of off-label use of antipsychotics, particularly among groups of special concern such as children in foster care.<sup>2</sup>

Several agencies in the Department of Health and Human Services (HHS) have responsibilities related to children's mental health. The Administration for Children and Families (ACF) provides funding for and

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<sup>1</sup>GAO, *Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions*, [GAO-12-201](#) (Washington, D.C.: Dec. 14, 2011); *Children's Mental Health: Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care*, [GAO-13-15](#) (Washington, D.C.: Dec. 10, 2012).

<sup>2</sup>Off-label use refers to the prescription of a medication for uses other than what the Food and Drug Administration (FDA) has approved. Medicaid Medical Directors Learning Network and Rutgers Center for Education and Research on Mental Health Therapeutics, *Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide from a 16-State Study* (New Brunswick, N.J.: July 2010).

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oversees states' child-welfare programs, which are responsible for monitoring and coordinating mental-health services for children in foster care, among other things. The Centers for Medicare & Medicaid Services (CMS) oversees, and jointly finances with the states, Medicaid and the State Children's Health Insurance Program (CHIP), which provide health coverage for low-income children. State Medicaid programs are required by federal law to provide coverage for certain health services, which may include mental-health services, for children through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. The Substance Abuse and Mental Health Services Administration (SAMHSA) works to increase the quality and availability of mental-health services, such as by awarding grants that support the development of community-based services for children with mental-health conditions, including children in foster care.

Children in foster care who are enrolled in Medicaid may receive services generally through one of two distinct service-delivery and financing systems—managed care or fee-for-service. Under a managed-care model, states contract with a managed-care organization (MCO) and prospectively pay the plans a fixed monthly fee per patient to provide or arrange for most health services, which may include prescription-drug benefits. 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.

In December 2011, we reported that children in foster care in the five states analyzed were prescribed psychotropic medications at higher rates than nonfoster children in Medicaid during 2008.<sup>3</sup> According to research, experts consulted, and certain federal and state officials interviewed as part of our December 2011 report, this could be due in part to foster children's greater exposure to traumatic experiences, and the challenges of coordinating their medical care and records due to frequent changes in placement. Prescriptions to foster children in these states were also more likely to have indicators of potential health risks. According to the experts

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<sup>3</sup>[GAO-12-201](#). We initially selected six states—Florida, Maryland, Massachusetts, Michigan, Oregon, and Texas—that had a fee-for-service Medicaid prescription program, reflected a range of geographic diversity, and included large and small populations of children in foster care. However, Maryland's 2008 foster care data were determined to be unreliable for the purposes of our previous work, so that state was excluded from our December 2011 report and is not part of this review.

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we consulted for our December 2011 report, no evidence supports the concurrent use of five or more psychotropic medications in adults or children, yet hundreds of both foster and nonfoster children in the five states had such a drug regimen. Similarly, in our December 2011 report, we found thousands of foster and nonfoster children were prescribed doses higher than the maximum levels cited in guidelines developed by the state of Texas, based on Food and Drug Administration (FDA)–approved or medical literature maximum dosages for children and adolescents, which experts said increases the risk of adverse side effects and does not typically increase the efficacy of the medications to any significant extent.<sup>4</sup> We also found that the monitoring programs of these states for psychotropic medications provided to children in foster care varied and fell short of best-principles guidelines published by the American Academy of Child and Adolescent Psychiatry (AACAP).<sup>5</sup> This variation was expected because states set their own guidelines and HHS had not endorsed specific measures for state oversight of psychotropic prescriptions for children in foster care. In our December 2011 report we recommended, and HHS agreed, to consider endorsing guidance for states on best practices for overseeing psychotropic prescriptions for children in foster care. The status of this recommendation is discussed later in this report.

You asked us to continue our review of psychotropic medications provided to children in foster care. This report (1) examines the extent to which the use of psychotropic medications was supported by foster and medical records for selected case studies of children in foster care who were prescribed these medications; and (2) describes selected states’ policies or procedures intended to address oversight of psychotropic medications, and assesses what, if any, actions HHS has taken to help states oversee psychotropic medications prescribed to children in foster care since our December 2011 report.

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<sup>4</sup>Analysis included in our December 2011 report used dosage guidelines developed by the state of Texas based on FDA-approved or medical literature maximum dosages for children and adolescents. ACF lists these guidelines as an example for other states. For additional information, see [GAO-12-201](#) and Texas Department of Family and Protective Services, and the University of Texas at Austin College of Pharmacy, *Psychotropic Medication Utilization Parameters for Foster Children* (Austin, Tex.: December 2010).

<sup>5</sup>American Academy of Child and Adolescent Psychiatry, *A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents* (Feb. 12, 2012).

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To examine the extent to which the use of psychotropic medications was supported by foster and medical records, we selected a nonrepresentative sample of 28 children in foster care covered by Medicaid in Florida, Massachusetts, Michigan, Oregon, and Texas in 2008.<sup>6</sup> Thus, the results of our case-study analysis are not generalizable to the foster-child population within each of the five states we examined, or to those of other states.

For each state included in our review, we randomly selected four cases; each case represented one of the following four categories:

- children prescribed any psychotropic medication during calendar year 2008 and in foster care as of January 2010;
- children with prescriptions exceeding dosage guidelines developed by the state of Texas, which were based on FDA-approved or medical literature maximum dosages for children and adolescents, during calendar year 2008 and in foster care as of January 2010;
- children prescribed five or more medications concurrently during calendar year 2008 and in foster care as of January 2010; and
- children less than 1 year old prescribed any psychotropic medication during calendar year 2008 and in foster care as of January 2010.

In addition to the 20 cases above, we also nonrandomly selected all children less than 1 year old prescribed an ADHD, antipsychotic, or antidepressant medication during calendar year 2008, totaling 8 infants. These additional 8 cases were selected because, according to experts, it is not standard practice to prescribe psychotropic medications to infants, and these medications carry significant risks when prescribed to young children.

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<sup>6</sup>The case studies selected for this review were taken from the data used in our December 2011 report, [GAO-12-201](#). For the randomly selected cases, we selected from the population of children who were still in foster care as of January 2010. This date was used as it was the date of the most-recent enrollment data of children in foster care across all five states. The date requirement effectively sets a minimum amount of time the child is in foster care, which could skew our selection towards children with greater mental-health needs, as children who stay in foster care longer tend to be older and have more medications. Once the cases were selected, experts reviewed foster and medical information spanning the entire time the child was in foster care, which included the most-recent records available.



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After preliminary analysis, we excluded four selected cases from our review. One case removed was a nonrandomly selected infant case in which the prescription was identified as potential Medicaid fraud and the case was referred to the state Medicaid Office of Inspector General for follow up. Two other nonrandomly selected infant cases were removed due to data-entry errors that indicated children received psychotropic medications, when they had not.<sup>7</sup> The fourth case removed was a randomly selected infant case. In this case, the records provided did not include any mental-health or prescription information for experts to review. State officials confirmed the psychotropic medication prescribed to the infant was for non-mental-health purposes. Thus, 24 cases were included in our final case-file review.

To provide a clinical perspective on our cases, we contracted with two child psychiatrists who are board certified in child and adolescent psychiatry, have conducted clinical research regarding mental illness in children, and who are working on issues related to psychotropic medication use among children in foster care. For additional information on experts and the criteria that informed our selection, see appendix I. To review the cases, the two experts collaborated to develop categories that are applicable to the administration of psychotropic medications, as informed by AACAP guidelines and their clinical experience. The categories include, but are not limited to, the quality of documentation related to psychiatric evaluations, monitoring and efficacy of medications, and changes in medication doses.<sup>8</sup> GAO obtained medical and child-welfare documentation spanning the children's time in foster care, and redacted personally identifiable information prior to experts' review of cases. For each case, experts reviewed the child's medical and foster care information (such as case-file notes, medical history, and prescriptions) covering the entire period the child was in foster care, and provided an opinion on the categories reviewed, as well as a summary narrative describing the facts and circumstances surrounding the child's use of psychotropic medication.<sup>9</sup> Experts noted any potential issues

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<sup>7</sup>For each of these cases, we asked state officials to review the child's records and confirm the child had not received a psychotropic medication.

<sup>8</sup>Experts used the categorization "not applicable" for instances where the category did not apply to the child's case, such as an infant prescribed a psychotropic drug for non-mental-health reasons.

<sup>9</sup>State officials noted that in some circumstances that additional medical documents may exist, but these documents were not located and provided to GAO as requested.

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related to the use of psychotropic medications based on supporting documentation, which was reviewed from a quantitative and qualitative standpoint. The experts' opinions are presented topically using ACF's program instructions regarding (1) screening, assessment, and treatment planning; (2) medication monitoring; and (3) informed and shared decision making as a framework to illustrate case findings.

We provided officials from selected states with copies of the experts' preliminary case reviews to help ensure all available documentation was included for experts' evaluations and to allow state experts, including experts in child and adolescent psychiatry, to review the expert case descriptions. State officials were given an opportunity to provide additional comments or documentation, and we incorporated their comments into this report as appropriate.

To describe the five selected states' policies or procedures intended to provide oversight of psychotropic medications and determine what, if any, actions HHS has taken to help states oversee psychotropic medications prescribed to foster children since December 2011, we reviewed federal statutes, regulations, and state policies related to the prescribing and oversight of psychotropic medications to foster children. We also interviewed officials from ACF, CMS, and SAMHSA, as well as child-welfare and Medicaid officials from selected states, to understand their approach to providing oversight of psychotropic medications. We assessed HHS's efforts, including guidance provided to state Medicaid and child-welfare programs regarding the monitoring of psychotropic medications prescribed to children in foster care, using GAO's *Standards for Internal Control in the Federal Government*.<sup>10</sup> We did not evaluate the extent to which the five selected states' procedures were being implemented effectively.

We conducted this performance audit from January 2012 through April 2014 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our audit findings and conclusions based on our audit objectives. We

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<sup>10</sup>GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999).

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believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

Children enter state foster care when they have been removed from their parents or guardians and placed under the responsibility of a state child-welfare agency. Removal from the home can occur because of reasons such as abuse or neglect. When children are taken into foster care, the state's child-welfare agency becomes responsible for determining where the child should live and providing the child with needed support. The agency may place the foster child in the home of a relative, with unrelated foster parents, or in a group home or residential treatment center, depending on the child's needs. The agency is also responsible for arranging needed services, including mental-health services.

Coordinating mental-health care for children in foster care may be difficult for both the medical provider and the caseworker depending on the complexity of the child's needs, and because multiple people are making decisions on the child's behalf. In addition, caseworkers in child-welfare agencies may have large caseloads, making it difficult for them to ensure each child under their authority receives adequate mental-health services.

In 2011, the Child and Family Services Improvement and Innovation Act amended the Social Security Act to require states to identify protocols for monitoring foster children's use of psychotropic medications and to address how emotional trauma associated with children's maltreatment and removal from their homes will be monitored and treated.<sup>11</sup> ACF requires states to address these issues in their required Annual Progress and Services Reports (APSR) and has provided guidance detailing how states are to address protocols for monitoring foster children's use of psychotropic medications as part of the state's APSR.<sup>12</sup> Among other things, state monitoring protocols are to address

- screening, assessment, and treatment planning to identify children's mental-health and trauma-treatment needs, including a psychiatric

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<sup>11</sup>Child and Family Services Improvement and Innovation Act, Pub. L. No. 112-34, § 101(b)(1) and (2), 125 Stat. 369 (amending 42 U.S.C. § 622(b)(15)(A)).

<sup>12</sup>See U.S. Department of Health and Human Services, Administration for Children and Families, Program Instruction, ACYF-CB-PI-12-05 (Washington, D.C.: Apr. 11, 2012).

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evaluation, as necessary, to identify needs for psychotropic medications;

- effective medication monitoring at both the client and agency level; and
- informed and shared decision making and methods for ongoing communication between the prescriber, the child, caregivers, other health care providers, the child-welfare worker, and other key stakeholders.

According to ACF, child-welfare systems that choose to pursue comprehensive and integrated approaches to screening, assessing, and addressing children’s behavioral and mental-health needs—including the effects of childhood traumatic experiences—are more likely to increase children’s sense of safety and provide them with effective care. In particular, ACF, CMS, and SAMHSA noted the role of evidence-based practices—interventions shown to produce measureable improvements or promising results—in decreasing emotional or behavioral symptoms. In addition, according to ACF, psychotropic medication use with young children, including infants, is of special concern since this population may be especially vulnerable to adverse effects, necessitating careful management and oversight.

As we reported in December 2011, oversight procedures such as prescription monitoring help states to identify and review potentially risky prescribing practices in the foster-care population.<sup>13</sup> Monitoring for appropriate dosage can be beneficial as it is important for any medication or combination of medications prescribed to use appropriate dosages to maximize the likelihood of effectiveness while also minimizing the chance of potential adverse effects. Monitoring for concurrent use of multiple psychotropic medications can be beneficial because, according to ACF, there is little evidence of the effectiveness of using multiple psychotropic medications at the same time and no research to support the use of five or more psychotropic medications.

According to AACAP, treatment planning should include discussions by key stakeholders, such as prescribers and caregivers, about the assessment of target symptoms, behaviors, function, and potential

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<sup>13</sup>[GAO-12-201](#).

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benefits and adverse effects of treatment options. As we reported in December 2011, informed consent helps ensure that caregivers are fully aware of the risks and benefits associated with the decision to medicate with psychotropic medications and to accurately assess and monitor the foster child's reaction to the medications.<sup>14</sup>

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## Case Studies Varied in Quality of Documentation Supporting the Use of Psychotropic Medications

Expert reviews of 24 foster children's foster and medical files in five selected states found that the quality of documentation supporting the prescription of psychotropic medication usage varied with respect to (1) screening, assessment, and treatment planning; (2) medication monitoring; and (3) informed and shared decision making.

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## Quality of Documentation to Support Sufficient Screening, Assessment, and Treatment Planning Varied among Selected Cases

For each of our 24 cases, experts evaluated the foster and medical records across six categories they developed collaboratively that relate to screening, assessment, and treatment planning and provided their professional opinion for the case. Examples of screening, assessment, and treatment planning categories reviewed include the extent to which medical examinations, psychiatric evaluations, and evidence-based therapies were provided, and whether the impact of trauma was addressed by treatment.<sup>15</sup> As shown in table 1, experts found that the quality of screening, assessment, and treatment planning varied among selected cases according to documentation reviewed. To see how experts scored all six categories, see appendix II.

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<sup>14</sup>[GAO-12-201](#).

<sup>15</sup>Other categories reviewed that related to screening, assessment, and treatment planning include "psychosocial services provided" and "diagnosis fits history" and are shown in app. II.

**Table 1: Quality of Documentation Support Related to Screening, Assessment, and Treatment Planning**

<b>Category</b>	<b>Mostly supported in foster file or medical records</b>	<b>Partially supported in foster file or medical records</b>	<b>Not supported in foster file or medical records</b>	<b>Not applicable</b>	<b>Total applicable cases</b>
Medical pediatric examination	22	2	0	0	<b>24</b>
Psychiatric evaluations	12	3	2	7	<b>17</b>
Evidence-based therapies provided	3	11	1	9	<b>15</b>
Impact of trauma addressed by treatment	3	8	3	10	<b>14</b>

Source: Expert reviewers.

Notes: The data are from expert reviews of foster file and medical records for 24 selected cases. Experts reviewed each of the categories from a quantitative and qualitative standpoint and provided their consensus evaluation based on documentation reviewed. The case selections include children prescribed a psychotropic drug as of 2008 and in foster care as of 2010 (nonrandomly selected infants did not have the 2010 restriction); however, the experts reviewed foster and medical information from the entire time the child was in foster care, which included the most-recent records available. Experts used the categorization “mostly supported in foster file or medical records” for instances where the documentation reviewed met both quantitative and qualitative measures as deemed appropriate by experts. Experts used the categorization “partially supported in foster file or medical records” for instances where the documentation included some information for the assessed category, but the documentation was either quantitatively or qualitatively, or both, lacking in some regard, according to experts. Experts used the categorization “not supported in foster file or medical records” for instances where there was no documentation for the assessed category, or the information provided was deemed substantively lacking by experts.

### Medical Pediatric Examinations

Experts found that medical pediatric examinations were mostly supported by documentation for 22 of 24 cases. Experts found in 2 of 24 cases the medical pediatric examinations were partially supported, such as when the medical pediatric exams were mentioned in the documentation, but not actually included in the records, preventing experts from evaluating what the examinations consisted of, and whether monitoring for psychotropic agents, such as assessing height, weight, or laboratory functions, was conducted. In one example, whereby experts scored the medical pediatric exam category as mostly supported in documentation, a child with a history of behavioral and emotional problems—including aggression and hyperactivity—was prescribed multiple ADHD medications. In this case, experts noted the child’s records had thorough psychological and pediatric assessments, with comprehensive discussions of diagnostic issues and medication rationale as well as good case-management summaries.

### Psychiatric Evaluations

Experts found that psychiatric evaluations were mostly documented for 12 of 17 applicable cases. Experts found 3 of 17 cases had partial documentation to support that the child had received a full psychiatric

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evaluation and 2 of 17 cases had no evidence that a psychiatric evaluation took place. For example, in 1 case with mostly supporting documentation, experts found that a child with a history of disruptive behavior, poor impulse control, anger outbursts, and sexual acting-out behaviors, among other things, received comprehensive psychosocial, psychosexual, and neuropsychological evaluations. Moreover, experts noted the child received special educational services and intensive therapeutic services, and visited a psychiatrist monthly for several months, then was referred back to the pediatrician with scheduled psychiatric check-ins as appropriate.

## Evidence-Based Therapies

Experts found that documentation reviewed supported that evidence-based therapies were mostly provided in 3 of 15 applicable cases where the child may have benefited from such treatment. However, in 11 of 15 cases, the experts scored the category as partial, such as for instances when some psychosocial or evidence-based therapies were documented as provided, but other evidence-based therapies that may have been more applicable or beneficial to the child were not provided, based on documents reviewed. In 1 of 15 cases, there was no documentation that evidence-based therapies were provided. In one case, experts found that a child initially placed in foster care as a toddler with over 10 foster-care placements—including group care from 14 to 16 years of age—had experienced early neglect, exposure to domestic violence, and physical abuse, and suffered from severe mood swings and explosive outbursts of anger. According to experts, a larger focus on evidence-based treatments such as trauma-focused cognitive behavioral therapy would have likely benefitted the child, but there was no documentation showing this occurred. However, according to the experts' evaluation of the documentation, the child's psychiatric diagnoses and medication regimens were stable over time, and treatment response, level of treatment intensity, and level of psychosocial functioning were all evaluated appropriately.

In another example, experts found that a child removed from the home at age 13 after being physically assaulted by his mother and witnessing domestic violence received supportive psychotherapy and counseling, but there was no documentation of evidence-based psychotherapies, such as trauma-focused cognitive behavioral therapy. In addition, the forms used to document the therapy each represented 1 month of treatment with progress notes from each of the four weekly sessions. However, the report of the sessions, and often the entire content of the month's psychotherapeutic work, was duplicated for months at a time. One week's

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Impact of Trauma  
Addressed by Treatment

psychotherapy content was duplicated for over 1 year, raising questions about what services were actually provided.

Experts found the documentation reviewed supported that the impact of trauma was mostly addressed by treatment for 3 of 14 applicable cases. However, for 8 of 14 cases, the impact of trauma was partially addressed by the treatment provided to children who had suffered from traumatic events, and in 3 cases there was no evidence that the trauma was addressed, according to documentation reviewed. For example, experts found in one case with no supporting documentation, that a child was placed in foster care at 5 years of age for neglect and physical abuse and diagnosed with a variety of different psychiatric conditions, including bipolar disorder, post-traumatic stress disorder (PTSD), schizotypal<sup>16</sup> personality disorder, paranoia, and possible psychosis. According to experts, psychosis and personality disorders are typically considered adult conditions, and are usually not diagnosed in younger children. In this case, the child was treated with variable combinations of ADHD medications, antidepressants, anticonvulsants, and antipsychotics. While hospitalized at age 9 years, the child received an ADHD and antipsychotic medication at dosages that exceeded dosage guidelines based on FDA-approved or medical literature maximum dosages for this age group, and the medications were elevated to these high dosages over a 1 week period. During this time, the child's brother died, yet this was not addressed or acknowledged during the psychiatric hospitalization, according to documentation.<sup>17</sup>

In another example, experts found that a child placed in foster care at 9 years of age due to neglect, physical abuse, and exposure to social chaos and domestic violence received treatment that partially addressed the impact of trauma on the child, according to documentation reviewed. In this case the child reported additional trauma, saying his mother's boyfriend forced him to engage in sexual behavior with his sister. The child's grandmother, who had been his caretaker, also died when he was

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<sup>16</sup>Schizotypal disorder is a condition in which an individual has disturbances in thought patterns, appearance, and behavior, among other things.

<sup>17</sup>Medication dose amounts were compared by experts to guidelines developed by the state of Texas, which are based on FDA approved or medical literature maximum dosages. For additional information see Texas Department of Family and Protective Services, and the University of Texas at Austin College of Pharmacy, *Psychotropic Medication Utilization Parameters for Foster Children*.



13 years old. Experts noted the history of trauma was acknowledged, but an evidence-based intervention was not provided to address the trauma, according to documents reviewed.

### Quality of Documentation Supporting Medication Monitoring Varied among Selected Cases

For each case, experts reviewed and provided their opinions across seven categories related to medication monitoring, including the extent to which prescriptions were appropriately monitored by medical providers, appropriate dosages were used, and concurrent use of multiple medications was justified based on documentation reviewed.<sup>18</sup> As shown in table 2, experts found that the quality of prescription monitoring by medical providers, and justification for dosage and concurrent use of multiple medications, varied among selected cases, based on documentation reviewed. See appendix II for a full listing of all categories experts reviewed related to medication monitoring.

**Table 2: Quality of Documentation Support Related to Medication Monitoring**

Category	Mostly supported in foster file or medical records	Partially supported in foster file or medical records	Not supported in foster file or medical records	Not applicable	Total applicable cases
Prescriptions appropriately monitored	13	9	2	0	24
Appropriate dosages used	13	11	0	0	24
Concurrent use of multiple medications justified	5	14	1	4	20

Source: Expert reviewers.

Notes: The data are from expert reviews of foster file and medical records for 24 selected cases. Experts reviewed each of the categories from a quantitative and qualitative standpoint and provided their consensus evaluation based on documentation reviewed. The case selections include children prescribed a psychotropic drug as of 2008 and in foster care as of 2010 (nonrandomly selected infants did not have the 2010 restriction); however, the experts reviewed foster and medical information from the entire time the child was in foster care, which included the most-recent records available. Experts used the categorization “mostly supported in foster file or medical records” for instances where the documentation reviewed met both quantitative and qualitative measures as deemed appropriate by experts. Experts used the categorization “partially supported in foster file or medical records” for instances where the documentation included some information for the assessed category, but the documentation was either quantitatively or qualitatively, or both, lacking in some regard, according to experts. Experts used the categorization “not supported in foster file or medical

<sup>18</sup>Other categories reviewed related to medication monitoring include “prescriptions indicated for diagnostic status,” “duration of trials adequate,” “ongoing efficacy evaluated,” and “medication increases or changes systematic” and are shown in app. II.

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records” for instances where there was no documentation for the assessed category, or the information provided was deemed substantively lacking by experts.

## Prescriptions Appropriately Monitored

Experts found in 13 of 24 cases that prescriptions were mostly monitored by medical providers based on documentation reviewed. However, in 9 of 24 cases the prescriptions were partially monitored, and in 2 other cases there was no evidence that prescriptions were monitored by medical providers, according to documentation reviewed. For example, experts found in one case with partially supporting documentation that the monitoring of height, weight, vital signs, and metabolic effects of antipsychotic medications was lacking and that the records did not provide an adequate overview of medication risks and concerns regarding concurrent use of multiple psychotropic medications. According to the experts, these factors are important for medical providers to monitor in order to better assess the potential adverse effects of the medication and adjust as necessary to improve patient outcomes. In this case, the child entered foster care at 3 years of age and was noted to be aggressive, oppositional, not sleeping well, and hyperactive. Experts noted some of the antipsychotic prescriptions (quetiapine and olanzapine) were given “as needed” rather than scheduled, which, according to experts, is not considered a good medical practice in a traditional foster-care setting. Experts described the medication management as extremely aggressive, with complicated regimens and dosages at or above the standard recommendations. Furthermore, documentation that the medications were effective was lacking.

## Appropriate Dosages Used

For 13 of the 24 cases, experts found that the dosages were mostly supported for the children’s medications based on documentation reviewed. Although experts did not rate any cases as having no support for the dosages for the entire medication regimen, in 11 of 24 cases the experts noted that the justification to support a particular dosage level was partially supported by the documentation. For example, experts found in 1 case with partially supporting documentation, that a child concurrently on seven different psychotropic medications received a dosage for an ADHD medication (Adderall) exceeding dosage guidelines based on FDA-approved or medical literature maximum dosages for

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Justification for Concurrent  
Use of Multiple Medications

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children and adolescents.<sup>19</sup> Moreover, the documentation showed the child received a very small dose of an antipsychotic medication (quetiapine), suggesting that this agent was used for sleep, which experts said is not considered a good medical practice. In this case, the child was removed from the home at 14 months for, among other things, neglect and physical abuse.

Experts found that for 5 of 20 applicable cases, concurrent use of multiple psychotropic medications was mostly supported based on documentation. However, 14 of 20 cases included documentation that partially supported the concurrent use of multiple medications, and 1 case did not include any documentation to support concurrent use. For example, experts found in one case with partially supporting documentation that a toddler diagnosed with ADHD/oppositional defiant disorder and bipolar disorder was treated with complicated medication regimens, including mood stabilizers and antipsychotics, when other nonmedication interventions could have been considered, based on documentation reviewed. In this case the child was prescribed an ADHD medication (methylphenidate) and an antipsychotic medication (quetiapine) at 3-½ years of age. An ADHD medication (clonidine) and mood-stabilizing medication (oxcarbazepine) were tried by the time he was 4 years of age, and the child was maintained on as many as four psychotropic medications concurrently. As a 6-year-old, the child was treated with an antipsychotic (paliperidone) that has not been studied in children this age. There was limited discussion of potential risks or side effects though there were several reported adverse effects, including insomnia, agitation, and a possible movement disorder, potentially due to the use of antipsychotic medications, according to documentation reviewed.

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<sup>19</sup>Medication dose amounts were compared by experts to guidelines developed by the state of Texas, which are based on FDA approved or medical literature maximum dosages. For additional information see Texas Department of Family and Protective Services, and the University of Texas at Austin College of Pharmacy, *Psychotropic Medication Utilization Parameters for Foster Children* (Austin, Tex.: December 2010).

## Quality of Documentation to Support Informed and Shared Decision Making Varied among Selected Cases

For each of our cases, experts evaluated the foster and medical records for information related to informed and shared decision making—specifically, documentation of informed consent and communication between treatment providers. As shown in table 3, experts found that documentation to support informed consent and communication between treatment providers varied among selected cases reviewed.

**Table 3: Quality of Documentation Support Related to Informed and Shared Decision Making**

Category	Mostly supported in foster file or medical records	Partially supported in foster file or medical records	Not supported in foster file or medical records	Not applicable	Total applicable cases
Informed consent	5	11	7	1	23
Communication between treatment providers	15	5	3	1	23

Source: Expert reviewers.

Notes: The data are from expert reviews of foster file and medical records for 24 selected cases. Experts reviewed each of the categories from a quantitative and qualitative standpoint and provided their consensus evaluation based on documentation reviewed. The case selections include children prescribed a psychotropic drug as of 2008 and in foster care as of 2010 (nonrandomly selected infants did not have the 2010 restriction); however, the experts reviewed foster and medical information from the entire time the child was in foster care, which included the most-recent records available. Experts used the categorization “mostly supported in foster file or medical records” for instances where the documentation reviewed met both quantitative and qualitative measures as deemed appropriate by experts. Experts used the categorization “partially supported in foster file or medical records” for instances where the documentation included some information for the assessed category, but the documentation was either quantitatively or qualitatively, or both, lacking in some regard, according to experts. Experts used the categorization “not supported in foster file or medical records” for instances where there was no documentation for the assessed category, or the information provided was deemed substantively lacking by experts.

## Informed Consent

Experts found that informed-consent decisions were mostly documented in 5 of 23 applicable cases. In 11 of 23 cases experts found partial documentation of informed consent—such as when some, but not all, medications prescribed to the child included documentation of informed consent—and 7 other cases did not include any documentation of informed consent. For example, in one case, experts reported there was no documentation of informed consent, psychiatric evaluation, psychiatric diagnosis, or monitoring of antipsychotic medication. In this case, the child was prescribed an antianxiety medication (buspirone), an antipsychotic medication (risperidone), and an ADHD medication (clonidine) at 4 years of age, presumably to treat psychiatric symptoms that interfered with his functioning, including short attention span, wandering off, self-injury, and aggression. However, experts noted the documentation was too sparse to determine why the psychotropic

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medications were prescribed, and the indications, monitoring, and side effects could not be evaluated.

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Communication between Treatment Providers

Experts found that communication between treatment providers was mostly documented in 15 of 23 applicable cases. However, communication between treatment providers was partially documented in 5 of 23 cases, and there was no evidence that such communication occurred in 3 of 23 cases. For example, experts found in one case with partially supporting documentation that a teenage foster child with cognitive delays and fetal alcohol effects/exposure was diagnosed with ADHD and oppositional defiant disorder, and the quality of documentation showing communication between treatment providers varied by the child's placement setting. When the child was placed in a residential treatment facility, the communication between treatment providers was better documented than when the child was placed in a foster home. However, there was no clear documentation of communication between inpatient and outpatient providers and there was no clear evidence in the foster care files that the recommendations made by inpatient providers were actually provided as part of outpatient care.

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Some Prescriptions in Infant Cases Were for Non-Mental-Health Reasons, but others Were for Psychiatric or Unclear Reasons

Of the 24 cases reviewed, 9 were infant cases that the experts evaluated to determine whether the prescriptions were for psychiatric or non-mental-health reasons.<sup>20</sup> Experts found in 4 of 9 infant cases reviewed that the prescription of psychotropic medication was for non-mental-health purposes, based on documentation reviewed. However, experts found that in 2 of 9 cases the infants were prescribed psychotropic medications for psychiatric reasons, and the rationale and oversight for such medications were partially supported by documentation. In 3 of 9 infant cases, experts were unable to discern whether the psychotropic

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<sup>20</sup>The infant cases selected included five infants less than 1 year of age prescribed any psychotropic medication during calendar year 2008 and in foster care as of January 2010. In addition, we also selected all children less than 1 year of age prescribed an ADHD, antipsychotic, or antidepressant medication during calendar year 2008, resulting in eight additional infant cases. However, we removed four of the cases from this review due to data-entry errors and potential Medicaid fraud, thus, a total of nine infant cases were reviewed. Because the experts reviewed foster and medical records spanning the entire period the child was in foster care, in some infant cases the medication regimens reviewed go beyond the child's infancy. To the extent possible, the specific age of the child when the medication was prescribed is noted. To determine the categorizations of whether the medications were provided for mental- or non-mental-health reasons, we considered the experts' review of infant cases for up to 2 years of age.

medications were prescribed to infants for mental-health purposes or for some other medical reason, based on documentation reviewed. These results are summarized in table 4, below.

**Table 4: Quality of Documentation Support Related to Infants Prescribed Psychotropic Medications**

Category	Prescribed for non-mental-health purposes based on foster file and medical records	Prescribed for psychiatric purposes based on foster file and medical records	Not clear based on foster file or medical records	Total applicable cases
Infants prescribed psychotropic medications	4	2	3	9

Source: Expert reviewers.

Notes: Experts reviewed the case documentation from a quantitative and qualitative standpoint and provided their consensus evaluation. The infant cases selected included five infants less than 1 year of age prescribed any psychotropic medication during calendar year 2008 and in foster care as of January 2010. In addition, we also selected all children less than 1 year of age prescribed an ADHD, antipsychotic, or antidepressant medication during calendar year 2008, resulting in eight additional infant cases. However, we removed four of the cases from this review due to data-entry errors and potential Medicaid fraud, thus, a total of nine infant cases were reviewed. The experts reviewed foster and medical information from the entire time the child was in foster care, which included the most-recent records available.

**Psychotropic Medications Prescribed to Infants for Non-Mental-Health Reasons**

Experts found in two of nine infant cases that an antianxiety medication (hydroxyzine) was prescribed to treat skin conditions such as a rash and itchiness, and was not used for psychiatric purposes. In two other of nine other infant cases reviewed, an ADHD medication (clonidine) was used to treat sleep and irritability in children who had severe brain damage, and who by the clinical descriptions were inconsolable. For each of the above infant cases, experts agreed that there are no established standards for treating problems associated with devastating neurological impairment in infants. According to experts, although other medications, and possibly nonmedication interventions, could have been used instead of clonidine, the decision to treat was based on humanitarian reasons, and may have been necessary to maintain the child in the foster home given the marked distress displayed by the infants in these two cases. While physicians may use their discretion to prescribe these psychotropic medications to infants in these rare situations, non-mental-health uses still carry the same risk of adverse effects, including, for the ADHD medication clonidine, lowered blood pressure, changes in heart rate, and the potential for sudden death, and should therefore be carefully monitored.

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Psychotropic Medications  
Prescribed to Infants for  
Psychiatric Reasons

Experts found in two of nine infant cases reviewed that the psychotropic medications were prescribed for psychiatric reasons, yet the justification for such prescriptions was not clear based on documentation. For example, experts found in one infant case that the child was prescribed an antidepressant (amitriptyline) at 9 months of age, and a prescription for an ADHD medication (clonidine) was added at 15 months of age to target complications of his neurological condition, including self-injurious behaviors, agitation, and aggression. Experts said there is no systematic research supporting the use of amitriptyline for self-injurious behaviors in any age group and the medication carries significant potential side effects, including cardiac side effects, and has been associated with sudden death in young children. Additionally, according to experts, amitriptyline can cause or exacerbate corneal ulceration, a painful condition for which this toddler was being treated, and which reportedly exacerbated the child's agitation. The case notes focus on medical issues with limited discussion of rationale, efficacy, or tolerability of psychotropic medications. In another infant case, experts found that clonidine was prescribed for sleep and behavioral issues, but the records did not show that the associated risks of the medications were discussed, and informed consent was not documented. According to experts, the medical records in this particular case also included a note from the prescribing doctor when the child was 20 months of age stating that clonidine was not a psychotropic medication while also stating that the medication was for behavioral problems.

Psychotropic Medications  
Prescribed to Infants for  
Unclear Reasons

Experts found in three of nine infant cases reviewed that documentation was unclear as to whether the psychotropic medications were prescribed for mental or non-mental-health purposes. For the first infant case with unclear documentation, experts noted that the child received a 2-month trial of an ADHD medication (clonidine) at 16 months of age, which experts stated they presumed was prescribed for irritability or difficulty sleeping, based on available documentation, but the actual indications were not documented. In the second infant case with unclear documentation, experts' review showed the child received a number of different anticonvulsants to try to improve seizure control. However, the infant was also prescribed a 2-month trial of an antianxiety medication (clonazepam) as a 1-year-old, and, according to the experts, the records did not indicate whether the medication was prescribed to treat the seizures or for psychiatric purposes. In the third infant case with unclear documentation, experts reported the child was prescribed an antianxiety medication (hydroxyzine), presumably to treat a skin irritation; however, there were no notes describing the rationale for the medication.

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The experts agreed that prescriptions of psychotropic medications to infants carries significant risk as there are no established mental-health indications for the use of psychotropic medications in infants and the medications have the potential to result in serious adverse effects for this age group.

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## Selected States Have Policies and Procedures Intended to Address Oversight of Psychotropic Medications to Foster Children, and HHS Issued Guidance for Monitoring Psychotropic Medications

Selected states have policies and procedures that are intended to provide oversight of psychotropic medications given to foster children. In addition, HHS has issued guidance, provided technical assistance, and facilitated information-sharing efforts among state child-welfare and Medicaid officials related to oversight of psychotropic medications for children in foster care. However, additional HHS guidance could help state child-welfare and Medicaid officials manage psychotropic medications as states transition prescription drug benefits to managed care.

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## Selected States' Policies and Procedures Address Oversight of Psychotropic Medications to Foster Children

To varying degrees, each of the five selected states we reviewed has policies and procedures designed to address the monitoring and oversight of psychotropic medications prescribed to children in foster care. Some variation is expected because states set their own oversight guidelines. However, the 2011 Child and Family Services Improvement and Innovation Act required states to establish protocols for the appropriate use and monitoring of psychotropic medications prescribed to children in foster care, which ACF described in a 2012 program instruction.<sup>21</sup> According to ACF, the unique factors of each state, such as whether the child-welfare service-delivery structure is state- or county-administered, the type of Medicaid delivery system in place, and the availability of qualified practitioners, may influence how officials develop

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<sup>21</sup>Child and Family Services Improvement and Innovation Act, Pub. L. No. 112-34, § 101(b)(2), 125 Stat. 369 (2011). See Administration for Children and Families, Program Instruction, ACYF-CB-PI-12-05.



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oversight protocols. Thus, according to ACF, each state needs to carefully assess existing oversight mechanisms and evaluate options in light of how they fit with the state's own set of needs and challenges. As part of ACF's 2012 program instructions, states are to address protocols for monitoring foster children's use of psychotropic medications as part of the state's APSR, which include protocols to address: (1) screening, assessment, and treatment planning mechanisms; (2) effective medication monitoring at both the client and the agency-wide level; and (3) shared decision making and communication among the prescriber, the child, caregivers, other health care providers, and the child-welfare worker.<sup>22</sup> Below are examples of selected states' policies and procedures—based on documents we reviewed and interviews with state Medicaid and child-welfare officials—that are intended to provide oversight of psychotropic medications to children in foster care. The information is presented using the same categories discussed above for experts' review of case studies. We did not assess the extent that these activities are being implemented effectively in the states.

**Medical Pediatric Examinations** Each of our five selected states require that children in foster care receive medical examinations. For example, officials reported that in Oregon a child must receive a medical examination within 30 days and a mental-health exam within 60 days after the child enters the foster-care system, whereas Michigan officials said that both the medical and mental-health exams are to occur within 30 days.

**Psychiatric Evaluations** All five selected states' foster-care programs use some type of functional assessment or screening tool, such as the Child and Adolescent Needs and Strengths (CANS), for screening and treatment planning, which may prompt a referral for a psychiatric evaluation as deemed appropriate. However, according to foster-care officials from Massachusetts, the CANS assessment tool is not sufficient to screen for a child's exposure to trauma and there is a need for a separate trauma-screening mechanism. Medicaid and foster-care officials from Texas told us in July 2013 that they are working to research and develop a comprehensive psychosocial-assessment process with trauma screening/assessment components that is tailored to the unique needs of children in foster care. In April 2014, officials estimated that the process will take at least another year to

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<sup>22</sup>See Administration for Children and Families, Program Instruction, ACYF-CB-PI-12-05.

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implement and may be phased in so they could evaluate the effectiveness and refine the process.

**Evidence-Based Therapies Provided**

Each of our five selected states has taken action to increase children's access to evidence-based therapies. For example, Oregon mental-health officials said that state law requires that 75 percent of the funding for mental-health agencies is to be used for evidence-based practices, and that the state surveys its mental health providers every 2 years on their utilization of evidence-based practices and reports these results to the state legislature. Oregon mental-health officials also said site reviews of mental-health providers occur every 3 years to make sure the providers are using practices on the state's approved list of evidence-based practices and if deficiencies are identified, correction plans are developed. As another example, Massachusetts's foster-care agency—through a federally funded grant—has provided evidence-based training on trauma-focused cognitive behavioral therapy, child-parent psychotherapy, and attachment self-regulation to both general practitioners and child-welfare staff to raise awareness and improve methods for treating and overseeing the child's overall health.

**Impact of Trauma Addressed by Treatment**

Each of our five selected states has taken action to improve focus on trauma-related needs of children in foster care. For example, Oregon was awarded a 3-year technical assistance grant by the Center for Health Care Strategies in April 2012. According to Oregon officials, one of the goals of this grant is to better understand the impact of trauma on emotions, behavior, and relationships, and to support training and policy development in this area. Beginning in May 2012, Texas implemented a 5-year strategic plan regarding trauma-informed care across the state for foster-care children. To do this, the state Medicaid program, foster-care agency, and managed-care organization (MCO) under contract are all working together to build a trauma-informed care system by incorporating trauma screening/assessment into psychosocial-assessment processes, enhancing clinical capacity to provide trauma-focused, evidence-based psychosocial therapy, training key stakeholders, and incorporating the principles of trauma-informed care into child-welfare policy and practices, according to Texas officials.

**Prescriptions Appropriately Monitored**

All five of the selected states have designed a mechanism to coordinate and share some or all Medicaid prescription claims data with the state's foster-care agency to help monitor and review cases based on varying criteria, such as prescriptions for children under a particular age, high dosages, or concurrent use of multiple medications. For example, according to Florida Medicaid officials, beginning in 2011 the state began

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requiring documentation of safety monitoring, such as metabolic monitoring, and body-mass-index information, to be included as part of the prior-authorization review process before particular medication regimens are approved for reimbursement.<sup>23</sup> However, these reviews are limited to those prescription claims paid for on a fee-for-service basis. Beginning in October 2014, foster children in Florida are to receive all of their Medicaid benefits through a third-party MCO, and it was unclear to state Medicaid officials how MCOs will provide oversight of psychotropic medications after the transition from fee-for-service to managed care occurs. Massachusetts uses both a fee-for-service model and MCOs to administer prescription claims benefits. Massachusetts child-welfare officials said that in the fee-for-service program, certain parameters, such as children in foster care prescribed four or more psychotropic medications, or two or more psychotropic medications of the same class, or children less than 6 years old prescribed a psychotropic medication, are flagged and forwarded to a child psychiatrist for additional review. However, among children served by MCOs, state Medicaid officials said that MCOs flag cases for children prescribed psychotropic drugs who are less than 6 years old, but state Medicaid officials were uncertain how MCOs followed up on these cases. In Texas there is a single MCO used to coordinate all prescription claims and medical services for children in foster care, and this organization works closely with the state foster-care agency to identify and monitor psychotropic medication use among children in foster care.

## Appropriate Dosages Used

All five of the selected states have designed measures to review certain prescriptions that have dosages above a particular threshold. For example, in February 2005, Texas developed psychotropic drug-utilization parameters that outline what prescribing scenarios require an additional review, and these parameters were updated in January 2007, December 2010, and September 2013. Prescriptions that exceed usual recommended dosages for the child's age trigger an additional review from a child psychiatrist. Similarly, in 2012, Michigan's Medicaid and foster-care agencies began identifying and reviewing foster children's prescriptions if the medication exceeds the recommended dosages. According to officials, Florida, Massachusetts, and Texas Medicaid programs also require prior authorizations before a prescription is

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<sup>23</sup>Medication regimens that require prior authorization include antipsychotic prescriptions that exceed a particular dosage, and antipsychotic or antidepressant medications prescribed to a child less than 6 years old.

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## Justification for Concurrent Use of Multiple Medications

approved for reimbursement for various prescribing scenarios specific to psychotropic medications.<sup>24</sup> As stated in the section above concerning prescription monitoring, state Medicaid officials from Massachusetts and Florida told us they are still in the process of determining to what extent monitoring and oversight protocols—including prior authorizations—function for children in foster care who are prescribed medications through MCOs.

All five of the selected states have designed measures to review prescriptions for concurrent use of multiple medications to a varying extent. For example, the MCO that handles prescription claims for children in foster care in Texas monitors and completes additional reviews for concurrent prescriptions, and shares that information with the state foster-care and Medicaid agencies for the following medication regimens as stated in the September 2013 Texas Utilization parameters:

- four or more concurrent psychotropic medications;
- two or more concurrent antidepressants;
- two or more concurrent antipsychotic medications;
- two or more concurrent stimulant medications; and
- three or more concurrent mood-stabilizer medications.

Similarly, since 2012, the Michigan Medicaid agency monitors concurrent use of multiple medications using criteria, including four or more concurrent psychotropic medications, or two or more concurrent psychotropic medications within the same class, and shares this information with the state foster-care agency to facilitate additional reviews. Each of the above prescribing scenarios triggers an additional review that may include discussions with the prescriber to review the details and justification in support of the prescriptions. As mentioned previously in this report, Florida, Massachusetts, and Texas Medicaid programs also require prior authorizations before a prescription is approved for reimbursement for various prescribing scenarios specific to

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<sup>24</sup>For example, we were told that Florida requires prior authorization for children ages 6-17 years who are prescribed a high-dose antipsychotic medication, and Texas has dosage requirements for some antidepressants. Massachusetts reportedly has prior-authorization requirements for certain psychotropic drugs, such as antipsychotic medications. Officials explained that state law restricts Oregon and Michigan's ability to conduct prior authorizations at the point of sale for behavioral-health medications generally.

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psychotropic medications. However, as stated above concerning prescription monitoring, state Medicaid officials from Massachusetts and Florida told us they are in the process of determining to what extent monitoring and oversight protocols—including prior authorizations—function for children in foster care prescribed medications through MCOs.

### Informed Consent

Each of the five selected states require informed consent for psychotropic medications, but state practices vary. For example, according to agency officials, individuals authorized to give informed consent for a foster child vary across states. In Oregon, foster parents are not authorized to give informed consent for children in state custody—the foster child’s case supervisor provides informed consent for psychotropic medications. As another example, officials from Texas told us that according to state law, when the court places a child in the custody of the state foster-care program, the court must authorize an individual or the child-welfare agency to consent to medical care for a child in foster care. When the court authorizes the child-welfare agency, the agency must designate a medical consenter—which typically includes emergency-shelter employees or live-in caregivers if the child is placed in community settings, or child-welfare staff when children are placed in facilities such as residential treatment centers.

### Communication between Treatment Providers

Four of five selected states have some limitations regarding the extent to which a child’s medical history is available to treatment providers. For example, in Oregon, medical providers have access to a child’s prescription claims and medical history so long as the child was treated by a medical provider within the same Coordinated Care Organization (i.e., MCO), though the accessibility of information varies by each Coordinated Care Organization and is largely unavailable from competing Coordinated Care Organizations within the state. As another example, state Medicaid and foster-care officials from Michigan said they were in the process of developing electronic health records to improve access to information for prescribers, but noted that privacy concerns and legal limitations make it very difficult to share medical information across various medical providers. Texas is unique in that the state uses a single MCO to coordinate all prescription claims for children in foster care, which gives all participating medical providers access to prescription claims and the child’s medical history electronically.

### Psychotropic Prescriptions to Infants

Each of the five selected states, to varying extent, have designed measures to review prescriptions of psychotropic medications based on the child’s age, which includes prescriptions to infants. For example, Oregon officials said that state law requires an annual review of

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medications by a licensed medical professional or qualified mental-health professional with authority to prescribe medications, other than the prescriber, if the child is covered by Medicaid and under the age of 6 years. Similarly, since 2012, Michigan’s foster-care agency reviews medical records of all children in foster care less than 1 year old who are prescribed psychotropic medication to determine whether the prescription was for psychiatric purposes or non-mental-health reasons. As mentioned previously in this report, Florida, Massachusetts, and Texas Medicaid programs also require prior authorizations before a prescription is approved for reimbursement for various prescribing scenarios specific to psychotropic medications. Officials from Massachusetts and Florida told us they are in the process of determining how monitoring and oversight currently function for children in foster care who are prescribed medications through MCOs.

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**HHS Has Issued Guidance, Provided Technical Assistance, and Facilitated Information Sharing**

In response to concerns and our December 2011 report recommendation related to the need for additional guidance for the prescribing of psychotropic medications for children in foster care, HHS’s ACF has taken actions to improve the capacity of states’ child-welfare agencies to effectively respond to the complex needs of children in foster care.<sup>25</sup> As previously mentioned in this report, ACF issued a program instruction in April 2012 to help states implement the new requirements in the Child and Family Services Improvement and Innovation Act regarding the development of protocols for oversight of psychotropic medication.<sup>26</sup> In addition, since our December 2011 report, ACF has worked collaboratively with CMS and SAMHSA to help states strengthen oversight of psychotropic medications to children in foster care by emphasizing the need for collaboration between state Medicaid, child-welfare, and mental-health officials in providing oversight; providing

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<sup>25</sup>[GAO-12-201](#).

<sup>26</sup>See Administration for Children and Families, Program Instruction, ACYF-CB-PI-12-05.

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technical assistance; and facilitating information sharing.<sup>27</sup> Several initiatives were performed, including the following:

- CMS and SAMHSA participated in an ACF-led 2012 webinar series to help provide states with technical assistance in developing oversight and monitoring plans for psychotropic medications, as required by the Child and Family Services Improvement and Innovation Act. Using a question-and-answer format, the webinars featured experts, including researchers, child psychiatrists, and ACF staff, who provided ideas and feedback to state officials on planning efforts.
- In August 2012, ACF, CMS, and SAMHSA cohosted a conference for state child-welfare, Medicaid, and mental-health officials on strengthening the management of psychotropic medications for children in foster care. Conference sessions focused on effective collaborative medication monitoring, as well as creating data systems to facilitate collaboration, among other things. According to ACF, CMS, and SAMHSA officials, the conference was an opportunity for states to talk and share practices. According to ACF officials, representatives from 49 states attended, including officials from 4 of the 5 states covered by our review.<sup>28</sup> Officials from one of these states said the conference was beneficial. Officials from another state said participation challenged them to augment their system; officials from another state said it was helpful to hear what other states were doing; and officials from a fourth state said that it was important for the three federal agencies to have common goals, which would help sustain interagency collaboration at the state level.

In addition, CMS officials said the issue of psychotropic medications was a catalyst that caused the HHS agencies to look at broader issues related to mental health, including trauma-informed care and the use of mental-health screening tools and evidence-based therapies. ACF, CMS, and SAMHSA have undertaken several efforts, including the following:

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<sup>27</sup>In November 2011, shortly before our previous report was issued, ACF, CMS, and SAMHSA officials cosigned a letter to the directors of state child-welfare, Medicaid, and mental-health agencies outlining the actions each division was taking to support state efforts to strengthen psychotropic prescription oversight. In addition, the letter also noted that it is essential for state child-welfare, Medicaid, and mental-health officials to collaborate, particularly in efforts to improve medication use and prescription monitoring.

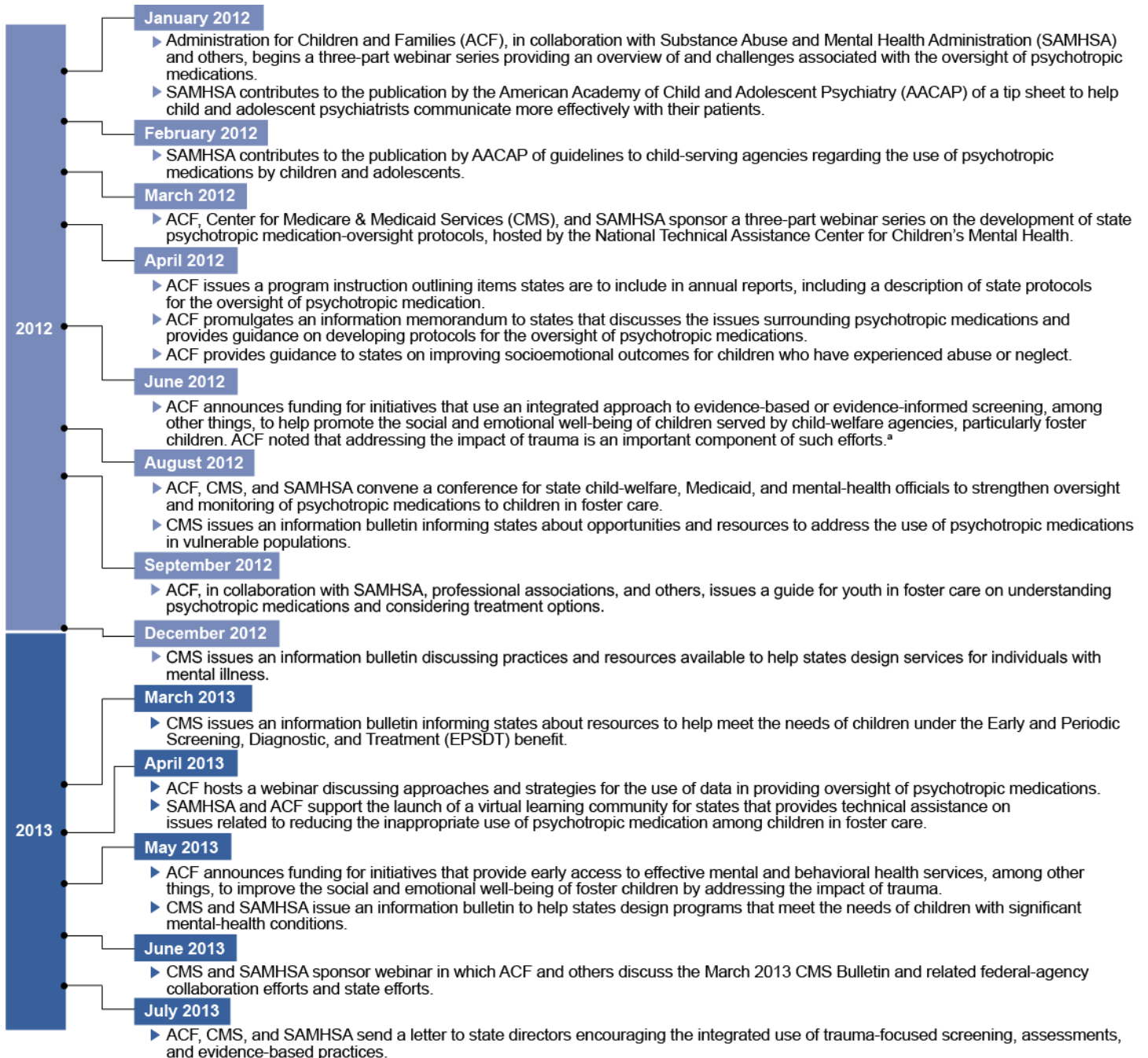
<sup>28</sup>A Florida child-welfare official said that Florida officials were unable to attend the conference due to a hurricane.

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- In 2012 and 2013, ACF announced funding opportunities for projects supporting the comprehensive use of evidence-based screening and assessment of mental and behavioral health needs, among other things.
  - In March 2013, CMS issued guidance informing states about resources available to help meet the needs of children under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Medicaid benefit. Under the EPSDT, eligible individuals, such as children in foster care, are to be provided periodic screenings that include assessments of physical and mental-health development, as well as any medically necessary screenings to detect suspected illnesses or conditions not discovered during periodic exams. Results from screenings may trigger the need for further assessment to diagnose or treat a mental-health condition.
  - In July 2013, ACF, CMS, and SAMHSA officials cosigned a letter to state child-welfare, Medicaid, and mental-health officials encouraging the integrated use of trauma-focused screening, functional assessments, and evidence-based practices to improve child well-being. In particular, federal officials noted that a high percentage of children in state foster care have been exposed to traumatic events and that there is reason to believe that problematic use of psychotropic medications is a reaction to the complexity of symptoms among children exposed to trauma and the lack of appropriate screening, assessment, and treatment.

Figure 1 below lists initiatives undertaken since our previous report by ACF, CMS, and SAHMSA.



**Figure 1: Department of Health and Human Services (HHS) Efforts to Support States' Oversight of Psychotropic Medications among Children in Foster Care and Encourage the Use of Mental-Health Assessments and Screening Tools, since December 2011**



Source: GAO analysis of ACF, CMS, and SAMHSA documents and interviews.

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<sup>a</sup>In June 2011, ACF announced the first of three recent funding initiatives focused on improving the social and emotional well-being of children in the child-welfare system by addressing the impact of trauma, among other things. The other two related funding initiatives were announced in June 2012 and May 2013.

In addition, according to ACF officials, in collaboration with SAMHSA and others, ACF plans to issue guidance in August 2014 to foster parents regarding psychotropic medication to enhance their understanding of these medications.<sup>29</sup>

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### Additional Guidance Could Help Officials Manage Psychotropic Medications as States Transition Prescription-Drug Benefits to Managed Care

Three of five states included in our review use, or are transitioning from fee-for-service to, MCOs to administer prescription-drug benefits for mental-health medications; however, Medicaid officials from two of those three states reported that their states had conducted limited planning to ensure appropriate oversight of MCOs administering psychotropic medications—which creates a risk that state controls instituted in recent years under fee-for-service may not apply to managed care—and could benefit from additional federal guidance.

- In Massachusetts, most foster children receive drug benefits through fee-for-service, according to state Medicaid officials, though some children receive these benefits through MCOs.<sup>30</sup> Under fee-for-service, beginning in 2012, state Medicaid prescription claims data were to be provided to the state child-welfare agency to monitor and facilitate additional reviews, as necessary, for children prescribed medications in foster care. For example, according to child-welfare officials, cases that meet certain criteria—children less than 6 years old prescribed a psychotropic medication; children prescribed four or more psychotropic medications; or children prescribed two or more psychotropic medications in the same class—are flagged and forwarded to a child psychiatrist for further review. According to Massachusetts Medicaid officials, MCOs currently review cases when

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<sup>29</sup>In addition, the President's fiscal year 2015 budget submission proposes a new Medicaid demonstration project in partnership with ACF to encourage states to provide evidence-based psychosocial interventions to children and youth in foster care.

<sup>30</sup>As part of our December 2011 report, we analyzed Medicaid claims data for 2008 and determined that about 72 percent of foster children in Massachusetts received drug benefits through fee-for-service. In the fall of 2013, Massachusetts Medicaid officials confirmed that most children in foster care continue to receive drug benefits through fee-for-service.

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a child less than 6 years old is prescribed a psychotropic medication. State Medicaid officials said they did not know how MCOs followed up on cases last year. However, state Medicaid officials and other members of an interagency committee on psychotropic medications have met with MCO administrators to learn what they are doing to review cases and will continue to monitor MCOs, according to Massachusetts state officials.<sup>31</sup> Such operational information is important for the child-welfare agency to obtain to help ensure that appropriate oversight of psychotropic medication prescribed to foster children occurs. In addition, as part of the state's efforts to improve the prescribing, authorization, and monitoring of psychotropic medications, a Massachusetts interagency committee on psychotropic medications and foster children noted that MCOs' and the state's primary-care clinician plan program's role in the prior-authorization process has not been determined, in particular whether these organizations will have to assume responsibility for assuring that psychiatrists in their network adhere to the state's prescribing and monitoring practices.<sup>32</sup>

- Florida Medicaid officials said that beginning in 2014, MCOs will provide Medicaid participants, including foster children, with mental-health services, but it was unclear to state Medicaid officials how MCOs will provide oversight of psychotropic medications after the transition from fee-for-service to managed care occurs. Such operational information is also important for Florida's child-welfare agency to help ensure that appropriate oversight of psychotropic medication prescribed to foster children occurs. Florida Medicaid officials said that there will probably no longer be point-of-sale controls, which were instituted under fee-for-service in 2011. These controls, for example, required prescribers to submit forms indicating

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<sup>31</sup>Formed in 2007, the Psychoactive Medications in Children Working Group comprises MassHealth, the Massachusetts Department of Mental Health, and the Massachusetts Department of Children and Families, among others, and works to evaluate and recommend strategies to improve psychoactive medication management in children served by MassHealth.

<sup>32</sup>Formed in 2012, the Steering Committee for Monitoring Psychotropic Medications for Children in Foster Care was charged with developing a plan to promote best practices related to the prescription, authorization, and monitoring of psychotropic medications. The committee is led by the Massachusetts Child Advocate and the Department of Children and Families Commissioner. According to Massachusetts officials, the committee has developed a proposed initiative that would require prior authorization on combinations of medications that have little or no evidence of safe and effective use in the very young as well as situations identified as polypharmacy.

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that safety monitoring, such as monitoring for signs of abnormal involuntary movement and metabolic monitoring, was performed for certain medications. If such point-of-sale controls are not continued under MCOs, then safety monitoring developed by the state under fee-for-service may not continue for children administered medications through MCOs.

ACF officials we met with noted that state child-welfare have experienced challenges coordinating with state Medicaid programs regarding the transition to MCOs, particularly with regard to data sharing. There are indications that the number of states using MCOs to administer drug benefits may increase. In 2012, the HHS Office of Inspector General (OIG) reported that 16 states used MCOs to administer drug benefits, and another 5 states had, or were planning, to switch to MCOs as a result of the Patient Protection and Affordable Care Act expansion of the Medicaid drug-rebate program, which allows states to obtain rebates from manufacturers for covered outpatient drugs.<sup>33</sup> Previously, medications dispensed by MCOs were excluded from such rebates.

According to *Standards for Internal Control in the Federal Government*, internal controls should generally be designed to assure that ongoing monitoring occurs in the course of normal operations, and is performed continually and ingrained in the agency's operations.<sup>34</sup> ACF requires states to develop effective medication monitoring at the agency and patient level. To this end, ACF, CMS, and SAMHSA have developed guidance for state Medicaid, child-welfare, and mental-health officials related to the oversight of psychotropic medications underscoring the need for collaboration between state officials to improve prescription monitoring. However, this guidance does not address oversight within the context of a managed-care environment, in which states rely on a third party to administer benefits such as psychotropic medications.<sup>35</sup> Additional guidance from HHS that helps states prepare and implement

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<sup>33</sup>Department of Health and Human Services, Office of Inspector General, *States' Collection of Rebates for Drugs Paid Through Medicaid Managed Care Organizations*, OEI-03-11-00480 (September 2012); Pub. L. No. 111-148, § 2501(c), 124 Stat. 119, 308 (2010).

<sup>34</sup>GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999).

<sup>35</sup>CMS has made tools available on its website to help states design programs to manage MCO quality.

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monitoring efforts within the context of a managed-care environment could help ensure appropriate oversight of psychotropic medications to children in foster care.

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## Conclusion

Since our December 2011 report, HHS has issued guidance regarding the oversight of psychotropic medications among children in foster care and has undertaken collaborative efforts to provide guidance and promote information sharing among states. In addition, HHS efforts have focused on using mental-health screening tools and providing therapies that address trauma, which seek to ensure that the mental-health needs of children in foster care are appropriately met. However, many states have, or are transitioning to, MCOs to administer prescription-drug benefits, and, as our work demonstrates, selected states have taken only limited steps to plan for the oversight of drug prescribing for foster children receiving health care through MCOs—which creates a risk that controls instituted in recent years under fee-for-service may not remain once states move to managed care. Additional guidance from HHS that helps states prepare and implement monitoring efforts within the context of a managed-care environment could help ensure appropriate oversight of psychotropic medications to children in foster care.

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## Recommendation for Executive Action

To assist states that rely on or are planning to contract with an MCO to administer Medicaid prescription benefits, and to help provide effective oversight of psychotropic medications prescribed to children in foster care, we recommend that the Secretary of Health and Human Services issue guidance to state Medicaid, child-welfare, and mental-health officials regarding prescription-drug monitoring and oversight for children in foster care receiving psychotropic medications through MCOs.

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## Agency and Third-Party Comments and Our Evaluation

We provided a draft copy of this report to HHS and the state foster-care and Medicaid agencies of the five selected states for their review. HHS, the Florida Agency for Health Care Administration, and the Massachusetts Executive Office of Health and Human Services provided written comments that are summarized below and reprinted in full in appendixes III, IV, and V, respectively. HHS, Massachusetts, Oregon, and Texas provided technical comments, which we incorporated as appropriate. Michigan did not have any comments on the report.

In its response, HHS concurred with our recommendation to issue guidance to state Medicaid, child-welfare, and mental-health officials

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regarding prescription-drug monitoring and oversight for children in foster care receiving psychotropic medications through MCOs, and stated that CMS will work with other involved agencies to coordinate guidance between CMS and other HHS agencies. HHS further stated that guidance can be targeted regarding the use of MCOs for the foster-care population, but noted that previously issued guidance to state agencies from HHS already applies. However, the guidance that HHS referred to in its written comments is not specific to oversight within the context of a managed-care environment, and officials from the states in our review agreed that additional federal guidance could be beneficial. Therefore, we continue to believe that specific guidance to help states prepare and implement monitoring efforts within the context of a managed-care environment is needed to help ensure appropriate oversight of psychotropic medications to children in foster care.

In its written comments, the Florida Agency for Health Care Administration did not indicate whether it agreed or disagreed with our findings and recommendation, but said that it appreciated our efforts to evaluate Florida's Medicaid program and the reimbursement of psychotropic medications for foster children. Florida's response also provided additional information about the state's future plans for using managed-care plans and drug-utilization review requirements. For example, Florida's response stated that these managed-care plans must adhere to Florida statute requirements regarding prior-authorization procedures for covering medically necessary services, including prescription-drug services. However, the extent to which drug-utilization reviews and point-of-sale controls currently used by the state under fee-for-service would apply after transitioning to MCOs is still unclear. For example, as we discussed in the report, if point-of-sale controls are not continued under MCOs, then safety monitoring developed by the state under fee-for-service may not continue for children administered medications through MCOs.

In its written comments, Massachusetts's Executive Office of Health and Human Services did not indicate whether it agreed or disagreed with our findings and recommendation, but thanked us for recognizing the work Massachusetts has done in the area of psychotropic medications being administered to children in foster care and agreed that discussion and investigation of this topic is timely and important to improve the health and welfare of children in foster care. In its response, Massachusetts noted that MCO contracts require the MCOs to monitor psychotropic prescribing for members under the age of 19 in accordance with guidelines established by Massachusetts's Psychoactive Medications in

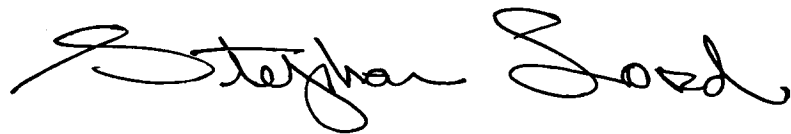
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Children Working Group. Massachusetts also stated it conducted an operational review with each MCO to ensure that there is an established follow-up process for cases that are flagged, and that it continues to monitor MCOs closely to assure they remain in compliance with this contract requirement. However, the extent to which Massachusetts has developed guidelines, conducted operational reviews, and monitored for MCO compliance is still unclear.

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As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Secretary of Health and Human Services, relevant state agencies, and interested congressional committees. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you have any questions concerning this report, please contact me at (202) 512-6722 or [lords@gao.gov](mailto:lords@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in appendix VI.



Stephen M. Lord  
Managing Director, Forensic Audits and Investigative Service

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*List of Requesters*

The Honorable Thomas R. Carper  
Chairman  
Committee on Homeland Security and Governmental Affairs  
United States Senate

The Honorable John McCain  
Ranking Member  
Permanent Subcommittee on Investigations  
Committee on Homeland Security and Governmental Affairs  
United States Senate

The Honorable Charles E. Grassley  
Ranking Member  
Committee on the Judiciary  
United States Senate

The Honorable Susan M. Collins  
United States Senate



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# Appendix I: Expert Selection and Biographies

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To provide a clinical perspective on our cases, we contracted with two child psychiatrists who have clinical and research expertise in the use of psychotropic medications in children. We reviewed the curriculum vita for each expert who responded to our contract solicitation to determine whether the expert met all of the following criteria:

- is a medical doctor;
- is trained in child psychiatry;
- is board certified in child psychiatry;
- conducted relevant research or had relevant experience; and
- is a member of a relevant association (e.g., American Academy of Child and Adolescent Psychiatry).

We also conferred with officials from the National Institute of Mental Health.

We selected Jon McClellan, MD, and Michael Naylor, MD. Dr. McClellan is an attending psychiatrist at Seattle Children's Hospital; a professor at the University of Washington School of Medicine; and the medical director at Washington's Child Study and Treatment Center, the children's psychiatric hospital for the state of Washington. He is board certified in psychiatry and child and adolescent psychiatry, has conducted research regarding mental illness in children, and contributed to a forum on psychotropic medication use amongst children in foster care. Dr. Naylor is an associate professor at the University of Illinois at Chicago, School of Medicine, and the director of the Behavioral Health and Welfare Program, which was formed to address the mental-health needs of the most severely disturbed children in state care. He directs the Clinical Services in Psychopharmacology program, which provides an independent review of all psychotropic medication consent requests for foster children in Illinois. He is board certified in child and adolescent psychiatry, general psychiatry, and sleep-disorders medicine.

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# Appendix II: Case-Rating Summary Table

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The figure below contains the ratings assigned by experts for the quality and quantity of certain types of documentation contained in each child's foster and medical files. Cases are organized by the criteria used to randomly and nonrandomly select them and include reviews of cases from each of our selected states—Florida, Massachusetts, Michigan, Oregon, and Texas.

Appendix II: Case-Rating Summary Table

Figure 2: Case-Rating Summary Table

	Foster Child																								Total:																							
	Randomly selected from each state														Nonrandomly selected from each state																																	
	A child prescribed any psychotropic medication during calendar year 2008				A child with prescriptions exceeding dosage guidelines developed by the state of Texas, based on medical literature and FDA-approved maximum dosages					A child prescribed five or more medications concurrently					A child less than 1 year of age prescribed any psychotropic medication				Any child less than 1 year old prescribed an attention deficit hyperactivity disorder (ADHD) medication, antipsychotic, or antidepressant																													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24																								
▶ Medical pediatric examinations																									22	2	0	0																				
▶ Psychiatric evaluations																									12	3	2	7																				
▶ Evidence-based therapies provided																									3	11	1	9																				
▶ Impact of trauma addressed by treatment																									3	8	3	10																				
▶ Prescriptions appropriately monitored																									13	9	2	0																				
▶ Appropriate dosages used																									13	11	0	0																				
▶ If used, was concurrent use justified																									5	14	1	4																				
▶ Informed consent obtained																									5	11	7	1																				
▶ Communication between treatment providers																									15	5	3	1																				
▶ Psychiatric diagnosis fit history																									12	11	1	0																				
▶ Prescriptions indicated for diagnostic status																									17	6	1	0																				
▶ Duration of trials adequate																									23	0	1	0																				
▶ Medication increases or changes systematic																									21	3	0	0																				
▶ Ongoing efficacy evaluated																									14	7	3	0																				
▶ Psychosocial services provided																									22	1	0	1																				
<b>Total:</b>																									12	7	4	5	8	11	8	7	8	7	8	10	8	5	8	11	12	12	6	11	11	4	11	6
																									2	8	10	7	7	3	7	1	5	8	0	1	1	3	4	0	0	0	6	3	4	9	4	9
																									0	0	1	3	0	1	0	7	1	0	0	2	2	6	0	0	0	0	0	0	0	2	0	0
																									N/A	1	0	0	0	0	0	0	1	0	7	2	4	1	3	4	3	3	3	1	0	0	0	0

Mostly supported in foster file or medical records  
 Partially supported in foster file or medical records  
 Not supported in foster file or medical records  
 N/A Not applicable

Source: Expert reviewers.

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**Appendix II: Case-Rating Summary Table**

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Notes: The data are from expert reviews of foster file and medical records for 24 selected cases. Experts reviewed each of the categories from a quantitative and qualitative standpoint and provided their consensus evaluation based on documentation reviewed. The case selections include children prescribed a psychotropic drug as of 2008 and in foster care as of 2010 (nonrandomly selected infants did not have the 2010 restriction); however, the experts reviewed foster and medical information from the entire time the child was in foster care, which included the most-recent records available. Experts used the categorization “mostly supported in foster file or medical records” for instances where the documentation reviewed met both quantitative and qualitative measures as deemed appropriate by experts. Experts used the categorization “partially supported in foster file or medical records” for instances where the documentation included some information for the assessed category, but the documentation was either quantitatively or qualitatively, or both, lacking in some regard, according to experts. Experts used the categorization “not supported in foster file or medical records” for instances where there was no documentation for the assessed category, or the information provided was deemed substantively lacking by experts.

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

APR 8 2014

Stephen M. Lord  
Managing Director, Forensic Audits  
and Investigative Service  
U.S. Government Accountability Office  
441 G Street NW  
Washington, DC 20548

Dear Mr. Lord:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Foster Children: Additional Federal Guidance Could Help States Oversee Psychotropic Medications Administered by Managed-Care Organizations*" (GAO-14-362).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea  
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "FOSTER CHILDREN: ADDITIONAL FEDERAL GUIDANCE COULD HELP STATES OVERSEE PSYCHOTROPIC MEDICATIONS ADMINISTERED BY MANAGED-CARE ORGANIZATIONS" (GAO-14-362)**

The Department appreciates the opportunity to review and comment on this draft report.

**GAO Recommendation**

To assist states that rely on or are planning to contract with an MCO to administer Medicaid prescription benefits, and to help provide effective oversight of psychotropic medications prescribed to children in foster care, GAO recommends that the Secretary of Health and Human Services (HHS) issue guidance to state Medicaid, child-welfare, and mental-health officials regarding prescription-drug monitoring and oversight for children in foster care receiving psychotropic medications through MCOs.

**HHS Response**

We concur. It should be noted that in 2011, the Centers for Medicare & Medicaid Services (CMS), along with the Administration for Children and Families and the Substance Abuse and Mental Health Services Administration, issued guidance to states on the effective use of psychotropic medications to children in foster care. In August of 2012, CMS released an informational bulletin containing additional information regarding managing the use of these drugs in vulnerable populations. Additionally, in July of 2013, CMS issued guidance regarding interventions to address trauma for youth in foster care who often have high rates of psychotropic medication use. While we may agree that guidance can be targeted regarding the use of managed-care organizations for this population, CMS has not been silent on the issue to state agencies, and the guidance already issued applies regarding delivery systems. CMS will work with other involved agencies to coordinate guidance between CMS and other HHS agencies.

# Appendix IV: Comments from the Florida Agency for Health Care Administration



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

March 28, 2014

Stephen Lord  
Managing Director, Forensic Audits and Investigative Service  
United States Government Accountability Office  
441 G Street, Northwest  
Washington, DC 20548

Dear Mr. Lord,

Thank you for providing the Agency for Health Care Administration, as the state agency which administers the Florida Medicaid program, with the opportunity to comment on the draft report entitled *FOSTER CHILDREN Additional Federal Guidance Could Help States Oversee Psychotropic Medications Administered by Managed-Care Organizations (GAO-14-362)*.

We support the Government Accountability Office's (GAO) efforts to evaluate Florida's Medicaid program and the reimbursement of psychotropic medications for foster children. The information that follows is intended to demonstrate specific safeguards the Agency has implemented to monitor prescription psychotropic medications provided for children receiving foster care services.

By October 2014, the Agency will finalize implementation of the Managed Medical Assistance component of the Statewide Medicaid Managed Care Program. The Agency has procured contracts with managed care plans to manage primary care, acute care and behavioral health services for Florida's Medicaid recipients. Most of Florida's Medicaid recipients, including foster children, will be enrolled in a managed care plan. The Agency has contracted with Sunshine Health to offer a Child Welfare specialty plan for foster children. This specialty plan will cover the same services as other managed care plans and additionally provide care coordination and enhanced provider ratio requirements for its plan enrollees.

Managed care plans must adhere to Florida Statute requirements regarding prior authorization procedures for covering medically necessary services, including prescribed drug services. During the first year of operation, the managed care plans must utilize the Agency's Preferred Drug List (PDL). Additionally, managed care plans require that prescriptions for psychotropic medications prescribed for an enrollee under the age of 13 be accompanied by informed consent of the parent or legal guardian. Plans must ensure that the pharmacy is provided with a signed attestation of the consent with the prescription. Every new prescription will require a new informed consent form.

The Agency requires managed care plans to design and implement drug utilization review (DUR) programs designed to encourage coordination between the enrollee's primary care provider and the prescriber of a psychotropic or similar prescription drug for behavioral health problems. The DUR program identifies medications for other serious medical conditions posing

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**Appendix IV: Comments from the Florida  
Agency for Health Care Administration**

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Mr. Stephen Lord  
March 28, 2014  
Page 2

significant risk to the enrollee by potential drug interactions. When potential risks are identified, the managed care plan must notify all related prescribers that certain drugs may be contra-indicated, encouraging prescribers to coordinate their care.

Again, we appreciate the opportunity to provide comments on your draft report. Should you have any questions about our comments or require further information, please contact me at (850) 412-3603.

Sincerely,



Elizabeth Dudek  
Secretary

ED/tj



# Appendix V: Comments from the Massachusetts Executive Office of Health and Human Services

Page numbers in draft  
report may differ from  
those in this report.



DEVAL L. PATRICK  
Governor  
JOHN W. POLANOWICZ  
Secretary

The Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
One Ashburton Place, Room 1109  
Boston, Massachusetts 02108

Tel: (617) 573-1600  
Fax: (617) 573-1891  
[www.mass.gov/cohhs](http://www.mass.gov/cohhs)

April 14, 2014

Matt Valenta, Assistant Director  
Forensic Audits & Investigative Service  
U.S. Government Accountability Office (GAO)  
1999 Bryan Street, Suite 2200  
Dallas, TX 75201-6848

RE: GAO-14-362

Dear Mr. Valenta:

Thank you for the opportunity to review and comment on the draft General Accounting Office's report: *Foster Children Additional Federal Guidance Could Help States Oversee Psychotropic Medications Administered by Managed Care Organizations*. We appreciate the courtesy you have extended in providing the time necessary to substantively respond to this draft report.

We also thank you for recognizing the work Massachusetts has done in the area of psychotropic medications being administered to children in foster care. As you mention in the draft report, some of the efforts Massachusetts has taken in this area include:

- Providing evidence-based training to general practitioners and child welfare staff on trauma-focused cognitive behavioral therapy, child-parent psychotherapy, and attachment self-regulation;
- Flagging and forwarding to a child psychiatrist for additional review certain cases such as those where children in foster care are prescribed four or more psychotropic medications or two or more psychotropic medications of the same class and where children less than six years old are prescribed a psychotropic medication;



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- Determining how monitoring and oversight protocols, including prior authorization, can be most effectively implemented for children in foster care who are prescribed medications through our MassHealth-contracted managed care entities (such as our managed care organizations or MCOs); and
- Creating and maintaining interagency workgroups, such as the Psychoactive Medications in Children Working Group and the Steering Committee for Monitoring Psychotropic Medications for Children in Foster Care, to evaluate and recommend strategies to improve psychoactive medication management in children served by MassHealth and to develop a plan to promote best practices related to the prescription, authorization and monitoring of psychotropic medications.

We are very proud of these efforts and agree that discussion and investigation of this topic is timely and important to improve the health and welfare of children in foster care. Assuring quality mental health treatment of children in Massachusetts is our highest priority. We would like to take this opportunity to clarify a couple of points in your report specific to Massachusetts. We hope you find these comments helpful as you finalize the report.

1. On page 25, and other areas such as page 33, the report states that Massachusetts Medicaid officials are not certain on how managed care organizations (MCOs) follow up on cases that are identified or flagged as potential inappropriate use of psychotropic medications. MassHealth's MCO contracts require the MCOs to monitor psychotropic prescribing for members under the age of 19 in accordance with guidelines established by Massachusetts' Psychoactive Medications in Children Working Group. In addition, MassHealth conducted an operational review with each MCO to ensure that there is an established follow-up process for cases that are flagged. We continue to monitor the MCOs closely to assure they remain in compliance with this contract requirement.

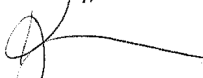
In addition, the Psychoactive Medications in Children Working Group meets quarterly and has representation from several Massachusetts agencies and all MassHealth-contracted managed care entities that serve children. One of the goals of this workgroup is to develop consistency among MassHealth and its MCOs around processes and procedures for reporting and monitoring psychoactive medication use in children. The workgroup also facilitates clinical reviews of outlier cases encountered by managed care entities and conducts site visits to each contracted managed care entity to review their setting and monitoring policies and procedures, including review and monitoring of cases involving children younger than six years of age.

Appendix V: Comments from the  
Massachusetts Executive Office of  
Health and Human Services

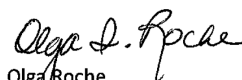
2. Pages 26 and 29 mention that state Medicaid officials from Massachusetts and Florida are in the process of determining to what extent monitoring and oversight protocols – including prior authorizations – function for children in foster care who are prescribed medications through MCOs. Again, thank you for recognizing the efforts of our workgroup; however, we would like to clarify footnote 22. Massachusetts requires prior authorization for certain dosages of psychotropic drugs. Further, since 1983 when the Massachusetts Supreme Judicial Court decided *Rogers v. The Commissioner of the Department of Mental Health*, DCF seeks a court order approving the administration of extraordinary medical treatment for children in foster care, such as the administration of psychotropic medication.
3. Finally, page 34 states that Massachusetts' Interagency Committee on Psychotropic Medications and Foster children noted that MCOs' and the state's primary care clinician plan program's role in the prior-authorization process has not yet been determined, in particular whether these organizations will have to assume responsibility for assuring that psychiatrists in their network adhere to the state's prescribing and monitoring practices. We note that the committee has made progress on this important matter and has developed a proposed initiative that would require prior authorization on combinations of medications that have little or no evidence of safe and effective use in the very young as well as situations identified as polypharmacy. As a method for continuous quality assurance, improvement, and transparency, a multidisciplinary therapeutic class management (TCM) workgroup will be created to retrospectively review prior authorizations that do not meet set criteria and to serve as an expert group who can outreach to individual providers for purposes of clarifying missing information or for further clinical discussion.

Again, thank you for the opportunity to provide comments. Please feel free to contact my office if you have questions.

Sincerely,



Kristin L. Thorn  
Medicaid Director



Olga Roche  
Commissioner  
Department of Children and Families

cc: Scott Clayton, CFE, GAO  
Analyst, Forensic Audits & Investigative Service

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# Appendix VI: GAO Contact and Staff Acknowledgments

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## GAO Contact

Stephen M. Lord, (202) 512-6722 or [lords@gao.gov](mailto:lords@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, Matt Valenta, Assistant Director; Adam Anguiano; Erika Axelson; Scott Clayton; Marcus Corbin; Jennifer Costello; Dennis Fauber; Wilfred Holloway; Olivia Lopez; Flavio Martinez; Maria McMullen; Linda Miller; Sandra Moore; James Murphy; Joy Myers; Anna Maria Ortiz; April Van Cleef; Abby Volk; and Monique Williams made significant contributions to this work.

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## Congressional Relations

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## Public Affairs

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