Monitoring the Quality of Health Care Provided to Children in Foster Care

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STATE INSTITUTE ON IMPROVING HEALTH CARE FOR CHILDREN IN FOSTER CARE

by

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This paper is part of a larger National Academy for State Health Policy effort funded by the Cummings Foundation, the “State Institute on Improving Health Care for Children in Foster Care.” This project is a three-year effort (1996-1999) among five states to improve coordination and delivery of health care for a group of very vulnerable Medicaid beneficiaries — children in foster care. The project involves interagency collaboration and teamwork between Medicaid and Child Welfare services at the state level within each state. The five states participating in the Cummings Institute are Alaska, California, Massachusetts, Texas, and Utah.

These states established goals and specific projects to accomplish during the grant period. There is both diversity and commonality in what each state intends to accomplish. For example, all of the states decided to improve or implement a medical service record, one that resides with foster parents and the state or local government and that is accessible to caregivers regardless of changes in foster home placement or health care providers. All of the states are thinking through the opportunities and challenges posed by enrolling these children in risk-based Medicaid managed care. Four of the states intend to develop standards of care for these children, and three others are focusing on improving the level of understanding among foster parents and case workers about the importance of health and mental health care for children in foster care.

Through the Institute, state interagency teams access the advice and expertise of leaders in foster care and health care. Work done for the Institute by the National Academy for State Health Policy and by project consultants will be made available to other states as the project progresses.

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EXECUTIVE SUMMARY

As states continue to expand managed care to serve people with complex needs, the number of children in foster care served by Medicaid managed care continues to grow. By 1996, nearly half of the states (22 in all) had enrolled children in foster care into risk-based Medicaid managed care; 17 of these states required at least some of these children to enroll with a managed care plan. (The Balanced Budget Act of 1997 identified children in foster care as one of the few remaining groups for which Medicaid agencies must obtain a waiver before implementing mandatory enrollment into managed care.)

Most Medicaid agencies enrolling beneficiaries into Medicaid managed care have “quality oversight” systems. Designed to measure, improve, and assure health-plan compliance with state standards, these systems monitor a plan’s service delivery to the general Medicaid population. Unfortunately, these existing systems may not adequately address the needs of children in out-of-home placement, many of whom have complex health issues and all of whom—as foster children—have very specific needs.

Among those needs and issues are the following:

- Placement changes
- Confidentiality
- Need for outreach and education
- Screening and treatment standards
- Specialty providers
- Coordination of care
- Child welfare medical record
- Medicaid eligibility

In addition, state Medicaid agencies share with state child welfare agencies the responsibility and accountability for the health care provided to children in foster care. Few Medicaid primary care case management programs or child welfare agencies have fully-developed quality oversight systems in place to monitor the quality of service and care they provide to children in foster care. Both could benefit from the numerous resources and techniques used to oversee quality in Medicaid managed care.

The roles of state Medicaid and child welfare agencies

A major challenge for states seeking to assure quality care for foster children is integrating the roles of these two agencies and taking advantage of the expertise of both. Each of these agencies has resources, information, and expertise which, in combination, can strengthen the capacity of the state to monitor and improve the quality of care provided these children. In the absence of such collaboration, however, the independent roles of both agencies can undermine the effectiveness of quality oversight efforts.

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There are a number of complimentary roles that these two agencies can play in the design and implementation of quality oversight systems for children in foster care. They include education and outreach, assessment of network adequacy, and data exchange.

**Quality oversight for children in foster care**

Typically, quality oversight systems include five major components. In order to ensure quality care and address the very specific and complex needs of children in foster care, state Medicaid and Child Welfare professionals concerned with quality oversight may want to consider modifying their existing system or establishing an entirely new one. The components they will need to address include:

- Establishment of clear goals and standards
- Establishment of mechanisms to measure performance
- Establishment of mechanisms to improve performance
- Enforcement of compliance
- Assessment of the effectiveness of the Quality Oversight System

Those agencies that elect to establish a quality system will need to identify their health care goals for this population, how they can measure progress toward those goals, and how they will use this information to produce an improvement in the care delivered to children in foster care. The two agencies may find that a joint process is most effective. Each agency has its own role and experience in the delivery of health care to this population, and a joint process can take advantage of both agencies' knowledge and sources of information. In addition, a joint process could create an opportunity for dialogue between agencies, leading to greater understanding of each agency's role and the critical issues in delivering quality care to children in foster care.
INTRODUCTION

As states continue to expand managed care to serve people with complex needs, the number of children in foster care served by Medicaid managed care continues to grow. In fact, by 1996 nearly half of the states (22 in all) had enrolled children in foster care into risk-based Medicaid managed care; 17 of those states required at least some of these children to enroll with a managed care plan.

As more children with unique and complex health issues are enrolled into Medicaid managed care on a voluntary or mandatory basis, states will face new system design and quality oversight issues. This paper discusses those challenges, with a specific focus on quality oversight, and presents options for addressing them.

Most Medicaid agencies enrolling beneficiaries into Medicaid managed care have "quality oversight" systems. Designed to measure, improve, and assure health-plan compliance with contract standards, these systems monitor a plan's service delivery to the general Medicaid population. Unfortunately, these systems may not adequately address the needs of children in out-of-home placement.

Also, the techniques highlighted in this paper could be used to build a quality oversight system to oversee the quality of health care delivered through Child Welfare agencies or Medicaid fee-for-service programs (including PCCM programs) to children in foster care. Given the proven usefulness of quality oversight for Medicaid managed care, some states might consider undertaking similar activities in these delivery systems. In particular, the Child Welfare role is critical in ensuring the delivery of health care to children in foster care and may merit specific oversight. Finally, enrolling Child Welfare children into Medicaid managed care creates an opportunity for dialogue between the two agencies, which could lead to greater understanding by

1 Readers should note that the Balanced Budget Act of 1997 (BBA) identified children in foster care as one of the few remaining groups for which Medicaid agencies must obtain a waiver before implementing mandatory enrollment into managed care.

2 Nine states required all children in foster care to enroll into general health managed care plans and four required those living in some regions to enroll. Three states required all children in foster care to enroll into a mental health managed care plan. Finally, in one of the states that reported mandatory enrollment, the enrollment is not with a managed care plan, but rather with the county. (The county receives a capitation from the Medicaid agency and in turn pays for services on a fee-for-service basis.) These statistics are from: Jane Horvath, et al. "Current Medicaid Managed Care Program Scope and Operations," Medicaid Managed Care: A Guide for States, (Portland, ME: National Academy for State Health Policy, 1997) Vol. 1.

3 In a PCCM (Primary Care Case Management) program a health care provider (or group of providers) agrees to act as enrollees' gatekeeper for medical services for a small care-coordination fee (usually about $3/enrollee/month in addition to fee-for-service payments for any services provided to enrolled beneficiaries).
both agencies of the critical issues and challenges in providing health care to children in foster care.

This paper will:

- provide a general overview of existing state quality oversight systems;\(^4\)

- discuss factors that impact the ability to deliver care to children in foster care and the quality oversight system;

- detail the elements needed and specific techniques states use to develop a quality oversight system for children in foster care.

**Overview of Quality Oversight in Medicaid Managed Care**

Because Medicaid agencies have extensive experience in quality oversight of Medicaid managed care, the systems developed for those programs (and the lessons learned) provide a good basis for developing systems specific to children in foster care both in Medicaid and Child Welfare. This section presents an overview of the oversight systems most Medicaid agencies have implemented for their general Medicaid population and creates the context for discussing specific issues in quality oversight of the health care provided to children in foster care.

Regardless of the populations enrolled, the movement to managed care changes how states do business. Rather than paying individual providers for each service provided, states purchase services from health plans (risk-based model) or have direct agreements with providers to manage the care provided to individuals (PCCM model). In addition, states expect Managed Care Entities (MCEs)\(^5\) to oversee Medicaid enrollee health and assure needed services are provided in a timely manner. States establish quality oversight systems to ensure that MCEs meet these goals. Ideally, these systems not only detect poor quality but foster quality improvement.

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\(^4\)This paper focuses on state activities, but most health plans also have internal quality oversight systems. Several publications from The National Academy for State Health Policy provide more information about plan activities. These include: *Look Before You Leap: Assuring Quality in Managed Care Programs Serving Older Persons and Persons with Disabilities*, by Maureen Booth; *Quality Improvement Primer: Final Report*, by Maureen Booth and Elaine Fuller; and *Quality Improvement Standards and Processes Used by Select Public and Private Entities to Monitor Performance of Managed Care Plans: A Summary*, also by Maureen Booth and Elaine Fuller.

\(^5\)In this paper the term "Managed Care Entities" or "MCEs" means both health plans and those providers who agree to act as gatekeepers in a PCCM program.
Establishing clear goals and standards is the first component of a quality oversight system. Standards define what an MCE must do to manage and improve the quality of care provided to enrollees. Most states place their standards in a written agreement with each MCE. Although not a guarantee of quality, MCE attainment of state standards increases the likelihood of good care for enrollees.

There are three types of standards that states use in combination to assure and improve quality.

- **Structure**: Does the MCE have the basic infrastructure to provide good care? Examples include such factors as number, location, type, and qualifications of network providers.

- **Process**: Does the MCE engage in activities likely to produce quality? Examples include whether children are fully immunized or the response time for resolving complaints.

- **Outcome**: Is there evidence that the activities improve health care status or beneficiary satisfaction? Examples include avoiding low birth weight, maintaining or improving functional capacity, or satisfying members.

State standards must comply with federal and state regulations. States also turn to standards used in the private sector (such as the National Committee for Quality Assurance or NCQA), professionally accepted standards of care (such as the U.S. Preventive Task Force), and other state standards such as those of Public Health or Licensing agencies. Similar standards used by different organizations create opportunities for collaborative oversight.

Measuring MCE performance is the second component of a quality oversight system and plays a role in both selecting an MCE and monitoring its performance. When making an initial decision to contract with a plan or PCCM provider, the Medicaid agency relies most heavily on structure and process standards because the MCE has not had time to produce outcomes for the Medicaid population. All three types of standards come into play in contracting and oversight decisions after the MCE participates in the managed care program long enough to produce outcomes.

States generally conduct both paper and onsite inspections during contractor selection. States score potential contractors based on documentation showing compliance with each appropriate standard. During onsite reviews, a state assesses whether all processes are functioning as required and whether the MCE is ready to meet the demands of enrollment. States need to consider which standards they will measure for new and existing MCEs, what sources of information they will use, and when during the purchasing process they will examine MCE compliance.

States use a combination of approaches and data to determine whether their contractors continue to meet standards after they have been approved.
- **Routine submission of data:** Most Medicaid agencies require MCEs to submit data at regular intervals, including: utilization data; member complaints or grievances; survey findings; measures from national performance measure sets\(^6\) and results of quality studies.

- **Periodic on-site reviews:** State staff may periodically conduct onsite reviews. These visits may include assessment of provider offices, review of medical records, interviews with key staff, review of records showing consistency with policies, and quality interventions.

- **Independent, external reviews:** Federal regulations require states to contract with an external quality review organization (EQRO) to independently evaluate the quality of care provided in Medicaid managed care. Federal guidelines suggest using the external review as an opportunity to conduct focused studies on areas of concern, such as childhood immunization.

- **Other data and information sources:** Some states use data collected by agencies other than Medicaid (and for purposes other than overseeing the quality of care provided to Medicaid managed care enrollees) to assist in their quality oversight efforts. For example, state Insurance and Licensing agencies often maintain information about plans or providers operating in the state, including those that contract with Medicaid agencies.

*The third component of a quality oversight system is a means for fostering needed improvement.* Usually, this involves working with MCEs to identify and address the cause of poor performance, then re-examining performance to make sure the intervention worked. States frequently develop plans to address the identified issues. These plans may include actions by the State or MCE(s).

*The fourth component of a quality oversight system is to establish interventions for when an MCE does not meet state standards or complete the actions committed to in an improvement plan.* Depending on the violation, states may temporarily suspend enrollment, issue fines, or, in the extreme, terminate the contract.

*The fifth component of a quality oversight system is a means for periodic review of the overall system to determine its effectiveness at promoting and improving the health of Medicaid beneficiaries enrolled in managed care.* Without periodic, ongoing review there is no assurance that the system is still using the right sources of information to examine the right issues, much less producing the desired results.

**Importance of Public Input**

Medicaid staff report that involving plans, enrollees, advocates, and providers in many aspects of a managed care program, including quality oversight, can be beneficial. If Medicaid agency staff

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\(^6\)Several initiatives in recent years popularized the use of performance measures. For example, NCQA published a Health Plan Employer Data and Information Set (HEDIS) consisting of measures which can be used to evaluate plan performance in the areas of access, clinical effectiveness, cost, and satisfaction.
have good working relationships with each of these groups, performance measurement is enhanced, as is the identification and resolution of problems.

Medicaid agencies advise that building and maintaining good working relationships requires effective communication and mutual trust. States must be confident that MCEs are providing information that is not deliberately falsified, and MCEs must be confident that states will not release information until they verify the data and discuss any discrepancies with the MCE. Similarly, states must be confident that advocates are providing factual information about issues important to their constituencies, and advocates must be confident that states will consider and respond to their concerns.

Good working relationships allow information to flow freely. Agencies, plans, providers, and advocates are more willing to discuss potential means for addressing their individual concerns. They are also more likely to provide information that state staff can use to study these concerns. For example, advocates might ask their clients for permission to provide state staff case-specific information enabling states to pinpoint chart reviews, or plans could provide utilization rates or other information that they are not required to release under their contract with the state.

Involving all stakeholders also creates buy-in and enables them to identify legitimate concerns about whether the system will address their issues.

States should not underestimate the importance of competition and public disclosure. MCEs compete against each other to enroll and retain Medicaid and commercial members. This competition can create a situation in which MCEs attempt to outperform each other. This can be particularly effective in improving performance in areas pertinent to many commercial enrollees, such as childhood immunizations.

**FACTORS IMPACTING QUALITY OVERSIGHT FOR CHILDREN IN FOSTER CARE**

There are a number of factors that, although they are not formally part of quality oversight will impact quality oversight for children in foster care. Each of the factors discussed here will come into play in several components of quality oversight. For example, the key issues in health care delivery need to be considered in the development of standards (first component), as well as, the periodic review of the overall system (fifth component).

**The Roles of Medicaid and Child Welfare**

State Medicaid and Child Welfare agencies share responsibility and accountability for the health care provided to children in foster care. Each has resources, information, and expertise which, in combination, strengthen the capacity of a state to monitor and improve the quality of care.
provided to children in foster care. In the absence of collaboration and coordination, however, the independent roles of state Medicaid and Child Welfare can undermine the effectiveness of quality oversight. This section examines the intersecting responsibilities of these agencies as they impact quality improvement and assurance.

State Medicaid agencies have statutory responsibility for assuring that beneficiaries receive timely and appropriate health care services within a scope of benefits defined by the state plan. Under managed care, Medicaid agencies fulfill these responsibilities through MCEs. State Medicaid agencies want to design delivery systems which meet the needs of the enrolled population which, in the case of children in foster care, may require special protections and services not typically addressed in a general managed care program.

Child Welfare agencies are entrusted with the care of individual children and are thus responsible for each child's overall welfare, including health. As a child's protective guardian, Child Welfare agencies assess the needs of children and assign caseworkers to assure that those needs are met through an array of social support, health, and behavioral health services. In their role as guardians, Child Welfare agencies advocate for individual children served by Medicaid and other state and community agencies.

Due to its specialized knowledge, Child Welfare is uniquely positioned to work with Medicaid in the design and oversight of managed care programs to assure that these programs respond to the collective needs of children in foster care. And Medicaid agencies — with their specialized knowledge and the data they collect about the delivery of health care to children in foster care — are uniquely positioned to work with Child Welfare agencies to help determine how well Child Welfare is fulfilling its role in the delivery of health care to children in foster care.

There are a number of complimentary roles which Medicaid and Child Welfare can play in the design and implementation of quality oversight systems. These are described more specifically in Section IV, but in general, they include:

- **Education and outreach**: The child welfare population is represented by groups different from traditional low-income advocacy groups. Child welfare case workers know well the limitations of the current systems of care and typically have concerns about the impact of managed care on their clients. In addition, traditional providers of care to children in foster care are aware of the treatment needs of this group and often have opinions about how a new system should operate. Each of these constituencies have much to offer state Medicaid agencies when developing contracting, enrollment, and oversight policies. Conversely, Medicaid has much information that could allow Child Welfare to advocate more effectively for their charges, particularly during a switch to managed care which often results in a whole new set of rules. Through direct meetings or surveys, there is an opportunity for both agencies to gain directly from these stakeholders’ perspectives and knowledge.

- **Assessment of network adequacy**: Under traditional fee-for-service, Child Welfare agencies were responsible for seeking out appropriate providers and services for children in foster care.
care. As a result, these agencies have extensive knowledge of the provider qualifications needed to serve this population and of provider capacity to handle increased caseloads. This knowledge can be applied when state Medicaid agencies make determinations regarding the adequacy of a managed care plan’s network to meet the needs of children in foster care.

- **Data exchange:** Each agency collects information that could be useful to the other. For example, encounter-level data maintained by State Medicaid agencies can be used to determine whether Child Welfare treatment plans are being carried out or whether children are being screened within 72 hours of removal from the home. This same assessment data can be used by Medicaid to better understand the special needs of children in foster care and to determine whether MCEs are meeting them.

These are but a few of the areas where state Medicaid and Child Welfare agencies can work together. States effectuate these working relationships through a variety of means. There may be a Memorandum of Understanding outlining shared responsibilities and data exchange. Task forces or committees may be established with joint membership to advise on the design, implementation, and evaluation of new Medicaid or Child Welfare strategies to facilitate access to health care.

**Key Issues in Health Care Delivery**

Ireys et al., identified seven key issues for evaluating the adequacy of the health care system’s ability to serve special needs children.\(^7\) Given that many children in the child welfare system qualify for Title V services for children with special health care needs and that almost all can be considered to have special needs, these issues provide a good starting for a discussion of needs of the population and appropriate goals. These particular issues can be used to develop goals and performance standards for health plans, providers, Medicaid, or Child Welfare agencies, although each organization needs different measures. They may also be used to evaluate the over-all performance of the quality oversight system itself. The seven key issues are:

**Access To Care**

- Did the child have access to timely health, mental health, and development screens and assessments provided by qualified providers? (Applies to Child Welfare and/or MCE.)
- Is the child enrolled and disenrolled in a prompt fashion? (Applies to Medicaid or Child Welfare as appropriate.)

** Appropriateness of Services**

- Are the accessed services appropriate — medically and culturally — to the needs and specific situation of the child? (Applies to Medicaid and MCE.)


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Comprehensiveness of Care

- Do the child health assessments thoroughly address the different aspects of the child's functioning? (Applies to MCE and its subcontracted providers.)
- Do the care plan and delivered services address all aspects of a child's care needs? (Applies to MCE and Child Welfare.)

Coordination

- Is there a care plan established for the child? (Applies to MCE and Child Welfare.)
- Is there follow-up on the child's referral and treatment recommendations? (Applies to MCE and Child Welfare.)

Continuity

- Has the Child Welfare agency considered issues of continuity of care in the placement of the child (and potential changes to the placement of the child)? (Applies to Child Welfare.)
- Are the health passport and medical record up to date? (Applies to Child Welfare and MCE as appropriate.)

Relation to Community

- Does the assessment process, care plan, or service referral use community-based organizations and services to support the child and the foster family? (Applies to MCE and Child Welfare.)
- Has the agency or plan cultivated those relationships, educated caseworkers, and medical providers about the existence and importance of these organizations? (Applies to MCE, Medicaid, and Child Welfare.)

Family-Centered Service

- Is the participation of foster parents and biological parents encouraged in the ongoing care and treatment of children in foster care? (Applies to MCE and Child Welfare.)
- Does the assessment process include a review of the capability of the care-giving family to meet the needs of the child? (Applies to Child Welfare.)

Unique Needs of Children in Foster Care

Children in foster care have several unique needs that any program seeking to serve them must address. It is important that Medicaid and Child Welfare agencies take these into account not only in program design but also when developing performance standards and assessing performance. These needs and some options states have developed for addressing them are briefly identified here.
Placement Changes
Children in foster care often change placements. Placement changes typically mean not only a geographical move, but also a change in “parents.” The geographical move may remove the child from his or her current MCE service area, necessitating a change of MCE and, likely, of provider. Also, very often, the new parents will have little knowledge of the child’s health care needs and treatments and will be unable to supply this information to a new plan or provider. Medical records need to be transferred quickly. Even if the child’s new placement is within the current MCE’s service area, a new provider may be needed. Further, while a placement change may not require the child to change MCE or provider, the new foster parents may prefer another MCE or provider.

The issue of frequent placement changes could be partially addressed by requiring the previous MCE to forward the child’s medical records to the new MCE and/or provider within a specified time. This requirement could come into play both when a child changes providers without changing MCEs and when a child changes MCEs. States need to develop a specific trigger mechanism and responsible requesting party (such as the Child Welfare case worker, the foster parent, the new MCE, the new provider, or the Medicaid agency). Also, the Medicaid agency and the MCE need quick notification of placement changes so that they can respond rapidly. In Oregon, the Child Welfare caseworker does the actual plan enrollment on-line, including enrollment changes that result from new placements. This assures there is no time lag between entities and could facilitate rapid forwarding of medical records.

MCE enrollment policies can also address this issue. In Utah, for example, if the child was enrolled with a plan or provider prior to removal from the home or a change in placement, the new foster parents may not select a new plan or provider for the child, unless the placement is outside the current plan’s or provider’s service area. However, most states appear to be adopting Oregon’s approach in which each new set of foster parents selects a new plan or provider for the child. These states found that few children in foster care have a regular source of care upon entering the system (continuity of provider is not an issue) and feel this approach facilitates children’s access by making it easier for foster parents to access care for children. (If all children cared for by one set of foster parents see the same plan or provider, the provider’s office is probably convenient for the parents and they only need to learn one MCE’s requirements.)

Finally, the Child Welfare agency could make continuity of provider a factor in placement decisions. To the extent possible, new placements would be selected that permit a child to remain with his or her current provider. It is not clear the extent to which this policy could be carried out given the dearth of available foster care parents. However, states could consider placing particular emphasis on continuity of provider when placing children who are receiving treatment for complex and continuing medical needs or severe emotional problems.

Confidentiality
Some of these transition issues can be complicated by confidentiality requirements. For instance, mental health and substance abuse providers operate under strict confidentiality rules. This
makes it very difficult in some states for other providers, including the primary care provider, to obtain information about the treatment the child is receiving. Given the interrelatedness of mental and physical health, this can impede the delivery of appropriate services to the child. For example, if the primary care provider knows that a child is being treated for sexual abuse, that provider may decide to perform a pelvic exam, even though the child would normally be considered too young for that to be needed. Or if the mother abused alcohol during her pregnancy, the abuse would likely impact the health of the child. But some agencies have found that the requirement to keep the information about the mother confidential impedes their ability to share this information with the child’s provider, even though this information is needed to help treat the child.

Some states have found it necessary to involve legal experts in untangling the requirements of different organizations and then convey this information to those on the “front-lines” of providing care. Alaska, for instance, involved the State’s Attorney General in their efforts to clarify conflicting confidentiality requirements.

Need for Outreach and Education
A number of entities (foster parents, providers, health plans, etc.) must work together to deliver health care to children in foster care. If any one of these entities does not know what to do, children may not receive the care they need. Caseworkers and foster parents need information that enables them to advocate for these children within the health care delivery system. Plans and providers need information that helps them understand and meet the special needs of children in foster care. Medicaid and Child Welfare agencies need to work together to first educate each other and then their constituencies about the health care delivery system and these children’s needs. Each audience needs targeted education.

In addition to training sessions, caseworkers and foster care parents may benefit from resource materials (such as the tailored handbooks several states are preparing) that tell them how to use the system. Issues of particular concern to these two groups include: how health plan enrollment works, how medical records or a health passport will be transmitted, how to access screening and treatment services (and when to expect such services), which services are covered by the MCE and which are on fee-for-service, and perhaps most importantly, what to do if things are not working for the child. Some states may also consider holding forums, such as those Utah plans, with caseworkers to inform them about how to access health care and answer their questions. Some states hold similar forums with foster parents and other care givers.

Child Welfare agencies in some states hold education/training sessions for MCEs before enrolling these children. Potential training issues include: how the child welfare system works, the complex needs of these children, what documents and medical records are used by the courts, provider involvement in the legal process, confidentiality issues, health passport or other medical record systems and their purpose, other organizations that serve these children and the relationship of these entities to the health care system, the role of foster parents and biological parents, the role of the case worker, and who to contact within the agency for assistance.
concerns, and questions. State agencies may also want to know how the MCE will communicate this information to the providers who care for these children as well as how to ensure communication between the plan, its providers and care managers, and Child Welfare caseworkers.

**Screening and Treatment Standards**
While Medicaid is familiar with EPSDT screening and treatment standards, the American Academy of Pediatrics (AAP) and the Child Welfare League of America (CWLA) recommend a slightly more stringent set of standards for children in out-of-home placements. The differences between EPSDT and foster care standards include: more frequent mental health screens, screens within 24 hours to five days of removal from the home, and a full health and developmental exam within 30 days of removal, and special attention to screening for trauma or abuse.

Medicaid agencies may want to modify their existing screening standards to accommodate these special standards for children in foster care. If the agency contracts with MCEs these more stringent standards can be incorporated into that contract. New Jersey, for example, includes the initial screen upon removal from the home within the definition of emergency services so these screens are treated by the health plan like all other medical emergencies. Texas intends to require plans to provide more frequent health screens to children in foster care. Instead of incorporating these requirements into the plan contract, some states may choose to leave specific screens (such as the initial screen upon removal from the home) on fee-for-service. This can assure payment to whoever provides the screen, even if that provider is not the PCCM provider or in a health plan’s network.

**Specialty Providers**
In many states, Child Welfare agencies rely on certain providers with expertise in diagnosing or treating abused and neglected children for both a child’s initial and ongoing health care diagnosis and treatment. Medicaid MCEs often do not have relationships with these providers and may not have relationships with other providers sufficiently skilled in diagnosing, treating, or referring abuse cases. In response, some states require MCEs to demonstrate that their networks include providers who can screen for and treat abuse cases. New Jersey left payment for abuse/neglect screens on fee-for-service so that the Child Welfare agency can continue using its regional specialists, regardless of the child’s enrollment in a health plan. Others may work with MCEs to train the MCE and any affiliated providers to identify and treat cases of abuse and neglect.

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9 For a full discussion of these differences see: Jane Horvath, *Health Care Protocols for Treatment of Children in Foster Care*, (Portland, ME: National Academy for State Health Policy, 1997).
Care Coordination

Children in foster care frequently have complex health care needs that may impact non-medical needs. As a result, many children in foster care, like other special-needs children, could benefit from coordination across systems of care and treatment: education, health, mental health and developmental services among others.

In some states, such as Oregon, plans must fund care coordinators for particular enrollees (children with special health care needs, for example). The care coordinator assists children in foster care by identifying the child’s health and other needs (mental health, social service, educational) and helping the family access and coordinate those services. Require the plan’s care coordinator to work directly with the child’s caseworker to create a link between the two systems is an example of a minimum requirement that could facilitate coordination. Some states require the plan’s care coordinator to attend meetings between the Child Welfare caseworker and the foster parents. Also, in an effort to establish the basis of a good working relationship, New Jersey’s Medicaid agency arranged and hosted two meetings between Child Welfare’s nurses and the health plans’ nurse and social worker case managers to discuss common issues.

Utah, on the other hand, funds an external nurse case manager for each child in foster care, regardless of health plan enrollment. The case manager advocates for the child to ensure the plan provides needed services. The case manager also coordinates the health and mental health care systems for the child and family. The case manager works to assure that proper screening, treatment, and follow-up services are provided.

Regardless of who funds the case manager, it is important to remember the child in foster care may have many different professionals from several disciplines involved in his or her care. Simply adding one more professional to the mix may not benefit the child. Therefore states need to consider how the two systems will work together (e.g., which case manager is responsible for what and how do they communicate with each other?)

Child Welfare Medical Record

Child Welfare agencies must maintain basic information on each child’s health and make it accessible to each new set of foster parents or other out-of-home placement provider. Some agencies get that information from Medicaid fee-for-service claims data. These agencies will need to develop a new system for data collection when children in foster care enroll into managed care plans. Medicaid agencies may be able to replace the claims data with encounter data, but such a system will always have a significant time lag between the date the service was provided and the encounter was reported. Some states may wish to stipulate in plan contracts that plan providers must provide to Child Welfare (within a specified time) information about services delivered to children in foster care.
Some states have developed systems to track some of the health care provided to children, and these systems could be expanded to track more of the care provided to children in foster care.\textsuperscript{10} For example, in Connecticut, health plans report well-child encounter data that is used to generate EPSDT screening rates for all enrolled children. Each plan also receives a list of individual children who have not had an age-appropriate screen. The Child Welfare agency receives a sub-report of children in out-of-home placements. Child specific information on encounters to complete (or generate) a health record could be culled from a system like this one.

Massachusetts Medicaid uses claims data to produce Provider Profile reports on well-child care services provided to children enrolled in the State’s PCCM program. These reports, which are sent to each PCCM provider with over 200 members in his or her patient panel, summarize the individual provider’s performance and compares it to the aggregated performance of all PCCM providers. (See Appendix B for the user’s guide for this report.) Massachusetts also prepared an aggregate report showing the experience of children in foster care compared to other children in the PCCM program for use by the Child Welfare agency. Finally, the state intends to use claims data to identify the providers seen by children who received Medicaid before entering the foster care system.

**Medicaid Eligibility**

Two Medicaid eligibility issues can also create barriers to delivering care to children in foster care. First, the child’s removal and return to the family may change the child’s and family’s Medicaid eligibility status. Obviously, during times of ineligibility the health of the child (and other members of the family) could deteriorate if the family does not have other insurance. (Unless state performance measures accommodate the impact of this situation on managed care’s ability to improve the family’s — including the child’s — health, MCE performance may appear poorer than actual.)

Secondly, Medicaid eligibility requirements and federal audit requirements (and the potential for loss of federal funding if the agency’s eligibility error rates exceed a specified threshold) combine to encourage conservative interpretations of Medicaid rules by the medicaid eligibility determination agency. As a result, in the case of children in foster care, caseworkers must complete relatively extensive paperwork (even for children who were Medicaid beneficiaries before removal from the home) before granting eligibility to members of a population that are almost all ultimately found eligible for Medicaid. In the meantime, the children are frequently without health care coverage.

Title IV-E eligibility introduces additional complexities. In most states, Child Welfare determines IV-E eligibility \textit{then} sends the appropriate information to Medicaid. But Medicaid requires a signed paper application, among other things. Some cases also require more information and documentation which can delay the child’s receipt of Medicaid benefits. In

\footnote{State innovations and work in developing health passports and other case records of health care within Child Welfare are more fully discussed in \textit{Health Care of Children in Foster Care: Who’s Keeping Track}, NASHP 1997.}

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these states, if the child is not found to be IV-E eligible,\textsuperscript{11} it may take even longer for the child to get Medicaid because the Medicaid eligibility determination agency must determine if the child qualifies for Medicaid under another type of eligibility. Once again, this means more paperwork and further delay, since in some states this process does not begin until after the IV-E process is completed. States need to consider this issue both in program design and quality oversight system design.

Much of this is beyond the scope of authority of the Child Welfare or Medicaid agency, much less the MCE. However, some states are establishing an electronic information transfer between Child Welfare and Medicaid to speed up eligibility determination. Unfortunately, it is uncertain how much improvement this transfer will create, since the federal requirement for a signed application continues to exist, and it is unclear if an electronic copy of an application will suffice. Finally, the new Children's Health Insurance Program (CHIP) has the potential to both help and hinder efforts to address these problems. It could help by offering health insurance to some low-income children who become ineligible for Medicaid upon return to their families. On the other hand, those states developing a separate CHIP application process will need to avoid recreating the Medicaid/Child Welfare communication issues.

**Quality Oversight for Children in Foster Care**

As previously discussed, a quality oversight system includes five components. Each of these will be discussed in detail in this section. This discussion will include specific techniques states use and how the characteristics of the foster care population impacts the system.

**Component 1: Establishing Clear Goals and Standards**

Clear goals and standards are the roots of a quality oversight system. Ideally, these standards and goals are reflected in a written agreement (typically a contract) that all parties understand. Producing a written agreement provides an opportunity for all concerned to voice their opinions and seek clarification of unclear goals and standards.

In truth, establishing goals is typically one of the first steps in program design, so it is likely that they already exist — at least on a broad scale. One broad goal that Medicaid and Child Welfare agencies typically share is the improvement of the quality of care provided to children in foster care. For purposes of developing a quality oversight system, this overarching goal must be broken into subgoals based on the needs of children in foster care. This process provides an

\textsuperscript{11} Utah, for example, estimated that only 44% of the average number of children in out-of-home care are eligible for Title IV-E. (Readers should note that Utah is moving toward a single eligibility determination process for Title IV-E and non-Title IV-E eligibility.)
excellent opportunity for Medicaid and Child Welfare agencies to begin working together to identify these children’s needs and to develop goals (and subsequently standards) that address those needs. Examples of potential subgoals include:

- ensuring that every child that enters the foster care system sees a health-care provider within 48 hours of placement; and

- ensuring that foster care parents are notified — within one week of placement — of who to call when a child needs care.

There are a few things the two agencies should keep in mind as they develop goals. First, Child Welfare and Medicaid staff, due to their differing roles and responsibilities, may define the term “goal” differently. The Child Welfare agency’s role is to act as a guardian for each child, focusing on the needs of the individual child and assuming many responsibilities for the child in addition to health care. Medicaid agencies emphasize the needs of the entire population of children in foster care; their responsibility is to deliver health care to all Medicaid beneficiaries, including children in foster care.

Consequently, a typical goal for a Child Welfare caseworker might be: “This child’s mental health will improve to the point where the child will not create a disturbance in class and can therefore attend classes with other students.” At the same time, a typical goal for Medicaid staff is: “Abused children with mental health conditions will be treated by providers with a specific expertise in treating victims of child abuse.”

These differing goals do not mean that the agencies cannot come to agreement about appropriate goals. However, they do mean that neither agency should assume during goal development that because they use the same terms they are discussing the same things.

Secondly, it has been widely documented that children in foster care often have complex physical and mental health needs. Many live in situations (before entering foster care) that are not ideal for addressing these issues. Also, stays in out-of-home placements are often brief. These factors need to be considered in goal development. When performance measures are first taken, it should not be a surprise that these children’s health status is extremely poor. It also should not be a surprise if the health status of children in foster care does not change dramatically while in managed care as a child in foster care. Many children will not be enrolled long enough (as a child in foster care) to produce measurable improvement in chronic conditions, and some of those whose health does improve may be returned to their families and removed from the system. Of course this disruption also occurs when children in foster care are served by Medicaid fee-for-service. Indeed if a child was enrolled with an MCE (either commercially or through Medicaid) before removal from the home, it is quite possible that placing the child on fee-for-service would cause an interruption in care.

Given these issues, Child Welfare and Medicaid agencies may consider extending their quality oversight activities for this population into the period of time after the child is returned to the

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home, at least for those children who remain on Medicaid. Also these agencies may wish to emphasize the use of structure and process (such as childhood immunization) over outcome goals/measures in their quality oversight activities for programs that serve children in foster care.

Once the agencies develop goals, the next step is to turn these goals into performance standards that MCEs (and their contracted providers)\(^{12}\) are expected to meet. Performance standards need to be clear, obtainable, and measurable and result in reaching the desired goal.

Ideally, performance standards should be clear to everyone involved in the delivery of health care to children in foster care. State agencies, health plans, parents, case-workers, providers and sometimes the children themselves all need to know: what they are expected to do; what others are expected to do; and what to do if those expectations are not met. Program managers should also be aware that if two parties dispute the interpretation of a contract, the court will interpret it in favor of the party that did not write the contract (typically the MCE). On the other hand, if a state agency and its contractor dispute the interpretation of laws and regulations, the court will interpret the law or regulation in favor of the state agency.

For best results, performance standards should also be obtainable. A state may, as a matter of program policy, wish to identify the program goals or a gold standard for performance, even if it knows that MCEs will not be able to meet that standard during the contract period. However, including a gold standard without translating it into attainable measures within the written agreement could create a situation in which health plans or PCCM providers do not truly know what they need to do, and those who use the system expect more than the MCE can deliver.

Finally, everyone needs to keep in mind that performance standards can change over time, so that as the system improves, the “bar” can be raised until the ultimate goal is achieved.

Performance standards need to be measurable. If a standard cannot be measured, no one will be able to tell whether it is met. One way to ensure that performance standards are measurable is to identify the means for measuring the standard as part of standard development. Massachusetts, for example, developed purchasing specifications that identify both the standards that plans are to meet and the measurements for those standards. For instance, the state requires health plans to provide non-symptomatic office visits within 45 calendar days. This standard further specifies that the plan must: “Provide current or prior Contract Year summary-level scheduling data which demonstrates compliance with Purchasing Specification 1.4 [the 45 day requirement].”

The process used to develop agreement on goals and standards between states and MCEs could also be used to formalize the relationship and performance expectations between the Medicaid and Child Welfare agencies themselves. (Or the Child Welfare agency may wish to develop

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\(^{12}\)Program managers should note that some Medicaid agencies have found that they need to make sure that the plan not only knows about the goals and standards, but that providers are aware of these as well. Massachusetts, for example, has specific performance requirements for provider training that plans must fulfill. Other states, such as California, are developing protocols for the assessment and medical management of children in foster care that are anticipated to be distributed directly to providers.
internal standards for its own performance.) Indeed, it is likely that the subgoals developed for Medicaid and Child Welfare will be very similar to those developed for MCEs. For example, the two subgoals identified earlier in this section could be developed into standards for any or all of the three organizations (Medicaid, Child Welfare, and the MCE) involved in the delivery of health care to a child in foster care. Since neither the Medicaid nor the Child Welfare agency pays the other, the resulting agreement need not be a formal contract. The process of developing an agreement could clarify the roles and responsibilities of each agency in the delivery of health care to children in foster care. Creating performance standards for both Child Welfare and Medicaid may be important if state officials are concerned with the structure and quality of the entire system that interacts with and acts on behalf of that child.

In Massachusetts, for example, Child Welfare and Medicaid agencies worked together to identify short, intermediate, and long-term goals for children in foster care. For each of these goals the agencies identified, among other things, the process for reaching the goal, the date for completing the process, who (social workers, foster care parents, etc.) is responsible for attaining the goal, and how to measure achievement. (Appendix A is the document produced by Massachusetts.)

The process of developing goals and performance standards can be a long and difficult one. For best results Medicaid and Child Welfare must work together; each has part of the information needed to do a good job. Unfortunately, differing roles and responsibilities may complicate this task. For example, Child Welfare acts as the guardian of the child; ensuring delivery of health care is only one of the functions that agency must fill. At times this may seem a lesser priority than other responsibilities such as locating a place for the child to live. Thus, a child’s other needs could impact the Child Welfare agency’s performance in ensuring access to health care.

Medicaid’s role, on the other hand, is solely to provide health care to children in foster care — and all other Medicaid beneficiaries. The Medicaid role has two consequences. First, if the child is a Medicaid beneficiary when not in the foster care system, Medicaid’s charge extends beyond the child’s stay in the foster system. Also, because the number of children in foster care is very small compared to the total number of Medicaid beneficiaries, Medicaid agencies will need to focus specific attention on the care provided to children in foster care or risk obscuring its performance in this area. (In some cases the total number of children in foster care as a percent of all Medicaid beneficiaries could be so small that an adverse event experienced by all children in foster care might not create a statistically significant impact on a measure designed to capture the quality of care delivered to all Medicaid beneficiaries.)

Component 2: Measuring Performance

Once states develop performance standards they then measure MCE and program performance against those standards to determine any areas that need improvement. As previously mentioned, Medicaid agencies operating managed care programs have experience in developing quality oversight programs for the general Medicaid population, and these can be very valuable to those
concerned with the health care of children in foster care. However, even if children in foster care enroll with the same MCEs as other Medicaid beneficiaries, Medicaid agencies should consider looking specifically at this population. These children are only a small portion of the general Medicaid population, and their health care experiences could be hidden in measures designed for the larger population. Also, because this population is unique, generalizations about the whole Medicaid child population may not be satisfactory. Similarly, if these children remain in fee-for-service (especially a fee-for-service managed care program such as a PCCM program), the Medicaid agency may want to use some of the techniques used to examine health plan performance to examine the performance of fee-for-service providers who serve these children.

Child Welfare clearly plays an ongoing role in accessing, tracking, and coordinating health care services for children in its custody. Since the overall system includes both Medicaid and Child Welfare in the health care of these children, states might consider measuring the Child Welfare agency’s performance within the system to ensure that it completes the appropriate tasks. This may be essential to improving the overall system of care for these children.

Examples of potential standards and measures for Child Welfare agency performance include:

- **Child Welfare Standard**: 80% of children entering or changing out-of-home placements will not need to change Primary Care Providers.

  **Potential Measures**: The Child Welfare agency could review a sample of its case records (which should identify both past and current providers) to determine the percent of children who did not need to change primary care providers. Also, for those children receiving Medicaid before removal from the home or a change in placement, the Medicaid agency could examine its eligibility and claims files to determine if continuity of provider was maintained. In particular, Medicaid could identify the percent of those enrolled with a health plan or PCCM provider before the removal or placement change who remained enrolled with that same plan or provider after the change.

- **Child Welfare Standard**: 90% of children entering foster care will receive a full health and mental health care examination within 30 days of placement.

  **Potential Measures**: Once again the Child Welfare agency could review a sample of its case records to determine the percent of children who received the examination, or the Medicaid agency could produce that number from its claims or encounter records. In this case, foster parents could also be surveyed to find out the percent of children who received examinations and perhaps the reasons why some children were not examined.

As the examples illustrate, there may be several sources of information (from different agencies) that can be used to measure the standard. Indeed, for some important standards, states may consider using multiple sources of information. (If several different sources produce similar results, the perceived validity of the results increases.)
Many agencies report that they find it beneficial to develop a plan for measuring performance. These plans need to include such elements as: which standards will be measured, what means (information source and process) will be used to measure performance for each standard, and when each standard will be measured. Developing such a plan allows state agencies to determine how to best use their limited resources. If done jointly, it also allows Child Welfare and Medicaid to maximize each agency's resources by sharing information and provides an opportunity for the two agencies to jointly prioritize their work in this area.

The remainder of this section presents information that states can use to begin formulating such a plan. It identifies the sources of information available to Medicaid and Child Welfare regarding performance, discusses how these sources can be improved to better examine issues specific to the delivery of health care to children in foster care, and identifies how various sources of information can be used to examine particular issues.\(^{13}\)

**Medical Record Reviews**

Medicaid agencies extensively use medical chart reviews to evaluate plan performance. In fact, 37 of the 38 states with risk-based managed care programs on June 30, 1996, reported using medical record reviews.\(^{14}\) These agencies use medical record reviews three ways:

1. *Focused reviews* examine performance in specific areas by selecting a sample of chart belonging to enrollees who had certain health events, such as an EPSDT screen.

2. *Random reviews* examine the overall provision of care and identify areas for further examination by reviewing the care documented in the charts belonging to a random selection of plan enrollees.

3. *Individual charts* may be examined as part of the investigation into the individual's complaint or grievance.

In most focused and random reviews, the care provided to the enrollee is compared against a pre-established "screen" based on accepted standards of care. Some states, such as Oregon and Wisconsin, develop these screens with input from plans and local providers.

Medicaid agencies could examine medical records for some issues important to children in foster care, such as incorporation of information from the medical passport or whether the care provided was identified in the child's plan of care. In an effort to take into account the small number of children in foster care served by any one plan or provider, agencies may prefer to

\(^{13}\)For a more general discussion of the use of these sources in managed care contractor management please refer to: Neva Kaye, "Contractor Management" *Medicaid Managed Care: A Guide for States, 3rd ed.,* (Portland ME: National Academy for State Health Policy, 1997), Vol II, Ch 4.

examine these issues using a focused review of the charts belonging to children in foster care rather than a random review of the medical charts belonging to all Medicaid beneficiaries. At a minimum, agencies may want to use a random sample that includes a minimal percentage of children in foster care (say 30%) or look at records from all providers who act as Primary Care Providers for a threshold number of children in foster care. These larger samples will enable states to examine the overall care provided to children in foster care and address such specific issues as: “Do children in foster care receive a greater number of mental health referrals then other children?”

Finally, Child Welfare could take responsibility for reviewing a sample of medical records for foster care specific issues. Because of their status as guardians for children in foster care this agency should be able to access the medical records. It is also in a better position to easily identify all children in foster care. Regardless of which agency takes the lead in such a review, joint planning may yield the best results.

Child Welfare Caseworker Files
The Child Welfare agency’s case management files likely include plans-of-care, assessments, and follow-up activities. In addition, Congress passed legislation in 1989 requiring that a child in foster care’s case plan include: the names and addresses of the child’s health care providers, the child’s immunization record, any known medical problems, medications the child is taking, and any other health information determined appropriate by the Child Welfare agency. These files also contain information about needs other than health care.

Caseworker files are one of the few sources that allows state agencies to gauge how well the full range of services is coordinated for all children in foster care. These files may be the richest source of information regarding how well Child Welfare meets its own expectations. Unfortunately, examining these files, which are not typically computerized, can be a time consuming process even though the number of children in foster care is small. Therefore Child Welfare agencies may want to consider approaches such as those used to review medical records. For example, a sample of files for those children who changed placements during the past six months could be examined for documentation of attempts to maintain continuity of providers. Or, a sample of files for those children who were removed from the home due to abuse could be examined for documentation of appropriate referrals and treatment in the child’s plan of care.

Health Passports
As previously discussed, Child Welfare agencies are responsible for maintaining basic information about a child’s health history and ensuring this information is passed on to each new set of foster parents. In turn, the foster parents are to give this information to new providers to promote continuity of care. (For example, the new provider will not give the child a series of immunizations if he or she knows the child received them from a previous provider.) In some states this health history (referred to as a health passport) is simply information maintained in the

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case file. But some states have stand-alone systems that communicate basic information about the child’s health care needs to new foster parents, providers, and plans. A 1997 National Academy for State Health Policy survey found that in at least seven states (Iowa, Massachusetts, Oklahoma, Texas, Utah, Vermont, and Washington) this system is now computerized.\textsuperscript{16} Alaska and California are also working toward such a system.

Information from these systems, if complete, could be a source of information regarding the health care delivered to children in foster care. For example, information regarding immunizations could be used to examine Medicaid’s success at ensuring that all children are fully immunized by two years of age. Unfortunately, like the Child Welfare Caseworker files these passports are typically paper records and do not lend themselves well to analysis. However, more states are computerizing aspects of this system. The new computerized systems could be used not only to ensure continuity of care, but to measure performance.

\textbf{Surveys and Focus Groups}

Child Welfare, Medicaid, and plans may survey providers, enrollees, parents, and caseworkers. Surveys may examine satisfaction, provision of care (e.g., waiting times for appointments), system understanding (e.g., knowledge of how to access mental health services), and identify barriers. Thirty-four of the 38 Medicaid agencies with risk-based contracts in 1996 perform or have an outside party perform an enrollee survey. Also, some states, such as Texas, performed surveys and advisory groups of parents, caseworkers, and those providers who serve a number of children in foster care. (The protocols and initial results of the Texas effort are included as Appendix C). Given the small number of children in foster care, states may wish to survey 100\% of foster care parents to create the best chance of achieving scientific validity.

There are several considerations agencies must keep in mind when developing these studies. Surveys may be conducted through the mail, over the telephone, or in person. Mail surveys tend to be the least labor-intensive, but have the lowest response rate. Also, short surveys with simple questions are more likely to be returned. Providing multiple choice responses makes tabulation easier and more consistent, but may not capture responses that do not fit the choices. Open-ended questions are more difficult to analyze numerically but will capture information multiple choice questions might miss. All of these factors combine to mean that agencies need to first think through the purpose of a survey and then design a survey that meets that purpose.

\textbf{Grievances/Complaints}

The primary purpose of grievance and complaint procedures is to resolve individual enrollee or provider complaints. But the nature of the complaints and grievances filed by individuals can help agencies identify issues that need further investigation or that affect more than the individual complainant. For example: A foster care parent submits a grievance stating that the mental health provider to which the health plan wants to send an abused child is not qualified to treat the

\textsuperscript{16}For more information on health passports, please refer to: Lorrie L. Lutz and Jane Horvath, \textit{Health Care of Children in Foster Care: Who’s Keeping Track}, (Portland, ME: National Academy for State Health Policy, 1997).
child. In the course of investigating this case, the Medicaid agency discovers that indeed the provider is not qualified. In this case the Medicaid agency could not only resolve the individual foster parent’s issue, but also fix the system — by clarifying what qualifications mental health providers must have to treat abused children. The ultimate outcome of this grievance might include modifying the next contract between the state and the plans to clarify this issue.

Complaints and grievances can provide information about any aspect of plan performance, and they are one of the few sources of information that is almost “real time.” Most formal reports or surveys take a fairly long time to complete. For example, a service provided to an individual may not be reported to the Medicaid agency until several months after the service was provided. When the time needed to accumulate enough information to identify a pattern is added in, it could be more than one year before utilization information can be used to identify potential areas of poor plan performance. However, agencies must be careful when using this information because not every complaint or grievance is a sign of poor plan performance — the complaint may be invalid or an isolated occurrence.

Complaints may come directly to Child Welfare or Medicaid from foster parents, caseworkers, enrollees, providers, or advocates through hotlines, ombudsman programs, or meetings. Grievances may also come directly to the Medicaid agency from enrollees through the formal grievance or fair-hearing process. Complaints and grievances may also go to the MCE. In all cases, Medicaid and Child Welfare need to make sure that recording and reporting requirements are clear and will provide the information they need to use these grievances and complaints in quality oversight. Utah established a complaint system between the Medicaid and Child Welfare agencies to help the two systems work together to solve individual problems. (Appendix D contains a description of that process.)

There are several things agencies can do to help make the complaint/grievance system work to resolve individual problems and identify systems issues. Of course, the system needs to be easy to use, but staff also need to make sure that foster parents and those they turn to for information understand how and where to file complaints and grievances. It is also very helpful if the foster parents know the standards that plans must meet. Medicaid agencies may also wish to identify which complaints and grievances (both those filed with the agency and those filed with the plan) involve children in foster care. This will enable the agency to more easily analyze the complaint/grievance data for information specific to the treatment of these children.

**EPSDT (And Other Utilization) Reporting**

Utilization data provide some of the best information about the process used to deliver care and are the best predictor of some outcomes (e.g., reduction of childhood illnesses). In 1996, all 38

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states with risk contracts collected encounter and/or aggregate utilization data. Medicaid agencies can use this data to produce rates that enable states to compare performance across plans, programs, and over time.

Within the broad category of utilization data, data regarding EPSDT services will be one of the richest sources of information about the care provided to children in foster care. As discussed in previous publications, EPSDT is a core service and incorporates access to many other services these children may need. Furthermore, a list of the children that had EPSDT screens could serve as the starting point for a medical record examination of the appropriateness of care.

In Utah, the Child Welfare agency maintains its own utilization reporting system separate from the Medicaid system. Records are maintained for each child. Utah obtains the utilization information directly from providers through its previously described nurse case managers. For purposes of analyzing the care provided to children in foster care, this system has several advantages over the Medicaid utilization reporting system, especially after the complications of health plan enrollment are introduced. First, since Child Welfare’s system contains information only about children in foster care, it can easily identify all children in foster care. Second, because the system is updated directly by providers, a shorter period of time may elapse between the provision and reporting of a service. Third, this system contains information about all health services provided to these children, not just those funded by Medicaid. The major drawbacks are that it does not contain information about the services provided to children before they enter or after they leave the foster care system. (This may be significant since foster care placements may be short.) Also, this system cannot generate comparative data about other groups of children.

In another example, the Child Welfare agency in Massachusetts reviews the case record of every child in foster care every six months. During this review, all medical care provided to the child is reviewed for compliance with EPSDT standards. Also, the Child Welfare agency sends letters to foster parents reminding them when an EPSDT screen is due. Although this review focuses on individual children, information from this review could be extracted to create an aggregate measure of Child Welfare’s and Medicaid’s performance in delivering health care to children in foster care.

**Care Coordination Databases**

Some Medicaid managed care programs that emphasize care coordination may have another source of data. At least two state Medicaid agencies are developing systems for their programs that serve adults with complex needs that track health plan care coordination activities. (Colorado is currently piloting its system in one county, and Wisconsin’s is operational for its Partnership program.) These databases usually include the enrollee’s initial and ongoing assessments, care plan, and social support services provided to the individual. Some of these also incorporate data about the medical services enrollees receive. These systems are designed to help care coordinators. For example, if the enrollee’s needs assessment showed the need for a particular type of service, but there is no record of such a service, the system will bring the discrepancy to the care coordinator’s attention. These systems were not designed to provide data
for program managers, but both states report that they expect their systems to be a rich source of data regarding plan performance. Neither state uses these systems to examine the care provided to children in foster care. But, it seems logical that since many of these children are likely to have complex needs, they could benefit from such a system — both in terms of the care provided and in the state’s ability to measure performance.

**MCE Administrative Information**

Administrative information is information that relates to the way the MCE functions. It includes such items as: provider subcontracts, MCE preauthorization guidelines, and documentation defining the MCE's internal quality oversight system. Much of this information is not gathered on a regular basis, but can be accessed on request. This type of data is usually not used to identify a potential area of poor performance but to investigate an identified area to determine if the performance needs improvement and to identify specific actions that are most likely to result in improvement. For example, if access to specialists is determined to be a possible area of poor performance, the state and the MCE may wish to examine the prior authorization guidelines and a list of subcontracted providers. Examining these items will help identify whether the issue appears to be that the appropriate providers are not part of the provider network or that preauthorization guidelines are impeding adequate access.

Medicaid and Child Welfare agencies identified two types of administrative information as being particularly helpful in measuring performance. Reviewing the subcontracts between a plan and its providers can shed much light not only on what the plan requires its subcontractors to do, but also how well the requirements in the Medicaid contract are passed down to the providers. After all, it is the direct providers of care who can have the greatest impact on the health care delivered to children in foster care. Reviewing denials of service can also provide much information about whether children are receiving all the services they should.

**Non-Medicaid/Child Welfare Databases**

Although much of the discussion in this section centers on sources of data that are maintained by the Child Welfare agency, Medicaid agency, health plan, and provider, other entities also maintain information that can be useful in performance measurement. These include birth and death certificates, immunization registries, other registries maintained by the Public Health agency, reports filed with the Insurance agency, case records maintained by the education system, etc. Different data sets will be available in different states. These can be used to: examine issues that are not readily measurable through other sources (e.g., school records might document changes in the child's social skills or learning ability); verify information submitted by the plans (e.g., birth certificates usually record the infant’s birth weight); and information where neither the MCE nor the state may have complete data (e.g., an immunization registry would likely contain information about all immunizations provided to a child, regardless of payment source).

Although these data sets can be useful additional sources of information, there are several problems that Medicaid and Child Welfare agencies may encounter when working with other agencies to use these sets. By definition, these must be inter-agency projects and since not all
agencies agree on goals these relationships may be difficult to manage. Also, many other agencies have specific confidentiality requirements that may not match Medicaid’s or Child Welfare’s and thus make sharing information difficult. Finally, if there is a difference in the measures supplied by the MCE and those by the other source, the first question that must be answered is: "Which of the two sources is incorrect?" It is even possible that both are incorrect.

Despite these issues, some state agencies have worked together (and sometimes worked with the private sector) to develop and use more of these sources. For example, Arizona’s Medicaid managed care program worked with other state agencies and the private sector to develop an immunization registry that can provide information about all immunizations a child receives. Also, some states, such as Minnesota, are working to develop an information warehouse that will ultimately include information about services provided by Medicaid, Welfare, Child Support, and Social Services agencies. Finally, in Rhode Island, Tennessee, and Wisconsin the Medicaid and Vital Statistics agencies worked together to develop data for measuring health plan (and in Wisconsin’s case fee-for-service) performance from birth and/or death certificates.

Finally, the tables on the next two pages are intended to give states a starting point for examining issues of importance to children in foster care. It provides examples of the issues that can be examined using information from each of the sources discussed in this section.

**Component 3: Improving Performance**

After measuring performance, the next step in quality oversight is developing mechanisms to improve performance. As previously mentioned, states use a variety of strategies and techniques to address areas of apparent poor performance. For maximum effectiveness this component should consist of three steps: (1) identify needed improvements; (2) develop a plan for making improvements and (3) re-measure performance to ensure that the interventions worked.

Identifying needed improvements is the first step in developing a mechanism to improve performance. In this task, state agencies need to identify not only areas that appear to need improvement, but also identify why the performance in that area appears to be poor. The techniques for measuring performance discussed previously can be used for both sub-tasks. Medicaid agencies generally report that the measures they use to identify areas that need improvement are those produced from medical record reviews, enrollee and provider surveys, enrollee (advocate) and provider complaints, and standard utilization reports. Typically, Medicaid agencies use measures produced from these sources to compare MCE performance against other MCEs, against fee-for-service performance, and against pre-established benchmarks. This allows agencies to determine both when an individual plan or PCCM provider appears to have a problem and when the program as a whole is performing poorly. It is likely that Child Welfare agencies will use sources of information such as: Child Welfare case records, foster parent and provider surveys, and foster parent and provider complaints/grievances to identify areas that need improvement.
Table 1: Examples of using the various sources of information available to Medicaid to measure health plan provision of services to children in foster care.

<table>
<thead>
<tr>
<th>Medicaid Source</th>
<th>Access to Care</th>
<th>Appropriateness of Services</th>
<th>Comprehensiveness of Care</th>
<th>Coordination</th>
<th>Continuity of Care</th>
<th>Relation to Community</th>
<th>Family-Centered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Record</td>
<td>Time before seeing a PCP; Time from referral to appointment</td>
<td>Does care MCE match care provided; Does care provided match accepted medical practice</td>
<td>Were appropriate referrals provided; Does PCP record reflect knowledge of the results of referrals</td>
<td>Evidence of consultation with MCE case manager; PCP record includes specialist findings</td>
<td>Evidence medical treatments completed, even if begun while member of another MCE</td>
<td>Evidence of referrals to providers within child's community where possible</td>
<td>Evidence foster parents consulted</td>
</tr>
<tr>
<td>Enrollee/Foster Parent Surveys and Focus Groups</td>
<td>Time waiting in provider office; Ease of accessing specialist</td>
<td>Parents feel care provided was culturally appropriate</td>
<td>Child received health, mental and dental services parents feel were needed</td>
<td>Providers explain procedures and diagnosis to parent's satisfaction</td>
<td>See same physician at each visit</td>
<td>MCE refers child to providers in child's community</td>
<td>Parents report involvement in selecting treatments</td>
</tr>
<tr>
<td>Provider Surveys and Focus Groups</td>
<td>MCE payment adequate to support time needed</td>
<td>Provider able to refer the child to a qualified specialist with minimal &quot;hassle&quot;</td>
<td>Provider able to access entire range of services needed by child</td>
<td>Provider aware of MCE case management program</td>
<td>Not a good source of information to measure MCE performance on this issue</td>
<td>PCPs refer to community providers for specialist care, when possible</td>
<td>PCP shows understanding of need to involve parents</td>
</tr>
<tr>
<td>Complaints/ Grievances</td>
<td>Time before seeing a PCP; Access to appropriate specialists</td>
<td>Parents may question provider qualifications and sensitivity</td>
<td>Complaints regarding denial of services where MCE was not upheld</td>
<td>Complaints of duplication of service; conflicting recommendations from multiple case managers</td>
<td>Complaints of new MCE's denial of course of treatment begun in old MCE</td>
<td>Complaints of referrals to providers outside child's community</td>
<td>Complaints of physician not explaining diagnosis and treatment to family</td>
</tr>
<tr>
<td>EPSDT and Other Utilization Reporting</td>
<td>EPSDT screening according to special foster care schedule</td>
<td>Needs identified as part of EPSDT screen addressed through appropriate referrals and follow-up</td>
<td>Dental exams provided to all children</td>
<td>No evidence of preventative hospitalizations</td>
<td>Children entering mental health system receive enough visits to complete a course of treatment</td>
<td>Utilization patterns show use of providers within child's community</td>
<td>Not a good source of information to measure MCE performance on this issue</td>
</tr>
<tr>
<td>Care Coordination Databases</td>
<td>Time between referral and appointment</td>
<td>Translation and other enabling services identified in care plan</td>
<td>Care plan addresses non-medical issues</td>
<td>Shows provision of all medical and non-medical services identified in care plan</td>
<td>Contains complete information including reports from referred specialists</td>
<td>Not a good source of information to measure MCE performance on this issue</td>
<td>Evidence foster parents consulted</td>
</tr>
<tr>
<td>Administrative Information (subcontracts, denials of service, etc.)</td>
<td>Examine provider appointment books to see if meet waiting times; Do subcontracts with appropriate providers exist</td>
<td>Do denials of care indicate that needed care was denied; Are utilization review criteria and practice guidelines appropriate</td>
<td>Enrollee handbooks identify how to access mental health and dental care</td>
<td>Written protocols on coordinating with non-MCE case managers; Written MCE case management protocols address foster care</td>
<td>Written protocols facilitate quick transfer of medical records when child changes MCEs</td>
<td>MCE provider and case manager handbooks identifies community based specialists.</td>
<td>MCE practice guidelines identify need to involve family</td>
</tr>
<tr>
<td>Non-Medicaid Sources</td>
<td>Immunization registry shows that children are fully immunized; Health Passport shows recent visit to PCP</td>
<td>Child Welfare caseworker files show that medically necessary services in care plan provided</td>
<td>Health Passport shows delivery of full range of services</td>
<td>IEP includes information from physician; Child Welfare caseworker file indicates consultation with MCE case manager</td>
<td>Not a good source of information to measure MCE performance on this issue</td>
<td>Not a good source of information to measure MCE performance on this issue</td>
<td>Not a good source of information to measure MCE performance on this issue</td>
</tr>
</tbody>
</table>
Table 2: Examples of using sources of information available to Child Welfare to examine the agency's role in providing health care to children in foster care.

<table>
<thead>
<tr>
<th>Child Welfare Source</th>
<th>Access to Care</th>
<th>Appropriateness of Services</th>
<th>Comprehensiveness of Care</th>
<th>Coordination</th>
<th>Continuity of Care</th>
<th>Relation to Community</th>
<th>Family-Centered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Welfare Caseworker Files</td>
<td>Required percent of children receive initial screen within 48 hours of removal from home</td>
<td>Not a good source of information to measure Child Welfare Agency performance on this issue</td>
<td>Child's plan of care identifies non-medical and medical needs</td>
<td>Record reflects consultation with MCE case manager (if appropriate)</td>
<td>Files reflect attempts to consider current providers when making placements</td>
<td>Files show attempts to locate placements within child's community</td>
<td>Files document involvement of natural and foster families in developing child's care plan</td>
</tr>
<tr>
<td>Health Passports</td>
<td>Has child seen a PCP</td>
<td>Not a good source of information to measure Child Welfare Agency performance on this issue</td>
<td>Delivered services address all aspects of child's needs</td>
<td>Health passport current with medical record</td>
<td>Health passport current with medical record</td>
<td>Health Passport reveals use of community providers and resources</td>
<td>Not a good source of information to measure Child Welfare Agency performance on this issue</td>
</tr>
<tr>
<td>Enrolled/Foster Parent Surveys and Focus Groups</td>
<td>Foster parent is told who child's PCP is upon placement</td>
<td>Not a good source of information to measure Child Welfare Agency performance on this issue</td>
<td>Child received needed health, mental and dental services and the parent feels that all pertinent issues were addressed in the plan of care</td>
<td>Parents (foster and natural) report that caseworkers assess familiar with other case managers and their recommendations</td>
<td>Foster parent received copy of health passport upon placement; natural parent was interviewed to establish child's health history</td>
<td>Parents report caseworkers are familiar with community resources, including health resources</td>
<td>Parents report involvement in case plan development</td>
</tr>
<tr>
<td>Provider Surveys and Focus Groups</td>
<td>The provider knows about the Health Passport and how to use/update it</td>
<td>Not a good source of information to measure Child Welfare Agency performance on this issue</td>
<td>Provider feels that all issues were addressed in the plan of care</td>
<td>Providers feel that Child Welfare workers do not work with them to care for the child</td>
<td>Providers received information on child's needs and current treatments at first visit</td>
<td>Providers of care are located in child's community</td>
<td>Providers are aware of the need to involve foster and natural parents in care decisions</td>
</tr>
<tr>
<td>Complaints/Grievances</td>
<td>Complaints regarding lack of information from caseworker about child's health history and needs</td>
<td>MCE complains that Child Welfare workers make referrals for services that the child does not need</td>
<td>Parent complains that a child's needs are not addressed in the plan of care</td>
<td>Conflicting recommendations from multiple case managers; MCE complains that Child Welfare workers do not seek care for children within the MCE's network</td>
<td>Foster parents complain that they did not receive any information about child's previous health care.</td>
<td>Natural parents complain that child has been removed from community</td>
<td>Natural parents complain that they have not been involved in child's treatment</td>
</tr>
<tr>
<td>Administrative Information (Agency policies, foster parent training manuals, etc.)</td>
<td>Parent training manuals discuss child's need for preventive care</td>
<td>Not a good source of information to measure Child Welfare Agency performance on this issue</td>
<td>Not a good source of information to measure Child Welfare Agency performance on this issue</td>
<td>Written protocols on coordinating with non-child welfare case managers</td>
<td>Written protocols on coordinating with non-child welfare case managers</td>
<td>Written protocols on coordinating with non-child welfare case managers</td>
<td>Provider handbooks provided by Child Welfare agency identify community based specialists.</td>
</tr>
<tr>
<td>Non-Child Welfare Sources</td>
<td>Medicaid utilization data shows initial screens provided within 48 hours</td>
<td>Not a good source of information to measure Child Welfare Agency performance on this issue</td>
<td>Not a good source of information to measure Child Welfare Agency performance on this issue</td>
<td>Not a good source of information to measure Child Welfare Agency performance on this issue</td>
<td>Medicaid utilization data shows few changes in providers</td>
<td>Not a good source of information to measure Child Welfare Agency performance on this issue</td>
<td>Not a good source of information to measure Child Welfare Agency performance on this issue</td>
</tr>
</tbody>
</table>
As they identify areas for further study, agencies will encounter several issues that derive from the characteristics of the population of children in foster care. This process will work best if these issues are considered early in the process.

- **Small numbers** — The number of children in foster care is quite small. This impedes the ability to accumulate a statistically valid sample for performance measures.

- **Enrollment "churn"** — Children in foster care will almost certainly change placements while they are in foster care. This significantly reduces the likelihood that a child will remain with a provider or health plan long enough to meet the generally accepted continuous enrollment standard (time in which the organization is expected to be able to impact the health care of the enrollee) of one year. In many cases the child may not even remain within the foster care system for one year.

- **Identification difficulty** — It can be very difficult to identify children in foster care within the Medicaid population. If children were part of a family that receives Medicaid before entering the foster care system, they are likely to remain identified in the Medicaid eligibility system as a member of that family (and not as a child in foster care) until the child welfare system determines that the out-of-home placement will be “long term.” Since it is difficult to identify these children it is, therefore, difficult for either the MCE or the Medicaid agency to generate reports showing the care provided to all children in foster care.

These difficulties mean that states need to use the information they collect with care. Using information from multiple sources, focusing on improvement over absolute standards in some areas, and looking at preventable events\(^\text{18}\) are techniques states can use to accommodate the uncertainty in measurement created by these three difficulties. Also, because of the short stays within the foster care system as a whole, some states may want to consider emphasizing process and structure measures over outcome measures that can take years to produce. (This does not mean that agencies should not use outcome measures.) Some Medicaid agencies may also consider addressing the issue of short foster care stays by including (at least for those children who receive Medicaid when not in foster care) a period of time before and after the foster care stay (since it is likely that the children continue to have complex needs after return to the family).

Once an agency has identified an area of apparent poor performance, it must then work with appropriate parties (health plans, PCCM providers, Child Welfare case workers, other agencies, parents, etc.) to find the cause of the poor performance. This is an extremely important task, especially given the previously discussed difficulties agencies may encounter when identifying areas for further study. Essentially, if the reason for apparent poor performance cannot be

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\(^{18}\) Examples of preventable events include: (1) asthma hospitalizations were there is a previous visit to a primary care provider (Medicaid); or (2) changes in primary care providers resulting from a change in placement (Child Welfare).
identified, the agency has no assurance that the steps it takes to correct the problem will result in the desired outcome and not simply waste resources. Please note that in many cases (particularly those in which one or two MCEs appear to be performing poorly relative to others), it may be best for an MCE itself to examine the area because each MCE knows its own system better than an outside agency. However, for at least some issues, the agency may wish to review the MCE's study (and plan for addressing any identified issues) to make sure that it agrees with the approach and findings.

Agencies use a number of means to examine specific issues of care and quality more closely. Some of these include: examining appointment books to determine if the plan or PCCM provider met waiting time requirements; having 'secret shoppers' call to schedule appointments both to see if the MCE was in compliance with waiting times and how the assumed Medicaid enrollee was treated; examining MCE referral and prior authorization policies to see if they were creating barriers to care; examining how the MCE and Child Welfare systems processed requests from individuals who submitted complaints; having appropriately qualified individuals examine medical records to see if care was adequate; and examining the Child Welfare case records to make sure that appropriate medical information was accurately documented.

Once the agency has identified the cause(s) of a problem it must develop a plan for correcting the cause(s), including a means to determine if the implemented correction actually resolved the problem. Depending on the identified cause(s), there are a number of potential solutions. Many issues will require multiple actions by agencies and MCEs. Actions undertaken by MCEs include: add a specified number of providers with experience in identifying and treating child abuse, train providers about the special needs of children in foster care, or develop protocols for plan case manager coordination with other case managers. Actions agencies might undertake include: changing the MCE contract to clarify expectations or raise performance requirements, train health plan staff or PCCM providers regarding specific requirements, train foster parents and caseworkers regarding how to access care for children, or establish a workgroup of MCE, Child Welfare, and Medicaid staff to share information about strategies to address common issues.

Regardless of the specific actions selected, agencies should be sure that all involved understand and agree to the intended actions, including timelines. Once again, agencies and MCEs must clearly communicate expectations or risk failing to meet them. Additionally, for MCE actions, agencies need to be clear about how they will monitor corrective action plan implementation and under what conditions specific contract penalties might be imposed. (These are discussed in the Enforcement section.)

The final step in creating mechanisms to improve performance is to make sure that performance actually improved. In other words, re-measure performance. This will work best if the means for re-measuring performance are considered in the improvement plan. Agencies will want to use at least some measures that show changes quickly so that they can tell if their actions are not having the desired results before much effort is expended. Agencies will also encounter the issues that derive from the characteristics of the population of children in foster care (such as
small numbers) again and should plan for them. If the agency discovers that the expected improvements are not occurring, they will once again need to study the issue to determine why the actions are not working. Either the agency did not identify the correct cause, or the actions intended to address the cause are not doing so.

**Component 4: Enforcing Compliance**

Medicaid agencies have a variety of penalties they can use to enforce MCE compliance with contract standards and improvement plans. In 1997 George Washington University's Center for Health Policy Research studied 45 MCE contracts from 37 different states. They found that the most frequently used sanction was termination of contract (43 contracts/37 states). Other frequently used sanctions include: withholding capitation (40 contracts/34 states); suspending/freezing new enrollment or adjusting current enrollment (28 contracts/28 states); liquidated/exemplary damages (23 contracts/20 states); adjustment in payment (12 contracts/11 states); and mandated payment for medically necessary out-of-plan care or state payment for these services, recouped from the plan (8 contracts/7 states). Interestingly, in the seven states that have separate contracts for their behavioral health and physical health programs, three had the same sanctions in both contracts, and four had fewer sanctions in the behavioral health contract.19

Medicaid agencies emphasize the importance of intermediate sanctions for enforcement. They create intermediate sanctions, not because they want to penalize MCEs, but because the ability to impose believable penalties affects MCE behavior. This is particularly important for programs that serve children in foster care. Since this population is small, MCEs are unlikely to believe an agency would cancel a contract because the MCE, for example, failed to provide a health screen to 90% of children in foster care within 72 hours of removal from the home. However, the MCE will believe that states will impose financial penalties for this performance failure, especially if the penalty is in proportion to the performance failure. An MCE is likely to work harder to correct the deficiency if it believes it will incur a real (although perhaps minor) penalty.

**Component 5: Assessing the Effectiveness of the Quality Oversight System**

Periodic review of the overall system to determine how well it promotes and improves the health of children in foster care is a key component of quality oversight. Standards need to be kept current with the state-of-the-art. Data sources need to be periodically scrutinized to assure their

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continued reliability. Training needs of staff should be evaluated to be certain they have the
skills to do their work effectively. Consumer and provider surveys may be used to identify how a
state’s quality oversight system can be improved and targeted to special priorities. Meetings
between state agencies can help determine what is and is not working. Information from all these
and other sources may result in changes in standards or the tools and practices which states use to
monitor the health care provided to children in foster care.

CONCLUSION

Improving and assuring the quality of health care provided to children in foster care is a difficult
task. Many Medicaid agencies already have systems for the general Medicaid population
enrolled in managed care. But these systems may not fully address the needs of this small
population with complex needs. Nor do many agencies have quality oversight systems for the
fee-for-service system through which many children in out-of-home placements still receive care.
Finally, many Child Welfare agencies, which have the major responsibility for caring for the
individual child, do not have health care quality oversight systems in place. Given the complex
needs of this population, Medicaid and Child Welfare agencies may want to consider modifying
their existing systems or establishing new systems specifically designed for children in foster
care.

Those agencies that elect to establish a quality system will need to identify their health care goals
for this population, how they can measure progress toward these goals, and how they will use this
information to produce an improvement in the care delivered to the children. The two agencies
may find that a joint process is most effective. Each agency has its own role and experience in
the delivery of health care to children in foster care, and a joint process can take advantage of
both agencies’ knowledge and sources of information regarding the care delivered. In addition, a
joint process could create an opportunity for dialogue between Medicaid and Child Welfare,
leading to greater understanding of each agency’s role and the critical issues in delivering quality
care to children in foster care.
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A. Massachusetts Foster Care Goals and Standards
B. Massachusetts PCC Plan Profile Report Users’ Guide
C. Texas Survey Protocols and Results
D. Utah’s Child Welfare/Medicaid Complaint System
Appendix A

Massachusetts Foster Care Goals and Standards
## Health Care Goals

<table>
<thead>
<tr>
<th><strong>Short Term Immediate Goal:</strong></th>
<th><strong>Intermediate Goal:</strong></th>
<th><strong>Long Term Goal:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Document injuries,</td>
<td>1. Update medical history</td>
<td>Up to date medical exams/treatment in compliance with EPSDT guidelines and medical plan for the child. Comprehensive preventive care, treatment of acute illnesses, amelioration of chronic illnesses, linkages with mental health services and appropriate dental care.</td>
</tr>
<tr>
<td>2. Rule out dangerous life threatening conditions,</td>
<td>2. Provide medical care indicated to comply with EPSDT guidelines</td>
<td></td>
</tr>
<tr>
<td>3. Identify communicable diseases.</td>
<td>3. Referral and arrangement for dental care (goal of no later than 6 months after placement).</td>
<td></td>
</tr>
</tbody>
</table>

**Protocol:** Health Care Screen by M.D., RNP or PA.

**Protocol:** Comprehensive Medical Exam in compliance with EPSDT schedule, including vision and hearing screening and a developmental assessment, which is based on the American Academy of Pediatrics recommendations for preventive care. The clinician should develop a health care plan for the child.

**Protocol:** Compliance with EPSDT guidelines for well care, compliance with individual medical care plan for the child, if different. Annual examinations at ages 6 and 8 (not required by EDSDT).

**Process:** Social worker should access Medicaid managed care inform.; if there is a managed care provider on file, the child should be seen for the health screening by this provider, if possible. If this is not possible, the social worker should request a complete medical history.

**Process:** Foster parent should bring medical Passport and Health Screening form to exam. Foster parent should insure that the clinician completes the encounter form. The foster parent should give a copy of the encounter form to the child’s social worker.

**Process:** Foster parent is responsible for bringing the child for medical care. Encounter forms and medical passport should be kept current.

**Place of screening:** First choice:

**Place of screening:** Provider’s office,

**Place of screening:** Provider’s office,
<table>
<thead>
<tr>
<th>physicians office, community health center or hospital outpatient dept. For children in residential placement first choice is at the residential facility. Alternative choice: emergency dept.</th>
<th>community health center or residential facility. Choice of provider made by foster parent in conjunction with social worker within Medicaid guidelines. For children in residential placement choice made by residential facility in conjunction with DSS staff.</th>
<th>community health center or residential facility. Choice of provider made by foster parent in conjunction with social worker within Medicaid guidelines. For children in residential placement choice made by residential facility in conjunction with DSS staff.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exceptions:</strong> Child discharged from the hospital to placement.</td>
<td><strong>Exception:</strong> None</td>
<td><strong>Exceptions:</strong> None</td>
</tr>
<tr>
<td><strong>Timing:</strong> Within 7 calendar days of placement. Exception: Children who show signs of abuse or for whom there is concern about a medical issue should be taken for immediate medical attention.</td>
<td><strong>Timing:</strong> Within 30 calendar days of placement.</td>
<td><strong>Timing:</strong></td>
</tr>
<tr>
<td><strong>Responsible Person(s):</strong> SW/foster parent/family resource worker</td>
<td><strong>Responsible Person(s):</strong> Foster parent.</td>
<td><strong>Responsible Person:</strong> Foster parent/social worker.</td>
</tr>
<tr>
<td><strong>Documentation:</strong> Screening form</td>
<td><strong>Documentation:</strong> Encounter form.</td>
<td><strong>Documentation:</strong> Encounter form.</td>
</tr>
<tr>
<td><strong>Training:</strong> Social workers, investigators, hotline workers, family resource worker, foster parents, medical personnel.</td>
<td><strong>Training:</strong> Social workers, investigators, foster parents.</td>
<td><strong>Training:</strong> Social workers, foster parents.</td>
</tr>
</tbody>
</table>
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The PCC Profile Report is a practice management, quality improvement tool. It does not report compliance with program and billing regulations. The PCC Profile Report is not suggestive of the PCC's overall practice, but rather a review of specific measures. The PCC Profile Report contains confidential information that must be handled in accordance with State and Federal guidelines governing the confidentiality of medical information.

Please note, with PCC Profile Report V's enhancements, the January 1996 Users' Guide Template is no longer applicable. Please discard the template.
I. INTRODUCTION

The Primary Care Clinician (PCC) Profile Report is a practice management tool that reports PCC-specific and PCC Plan-level data on clinical measures. The PCC Profile Report provides PCCs with information that can be used to improve health care delivery and ultimately improve health outcomes of PCC Plan members. All PCC Profile Report data is based on paid claims. As a result, the quality of the data contained in each PCC’s report is based upon the accuracy of the information submitted on claims.

PCCs with 200 or more PCC Plan members receive the PCC Profile Report. The Plan's Regional Network Managers (RNMs) meet with each PCC receiving the PCC Profile Report and, in partnership with the PCC, set individual PCC improvement goals and identify interventions. Working together we can make breakthroughs in the quality of service we provide to our primary customer, the PCC Plan member.

II. PROCESS

The PCC Plan’s RNMs will visit each PCC who receives this PCC Profile Report every six months and:

- review the PCC Profile Report;
- identify the PCC’s opportunities for improvement;
- jointly develop and/or review the PCC’s improvement goal(s);
- collaboratively identify interventions to help the PCC achieve the goals; and
- review and/or identify measures of success for the improvement goal(s).

The PCC’s RNM is also available to assist the PCC on an ongoing basis to help the PCC meet his/her goals. The approach is individualized to best meet the needs of the PCC.

III. PCC PROFILE REPORT MEASURES

The PCC Profile Report measures were selected based on their relevancy to PCC Plan members, feasibility of data collection, and opportunity for improvement. The measures include:

- Pap Smear Screening;
- Mammography Screening;
- Asthma Admissions and ED Visits;
- Emergency Department Utilization; and
- Well Child Care

The PCC Profile Report contains two types of information: PCC practice performance rates and member-specific data. The individual PCC practice rates are accompanied by the PCC Plan rates as a point of comparison. Benchmarks are also displayed to assist the PCC Plan and its PCCs in identifying levels of achievable performance.

Member-specific information is provided to assist PCCs in identifying missed opportunities, to inform PCCs of members in their panel who are overdue for preventive care, and to provide data to help the PCC in managing their members' health care.

IV. MEASURE SPECIFICATIONS

A detailed description of each measure’s rationale, definition and member-specific information is provided on the following pages. A glossary of terms, eligibility criteria, data specifications, observation periods, and the equations used to calculate each measure may be found in the Glossary.
PAP SMEAR SCREENING

Rationale

Cervical cancer can be detected in early stages by regular Pap smear screening. However, cervical cancer is frequently diagnosed at a late stage, which may be the result a lack of early screening and detection, especially in older women. Pap smear testing is recommended annually for all women who are or have been sexually active or have reached the age 18. After a woman has had three consecutive satisfactory normal annual examinations, the Pap test may be performed less frequently at the discretion of her physician.\(^1\)(2)(3)

Use of family planning services and pregnancy have been shown to be the strongest predictors of a Pap smear. Women beyond the reproductive years are less likely to receive frequent Pap smears.\(^4\)

Description of Measure

The measure is the rate of Pap-eligible women, 18 to 64 years old, who had one or more Pap smears within a three-year period. The eligibility criteria can be found in the Glossary.

The number of women, 18 to 64 years old in your panel meeting the eligibility requirements is provided below the graph. This is the number used as the denominator to calculate your rate. The women's average length of enrollment is also provided to demonstrate the existence of established relationships with the PCC and the extent to which opportunities for screening were available to the PCC during the screening period.

The procedure codes used to identify women who have had a Pap smear can be found in the Glossary.

How to Read the Graph

The PCC rate is the proportion of Pap-eligible women in your panel who received a Pap smear test among all women who were eligible for the exam.

The PCC Plan rate is the weighted average screening rate amongst all PCC Plan Pap-eligible women.

With “Healthy People 2000,” the U.S. Department of Health and Human Services established a national objective to increase the proportion of women, aged 18 and older, receiving a Pap smear test within the preceding one to three years to 85%. The Healthy People 2000 goal is represented on the graph as a horizontal line.

Limitation

The denominator includes women who may have had a hysterectomy.

Member-Specific Information

This section provides detailed information on Pap-eligible women in the PCC panel without a Pap test during the observation period. The table also identifies women with a disability; studies have shown that they may have special needs when accessing Pap smear screening services. The member-specific information may help you in the following ways:

- it serves as a reminder system;
- it may demonstrate "missed opportunities" whereby women accessed care and an opportunity may have existed to perform a Pap, schedule a return visit, or make a referral;
- it lists women who haven't presented to you for care; and
- it may include women who were referred for a Pap, but never received the Pap test.

The RNM will review the list and provide resource information to support the development and implementation of improvement activities.
MAMMOGRAPHY SCREENING

Rationale
Breast cancer is the most frequent malignancy affecting women and is the second major cause of death from cancer in women. Effective screening tests for breast cancer are clinical examination of the breast, mammography and breast self-examination. The American Cancer Society recommends that women have a mammogram every year after age 40.\(^1\)\(^3\)

Studies show the strongest predictor of a women being screened for breast cancer is physician recommendation.\(^3\)

Description of Measure
The measure is the rate of mammography-eligible women, 50 to 64 years old, who had one or more mammograms within a one-year period. The eligibility criteria may be found in the Glossary.

The number of women, 50 to 64 years old in your panel meeting the eligibility requirements is provided below the graph. This is the number used as the denominator to calculate your rate. The women's average length of enrollment is also provided to demonstrate the existence of established relationships with the PCC and the extent to which opportunities for screening were available to the PCC during the screening period.

The procedure codes used to identify women who have had a mammogram can be found in the Glossary.

How to Read the Graph
The PCC rate is the proportion of mammography-eligible women in your panel who received a mammogram among all women who were eligible for the exam.

The PCC Plan rate is the weighted average screening rate amongst all PCC Plan mammography-eligible women.

The U.S. Public Health Service, through Healthy People 2000, has established a national objective to increase the proportion of women, aged 50 and older, receiving a clinical breast exam and a mammogram within the preceding two years to 60%. The Healthy People 2000 goal is represented on the graph as a horizontal line.

Limitation
The denominator includes women who may have had a bilateral mastectomy.

Member-Specific Information
This section provides you with detailed information on mammography-eligible women in the PCC Panel without a mammogram during the observation period. The table also identifies women with a disability, as studies have shown that they may have special needs when accessing mammography services. The member-specific information can help you in the following ways:

- it serves as a reminder system;
- it may demonstrate "missed opportunities" whereby women may have accessed care, and there may have been an opportunity to perform a mammography, schedule a return visit or make a referral;
- it lists women who haven't presented to you for care; and
- it may include women who were referred for mammography but never received a mammogram.

The RNM will review the list and provide resource information to support the development and implementation of improvement activities.
ASTHMA MEASURE

Rationale
One ongoing PCC Plan improvement goal is to decrease ED Visits and hospital admissions for members with asthma. The PCC Plan strives to achieve this goal by improving:
- clinician knowledge about current asthma management practices;
- member knowledge about asthma self management techniques; and
- care management for members with asthma.

The asthma measure identifies members in your panel who meet the specifications for the identification of members with asthma (see Glossary). For these panel members only, asthma-related hospital admissions, ED visits, and observation bed stays are presented.

Description of Measure
The asthma measure includes the following rates: asthma-related hospital admissions, ED visits, and observation bed stays per 100 “asthmatics” during the observation period. The measure provides the number of “asthmatics” with asthma-related hospital admissions, ED visits, and observation bed stays. It also reports the total number of “asthmatics” with any of these events and the number of each type of asthma event.

The data specifications used to identify members with asthma can be found in the Glossary.

How to Read the Graph
The PCC rates are the number of ED visits, hospital admissions, and observation bed stays for the treatment of asthma per 100 “asthmatics” during the observation period.

The PCC Plan rates are the number of ED visits, hospital admissions, and observation bed stays for the treatment of asthma per 100 “asthmatics” during the observation period.

The data table provides the number of ED visits, hospital admissions, observation bed stays, and asthmatic encounters during the observation period.

Limitation
The methodology to identify members with asthma relies on paid claims and does not include a confirmed clinical diagnosis. A clinical diagnosis of asthma is the ideal identification methodology.

Member-Specific Information
This section provides detailed information on all members in the PCC Panel enrolled with the PCC on the last day of the observation period who meet the criteria used to identify members with a diagnosis of asthma. The criteria may be found in the Glossary. The member-specific information can help you in the following ways:
- it may identify members with asthma who were unknown to you;
- admission to the Intensive Care Unit is provided as a severity-of-illness indicator; and
- secondary diagnoses are included as a co-morbidity index.

The RNM will review the list and provide resource information to support the development and implementation of improvement activities.
EMERGENCY DEPARTMENT UTILIZATION

Rationale
Emergency department visit rates provide an important indicator of member access. High ED rates may indicate a need for improved access to primary care providers or member education on proper use of the health care system. (1)

Description of Measure
The emergency department utilization measure is the number of emergency department visits that occurred during the observation period per member per year (PMPY).

How to Read the Graph
The PCC rate is the total number of emergency department (ED) visits (elective, emergent, newborn, urgent, and screening) during the observation period, per member per year.

The PCC Plan rate is the total number of ED visits per member per year for all members in the PCC Plan during the observation period.

To calculate the PCC Plan best practice rate, the rates of PCCs with 200 or more members are ranked in quartiles from lowest to highest, with those who performed the best being in the lowest quartile. The PCC Plan Best Practice Rate is that rate which separates the lowest 25th percentile of all PCCs from the remainder (e.g., if 25% of all PCCs achieved a rate of .35 emergency department visits per member per year, or less, as compared to the remaining PCCs, the Best Practice Rate would be .35). This rate is represented on the graph as a horizontal line labeled a PCC best practice rate.

Hospital-Specific Information
Utilization information on the two most frequented hospitals is provided to improve coordination and communication between PCCs and hospitals.

Limitation
The level of care reported is a reflection of those claims submitted, which may or may not be indicative of the member’s presenting symptoms.

Member-Specific Information
This section provides information on members in your panel with one or more emergency department visits during the observation period.

- The types of ED visits are coded as follows:
  - E = Emergent: The member required immediate medical intervention for the treatment of a severe, life-threatening, or potentially disabling condition or symptoms.
  - L = Elective: The member’s condition permitted adequate time to schedule necessary services.
  - M = Missing: The ED did not provide the level of care on the claim form.
  - N = Newborn: The member is a baby born in the facility on the date of service.
  - U = Urgent: The member required immediate attention for the care and treatment of a physical or mental disorder.
  - S = Screening: The member’s condition was determined to be most appropriately treated in the PCC setting.
- The pre-ED and post-ED visit types may be found in the ED section of the Glossary
- The Glossary contains conversion tables for the time of the visit and the diagnoses for the most common ICD-9 codes for ED visits
- An indicator identifying if the member is disabled
EMERGENCY DEPARTMENT UTILIZATION, continued...

The member-specific information can help you in the following ways:

- it may indicate the need for you to improve access;
- information on visits after a member was seen in an ED is provided to promote continuity of care (absence of follow-up care may also indicate noncompliance by the member); and
- members may need education about proper use of the ED.

The RNM will review the list and provide resource information to support the development and implementation of improvement activities.
WELL CHILD CARE

Rationale
In order to foster early detection and prompt treatment of health problems in children and adolescents, well-child care services are available to all MassHealth enrolled children and adolescents under age 21. In delivering well-child care services, PCCs should follow the EPSDT Medical Protocol and Periodicity Schedule.

A study by the PCC Plan found that compliance with the EPSDT Schedule increased as the number of well child visits increased. This supports the need for children and adolescents to have the required number of well visits in order to improve compliance with the EPSDT Schedule.

Description of Measure
The well-child care measure provides the percent of children and adolescents 15 to 30 months, 3 to 6 years, 7 to 11 years, 12 to 18 years, and 19 to 21 years who received the number of well visits required by the ESPDT Schedule during the observation periods.

How to Read the Graph
The PCC rate is the percent of children or adolescents within the appropriate age cohort who received the number of well-child care visits, provided by any MassHealth provider, required by the EPSDT Schedule during the observation period.

The PCC Plan rate is the percent of children or adolescents within the appropriate age cohort who received the number of well-child care visits required by the EPSDT Schedule during the observation period.

Limitation
At this time, the Division is unable to provide the member-specific information on children under 15 months of age, because the length of enrollment with a PCC is inadequate. This is mainly due to the notification of birth process.

The failure to use specific codes when submitting claims when well-child care is provided will impact the calculation of a PCC’s rate for the well-child care measure.

Member-Specific Information
This section provides information on children and adolescents who did not receive the number of well visits required by the EPSDT Schedule. The information can help you in the following ways:

- it serves as a reminder system;
- it may provide information on children unfamiliar to you; and
- it displays the number of visits children had with you for episodic care. This is an indicator of opportunities available to the PCC to educate and outreach members about preventive care as well as to provide well-child care services

The RNM will review the list and provide resource information to support the development and implementation of improvement activities.
WELL CHILD CARE, continued...

Well Child Care Visit Summary Table

This table displays the number of children in the PCC’s panel who received all of the well-child care visits required by the EPSDT Schedule. The table also displays the number of children in the PCC’s panel who did not receive the required number of visits. The table is designed to help the PCC identify particular age groups that may not be receiving the number of visits required by the EPSDT Schedule.

Billing Summary of Preventive Medicine Codes and EPSDT

This table summarizes the billing of Preventive Medicine Codes and EPSDT modifiers during the PCC Profile Report’s Well Child Care observation period. PCCs are strongly encouraged to bill using EPSDT modifiers to improve tracking of these services provided to PCC Plan members. PCCs receive an enhanced fee for providing well-child care services delivered in accordance with the EPSDT Schedule only when such enhancements are available and the claims are submitted in accordance with EPSDT billing regulations.

Invoice Type

- The 03 invoice type is used by outpatient departments.
- The 04 invoice type is the EPSDT (Project Good Health) claim form and can be used by all PCCs, with the exception of OPD PCCs.
- The 05 invoice type is the Physician Claim form and can be used by all PCCs, with the exception of CHCs.
- The 09 invoice type is used exclusively by CHCs.

HCPC Code Range

CPT code ranges 99381 - 99385 (new patient) and 99391 - 99395 (established patient) are preventive medicine codes. In addition to membership status (new versus established patient), these codes identify the age of the member. (Refer to the CPT 4 manual.)

EPSDT Modifier

- The “EP” modifier indicates the provision of EPSDT services to a new patient.
- The “Y3” modifier indicates the provision of EPSDT services to an established patient.
- CHCs using Claim Form 09 are unable to bill with these modifiers. However, the use of the appropriate preventive medicine code by CHCs will indicate a well-child care visit delivered in accordance with the EPSDT Schedule for CHCs.
- OPDs should indicate a visit delivered in accordance with the EPSDT Schedule by use of the Condition Code “A1” in the appropriate box on invoice 03.
PCC PANEL STATISTICS PAGE

Rationale

PCCs have requested that the PCC Profile Report contain PCC Plan administrative information as well as age, gender and disability demographics of their panel.

Description of Information

The information is divided into 2 components, PCC Information and PCC Member Information. The PCC Information section includes:

- PCC name
- PCC provider number
- PCC address
- PCC Site Names and Identification Numbers
- PCC Provider Type
- PCC Primary Specialty
- PCC Contact Person

Limitation

Please review the data reported and identify any necessary updates. If any inaccuracies exist in this data, please inform your RNM or contact the PCC Plan Hotline at (800) 682-1061.

The PCC Member Information tables display the number of members in the PCC’s panel by gender and age cohorts. The section also includes the frequency of disabled/non-disabled members for each of the age and gender cohorts.
GLOSSARY

PAP SMEAR SCREENING

Denominator
- Women age 21 through 64 years as of 6/30/97;
- Continuously managed care-eligible between 7/1/96 - 6/30/97 (allowing for one 45 day break); and
- Enrolled with the PCC on 6/30/97.

Numerator
- Number of women in denominator with a Pap smear during the observation period.

Observation Period
- 7/1/94 - 6/30/97

Data Specifications
A woman is considered to have had a Pap test if a claim was paid that meets one of the following criteria:
- CPT-4 code: 88150, 88151, 88155, 88156, or 88157 OR
- Revenue code: 923 OR
- Revenue code 300 or 310 in conjunction with one of the following cervical-related ICD-9 diagnosis codes: 180.x; 233.1; 622.x; 795.1; V72.3; V76.2. OR
- ICD-9 procedure code: 91.46. (3)

MAMMOGRAPHY SCREENING

Denominator
- Women age 51 through 64 years as of 6/30/97;
- Continuously managed care-eligible between 7/1/96 - 6/30/97 (allowing for one 45 day break); and
- Enrolled with the PCC on 6/30/97.

Numerator
- Number of women in denominator with a mammogram during the observation period.

Observation Period
- 7/1/96 - 6/30/97

Data Specifications
A woman is considered to have had a mammogram if a claim was paid that met one of the following criteria:
- CPT-4 code: 76090, 76091, or 76092 OR
- Revenue code: 401 or 403 OR
- ICD-9 procedure: 87.37 or 87.36(1).
ASTHMA

Denominator
- Members between the ages of 2 and 64 meeting the criteria for the identification of members with asthma;
- Continuously managed care eligible since 7/1/96 (allowing for one 45 day break); and
- Continuously enrolled with the PCC from 4/1/97 through 6/30/97 (no breaks allowed).

Note: The Asthma Member Detail includes any member fitting the criteria listed under “Identification of Members with Asthma,” regardless of continuous enrollment as specified above, as long as the member was enrolled with the PCC on 6/30/97. Therefore, the member detail may include a PCC member with no ED encounters, hospital admissions, or observation bed stays during the observation period (7/1/96 - 6/30/97).

Numerator
- Number of asthma related events for members in denominator during the observation period.

Identification of Members with Asthma
A member is classified “asthmatic”, if within a one-year period, the following criteria is met:
- member between the ages of 2 and 64; AND
- one or more ED encounters with a principal diagnosis of asthma (ICD-9 Code 493); AND/OR
- one or more observation bed stays with a principal diagnosis of asthma (ICD-9 Code 493); AND/OR
- one or more hospital admissions with a principal diagnosis of asthma (ICD-9 Code 493); AND/OR
- two or more face-to-face encounters in an ambulatory setting with a principle diagnosis of asthma (ICD-9 Code 493); AND/OR
- one or more face-to-face encounters in an ambulatory setting with a principle diagnosis of asthma (ICD-9 Code 493) and at least one prescription for asthma medications; AND/OR
- two or more prescriptions for asthma medications

Once a member with asthma is identified, that member remains in a PCC's denominator until that member is no longer enrolled with that PCC or no longer eligible for MassHealth, regardless of subsequent asthma-related service utilization.

Asthma Related Events
- Asthma Hospital Admission: a hospital inpatient admission during the observation period for a primary diagnosis of asthma;
- Asthma ED Visit: an ED visit during the observation period with a primary diagnosis of asthma; and
- Asthma Observation Bed Stay: An observation bed stay during the observation period for a primary diagnosis of asthma.

Observation Period
7/1/96 - 6/30/97

Asthma Rates

\[
\text{Asthma Rates} = \frac{\# \text{ asthma related events}}{\# \text{ of members with asthma}} \times 100
\]

Data Table
- Number of “asthmatics”: Total number of members meeting specifications for identification of members with asthma
- Number of events: Total number of asthma related events, as defined above.
- Number of “asthmatics” with events: Total (unduplicated count) of “asthmatics” with asthma related events.
EMERGENCY ROOM (ED) UTILIZATION

Denominator
- Members enrolled with a PCC at the time of the ED visit

Numerator
- Number of ED visits during the observation period by members in denominator

Observation Period
- 1/1/97 - 6/30/97

Data Specifications
A member is considered to have had an ED encounter if a claim was paid that meets one of the following criteria:
- Revenue Code 450 or 459 (Facility component); OR
- Revenue Code 981 (Professional component, salaried physicians); OR
- HCPC code and place of service is equal to '05' (Professional Component, Non-salaried Physicians).

ED Utilization Rate

\[
\frac{\text{# ED visits during observation period} \times 12}{\text{member months}}
\]

Pre and Post ED Visit Definitions
The first service the member accesses directly before and after the ED encounter is captured. The description of these visits is either:
- PCC Visit - a visit to the PCC Provider
- ED Visit - an ED visit
- Visit - an ambulatory visit to a provider other than a PCC
- HH Visit - a visit from a Home Health Care provider
- Other - a visit or services which may include day habilitation, dialysis, and private duty nursing.
- No Provider - no provider was reported

Time Conversion Table

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WELL CHILD CARE

Denominator
- Children aged 30 months, 3 - 6 years, 7 - 11 years, 12 - 18 years, or 19 - 21 years as of 6/30/97;
- Enrolled in the PCC Plan on 6/30/97;
- Continuously managed care-eligible since 7/1/96 (allowing a break of 45 days); and
- Enrolled with the PCC as of 6/30/97.

Numerator
- Number of well-child care visits by children in the denominator during the observation period.

Observation Periods
- 15 to 30 Months Cohort: 4/1/96 - 6/30/97 4 required EPSDT visits
- 3 to 6 Years Cohort: 7/1/96 - 6/30/97 1 annual required EPSDT visit
- 7 to 11 Years Cohort: 7/1/95 - 6/30/97 1 EPSDT visit every other year
- 12 to 18 Years Cohort: 7/1/95 - 6/30/97 1 EPSDT visit every other year
- 19 to 21 Years Cohort: 7/1/95 - 6/30/97 1 EPSDT visit every other year

Please note, effective 3/1/98 the number of EPSDT visits required for the above cohorts has been modified. Your RNM will provide you with the new EPSDT Periodicity Schedule.

Data Specifications
A well-child care visit is considered to have occurred if a claim was paid that meets one of the following criteria:
- CPT-4 Codes:
  Preventive Medicine services:
  99381-99387: New patient
  99391-99397: Established patient

  Evaluation and Management codes:
  99201-99205: New patient
  99211-99215: Established patient

  Note: Evaluation and Management CPT-4 codes must be in conjunction with V codes V20-V20.2 and/or V70.0 and/or V70.3-70.9.

OR
- X5902 in conjunction with ICD-9 codes:
  V20-V20.2: Health supervision of infant and child
  V70.0 General medical examination (routine)
  V70.3-V70.9 General medical examination
  Note: the above CPT-4 and ICD-9 codes may be used alone or with other codes.

OR
- ICD-9 codes:
  V20-V20.2: Health supervision of infant and child
  V70.0 General medical examination (routine)
  V70.3-V70.9 General medical examination
  Note: the above CPT-4 and ICD-9 codes may be used alone or in conjunction with other codes

OR
- Invoice 04: Item 30 Assessment Status indicates "yes"

OR
- Revenue Code starts with "51" in conjunction with V codes V20-V20.2 and/or V70.0 and/or V70.3-70.9.
PCC PANEL STATISTICS PAGE

Data Specifications

- Any member enrolled in the PCC's panel on 6/30/97
- Age of member as of 6/30/97
- Disabled members are identified as members who are also receiving benefits from Supplemental Security Income (SSI) and/or Massachusetts Commission of the Blind (MCB)

SOURCES


Appendix C

Texas Survey Protocols and Results
Results of Foster Care Parent Survey

Harris County Medicaid Information

State Medicaid Office, HHSC
Foster Parent Survey Results

The vast majority of foster parents who responded take their foster children to a doctor’s office versus a clinic or the emergency room. There were no trends seen regarding using one physician over another. Most foster parents used their own personal physician for their foster children, or else were referred by a friend.

Ninety-five percent of the foster parents surveyed said that their foster child(ren) had seen a physician within the last six months. It is important to remember that all foster children must see a physician upon entry into the system and many of the foster parents stated that this initial assessment accounted for their answer to this question.

The majority (66%) of the respondents said that they normally had a wait of less than one day after making an appointment. An additional 21% said that they had a wait of less than 3 days. This indicates that the current waiting times for an appointment from the day that the appointment is made are reasonable. Most respondents were satisfied with how quickly the children were seen by a physician after the initial phone call.

Eighty-nine percent of the respondents reported that for immediate care, same-day appointments were never a problem. They reported a high-level of satisfaction with immediate care appointments.

While the majority (69%) of respondents did not have trouble accessing medical care on the weekends, a significant percentage (24%) did. This finding warrants additional attention to weekend medical care access.

Eighty-seven percent of respondents have had no trouble finding a primary care physician. But, 54% of foster parents have noted difficulty in accessing health information on their foster children. This is an important issue for several reasons: 1) a foster child may have a condition that warrants immediate attention upon arriving at a new placement (e.g. insulin-dependent diabetes), 2) knowing the child’s medical history can improve preventive measures, 3) knowing the child’s medical history can decrease duplication of medical treatments (e.g. immunizations).

Although the vast majority (76%) of the respondents reported no difficulty in accessing medical specialists when needed, a significant proportion (20%), stated that they had had difficulty accessing specialists. This number warrants attention to increasing access to medical specialists. A similar trend is seen in the accessing of mental health/chemical dependency treatment. Of the respondents to whom this question applied 23% stated that they have had problems accessing MH/CD treatment for their foster children.

Sixty-five percent of the respondents stated that their foster children had not seen a MH/CD professional for treatment in the last six months (29% did), although, a significant percentage of respondents stated simultaneously that their foster children were
on Ritalin or other medications for ADHD, ADD, hyperactivity, and depression. This raises the concern that perhaps these children who are on psychotropic medication are not receiving proper monitoring of their condition, and, perhaps, inappropriate diagnosis by a physician who sees them infrequently. There is the concern that psychotropics are perhaps being over-prescribed, or, on the other hand, perhaps children who enter foster care are those children who have a pre-disposition toward activity disorders and this may be a correlation to their foster care placement. A focus study on this phenomenon is recommended in order to clarify the situation. If it were determined that foster children do actually have a higher rate of activity disorders than the average child population this could enable the system to address the situation with preventive measures (e.g. intervention with parents whose children seem predisposed to hyperactivity before abuse can take place) rather than palliative measures.

There were no distinct trends of where MH/CD care is attained when necessary. The options chosen in order of popularity (from most to least) are: private clinic, primary care physician, MHMR, residential treatment center, psychiatric hospital, and the emergency room.

Of the respondents asked to compare their foster children’s health to that of other children their age, 51% said that their foster children were in good health, 25% said their foster children were in excellent health. Most children are reported to be in relatively similar health to their peers.

Respondent population of foster children demographics:

The most important fact of age seems to be the great number of 2 year olds, 3 year olds, and 6 year olds in the system. It would be interesting to determine if these ages are considered particularly difficult in “striving for independence” phases and talking back to parents. Why are these kids so prevalent in the system? (prevention information).

There is not a strong trend in ethnicity/race for females. Black, Hispanic, and White are all fairly evenly represented.

There are more White and Black male children in this sample than children of other ethnicity's. Across gender and ethnicity, White male children make up the greatest proportion of this sample.

Of the respondent foster children that required regular medication treatment, 54% received medication for hyperactivity, ADHD, ADD, or “behavioral” problems. Other prevalent problems (in order of frequency) were asthma, depression, and seizures.

The most frequently listed conditions (in order of frequency) that require three visits to a health professional, as visit to the ER, or an overnight hospital stay were ADD, ADHD, and asthma.
The most frequently listed changes foster care parents would make to the care they receive for their foster children (in order of frequency) were: have the doctor handle immunizations as well as illness; dental care; more doctors taking Medicaid; quicker, easier medical record movement; an easier list of specialists who accept Medicaid; be able to go to any doctor; it should be mandatory that all doctors to accept Medicaid for well baby check ups; and long distance transportation is a problem and it also interferes with school.

The most frequent responses to what was liked about the care for the foster children were: the physician has a great relationship with the children; no appointment necessary; waiting period short; needs are met; one of the best pediatric associations in the area delivers ill children services.
Questions on Foster Children Health Care Issues

A. What are the most common complaints/symptoms presented by the foster child population? (Circle the most prevalent)
   1. Emotional/Behavioral/Learning Disability
   2. Respiratory/Ear, Nose, Throat/Allergies
   3. Fractures/Sprains/concussions
   4. Gastrointestinal/Flu
   5. Other (specify)

B. What are the most pressing/prevalent health issues and problems of your foster children patients?

C. Did you get preparation from the Department of Protective and Regulatory Services (PRS) regarding working with foster children? Yes No
   If yes, please specify ______________________________
   Would additional information make your job easier? Yes No
   If yes, then what format would be most useful in which to receive additional information? (Circle those which apply)
   1. Seminars/Classes
   2. Clinical Rounds
   3. Printed Materials
   4. Other (specify)

D. What about the current Medicaid fee-for-service system do you think:

Works: ______________________________________________________

________________________________________________________________

Doesn’t work: ________________________________________________

________________________________________________________________

E. What changes would help you do your job better?

________________________________________________________________

If you have any questions while filling out this survey, please contact Beth Ehrichs @ (512)424-6568 or email Beth at beth_e@hhsc.state.tx.us Please return survey by July 25, 1997. Thank you.
Summary of Provider Survey Results

The vast majority of providers who responded (N=18/327) stated that the two most common reasons that they see foster children are for emotional/behavioral problems (9/18) and for respiratory/ear problems (10/18). Two specialists responded with “other” category responses.

Unknown histories of foster children was a prevalent concern of respondents, as were mental health issues.

Four of the 18 respondents said that they received training from DPRS regarding working with foster children, and all but one said that additional information would be helpful. Of those who wanted additional information, all responded that printed materials would be helpful. A few also indicated that seminars would be helpful.

Most providers felt that the current Medicaid system allowed parents to access care in a timely manner for their children and felt that the care was well covered. The STAR program was felt to be confusing to some. An emphasis was placed on the need for better specialists who accept Medicaid to be added to the system. The most important issue seems to be that trouble with the Medicaid card (whether it does not get to families in a timely manner, or if it does not come at all).

The most important change that was mentioned by respondents as what could be helpful to them was better access to foster children medical records.
CPS Worker Survey

Questions on Foster Children Health Issues
If you have any questions while responding to this survey call Beth Ehrichs at (512) 424-6568 or send email beth_e@hhsc.state.tx.us Please return the completed survey by July 15, 1997

A. Where do the foster children on your caseload go for their regular source of medical care? (If there is a close second, or third, etc., please rank order with approximate percentage of foster children on your caseload that use each service):
   1. Doctor
   2. Clinic
   3. Emergency room
   4. Health Department
   5. Other (specify)

B. Many foster parents responded that they use Texas Children’s Hospital as their primary care source. What makes them stand out (e.g. particularly good quality, easy to work with, etc)?

C. What is the best way to inform foster parents about foster children’s health care issues and communicate with them, in general?

D. In regards to the current Medicaid system for foster children’s health care needs, what do you think are the most effective and the least effective components of the following areas:
   Providers:
   MOST
   LEAST
   Quality:
   MOST
   LEAST
   Access:
   MOST
CPS Worker Survey

LEAST

Other (e.g. Medicaid in general):
MOST

LEAST

E.a. **Is there a training component that would help you do your job better?**

YES   NO

If yes, please specify

b. **Do you feel that you have effective communication with physicians?** YES   NO

c. **Have you found that physicians are open to working with you regarding foster children health issues?** YES   NO

Thank you for your time and effort in answering this survey. We will let you know about the results of your answers.

You have several options for returning this survey:

**Mail to:**
HHSC Medicaid Division
P.O. Box 13247
Austin, TX 78711

attention: Beth Ehrichs

**FAX to:**
Beth at (512) 424-6585

e-mail to:
Bourland, Cindy

please return by July 15, 1997
CPS Worker Survey Results

N = 18

The vast majority of the respondents said that their foster children went to either a clinic or a doctor to receive their medical care.

Texas Children’s Hospital was recognized for an exceptional level of quality and attention to the children’s health care issues. Parent/caregiver education was also seen as an important aspect of the services the TX Children’s provided.

Question C was not phrased well, but the most appropriate responses to how to communicate with foster parents stated that telephone, meetings, and letters were the best.

Medicaid's not being accepted everywhere was a common complaint, as were the extensive waiting periods at clinics for service. Respondents felt that the cards were not reliable or consistent in their arrival, but when they did show up, they worked very well. Medicaid doctors were thought to be good, particularly the knowledge and experience that they had.

Few workers felt that a training component would help them, but those who did answer yes, said that training on the new system would be necessary when it was implemented. Several workers indicated that they were concerned/fearful of the new system.

8/18 workers felt that they did not have effective communication with doctors. 8/18 felt that they did have effective communication with doctors. Several said that it depends on the doctor, doctors sometimes spoke above laymen terminology, and some doctors are offended by questions. Although, most respondents found that doctors are open to working with the workers regarding foster children health issues.
Appendix D

Utah’s Child Welfare/Medicaid Complaint System
FHC/HCF Complaint Process

This process was developed jointly by DCFHS-FHC and DHCF-BMHC staff to work together more efficiently in resolving complaints and assuring access for children in the custody of the state.

When an issue around children served by the Fostering Healthy Children Program who are on Medicaid surfaces the following steps will be taken:

1. FHC staff will work through established channels to resolve. (Contact the health plan, contact Julie Thomas for MI-706 problems, etc.) If no satisfactory resolution is reached, ......

2. FHC staff will refer the issue to Julie Olson using the jointly developed complaint form. (See attached form instructions.)

3. Julie will review the complaint/issue, staff/consult with Kay Dietrich and/or Karen Ford and assign the issue to a lead DHCF staff member for resolution. Julie will notify FHC staff and other DHCF staff of assignment. Any staff member with information regarding the issue will coordinate with the assigned lead.

4. DHCF staff will respond with a resolution to the complaint/issue within the following time frames:
   - Billing/Contract issue within 30 days, if the issue cannot be resolved in this time frame, DHCF will provide weekly progress updates.
   - Access to routine care within 5 working days, if the issue cannot be resolved in this time frame, DHCF will provide weekly updates.
   - Access to Urgent care within 24 hours, if the issue cannot be resolved in this time frame, DHCF will provide daily updates.
   - Other, time frame and updates will be negotiated.

FHC staff will support DHCF staff by providing additional information as available, but allow DHCF staff to pursue complaint resolution.

5. DHCF will notify referring FHC staff of resolution and copy Julie.
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<tbody>
<tr>
<td>1.</td>
<td>Date:</td>
<td>2. Person making the referral:</td>
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<td></td>
<td></td>
<td>Phone #</td>
</tr>
<tr>
<td>3.</td>
<td>Client Medicaid ID #:</td>
<td></td>
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<td>5.</td>
<td>DOB:</td>
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<tr>
<td>4.</td>
<td>Client Name:</td>
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<td>6.</td>
<td>Where did the complaint originate? List name and telephone number.</td>
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<tr>
<td>7a.</td>
<td>Type of complaint:</td>
<td></td>
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<tr>
<td></td>
<td>□ Billing/Contract issue (w/ 30 days)</td>
<td>□ Other</td>
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<tr>
<td></td>
<td>□ Access to routine care (w/ 5 working days)</td>
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<td></td>
<td>□ Access to Urgent care (w/ 24 hours)</td>
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<td></td>
<td>c. Describe the problem:</td>
<td></td>
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<tr>
<td></td>
<td>d. Describe actions you have taken:</td>
<td></td>
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<td></td>
<td>e. Other information important to this complaint:</td>
<td></td>
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<td></td>
<td>f. Recommended Action:</td>
<td></td>
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<tr>
<td>8.</td>
<td>HCF progress notes:</td>
<td>9. Proposed Interim Solution/Action:</td>
</tr>
<tr>
<td>10.</td>
<td>Additional Information from FHC</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Final resolution:</td>
<td>How was referrer notified of resolution? How was notified?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Date notified.</td>
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</table>
FHC-DYC/HCF Complaint Tracking Form - Instructions

Note: this form is in an electronic format. Do not be constrained by cell size. You may enter as much information as necessary in each cell.

FHC/DYC staff will notify HCF of the complaint by entering the following information on the complaint form.

1. Enter the date of the referral.
2. Enter your name and your phone number.
3. Enter the client's (child's) Medicaid ID number.
4. Enter the client's name.
5. Enter the client's date of birth.
6. If this complaint came from a person or source other than you, please enter the name and telephone number of that individual.
7. Complaint information.
   a. Check off the type of complaint. If the complaint does not fit in one of the categories, check other. The lead person will contact you to negotiate a time frame for resolution.
   b. List the name of the plan and provider involved in the complaint.
   c. Describe the problem/complaint.
   d. Describe any actions you have taken to resolve the complaint prior to this referral. Include the names of people you have talked to and the date on which you talked.
   e. Enter any other information which is important to understanding the nature of this complaint.
   f. Describe the recommended.

HCF staff will note progress and resolution on the form by:

8. HCF staff will describe actions taken to resolve the complaint. Each entry will be dated. Once the outside time frame for resolution is reached, HCF staff will share these progress notes with the referent based on the agreed upon schedule.

9. HCF staff will describe a proposed course of action, if needed, to assure services while the issue is being resolved. This may be a joint solution arrived at by negotiation between the FHC staff and HCF staff.

10. FHC staff will report any additional information important to resolving the complaint that is available after the complaint has been made.

11. HCF staff will record the final resolution of the problem. Include a date of resolution and how the referrer was notified. Send the record to the FHC referent and copy Julie.