AUG 24 2004

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

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: Dara Corrigan
Acting Principal Deputy Inspector General

SUBJECT: OIG Final Report: "Children's Use of Health Care Services While in Foster Care: North Dakota," OEI-07-00-00643

Attached is a final report that assesses whether sampled children in the North Dakota foster care program are receiving health care services that fulfill Federal and State requirements. We conducted this inspection in response to concerns about the health care that children in foster care are receiving. This report is one of a series of inspections that focus on children's use of health care services while in foster care in eight States: Georgia, Illinois, Kansas, New Jersey, New York, North Dakota, Oregon, and Texas.

We determined that all 50 of the children in our sample had Medicaid coverage and Medicaid claims for health care services. Thirty-five of the fifty sampled children received their most recent required Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) examination, and 30 of 38 sampled children required to receive EPSDT dental services had received their most recent EPSDT dental service. Some sampled children waited months after entering foster care to receive an initial comprehensive medical examination recommended by the State. We also found that mental health needs were not documented for 12 of the 34 sampled children who received mental health services as Federal law requires. Such documentation is important to ensure children receive appropriate and necessary services timely. Finally, Federal law and State policy require that foster care providers (i.e., foster parents or residential care facility staff) receive medical information about the child in their care, yet 9 of the 48 foster care providers interviewed reported never receiving this information.

We recommend that the Administration for Children and Families (ACF) work with the North Dakota Division of Children and Family Services to examine how initial comprehensive medical examinations for children entering foster care are being provided; ensure that case plans reflect required mental health needs; and promote the importance of caseworkers obtaining medical information for children in foster care and giving the

medical information to foster care providers, in accordance with Federal requirements. We recommend that the Centers for Medicare & Medicaid Services (CMS) work with the North Dakota Division of Medical Services to develop a method for notifying foster care providers of when required EPSDT services are due; and to increase the number of dental providers accepting Medicaid in North Dakota. We also recommend that ACF and CMS work with the North Dakota Department of Human Services to coordinate State agency efforts to educate caseworkers and foster care providers regarding the importance and availability of EPSDT medical examinations; to ensure caseworkers and foster care providers understand the difference between comprehensive EPSDT examinations and medical examinations for specific health conditions; and to educate caseworkers and foster care providers regarding State EPSDT frequency schedules for dental services.

In response to our recommendations, ACF noted that it is actively working with the North Dakota Division of Medical Services to promote the importance of obtaining medical histories and providing medical information to foster care providers and that these issues are being addressed in the Program Improvement Plan developed in response to a Child and Family Services Review. They also note that only 79 percent of the cases reviewed during the on-site portion of the Child and Family Services Review substantially achieved the outcome measure which determines if children receive adequate services to meet their physical and mental health needs. CMS generally concurred with our recommendations but clarified that they should be carried out by joint action of the North Dakota Divisions of Medical Services and Children and Family Services. CMS stated that their regional office staff is available to provide technical assistance to both Divisions, as appropriate.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me or your staff may contact Elise Stein, Director, Public Health and Human Services Branch, at (202) 619-2686 or through e-mail [Elise.Stein@oig.hhs.gov]. To facilitate identification, please refer to report number OEI-07-00-00643 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

Inspector General

AUGUST 2004
OEI-07-00-00643

Office of Inspector General

http://oig.hhs.gov

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ABSTRACT

In response to concerns about the health care children in foster care are receiving, we conducted a series of studies in eight States to assess whether sampled children in foster care are receiving health care services that fulfill Federal and State requirements. This study determined that all 50 sampled children in the North Dakota foster care program had Medicaid coverage and claims. Thirty-five sampled children received their most recent required Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) examinations and 30 of 38 children required to receive dental services had their most recent EPSDT dental service. We also found that some children waited months after entering foster care to receive a comprehensive medical examination recommended by the State. In addition, 9 of 48 foster care providers (i.e., foster parents or residential care facility staff) reported never receiving a medical history for the sampled child in their care, and mental health needs were undocumented in the case plans for 12 of the 34 sampled children receiving mental health services, both of which are required to meet Federal requirements.

We recommend that the Administration for Children and Families and the Centers for Medicare & Medicaid Services work with the North Dakota Department of Human Services to address shortcomings.

OBJECTIVE

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

BACKGROUND

Sections 472(h) and 1902(a)(10)(A)(i)(I) of the Social Security Act (the Act) require States to provide Medicaid or Medicaid-equivalent coverage to children eligible to receive Title IV-E funds. North Dakota is the focus of this inspection and is one of a series of eight States chosen to represent a diverse cross-section of foster care nationwide. All Title IV-E children in the North Dakota foster care program are eligible for Medicaid. Federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines require each State to make preventive health care services available to Medicaid-eligible individuals under the age of 21 and establish State guidelines regarding the intervals for providing EPSDT examinations that meet reasonable standards of medical and dental practice, as outlined in Sections 1902(a)(43) and 1905(r) of the Act.

This inspection is based on information gathered from multiple sources. We reviewed Federal and State policies; analyzed child-specific Medicaid claims data and case file documentation for 50 randomly sampled children in the North Dakota foster care program; interviewed foster care providers (i.e., foster parents or residential care facility staff), caseworkers responsible for children in our sample, State child welfare and medical services staff, Child Welfare Program Directors representing 4 Native American Nations, and other State agency officials. Our analysis focused on a 3-year Medicaid claims history for the period November 1, 1999 to November 1, 2002.

FINDINGS

All 50 sampled children had Medicaid coverage and claims for health care services.

Each of the 50 sampled children was enrolled in the Medicaid program, had a Medicaid card or number, and had at least 1 Medicaid claim during the period covered by our study.

Thirty-five of the fifty sampled children received their most recent EPSDT medical examination, within State-established frequency guidelines.

Overall, 35 sampled children received their most recent EPSDT medical examination, within State-established guidelines, based on their age and length of time in foster care. Six children who did not receive an EPSDT examination remained in compliance with the State guidelines based on their age or the date they entered foster care. However, eight children who should have received an EPSDT examination, did not. Some foster care providers stated that they did not believe EPSDT examinations were necessary because the child was receiving care for a specific condition. The only systematic notification foster care providers received regarding required EPSDT services was an annual letter from the Division of Medical Services reminding them that EPSDT services are available.

Thirty of thirty-eight sampled children required to receive an EPSDT dental examination received their most recent EPSDT dental examination, within State-estabished frequency guidelines.

The EPSDT frequency guidelines adopted by North Dakota require that all children over 3 years of age receive dental services every 6 months. Thirty-eight of the sampled children were over age 3 and, because they had been in foster care more than 6 months, were required to have received dental services. Thirty of these thirty-eight children received their most recent required dental service within State-established EPSDT frequency guidelines. Based on the State-established guidelines, the 38 children should have received at least 121 dental services. However, only 64 of these 121 dental services were received timely, and 57 were received outside the required timeframe or not received at all. Thirteen of the forty-nine caseworkers for children in our sample reported a severe shortage of dentists willing to treat Medicaid patients.

Some sampled children waited months after entering foster care to receive a comprehensive medical examination recommended by the State.

Federal law requires States to ensure that all children in foster care are provided quality services that protect their health. North Dakota's foster care policy recommends that children receive an initial medical examination upon entry into foster care. We found that some sampled children waited months before receiving an EPSDT medical

examination. While 31 of 38 sampled children who entered foster care during the period covered by our study received an EPSDT medical examination, they waited 2 to 435 days from entry before their health needs were comprehensively assessed. The lack of a specific requirement for an initial medical examination may have contributed to the remaining seven children who entered foster care during the study period not having received an EPSDT medical examination, despite having been in foster care between 106 and 715 days.

Mental health needs were not documented for 12 of 34 sampled children receiving mental health services, as required.

In meeting Federal requirements to ensure that children in foster care placements are provided quality services that protect their health, North Dakota requires that individual case plans for children in foster care include their mental health needs. Our case file and claims data review indicated that 34 of the 50 sampled children received mental health services during the period covered by our study. However, the need for mental health services was not documented in the case plans for 12 of these 34 children.

Nine of forty-eight foster care providers reported never receiving medical information for the sampled children in their care.

Federal law requires that the health records of children in foster care be reviewed, updated, and supplied to the foster care provider at the time of placement. Of the 48 foster care providers we interviewed, 9 reported never receiving medical information for the sampled children in their care. However, caseworkers for eight of these nine children reported receiving or compiling medical information on the sampled children.

RECOMMENDATIONS

The Administration for Children and Families (ACF) should work with the North Dakota Division of Children and Family Services to:

- Examine how initial comprehensive medical examinations for children entering foster care are being provided.
- Ensure case plans reflect mental health needs, as required.
- Promote the importance of caseworkers obtaining medical information for children in foster care, and supplying the foster care providers with the information, in accordance with Federal requirements.

The Centers for Medicare & Medicaid Services (CMS) should work with the North Dakota Division of Medical Services to:

- Develop a method for notifying foster care providers when required EPSDT services are due.
- Increase the number of dentists accepting Medicaid in North Dakota.

ACF and CMS should work with the North Dakota Department of Human Services to coordinate State agency efforts to:

- Educate caseworkers and foster care providers regarding the importance and availability of EPSDT medical examinations.
- Ensure caseworkers and foster care providers understand the difference between comprehensive EPSDT examinations and medical examinations for specific health conditions.
- Educate caseworkers and foster care providers on State EPSDT frequency guidelines for dental services.

AGENCY COMMENTS

ACF noted that it is working with the North Dakota Department of Human Services to promote the importance of obtaining medical histories and providing medical information to foster care providers and that these issues are being addressed in the Program Improvement Plan developed in response to a Child and Family Services Review. It also notes that only 79 percent of the cases reviewed during the on-site portion of the Child and Family Services Review substantially achieved the outcome measure which determines if children receive adequate services to meet their physical and mental health needs.

CMS generally concurred with our recommendations, but clarified that the recommendations should be carried out by joint action of the North Dakota Divisions of Medical Services and Children and Family Services. CMS stated that its regional office staff is available to provide technical assistance to both Divisions, as appropriate.

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INTRODUCTION

OBJECTIVE

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

BACKGROUND

There are an estimated 542,000 children in foster care nationwide,[1] many of whom are reportedly in poor health. To determine if children in foster care are receiving mandated health care services, we selected eight States for review.[2] The States were chosen to represent a diverse cross-section of foster care nationwide. North Dakota was chosen for its small population size, geographic location, rural setting, county-administered child welfare system, Native American population, and fee-for-service provision of Medicaid services. North Dakota had 1,129 children in foster care at the end of fiscal year (FY) 2000, based on the most recent Federal data available at the time of our study.[3] The Administration for Children and Families (ACF) has regulatory oversight of the Title IV-E foster care program, including approval of State plans to ensure State foster care programs are operating within Federal guidelines. Within the North Dakota Department of Human Services, the Division of Children and Family Services manages the Title IV-E foster care program.

Compared with other children from the same socioeconomic backgrounds, children in foster care suffer much higher rates of serious physical and psychological problems.[4] Vision, hearing, and dental problems are prevalent in the foster care population, and physical

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[1] Department of Health and Human Services, Administration for Children and Families, Adoption and Foster Care Analysis and Reporting System Report for the period ending September 30, 2001. Retrieved April 5, 2004 from http://www.acf.hhs.gov/programs/cb/publications/afcars/report8.htm.

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

[3] Department of Health and Human Services, Administration for Children and Families, Foster Care: Entries, Exits, and In Care on the Last Day. The 1,129 children in foster care include children in both the Title IV-E and non-Title IV-E foster care programs. Retrieved April 5, 2004 from http://www.acf.dhhs.gov/programs/cb/dis/tables/entryexit2002.htm.

[4] Casey Family Programs, National Center for Resource Family Support, Health Care Issues for Children in Foster Care, March 25, 2002. Retrieved October 17, 2002 from http://www.casey.org/cnc/documents/health care issues.pdf.

health problems (e.g., delayed growth and development, malnutrition, and asthma) affect 30 to 40 percent of children in the child welfare system.[5]

Children in foster care have greater health care needs, yet many foster care providers (we use the term "foster care provider" to refer to foster parents or residential care facility staff) reported having difficulty finding health care professionals who were willing to care for these children.[6] The health care available for children in foster care is often characterized by lack of access; lack of information sharing among health care professionals; and long delays in obtaining services.[7] Furthermore, studies have shown that low percentages of children in foster care are actually receiving services. Therefore, concern exists that children with the greatest health care needs may not be receiving needed services.

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is designed to screen for, diagnose, and treat medical conditions in Medicaid-eligible individuals under age 21 that might otherwise go undetected or untreated. However, a General Accountability Office report released in July 2001 states that available data from short range studies show that the percentage of children in the general population receiving EPSDT services is very low.[8]

Periodic dental care is also included as part of EPSDT, and must be performed by a dentist. North Dakota EPSDT dental examinations are required for every child in accordance with the frequency guidelines developed by the State. Dental frequency guidelines must be established by the State after consultation with recognized dental organizations involved in child health care.

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[5] Factsheet: The Health of Children in Out of Home Care. Child Welfare League of America. Retrieved October 17, 2002 from http://www.cwla.org/programs/health/healthcarecwfact.htm.

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

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

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

Medicaid for Children in Foster Care

All children in the North Dakota Title IV-E foster care program are eligible for Medicaid. Sections 472(h) and 1902(a)(10)(A)(i)(I) of the Social Security Act (the Act) require States to provide Medicaid or equivalent health insurance coverage to all children in foster care, including those eligible to receive Title IV-E foster care program maintenance funds. Federal EPSDT guidelines require each State to make comprehensive and preventive child health services available to Medicaid-eligible individuals under the age of 21, as outlined in Sections 1902(a)(43) and 1905(r) of the Act. Within a broad framework, each State establishes its own Medicaid eligibility standards; determines the type, amount, duration, and scope of Medicaid services; sets the rate of payment for services to Medicaid patients; and administers its own Medicaid program.[9]

In FY 2000, Medicaid payments for children in foster care nationwide totalled over $3.3 billion.[10] North Dakota Medicaid expenditures for this population totalled approximately $10.7 million in 2000.[11] The Centers for Medicare & Medicaid Services (CMS) is responsible for the Federal oversight of individual State Medicaid programs. Within the North Dakota Department of Human Services, the Division of Medical Services manages the State Medicaid program.

North Dakota Health Tracks

In accordance with Federal law, participation in the Medicaid program requires States to establish EPSDT services for all Medicaid-eligible individuals under 21 years of age.[12] State EPSDT programs must provide medical, hearing, vision, and dental screenings, and other necessary health care and treatment at intervals established by the State that meet reasonable standards of practice published by

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[9] Retrieved September 12, 2002 from http://cms.hhs.gov/medicaid/mover.htm and http://cms.hhs.gov/medicaid/eligibility/criteria.asp.

[10] Department of Health and Human Services, Medicaid Statistical Information System (MSIS) Report Fiscal Year 2000: All States. Retrieved August 6, 2003, from http://www.cms.gov/medicaid/msis/00nd.pdf.

[11] Department of Health and Human Services, Medicaid Statistical Information System (MSIS) Report Fiscal Year 2000: North Dakota. Retrieved April 5, 2004, from http://www.cms.gov/medicaid/msis/00nd.pdf.

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

recognized health care organizations. North Dakota has established the Health Tracks program to meet Federal EPSDT requirements.

The current frequency schedule established for the Health Tracks program requires a complete physical examination at 1, 2, 4, 6, 9, 12, 15, and 18 months of age; during each year that the child is 2, 3, 4, 5, 6, 8, and 10 years of age; and during each year of the child's life thereafter through the age of 21. The Health Tracks program does not require EPSDT services for children 7 and 9 years of age. Health Tracks program guidelines require that vision and hearing screenings be included as part of every EPSDT physical examination for all children over 6 years of age. Health Tracks also requires a complete dental examination every 6 months, separate from the medical examination, for all children over 3 years of age.

North Dakota requires State child welfare staff (e.g., eligibility specialists or caseworkers) to inform the guardians of all Medicaid-eligible children of the availability of health services and to document that such services were offered. Foster care providers are generally responsible for ensuring the children in their care receive these examinations. North Dakota recommends, but does not require, that children receive a medical examination upon entry into foster care in addition to the health care services provided in accordance with the Health Tracks frequency guidelines.[13]

While Section 1905(r)(1)(B)(i) of the Social Security Act requires that mental health development be included in EPSDT screenings, North Dakota imposes no specific requirements for mental health screenings or the provision of mental health services for children in foster care beyond requiring that legal custodians provide for the physical, mental, and moral welfare of the children in their custody.[14] Case plans are required to address clinically diagnosed disabling conditions.[15]

Section 471(a)(22) of the Act requires States to develop a State plan that includes standards to ensure that children in foster care placements in public and private agencies are provided quality services that protect

[13] North Dakota Department of Human Services (NDDHS), Service Chapter 623 05 05-60.

[14] NDDHS 624-05-05-11.

[15] NDDHS 624-05-05-20.

their safety and health. Sections 422(b)(10)(B)(ii) and 475(5)(D) of the Act require procedures to ensure that health records for children in foster care be reviewed, updated, and supplied to the foster care provider at the time of placement. According to Section 475(1)(C) of the Act, health records should include, to the extent available and accessible, the names and addresses of the child's health care professionals, a record of the child's immunizations, the child's known medical problems, the child's medications, and any other relevant health information concerning the child determined to be appropriate by the State agency.

To meet Federal requirements, North Dakota requires that a permanency plan (case plan) addressing each child's medical and mental health needs, and a record of the child's immunizations and known medical problems, be developed within 30 days of a child's entry into foster care. The case plans are required to be reviewed and updated quarterly and should include all available health records. The health information contained in the case plans is to be supplied to the foster care providers.[16]

METHODOLOGY

This inspection focused on the receipt of health care and dental services that meet EPSDT guidelines; the receipt of mental health services; and the provision of medical information to foster care providers. This study did not address follow-up care or the appropriateness of ongoing health care in meeting the needs of children in foster care. The inspection is based on information gathered from multiple sources: reviews of Federal and State policies; child-specific Medicaid claims data for 50 randomly sampled children; case file documentation for 49 of the 50 sampled children (case file information for 1 sampled child was not provided); interviews with caseworkers and foster care providers for the 49 sampled children for which case files were received; and interviews with North Dakota State agency and Native American Nation officials.

Reasons for State Selection

North Dakota was selected for its small population size, geographic location, rural setting, county-administered child welfare system,

[16] NDDHS 624-05-05-17.

Native American population, and fee-for-service provision of Medicaid services.

Sample

Children who met the following criteria were included in the study population: (1) were in foster care on January 22, 2003; (2) resided in North Dakota; (3) were eligible for Title IV-E foster care program maintenance funds; and (4) had been in continuous out-of-home foster care placements for at least 6 months. The Division of Children and Family Services provided us with a list of the 381 children who met these criteria. We selected a simple random sample of 50 children from this list. Appendices A, B, and C provide information on the children included in our study, and the services they received.

Review of Policies, Medicaid Data, and Case File Documentation

Policy Review -- We reviewed Federal and State foster care, Medicaid, and EPSDT program policies. The North Dakota Health Tracks program meets Federal EPSDT requirements. Therefore, we used Health Tracks guidelines to determine whether children in foster care were receiving required EPSDT medical and dental services timely.

Medicaid Claims Data Review -- The Division of Medical Services provided us with up to 3 years of Medicaid claims data for each of the children in our sample. The data included Medicaid claims for physician, dental, pharmaceutical, and mental health services paid between November 1, 1999 and November 1, 2002, the most recent 3-year period for which claims data was available. We paid particular attention to the types of services provided and service dates. We included only those Medicaid claims for services provided after the child's most recent entry into foster care. For sampled children entering foster care on or after November 1, 1999, we analyzed Medicaid claims data from the date they entered foster care through November 1, 2002. All Medicaid services provided to sampled children were included in our analysis. However, sampled children who had been in foster care less than 6 months during our claims window were not considered out of compliance if they had not received the EPSDT service. Appendix B provides information regarding the Medicaid services each sampled child received.

Case File Documentation -- We requested case file documentation from the Division of Children and Family Services local offices for all of the children in our sample, including documentation of medical, dental, and mental health services provided, the child's medical history, the child's

initial and most recent case plan, duration of the child's stay in foster care, and information regarding the child's health and general well-being. We received and reviewed information for 49 children; despite repeated requests, we were not provided with the documentation for 1 child.

We also received and reviewed caseworker or residential treatment center notes for some of the sampled children indicating that the children had been referred for or scheduled to receive medical, dental, or mental health services or that they had actually received the services. However, in the absence of a Medicaid claim or other supporting documentation (e.g., an EPSDT form signed by a physician or other health care professional), we were unable to include the noted services in our analysis.

Interviews

Foster Care Provider Interviews -- We conducted structured interviews with 48 of the foster care providers (i.e., foster parents or residential care facility staff) responsible for the children in our sample (8 in person and 40 by telephone) between April 15, 2003 and May 29, 2003. We were unable to interview two foster care providers because we were unable to obtain the case file containing contact information for one sampled child and the caseworker failed to provide the foster parent contact information for another child within the timeframe of our study. The interviews with foster care providers focused on the Medicaid program and the services available, the training they received related to the health and well-being of children, and their experiences procuring health care services for the children in our sample.

Caseworker Interviews -- We conducted structured telephone interviews with 49 of the caseworkers assigned to the children in our sample between March 27, 2003 and May 22, 2003. We did not receive the case file for one child and therefore lacked the information needed to contact the caseworker. Each of these interviews focused on the caseworker's understanding of the Medicaid program and the services available, the training they received related to the health and well-being of children, their experiences accessing health care services, and any barriers to obtaining needed health care. Each caseworker spoke specifically about the sampled child's case, and generally about his or her own experiences working in foster care. We analyzed the caseworkers' responses and compared them to those of the foster care providers, noting any consensus or disagreement within and between the two groups.

State Agency and Native American Nation Officials -- To enhance our understanding of the State's foster care and Medicaid programs, we consulted, both in person and by telephone, with State staff and Child Welfare Program Directors for the Spirit Lake Sioux, Standing Rock Sioux, Three Affiliated Tribes, and Turtle Mountain Chippewa Nations.

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

FINDINGS

All 50 sampled children had Medicaid coverage and claims for health care services.

Federal law requires that all children eligible for the Title IV-E foster care program be provided Medicaid or Medicaid-equivalent services.[17] In North Dakota, all children in foster care are eligible for Medicaid, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.[18] Each of the 50 sampled children had Medicaid coverage and at least 1 Medicaid claim for health care services during the 3-year period covered by our study. Table 1 details the various types of Medicaid-covered services and the number of claims by type of service provided for the 50 sampled children.

Table 1: Number and Type of Medicaid Claims for 50 Sampled Children

Claim Type	Number of Children with at Least One Claim	Total Number of Claims
Physician Office	46	407
Prescription Drug	45	1001
Laboratory	30	139
Dental	33	346
Hospital/ASC*	30	443
Optometry/Audiology	30	157
Mental Health	34	617
Diagnostic	9	27
Physical/Occupational Therapy	8	133
Supplies	18	227
Transportation	13	60
Early Intervention**	2	21
Case Management***	22	449
Medication Review	15	94
Total		4121

* Ambulatory Surgical Center which includes emergency room visits.

** Includes respite care, speech and language, nursing, nutritional, and developmental services.

Source: Office of Evaluation and Inspections, analysis of North Dakota Medicaid claims data 2003.

***Includes 41 Medicaid claims for Targeted Case Management. The remaining Case Management claims are for child protective services and residential care services case management.

A detailed list of selected services for each of the 50 sampled children is located in Appendix B.

[17] Section 1902(a)(43) of the Social Security Act.

[18] NDDHS 623-05-05-63.

Thirty-five of fifty sampled children received their most recent EPSDT medical examination, within State-established frequency guidelines.

EPSDT medical examinations are intended to screen for and identify health care needs that may not be detected during a medical examination for a specific condition. All age-appropriate EPSDT examinations must be completed in accordance with the State-established EPSDT frequency guidelines. Overall, 35 sampled children received their most recent EPSDT medical examination, within State-established guidelines. Six sampled children had been in foster care less than the time period specified by the State frequency guidelines for their age group and were not required to receive EPSDT services during the period covered by our study. However, based on their age and length of time in foster care, and the State EPSDT frequency guidelines, eight children who should have received an EPSDT medical examination did not.

Based on their age and the length of time they were in foster care, 25 of the 50 sampled children were required to receive at least 1 EPSDT medical examination during the period covered by our review. Collectively, these 25 children were required to receive 49 EPSDT examinations. However, only 30 of these 49 required examinations were received.

Caseworkers or foster care providers for sampled children indicated that some EPSDT examinations were not performed because they believed them to be unnecessary. Some reported that the children were receiving routine medical care through their primary care physicians or the residential treatment centers in which some children were placed. Other caseworkers and foster care providers reported the children had recently been treated for a specific health care problem. Some children missed required EPSDT screenings because their caseworkers or foster care providers believed no services were necessary during the required times.

The lack of systematic reminders also may be critical in explaining why children did not receive required EPSDT examinations. In accordance with State foster care policy, all children entering foster care must be made aware of Health Tracks services. However, no systematic or standardized monitoring is done to ensure children actually receive the required Health Tracks services. Further, foster care providers are not systematically notified of services that are due or lacking. The only notification foster care providers received regarding EPSDT services was an annual letter from the Division of Medical Services reminding them that EPSDT services are available.

Thirty of thirty-eight sampled children required to receive an EPSDT dental examination received their most recent EPSDT dental examination, within State-established frequency guidelines.

The EPSDT frequency guidelines adopted by North Dakota require that all children over 3 years of age receive dental services at least every 6 months. Thirty-eight of the sampled children had been in foster care at least 6 months during the period covered by our study. Thirty of these thirty-eight children received their most recent required dental service in accordance with the State-established EPSDT frequency guidelines.[19] Two of the thirty-eight children had received a dental service at some time since entering foster care but did not receive their most recent service in accordance with the State-established frequency guidelines. Six children had received no EPSDT dental services. Overall, the 38 children should have received at least 121 dental services to meet the State-established EPSDT guidelines. Sixty-four of these one hundred twenty-one services were received timely, and 57 were received outside the required timeframe or not received at all.

EPSDT dental services were not required during our study period for the remaining 11 sampled children. Six of these eleven children were under age 3 at the end of the claims window and not required to receive EPSDT dental services based on the frequency guideline. Five of the eleven were in foster care less than 6 months during the period covered by our Medicaid claims (i.e., the child entered foster care between May 1, 2002 and July 22, 2002).

There are a variety of reasons children in foster care may not have received required EPSDT dental services. Twenty-one of the forty-nine caseworkers and 23 of the 48 foster care providers were unfamiliar with the EPSDT program or unaware of the dental frequency guidelines. Thirteen of the forty-nine caseworkers interviewed reported a severe shortage of dentists willing to treat Medicaid patients, which may contribute to foster care providers' difficulty in accessing dental services. In addition, 31 caseworkers and 18 foster care providers reported that dentists willing to treat Medicaid patients had long waiting lists for appointments and that many dentists were not accepting new Medicaid patients.

[19] Recent dental services include dental services provided during the last 6 months of our Medicaid claims data or services provided in the last 6-month period based on the State EPSDT frequency guidelines.

Some sampled children waited months after entering foster care to receive the comprehensive medical examination recommended by the State.

Section 471(a)(22) of the Act requires that States ensure all children in foster care are provided quality services that protect their health.

North Dakota State foster care policy recommends that children receive an initial medical examination upon entry into foster care.[20] We found that some children wait months before their health needs are comprehensively assessed. Thirty-eight sampled children entered foster care during the period covered by our Medicaid claims (November 1, 1999 to November 1, 2002). Thirty-one of these children received an EPSDT examination, which we used as evidence of receipt of a comprehensive medical examination, with at least two children waiting over 430 days to receive their first examination (see Table 2).

Table 2: Days to First Comprehensive EPSDT Medical Examination

Age	Number of Children in Age Group	Days to First Comprehensive Medical Exam (Range)	Days to First Comprehensive Medical Exam (Median)
0 - 6 months	3	2 - 117	27
7 - 23 months	1	127	127
2 - 5 years	8	22 - 431	67.5
6 - 9 years	7	6 - 435	118
10 - 21 years	12	10 - 203	113
Total	31	2 - 435	109

Source: Office of Evaluation and Inspections, analysis of Medicaid claims data and case file documentation.

Initial medical examinations being recommended versus required may have contributed to the remaining seven children who entered foster care during the study period not having received an EPSDT medical examination, despite having been in foster care between 106 and 715 days (see Table 3).

[20] NDDHS 623-05-05-63.

Table 3: Days in Foster Care Without a Comprehensive EPSDT Medical Exam			
Age	Number of Children in Age Group	Days Without Comprehensive Medical Exam (Range)	Days Without Comprehensive Medical Exam (Median)
0 - 6 months	0	0	0
7 - 23 months	0	0	0
2 - 5 years	1	113	113
6 - 9 years	2	155 - 444	299
10 - 21 years	4	106 - 715	208
Total	7	106 - 715	193

Source: Office of Evaluation and Inspections, analysis of Medicaid claims data and case file documentation.

Mental health needs were not documented for 12 of 34 sampled children receiving mental health services, as required.

Section 475(1)(B) of the Act requires that a case plan be developed for each child that enters foster care, and that the plan ensures that services address the child's needs, including mental health, while the child is in foster care. North Dakota requires that individual case plans for children in foster care include their mental health needs.[21] Further, case plans must address clinically diagnosed disabling conditions (e.g., attention deficit or hyperactive disorders, conduct disorders, emotional disturbances, and mental retardation).[22] Each child in foster care is to be provided with needed mental health services identified in his/her case plan.

Thirty-four of the fifty sampled children received at least one mental health service during the time period covered by our review. The receipt of mental health services were documented by Medicaid claims for 33 of the sampled children and by case file documentation for 1 child. However, the need for mental health services was not documented in the case plans for 12 of the 34 sampled children who received mental health services. A lack of documentation in the case

[21] NDDHS 624-05-05-20.

[22] NDDHS 624-05-05-20.

plans could result in children not continuing to receive services. If the child is placed with another foster care provider or assigned a new caseworker unaware of his/her mental health needs, services may not be continued without documentation.

Nine of the forty-eight foster care providers reported never receiving medical information for the children in their care.

Section 475(5)(D) of the Act requires the health records of children in foster care be reviewed, updated, and supplied to the foster care provider with whom the child is placed at the time of each placement in foster care. North Dakota requires that the health information contained in the case plans be supplied to foster care providers.[23] However, of the 48 foster care providers we interviewed, 9 reported never receiving medical information for the sampled children in their care. Caseworkers for eight of the nine children placed with these foster care providers indicated they had compiled or received some medical information for the sampled children. This indicates a problem in the communication of medical information from caseworkers to foster care providers.

Some of the foster care providers who did not receive medical information when the child was placed with them were unaware that they should have it or could ask for it. While we do not know why medical information contained in these case files was not given to the foster care providers, failure to provide available medical information to foster care providers could result in children's medical needs not being met.

[23] NDDHS 624-05-05-17.

RECOMMENDATIONS

States are required to ensure that all children in foster care are provided quality health care services that protect their health. The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is intended to detect various health needs. However, if children do not receive the required services or do not receive those services timely, their health needs may go undetected and untreated.

The Administration for Children and Families (ACF) should work with the North Dakota Division of Children and Family Services to:

- Examine how initial comprehensive medical examinations for children entering foster care are provided.
- Ensure case plans reflect mental health needs, as required.
- Promote the importance of caseworkers obtaining medical information for children in foster care and supplying foster care providers with the information, in accordance with Federal requirements.

The Centers for Medicare & Medicaid Services (CMS) should work with the North Dakota Division of Medical Services to:

- Develop a method for notifying foster care providers of when required EPSDT services are due.
- Increase the number of dental providers accepting Medicaid in North Dakota.

ACF and CMS should work with the North Dakota Department of Human Services to coordinate State agency efforts to:

- Educate caseworkers and foster care providers regarding the importance and availability of EPSDT medical examinations.
- Ensure caseworkers and foster care providers understand the difference between comprehensive EPSDT examinations and medical examinations for specific health conditions.
- Educate caseworkers and foster care providers on State EPSDT frequency guidelines for dental services.

AGENCY COMMENTS

ACF noted that it is working with the Department of Human Services to promote the importance of obtaining medical histories and providing medical information to foster care providers and that these issues are being addressed in the Program Improvement Plan developed in response to a Child and Family Services Review. They also note that only 79 percent of the cases reviewed during the on-site portion of the Child and Family Services Review substantially achieved the outcome measure which determines if children receive adequate services to meet their physical and mental health needs.

CMS generally concurred with our recommendations but clarified that the recommendations should be carried out by joint action of the North Dakota Divisions of Medical Services and Children and Family Services. CMS stated that its regional office staff is available to provide technical assistance to both Divisions, as appropriate.

APPENDIX ~ A

Demographic Characteristics of Sampled Children

The table below provides the demographic characteristics of each of the 50 sampled children and his or her foster care placement history as of May 2003.

ID	Sex	Age	Placement Setting	Entries into Foster Care (1)	Months Since Foster Care Entry (2)	Placements Since Last Entry (3)	Months Since Last Placement (4)	Caseworkers Since Last Entry (5)	Months Caseworker With Case (6)
1	F	17	Therapeutic	1	15	2	4	1	18
2	M	17	Residential	2	89	29	6	4	43
3	F	17	Residential	2	14	2	10	4	14
4	M	16	Therapeutic	1	10	2	4	1	13
5	M	15	Kinship	3	26	10	12	4	6
6	M	15	Residential	2	12	2	8	1	12
7	M	15	Residential	*	42	1	42	2	24
8	F	15	Residential	1	28	2	9	*	8
9	F	13	Family	1	9	1	9	1	10
10	M	14	Family	13	52	15	14	2	14
11	M	12	Therapeutic	1	29	6	3	2	14
12	M	12	Therapeutic	1	54	6	11	2	5
13	F	12	Kinship	2	52	4	4	1	48
14	F	14	Residential	5	67	7	15	6	24
15	F	12	Family	2	17	2	11	1	17
16	M	11	Family	1	29	2	25	2	9
17	F	11	Family	1	20	1	20	1	20
18	F	10	Therapeutic	1	92	1	92	2	120
19	F	12	Family	1	62	1	62	*	18
20	M	11	Family	3	26	12	6	4	6
21	M	10	Family	1	92	4	9	4	70
22	M	9	Family	2	20	1	20	1	20
23	M	8	Family	1	12	2	10	1	20
24	M	8	Family	1	22	2	17	3	90
25	F	11	Family	2	9	1	9	1	61
26	F	10	Family	1	26	4	18	2	8
27	F	7	Unknown	1	13	2	5	2	2
28	F	6	Kinship	1	35	3	17	3	21
29	M	12	Family	1	21	2	4	1	22
30	F	17	Residential	4	15	3	11	2	13
31	M	6	Family	1	14	3	13	1	14
32	F	5	Family	*	35	*	24	2	24
33	M	5	Family	2	21	2	12	1	21
34	F	5	Family	1	57	4	45	2	42
35	M	16	Residential	2	18	4	6	3	7
36	F	4	Family	1	21	2	4	1	21
37	F	4	Family	2	9	1	9	1	9
38	M	3	Family	1	29	2	13	2	6
39	F	3	Family	2	12	1	12	2	9

ID	Sex	Age	Placement Setting	Entries Into Foster Care (1)	Months Since Foster Care Entry (2)	Placements Since Last Entry (3)	Months Since Last Placement (4)	Caseworkers Since Last Entry (5)	Months Caseworker With Case (6)
40	M	3	Family	2	11	4	5	1	11
41	F	5	Kinship	1	22	1	22	1	22
42	M	10	Family	4	11	2	4	1	11
43	F	2	Family	1	25	2	7	2	18
44	F	1	Family	1	19	1	19	1	19
45	M	1	Family	1	14	1	14	1	14
46	F	17	Family	1	90	16	8	5	6
47	M	17	Therapeutic	1	12	1	12	1	16
48	F	16	Residential	1	22	3	9	2	24
49	F	15	Family	2	46	6	16	2	16
50*									

KEY

(1) Entries into Foster Care -- number of times a child has entered State custody.

(2) Months Since Foster Care Entry -- length of time from the date of the child's most recent entry into foster care until May 2003, when interviews were conducted with caseworkers and foster care providers, or the date the child left care if that date precedes May 2003.

(3) Placements Since Last Entry -- number of placements, in all settings (e.g., Foster Home, Residential Care Facility), the child experienced during his/her most recent entry into foster care.

(4) Months Since Last Placement -- length of time from the dae of the most recent placement to the date the foster care provider was interviewed.

(5) Caseworkers Since Last Entry -- number of caseworkers assigned responsibility for the child since his/her last entry into foster care, including family caseworkers and child-specific caseworkers.

(6) Months Caseworker With Case – number of months the most recent caseworker had been assigned responsibility for the child, which may be larger than the number of "Months Since Foster Care Entry," because some caseworkers were working with the child before the child officially entered foster care (e.g., through the juvenile justice system, family preservation services).

(*) Unknown.

APPENDIX ~ B

Medicaid Claims for Sampled Children

The table below indicates each of the 50 sampled children's paid Medicaid claims for physician and office visits, dental services, prescription medications, and mental health services while they were in foster care from November 1, 1999 to November 1, 2002.

Number of Medicaid Claims*				
OIG ID	EPSDT and Physician's Office Visits	Dental Services	Prescription Medications	Mental Health Services
1	5	11	4	0
2	5	3	50	64
3	2	1	11	3
4	0	0	4	0
5	5	19	4	1
6	2	0	2	1
7	3	4	0	22
8	5	11	6	8
9	1	4	4	4
10	11	25	2	38
11	4	9	19	3
12	12	28	142	88
13	21	12	7	25
14	9	11	62	51
15	1	9	11	15
16	7	15	44	24
17	7	0	2	6
18	12	15	185	0
19	2	7	2	0
20	10	11	18	28
21	1	0	3	4
22	4	6	4	21
23	7	4	9	2
24	3	0	2	0
25	0	0	3	5
26	8	11	11	44
27	1	0	0	0
28	14	14	8	0
29	0	10	0	11
30	7	0	4	10
31	7	9	1	7
32	2	13	2	0
33	8	3	3	0
34	19	0	57	0
35	5	8	25	20

Number of Medicaid Claims*				
OIG ID	EPSDT and Physician's Office Visits	Dental Services	Prescription Medications	Mental Health Services
36	8	15	3	8
37	2	0	0	1
38	3	0	0	0
39	3	0	1	0
40	3	0	2	3
41	3	6	1	0
42	0	0	13	5
43	52	0	24	0
44	36	0	10	0
45	24	0	5	0
46	5	8	14	3
47	3	4	38	6
48	18	8	47	20
49	26	12	30	46
50	11	20	102	20
Total	**407**	**346**	**1001**	**617**

KEY

* The Number of Medicaid Claims includes only services for which a Medicaid claim was paid. Services documented in the case file for which no Medicaid claims were paid are not included.

APPENDIX ~ C

EPSDT Services for Sampled Children

The table below reflects EPSDT services received by each of the 50 sampled children from November 1, 1999 to November 1, 2002 or from entry into care to November 1, 2002, whichever is shorter.

OIG ID	Medical History in Casefile (1)	Case Plan Completed in 30 Days (2)	Days Since Foster Care Entry (3)	Days to First Service (4)		Services Current (5)	
				EPSDT Medical	Dental	EPSDT Medical	Dental
1	N	Y	441	10	23	B	A
2	Y	N	2658	199	65	A	C
3	N	N	407	23	128	B	A
4	N	Y	295	56	X	B	D
5	Y	Y	776	117	112	A	A
6	Y	Y	347	X	36	D	A
7	N	Y	1265	156	152	A	C
8	N	N	853	203	128	A	C
9	Y	Y	272	48	92	B	B
10	N	Y	1571	261	322	A	A
11	Y	Y	862	X	607	C	A
12	Y	Y	1634	267	177	A	A
13	N	Y	1549	500	393	A	A
14	Y	Y	2017	196	169	C	A
15	N	N	504	182	105	B	A
16	N	Y	874	21	250	A	A
17	N	Y	602	X	X	D	C
18	N	N	2746	X	191	C	A
19	N	N	1863	329	337	A	A
20	Y	Y	776	118	112	B	A
21	N	N	2755	X	X	C	C
22	N	Y	610	435	69	A	A
23	Y	Y	360	150	13	B	A
24	N	Y	654	288	X	B	C
25	Y	Y	264	X	X	D	D
26	N	Y	766	6	115	A	A
27	N	Y	383	109	X	B	C
28	Y	Y	1060	134	134	B	A
29	N	Y	626	167	164	B	A
30	N	N	436	109	X	B	C
31	Y	Y	427	41	55	B	A
32	N	Y	1037	61	257	A	C
33	N	Y	644	431	317	A	A
34	Y	Y	1707	378	X	C	C
35	N	N	549	148	79	B	A
36	Y	Y	615	22	40	B	A
37	N	N	279	X	X	D	D
38	Y	Y	868	127	X	A	D
39	Y	Y	369	66	66	B	B
40	N	Y	334	69	X	B	D

A P P E N D I X ~ C

OIG ID	Medical History in Casefile (1)	Case Plan Completed in 30 Days (2)	Days Since Foster Care Entry (3)	Days to First Service (4)		Services Current (5)	
				EPSDT Medical	Dental	EPSDT Medical	Dental
41	Y	Y	653	429	478	B	A
42	Y	Y	319	X	103	D	B
43	Y	N	740	117	X	C	D
44	N	Y	558	2	X	C	D
45	N	Y	418	27	X	C	D
46	Y	Y	2687	1044	33	A	A
47	N	Y	370	X	158	D	A
48	N	Y	661	57	45	A	A
49	Y	Y	1369	532	178	A	C
50*							

KEY

(1) Medical History in Casefile -- casefile documentation provided by the caseworker included a medical history.

(2) Case Plan Completed in 30 Days -- case plan was completed within 30 days
Y -- case plan completed within 30 days.
N -- case plan not completed within 30 days.

(3) Days Since Foster Care Entry -- number of days the sampled child had been in foster care at the time the foster care provider was interviewed.

(4) Days to First Service:
A number indicates the number of days between November 1, 1999 (the beginning date for Medicaid claims included in our study) or the date the child entered foster care (if the child entered foster care after November 1, 1999) and the date the child received his/her first EPSDT medical or dental service.
X -- child did not receive this type of service within the period covered by our review.

(5) Services Current:
A - The most recent required service was received.
B - One or more services were received, but had they not been provided the child would not have been out of compliance based on age or length of time in foster care.
C - A recent required service was not received.
D - No services were received. but none were required during our claims window (i.e., the length of time the child had been in foster care and the period covered by our claims window did not extend the full length of time covered by the EPSDT frequency guideline for the child's age, or the child was under 3 years of age and not required to receive dental services).

*Unknown.

APPENDIX ~ D

Agency Comments - ACF

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

MAR 22 2004

TO: Dara Corrigan
Acting Principal Deputy Inspector General

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

SUBJECT: Comments on the Office of Inspector General (OIG) Draft Report: "Children's Use of Health Care Services While in Foster Care: North Dakota," OEI-07-00-00643

Attached are the Administration for Children and Families' comments on the above-referenced OIG draft report.

Should you have questions or need additional information, please contact Dr. Susan Orr, Associate Commissioner, Children's Bureau at (202) 205-8618.

Attachment

COMMENTS OF THE ADMINISTRATION FOR CHILDREN AND FAMILIES ON THE OFFICE OF INSPECTOR GENERAL'S (OIG) DRAFT REPORT: "CHILDREN'S USE OF HEALTH CARE SERVICES WHILE IN FOSTER CARE: NORTH DAKOTA," OEI-07-00-00643

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

OIG Recommendations: (directed to ACF)

OIG recommends that the:

ACF work with the North Dakota Division of Children and Family Services to:

- Examine how initial comprehensive medical examinations for children entering foster care are being provided.
- As required, ensure case plans reflect mental health needs.
- Promote the importance of caseworkers obtaining medical information for children in foster care, and providing the information to foster care providers, in accordance with Federal requirements.

OIG also recommends that:

ACF and the Centers for Medicare & Medicaid Services (CMS) work with the North Dakota Department of Human Services to coordinate State agency efforts to:

- Educate caseworkers and foster care providers regarding the importance and availability of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) medical examinations.
- Ensure caseworkers and foster care providers understand the difference between comprehensive EPSDT examinations and medical examinations for specific health conditions.
- Educate caseworkers and foster care providers on frequency schedules for dental EPSDT services.

ACF Comments

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

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

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

The second phase of the process involved an on-site review the week of September 24, 2001. The purpose of the on-site review included an examination of a sample of 50 cases for outcome achievement and interviews with community stakeholders to evaluate the systemic factors under review. The cases reviewed examined child-specific performance indicators. Through a combination of aggregate data reported on the statewide assessment and case-specific information gathered on-site, the review team was able to evaluate outcome achievement within programs and to identify areas where technical assistance is needed to make improvements.

During the on-site portion of the North Dakota review, only 79 percent of the cases reviewed to measure whether or not "children receive adequate services to meet their physical and mental health needs" substantially achieved this outcome. While there were a number of strengths identified related to the provision of health and mental health services, North Dakota did not achieve substantial conformity.

There were challenges identified related to health and mental health services during the 2001 CFSR in North Dakota. They included:

- Stakeholders stated that there are an adequate number of pediatricians and physicians to meet the physical health needs of children, but that there are only a few dentists who will accept Medicaid. This results in dental care being a frequent unmet need for foster children.

- Stakeholders stated that there is a lack of placement options for children with serious mental health service needs.

- In some of the cases that were reviewed, there was a lack of mental health assessments as well as services.

In November 2003, the ACF regional office and the state entered into a PIP to address areas of non-conformity with Federal requirements found during the North Dakota review. The PIP has specific action steps and benchmarks related to gathering medical information and providing it to foster families. The ACF regional office is monitoring the progress on the plan quarterly.

APPENDIX ~ E

Agency Comments - CMS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAY 28 2004

TO: Dara Corrigan
Acting Principal Deputy Inspector General

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

SUBJECT: Office of Inspector General (OIG) Draft Report: *Children's Use of Health Care Services While in Foster Care: North Dakota* (OEI-07-00-00643)

Thank you for the opportunity to review and comment on the above-referenced draft report. This report is one of a series of eight inspections that focus on children's use of health care services while in foster care. The Centers for Medicare & Medicaid Services (CMS) appreciates the effort that went into this report and the opportunity to review and comment on the issues it raises. We look forward to working with OIG on this and other issues pertinent to Medicaid health care services, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Our response to the audit recommendations follows.

OIG Recommendation
The CMS should work with the North Dakota Division of Medical Services to: 1) develop a method for notifying foster care providers of when required EPSDT services are due and 2) increase the number of dental providers accepting Medicaid in North Dakota.

CMS Response
We concur, in part, with this recommendation. CMS believes that the North Dakota Division of Medical Services should work more closely with the North Dakota Division of Children and Family Services, the part of the agency responsible for overseeing foster care in the state. The Medicaid agency should provide the foster care agency with the required state-specific periodicity schedule for the provision of EPSDT services and assist in notifying foster care providers, if necessary. The State Medicaid agency should also, if possible, provide the foster care agency with up-to-date lists of dental providers that accept Medicaid beneficiaries and ensure that there are an adequate number of dental providers for the Medicaid population.

OIG Recommendation
The Administration for Children and Families and CMS should work with the North Dakota Department of Human Services to coordinate state agency efforts to: 1) educate caseworkers and foster care providers regarding the importance and availability of EPSDT medical examinations; 2) ensure caseworkers and foster care providers understand the difference between comprehensive EPSDT examinations and medical examinations for specific health conditions; and 3) educate caseworkers and foster care providers on frequency schedules for dental EPSDT services.

Page 2 – Dara Corrigan

CMS Response

We concur, in part, with this recommendation. The Division of Medical Services and the Division of Children and Family Services both reside in the North Dakota Department of Human Services. The two divisions should work more closely to ensure that State foster care staff is educated on the appropriate provision of EPSDT services, including the State periodicity schedules for health screenings and dental services and the availability of medical services outside of the periodicity schedule. In turn, the Division of Children and Family Services will be better able to provide this information to caseworkers and foster care providers. CMS, through its regional office staff, is available to provide technical assistance to both agencies as appropriate.

ACKNOWLEDGMENTS

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

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