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Treatment Planning and Medication Monitoring Were Lacking for Children in Foster Care Receiving Psychotropic Medication

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Treatment Planning and Medication Monitoring Were Lacking for Children in Foster Care Receiving Psychotropic Medication

What OIG Found

In five States, one in three children in foster care who were treated with psychotropic medications did not receive treatment planning or medication monitoring as required by States. Additionally, the Administration for Children and Families (ACF) has suggested that States consider practice guidelines from professional organizations, including the American Academy of Child and Adolescent Psychiatry, (AACAP) related to treatment planning and medication monitoring. We found that State requirements for oversight of psychotropic medication did not always incorporate these professional practice guidelines.

Treatment planning is critical to enhancing continuity of care; improving coordination of services between health and child welfare professionals; and reducing the risk of harmful side effects. Effective medication monitoring can reduce the risk of inappropriate dosing and inappropriate medication combinations.

Key Takeaway

The five States we reviewed partially complied with their own State requirements for treatment planning and medication monitoring for children in foster care receiving psychotropic medication. Improved compliance and stronger State requirements will help protect children who are at risk for inappropriate treatment and inappropriate prescribing practices.

34%

of children did not receive treatment planning or medication monitoring



20% of children did not receive treatment planning



23% of children did not receive medication monitoring

8% percent of children received neither

What OIG Recommends

To ensure coordinated care for children in foster care who receive psychotropic medications, we recommend that ACF develop a comprehensive strategy to improve States' compliance with requirements related to treatment planning and medication monitoring for psychotropic medications. ACF should assist States in strengthening their requirements for oversight of psychotropic medications by incorporating suggested professional practice guidelines for monitoring children at the individual level. ACF stated that it concurred with some of our recommendations but not others; it did not specify which of the two formal recommendations it agreed with, and which it did not. OIG continues to recommend additional action by ACF as actions to date have not led to the needed outcomes.

Why OIG Did This Review

Up to 80 percent of children enter foster care with significant mental health needs. For children with mental health needs, psychotropic medications (i.e., medication used to treat clinical psychiatric symptoms or mental disorders such as depression, bipolar disorder, and schizophrenia) may be effective treatments. However, these medications can have serious side effects and, as ACF suggests and the five States in our sample require, should be used in conjunction with treatment planning mechanisms and effective medication monitoring.

A 2015 OIG report found—based on review of medical records—serious quality-of-care concerns in the treatment of children with psychotropic medications.

How OIG Did This Review

We selected a sample of 625 children in foster care from the 5 States that had the highest utilization of psychotropic medications in their foster care populations. On the basis of foster care case file documentation and Medicaid claims data, we determined the extent to which the children in our sample were treated with psychotropic medications in a manner consistent with their respective States' requirements. Additionally, we compared the five States' requirements for psychotropic medication oversight with treatment planning and medication monitoring practice guidelines from the American Academy of Child and Adolescent Psychiatry.

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BACKGROUND

Objectives

For the five States with the highest percentages of children in foster care treated with psychotropic medications:

1. to assess the extent to which children in foster care who were treated with psychotropic medications received treatment planning and medication monitoring consistent with States' requirements; and
2. to assess the extent to which States incorporate suggested professional practice guidelines for treatment planning and medication monitoring into their requirements for treatment of children with psychotropic medications.

In 2012, nearly 30 percent of the 400,000 children in foster care in the United States were taking at least one psychotropic medication.¹

Psychotropic medications are often used to treat clinical psychiatric symptoms or mental health disorders such as depression, bipolar disorder, schizophrenia, attention deficit/hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), and anxiety disorders.^{2, 3}

Psychotropic medications can be effective treatments for children who have mental health needs, including children in foster care.⁴ However, these medications can have serious side effects, such as drowsiness, weight gain, nausea, headaches, involuntary movements, and tremors, among others.⁵ There is limited research to guide the use of psychotropic medications in children.⁶ Therefore, psychotropic medications are to be used with care and as part of a comprehensive treatment plan.⁷

Many factors related to foster care can complicate efforts to provide appropriate mental health treatment. Up to 80 percent of children in foster care enter State custody with significant mental health needs.⁸ Unlike children from intact families, children in foster care often do not have a consistent interested party to coordinate treatment planning or to provide continuous oversight of their mental health treatment.⁹ Further, responsibility for children in foster care is shared among multiple people—foster parents, birth parents, and caseworkers—which creates risk of miscommunication, conflict, and lack of followup.¹⁰ Children in foster care may also experience multiple changes in placement and in physicians, which can cause health information about these children to be incomplete and spread across many sources.¹¹ Therefore, children in foster care may be at risk for inappropriate prescribing practices (e.g., too many medications, incorrect dosage, incorrect duration, incorrect indications for use, or inappropriate treatment).¹²

Effective ongoing oversight of children's care and monitoring of prescribing patterns has several potential benefits, such as enhanced continuity of care, increased placement stability, reduced need for psychiatric hospitalization, and decreased incidence of adverse drug reactions and dangerous drug-to-drug interactions.¹³ Ineffective monitoring may increase the risk for inappropriate dosing, frequent medication switches, or the use of inappropriate medication combinations.¹⁴ For example, if a prescriber is unaware that medications are not being taken as ordered, the prescriber may conclude that the existing medication regimen is inadequate and increase a dose or add another medication.¹⁵

A March 2015 Office of Inspector General (OIG) report found that children enrolled in Medicaid—including children in foster care—experienced quality-of-care issues related to their treatment with antipsychotic medications, which are a type of psychotropic medication. Two of the common quality-of-care issues that we identified through reviewing medical records were related to treatment and monitoring.¹⁶

Medicaid pays for a majority of the healthcare services that children in foster care receive, including psychotropic medications.¹⁷ In 2013, State Medicaid programs paid approximately \$366 million for psychotropic medications for nearly 240,000 children in foster care up to age 21.¹⁸

The Administration for Children and Families' (ACF) Oversight of State Foster Care Program Requirements

ACF is responsible for awarding Federal funding to States' child welfare programs and for overseeing those programs.

ACF Requirements for State Plans. ACF requires the State agency that administers the State's child welfare program to submit a State plan every 5 years, which outlines how it will comply with Federal requirements. As part of its State plan submission, each State must include a healthcare coordination and oversight plan. The State child welfare agency develops this plan with the State Medicaid agency, pediatricians, other healthcare experts, child welfare service experts, and recipients of these services. The plan addresses the oversight of prescription medicines, including requirements for monitoring the appropriate use of psychotropic medications.^{19, 20} The plan must address five elements (listed in Appendix A).²¹ Annually, ACF requires each State child welfare agency to describe in its Annual Progress and Service Report its protocols (official procedures used to accomplish the State plan) related to each of the five elements and provide additional information on how the child welfare workforce and providers are trained with regard to these requirements.²² Hereinafter, we refer to State agency as State and protocols as State requirements.

As noted earlier, previous OIG work has identified (through review of medical records) issues with children receiving inappropriate treatment and monitoring. Two of the five elements ACF requires to be part of a State's

plan include: (1) screening, assessment, and treatment planning mechanisms to identify children’s mental health needs and trauma-treatment needs, including a psychiatric evaluation, as necessary, to identify whether children need psychotropic medications; and (2) effective medication monitoring at both the client level and agency level.²³ Client-level monitoring—in this case, child-level monitoring—refers to monitoring an individual who receives medication. Child-level monitoring can include practices such as employing nurses to ensure that individual children receive necessary services or requiring review of individual prescriptions.²⁴ Agency-level monitoring—in this case, State-level monitoring—refers to activities that support and inform decisions for all clients of an agency. State-level monitoring could involve a State’s monitoring the rate at which children in foster care receive psychotropic medication, monitoring the types of psychotropic medications children receive, or establishing an advisory committee to oversee its medication formulary.²⁵

ACF Oversight of State Compliance. ACF oversight includes periodic reviews of each State’s child welfare system, known as Child and Family Services Reviews, to assess whether a State complies with its State plan requirements.²⁶ In this report, we refer to these reviews as compliance reviews. ACF determines compliance (i.e., substantial conformity) based on a number of factors, including the State’s ability to meet criteria related to outcomes for children and families.²⁷ In making its assessment, ACF uses a compliance review instrument that assesses particular criteria and makes a determination based on the entirety of the review.

If ACF finds that a State is not in substantial conformity with its State plan, it requires that the State develop a program improvement plan.^{28, 29} If the State fails to successfully complete a program improvement plan, ACF has the authority to withhold a certain amount of Federal funding.³⁰

The mental/behavioral health section of the compliance review instrument includes an assessment of needs, and services that the State provided to meet those needs, for a sample of children in foster care. The instrument includes criteria such as (1) ensuring the child was seen regularly by the physician to monitor the effectiveness of medication, assess side effects, and consider any changes needed in dosage; (2) regularly following up with foster parents/caregivers about administering medications appropriately and outcomes and side effects.³¹

Guidance on Oversight of Psychotropic Medications for Children in Foster Care

ACF’s instruction to States regarding development of requirements related to screening, assessment, treatment planning, and effective medication monitoring is broad. For example, ACF has not established requirements defining the periodicity of the screening, the assessment tools that should be used, or the details that should be included in the treatment plan.

ACF has suggested that States consider practice guidelines from professional organizations related to treatment planning and medication monitoring in efforts to improve their monitoring and oversight requirements of psychotropic medications. These organizations include the American Academy of Child and Adolescent Psychiatry (AACAP), the American Academy of Pediatrics, and prescription parameters developed by the State of Texas, which detail mechanisms that may be used to accomplish the broad requirements.³² ACF highlighted the AACAP guidelines as particularly relevant to States when developing their psychotropic medication oversight and monitoring requirements. However, ACF instruction acknowledges that States are unique and does not mandate States to incorporate professional practice guidelines in their requirements.

Professional practice guidelines highlight the importance of treatment planning and medication monitoring for children prescribed psychotropic medications.³³ Treatment planning should include collaboration among caregivers to discuss symptoms, behaviors, and potential benefits and side effects of treatment options.³⁴ This allows all parties to understand why medication is being used and the plan for followup.³⁵ Medication monitoring visits should occur regularly to enhance patient and guardian confidence in the treatment, and to promote effective management of longer term treatment and safety issues.³⁶ Specifically, medication monitoring enables prescribing professionals, patients, and guardians to establish a plan for followup and reduce the risk for an unidentified relapse or recurrence of symptoms.³⁷

Methodology

Scope

For five States, we determined whether children in foster care were treated with psychotropic medications consistent with their States' requirements related to: (1) screening, assessment, and treatment planning mechanisms, including (as necessary) psychiatric evaluations; and (2) medication monitoring. This study focuses on these two elements because of the quality-of-care concerns that we identified in previous OIG work.

We also determined the extent to which these State requirements were consistent with suggested professional practice guidelines focused on treatment of children with psychotropic medications.

In the States we reviewed, requirements related to screening and assessment applied only to children *entering* foster care. There was not a significant number of sampled children who entered foster care during the review period. Therefore, we were not able to project results related to screening and assessment requirements in the study.

Further, according to the States' requirements, psychiatric evaluations are required only "as necessary," or "if recommended." Because case files did not consistently document the need for psychiatric evaluation, we could not

assess compliance with this conditional requirement. Therefore, we were not able to project results related to psychiatric evaluation requirements.

State and Sample Selection

We selected the five States with the highest percentages of children in foster care who were treated with psychotropic medications in FY 2013, the most recent year for which there was complete data available in the Medicaid Statistical Information System (MSIS).³⁸ They were Iowa, Maine, New Hampshire, North Dakota, and Virginia.

We combined foster care eligibility data and Medicaid claims data obtained from the five States to determine the population of children in foster care treated with psychotropic medication during the review period, October 1, 2014, through March 31, 2015. From that population, we selected a simple random sample of 125 children from each of the 5 States, for a total of 625 children. We excluded 36 children for various reasons, such as the child's not having been in foster care for a sufficient time (see Appendix B).

Collection and analysis of documentation and data. For each child in our sample, we requested documentation from foster care case files and Medicaid claims data representing services received during the review period. We determined whether any services represented evidence that a required element—screening, assessment, treatment planning, psychiatric evaluation, and/or medication monitoring—occurred. For each instance of a requirement that the State appeared to have not met, we invited the State to provide additional evidence.

Comparing States' Requirements to Practice Guidelines Recommended by AACAP

ACF suggested States consider professional practice guidelines for improving their monitoring and oversight of psychotropic medications.³⁹ We selected professional practice guidelines from AACAP guidance documents for comparison with the five States' requirements for oversight regarding psychotropic medication.⁴⁰ See Appendix B for a detailed description of our methodology.

Limitations

Our estimates cannot be generalized beyond the five selected States.

It is possible that some children in our sample received healthcare services that were not paid for by Medicaid or were not included in the data submitted; therefore, this study may have underestimated the provision of required health services for these children.⁴¹

Standards

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

FINDINGS

One in three children in foster care who were treated with psychotropic medications did not receive required treatment planning or medication monitoring

Thirty-four percent of children in foster care who were treated with psychotropic medications, in the five States we reviewed, did not receive either treatment planning or medication monitoring (see Exhibit 1). Eight percent of these children received neither treatment planning nor medication monitoring. Treatment planning and effective medication monitoring are imperative because of the risks of inappropriate treatment and inappropriate prescribing practices (e.g., too many medications, incorrect dosage, incorrect duration, incorrect indications for use). See Appendix C for more information regarding States’ compliance with each requirement we reviewed.

Exhibit 1: One in three children in foster care who were treated with psychotropic medications did not receive required treatment planning or medication monitoring



Note: Results are rounded.

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.

See Appendix D for all point estimates and corresponding 95-percent confidence intervals.

Twenty percent of children in foster care did not receive treatment planning

In the five States reviewed, 20 percent of children did not receive treatment planning, as States required. Effective treatment planning provides a mechanism for caseworkers, foster parents, and prescribers to be aware of medications the child is receiving. For children in foster care, effective treatment planning is critical to enhancing continuity of care, improving coordination of services between health and child welfare professionals, and reducing the risk of harmful side effects.

In the following example, there was no evidence that a treatment plan was developed before starting the medication of a child in foster care. However, the child did receive a retrospective review of the four psychotropic medications prescribed. This review indicated concerns regarding the medical necessity of the child's drug regimen that should have been considered and documented in a treatment plan. Without a treatment plan, there is no evidence that the child's caregivers understood important concerns before medicating this child, such as (1) the rationale for each medication, (2) the potential benefits and side effects of each medication, and (3) the plan for followup.

Child Description—6-year-old child diagnosed with ADHD, behavior disorder, learning disability, tic disorder, dysarthria (speech disorder), oppositional defiant disorder, PTSD, trichotillomania (hair-pulling disorder). Prescribed four psychotropic medications.

Case Narrative—The State-employed nurse coordinator noted her opinion that the medications "were quite a bit for a child of his age," and initiated a referral for a medication review. The medication review indicated that the psychiatrist reviewer had questions regarding two of the four medications prescribed to this child. He acknowledged that current medication use could have been within the standard of care. However, there were questions concerning the following: (1) medical necessity for one of the medications; (2) side effects of one medication that could be exacerbating one of the child's conditions; and (3) a dosage increase in one medication that could have negated the need for the fourth medication. The medical review resulted in correspondence with the prescribing professional regarding the medical necessity for two of the child's four medications. Subsequent to this review, the child's drug regimen was changed.

In three of five States, over half of the children who received treatment planning did not have a complete treatment plan. Three of the five States have specific criteria for treatment plans. In those States, 52 percent of children who received treatment planning had plans that did not meet all State criteria. See Appendix C for each of the States' specific criteria for treatment plans, as well as the percentage of children for whom treatment plans did not meet all State-required criteria. Examples of State criteria for treatment plans in those three States include documentation of: diagnoses, assessment summaries, interventions, treatment progress, information about prescribed medications, and evidence of collaboration by a multidisciplinary team. Including these criteria in treatment plans helps caregivers to understand why medication is being used and the plan for followup. Further, treatment planning provides a mechanism for caregivers

to collaborate to assess target symptoms, behaviors, potential benefits, and adverse effects of treatment.

Twenty-three percent of children in foster care did not receive medication monitoring

In the five states we reviewed, 23 percent of children did not receive medication monitoring during the review period. Effective medication monitoring can reduce the risk of inappropriate dosing or inappropriate combinations of medications. For example, if a prescriber is unaware that medications are not provided as planned, the prescriber may unknowingly increase a dose or add another medication.

Medication monitoring is essential for children in foster care to promote communication among prescribing professionals, patients, and guardians, and to establish a plan for followup. Further, medication monitoring can reduce the risk for an unidentified recurrence of symptoms and promote effective management of longer term treatment and safety issues.

States acknowledged challenges in providing required services related to oversight of psychotropic medication for children in foster care

In the five States we reviewed, officials reported challenges in State plan implementation that can pose barriers to providing required services for children in foster care. These challenges included a lack of data for measuring outcomes and limited access to mental health services. Additionally, States noted that some gaps in meeting their requirements are related to transitions in the case-management workforce, developing effective accountability measures for caseworkers, and appropriate training for new caseworkers. Officials reported a need for additional guidance and technical assistance from ACF related to oversight of psychotropic medications prescribed to children in foster care.

States proposed some guidance and assistance that would be helpful to mitigate barriers to providing required services, including:

- national data for States to use as benchmarks in measuring their progress toward meeting the requirements;
- successful policy and practice strategies that have been used by other States to meet requirements; and
- assistance in improving communication between Medicaid and child welfare systems to facilitate the tracking of services provided to children in foster care and measure progress in meeting requirements.

State requirements for psychotropic medication oversight did not always incorporate suggested professional practice guidelines for treatment planning and medication monitoring

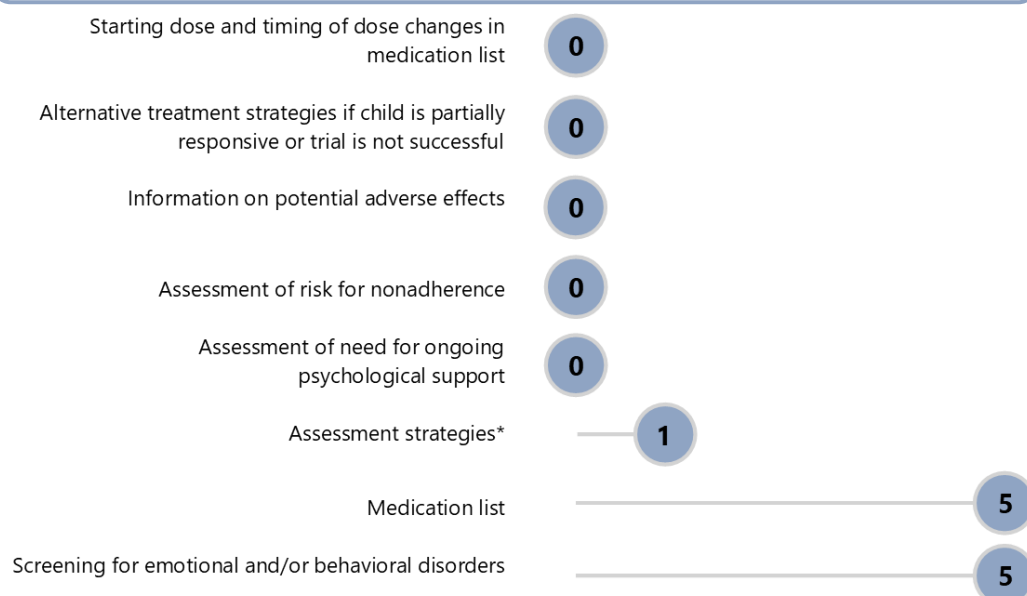
In the five States we reviewed, State requirements did not always incorporate professional practice guidelines regarding oversight of psychotropic medications for children in foster care, as suggested by ACF. Although ACF requires State plans to protect children by including treatment planning mechanisms and effective medication monitoring, it allows States flexibility in implementation. ACF suggests that States consider practice guidelines from professional organizations, including AACAP, to improve their treatment planning and medication monitoring requirements.

The five States' requirements did not consistently incorporate professional practice guidelines for child-level monitoring

Our review of five States found that State requirements did not always incorporate these recommendations related to child-level treatment planning and medication monitoring (see Exhibit 2). For example, none of the five States we reviewed included requirements to document medication dosages or potential adverse effects of medications within children's foster care case files.

Exhibit 2: States' requirements did not consistently incorporate elements of suggested professional practice guidelines for child-level oversight of psychotropic medication

Among five States, number that included suggested case file documentation requirements for child-level monitoring of psychotropic medications:



* For example, self-reports, parent or guardian reports, and teacher reports.

Source: OIG analysis of selected AACAP recommendations compared with States' requirements, 2017

Specifically, State child-level requirements did not include elements such as information on potential adverse effects or assessment of risk for nonadherence to the treatment plan. These elements provide essential information to accomplish effective oversight, to monitor prescribing, and

to enhance continuity of care. Without these child-level requirements, there is no mechanism to ensure that caregivers are consistently collaborating to assess target symptoms, behaviors, potential benefits, and adverse effects of treatment.

Child-level practice guidelines promote a coordinated strategy in oversight of individual children's psychotropic medication use. This guidance is critical due to known concerns in the foster care population, such as complex mental healthcare needs and changes in foster home placement. These concerns increase the risk of miscommunication among caregivers and ineffective and inappropriate medications or medication combinations. Additionally, previous work by the Government Accountability Office (GAO) concluded that States that do not incorporate AACAP's recommended elements limit their ability to identify potentially risky prescribing practices.⁴²

The following example highlights the importance of State child-level requirements. In this State, there is no requirement for caseworkers to follow up with foster parents about medication and the child's outcomes or assess the risk for medication nonadherence. The child was without prescribed medication for a time and experienced adverse effects. There was no evidence in the case file that the caseworker was aware of the nonadherence and the impact on the child's outcome.

Child Description—11-year-old child diagnosed with reactive attachment disorder, conduct disorder, anxiety, and ADHD. Prescribed two psychotropic medications.

Case Narrative—The child experienced a 3-month period during which the foster mother stated she had difficulties obtaining medication refills for the child. Two prescribing professionals said the child needed to be seen first by a psychiatrist. One prescriber agreed to provide a refill because the child was unmanageable without medications. The child was seen by a psychiatrist during the fourth month, at which time the notes indicated the child was without medications, had lost the ability to maintain normal psychological function, and had experienced a decline of his overall situation. The decline included increased stealing, lying, bullying, poor interactions with other children, and in-school suspension.

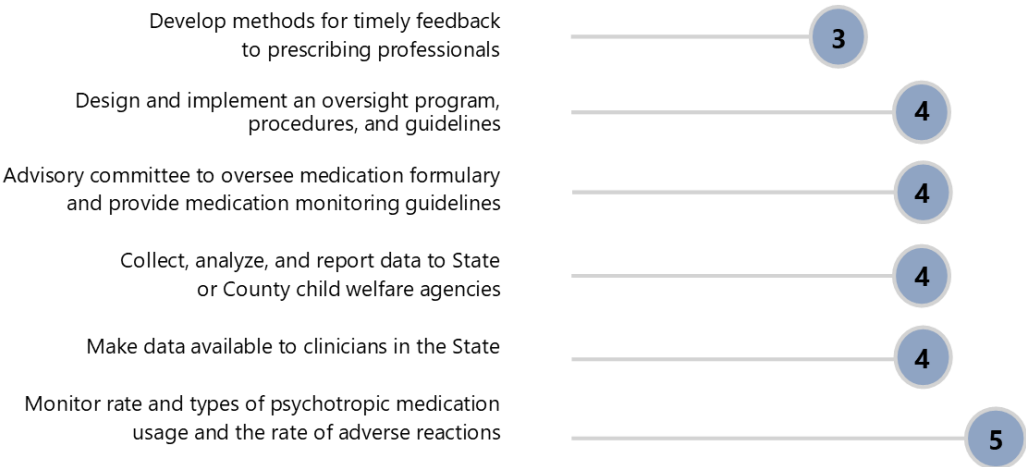
The five States' requirements generally incorporated suggested professional practice guidelines for State-level monitoring

Unlike States' child-level requirements, States' State-level requirements generally incorporated suggested professional practice guidelines (see Exhibit 3, on the next page). For example, States included a requirement to monitor the rates and types of psychotropic medication usage and rates of adverse reactions. These aggregate mechanisms can improve States' ability

to identify potentially risky prescribing practices and to improve oversight of psychotropic medications for children in foster care.

Exhibit 3: States’ requirements generally incorporated suggested professional practice guidelines for State-level oversight of psychotropic medication

Among five States, number that included suggested practice guidelines within their requirements for State-level monitoring of psychotropic medications:



Source: Source: OIG analysis of selected AACAP recommendations compared with States’ requirements, 2017

CONCLUSION AND RECOMMENDATIONS

The five States that we reviewed partially complied with their own State-established requirements for treatment planning and medication monitoring for children in foster care receiving psychotropic medications; further, State requirements did not always include suggested professional practice guidelines designed to protect these children. Specifically, 34 percent of children in foster care who were treated with psychotropic medications did not receive treatment planning or medication monitoring as required. Additionally, States' requirements did not consistently incorporate suggested professional practice guidelines, such as requiring assessment strategies and documenting information on potential adverse effects. Improved compliance and strengthened State requirements are imperative to provide protections for children who are at risk for inappropriate treatment and inappropriate prescribing practices.

To ensure coordinated care for children in foster care receiving psychotropic medications, we recommend that ACF:

Develop a comprehensive strategy to improve States' compliance with requirements related to treatment planning and medication monitoring for psychotropic medication

ACF must ensure that States coordinate care for children in foster care with regard to oversight of psychotropic medication. To do this, ACF should develop a comprehensive strategy that identifies methods for States to improve compliance with requirements for treatment planning and medication monitoring. The strategy should guide ACF in strengthening compliance and identifying gaps that need to be addressed. This will improve transparency and accountability, and assist States in doing the same. The strategy should include, at a minimum:

- providing enhanced training and technical assistance, through collaboration with professional provider organizations, for States related to implementing treatment-planning mechanisms and effective medication monitoring (e.g., continued education for caseworkers and supervisors).

Also, ACF may consider:

- helping States develop effective accountability measures and mechanisms for internal quality review;
- requesting that States report data on treatment planning and medication monitoring to the extent they can provide reliable and consistent data, and then providing the compiled national data to States to use as a benchmark for their progress in meeting requirements; and

- placing increased weight on treatment planning and medication monitoring when determining a State's substantial conformity with plan requirements, changing the assessment instrument as necessary, and following up with enforcement actions when appropriate (e.g., mandating program improvement plans, and, where appropriate, withholding Federal funds).

Assist States in strengthening their requirements for oversight of psychotropic medication by incorporating professional practice guidelines for monitoring children at the individual level

ACF must help States strengthen their requirements by incorporating child-level protections for children in foster care who are treated with psychotropic medications. To do this, ACF should:

- strengthen its annual review of States' protocols to confirm that State requirements incorporate professional practice guidelines related to treatment planning and medication monitoring,
- publish an Information Memorandum regarding specific mechanisms for child-level treatment planning and methods to achieve effective medication monitoring, and
- provide enhanced training and technical assistance for States related to incorporating professional practice guidelines in State protocols through collaboration with professional provider organizations.

Also, ACF may consider:

- providing standardized protocols or templates that include child-level recommendations and implementation strategies that States could adapt to meet local needs.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

ACF stated that it concurred with some of our recommendations but not others; it did not specify which of the two formal recommendations it agreed with, and which it did not. ACF comments addressed various subsections of each of these recommendations. We ask that ACF clarify in its Final Management Decision its concurrence or non-concurrence for each formal recommendation.

OIG recommended that ACF develop a comprehensive strategy to improve States' compliance with requirements related to treatment planning and medication monitoring for psychotropic medication. In response, ACF noted that it already has a well-established approach to program implementation that includes a regulated mechanism to identify and correct compliance issues. However, OIG found that one in three children were not receiving treatment planning or medication monitoring, as required in their respective States, which suggests the current approach to identifying and correcting compliance issues is insufficient and more needs to be done. ACF did agree to assess opportunities to continue to provide technical assistance in this area as well as ensure States are reporting on this requirement through Child and Family Services Plans and annual updates. If ACF does conduct such technical assistance and training activities, in collaboration with professional organizations, this would fulfill the intent of our first recommendation.

However, we encourage ACF to further consider our additional suggestions toward improving States' treatment planning and medication monitoring for children in foster care. We note that ACF disagreed with one of these suggestions related to reporting data on treatment planning and medication monitoring. ACF views this data reporting to be outside the scope of what can be reliably and consistently reported to an administrative data set. ACF notes that, by law, its administrative data set must be both reliable and consistent across the reporting population. OIG agrees that data reporting must be reliable and consistent. We continue to encourage ACF to consider innovative approaches to promote State reporting of basic information on treatment planning and medication monitoring that will be reliable and consistent. Likewise, ACF could actively assist States to develop effective accountability measures and mechanisms for internal quality review and consider placing increased weight in its review of treatment planning and medication monitoring during its compliance reviews of States.

With respect to the second recommendation, OIG recommended that ACF assist States in strengthening their requirements for oversight of psychotropic medication. In response, ACF stated that it is amenable to assessing what additional technical assistance and best practice guidance to provide to States regarding the monitoring of psychotropic medication. ACF described the mechanisms through which it makes technical assistance available to States and noted that, to date, no States have reached out around this area of need. ACF also stated that the Child Welfare Information Gateway will include a new article on improving the use of psychotropic medication for children in foster care. This article may represent a step toward providing technical assistance for States related to incorporating professional practice guidelines in State protocols, one aspect of OIG's recommendation. However, overall, ACF's response did not address the substance of OIG's recommendation. OIG continues to recommend that ACF actively engage with States through various actions. In addition to providing technical assistance, these actions should include strengthening its annual review of States' protocols to confirm that State requirements incorporate professional practice guidelines related to treatment planning and medication monitoring for children at the individual level.

The full text of ACF's comments can be found in Appendix F.

APPENDIX A: Five Required Elements for Monitoring the Appropriate Use of Psychotropic Medications

ACF program instruction directs States to include the following elements in their protocols:

1. comprehensive and coordinated screening, assessment, and treatment planning mechanisms to identify children's mental health and trauma-treatment needs, including a psychiatric evaluation, as necessary, to identify needs for psychotropic medications; and
2. informed and shared decision making and methods for ongoing communication between the prescriber, the child, the child's caregivers, and other stakeholders (e.g., healthcare providers and child welfare worker);
3. effective medication monitoring at both the client level and agency level;
4. availability of mental health expertise and consultation regarding both consent and monitoring issues by a board-certified child and adolescent psychiatrist; and
5. mechanisms for sharing accurate and up-to-date information related to psychotropics with clinicians, child welfare staff, and consumers (e.g., children and caregivers), including both data sharing mechanisms (e.g., integrated information systems) and methods for sharing educational materials.⁴³

APPENDIX B: Detailed Methodology

State Selection

We selected the five States with the highest percentages of children in foster care who were treated with psychotropic medications in FY 2013. Our assessment of Medicaid eligibility and claims data determined they were Iowa, Maine, New Hampshire, North Dakota, and Virginia. Appendix E contains further details on demographics and Medicaid fee-for-service (FFS) expenditures in all States.

Exhibit B-1: State Demographics Regarding Children in Foster Care Treated with Psychotropic Medications and Related Medicaid Expenditures

State	Population of Children in Foster Care	Number of Children in Foster Care Treated with Psychotropic Medications	Percentage of Children in Foster Care Treated with Psychotropic Medications	Total Medicaid FFS Expenditures for Psychotropic Medications for Children in Foster Care
Iowa	13,951	4,981	35.7%	\$7,135,849
Maine	3,527	1,155	32.7%	\$1,600,692
New Hampshire	2,614	944	36.1%	\$1,741,581
North Dakota	2,734	1,021	37.3%	\$1,184,934
Virginia	14,999	5,584	37.2%	\$11,959,404

Source: OIG analysis of MSIS eligibility and prescription drug claims data, 2016.

Collection of States' Data and Requirements

We sent a letter to the administrator of each selected State's foster care agency and to each Medicaid director to request a point of contact to respond to our requests for information. From the points of contact, we requested: (1) foster care eligibility data representing all children enrolled in foster care at any time during the review period; (2) a copy of the State's selected foster care requirements; (3) any supporting documentation accompanying those requirements (such as State policies or required forms); (4) State responses to questions that the team developed regarding how the State has implemented the requirements and any related guidance and technical assistance ACF has provided; and (5) all Medicaid-paid claims for psychotropic medications prescribed to children up to 21 years old between October 1, 2014, and March 31, 2015, from the States' Medicaid Management Information Systems (MMIS).

Sample Selection

We selected a simple random sample of 125 children from each State for a total of 625 children. A total of 36 children were determined to be ineligible

for the sample for one of the following reasons: the child was not in foster care during the review period, the child did not receive a Medicaid-paid psychotropic drug claim during their foster care eligibility or during our review period, the child was not in foster care for at least 30 days of our review period, or other limitations prevented review of the case file. Therefore, the overall weighted response rate was 92 percent. In total, 589 children were analyzed for this review. See Exhibit B-2 below regarding the population and sample sizes for the five States.

Exhibit B-2: Population of Children in Foster Care Enrolled in Medicaid Treated with Psychotropic Medications at Any Time Between October 1, 2014, and March 31, 2015

State	Population Size	Sample Size	Ineligible Sampled Children	Final Analyzed Sampled Children
Iowa	2,166	125	9	116
Maine	566	125	5	120
New Hampshire	244	125	1	124
North Dakota	280	125	7	118
Virginia	2,156	125	14	111
Total	5,412	625	36	589

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.

Case File Documentation and Medicaid Claims Data Review

We developed criteria based on the State's selected requirements related to screening, assessment, treatment planning, medication monitoring, and psychiatric evaluation. Using the foster care case file documentation and Medicaid claims data, we reviewed each child's treatment with psychotropic medications according to the State's requirements. For our study period, October 1, 2014 to March 31, 2015, we identified the case file documentation and healthcare services received by each child during the child's foster care eligibility. We then determined whether any of those services represented a required element.

For medication monitoring with a prescribing professional, any Medicaid claim for an evaluation and management visit with a mental health diagnosis was considered to fulfill this requirement.⁴⁴ Any documentation in the case file stating that an appointment occurred was considered to have fulfilled this requirement so long as we could determine it was with a prescribing professional or the child's psychotropic medication(s) were discussed. Caseworker notes, narrative, or emails that summarized changes in medication were also considered medication monitoring.

Because States gave minimal definition of treatment plans, we considered any case file documentation that was labeled "treatment plan," "case plan," or "care plan" to have fulfilled the treatment plan requirement.⁴⁵ Plans developed by prescribing professionals and/or by foster care caseworkers

were considered to have fulfilled this requirement. Documents developed by schools were not considered to have fulfilled treatment plan requirements.

Analysis of Results

We reviewed foster care case file documentation and Medicaid claims data for each sampled child. If either foster care case file documentation or the Medicaid claims demonstrated receipt of a particular required element by a sampled child, that element was counted as received. If neither the foster care case file documentation nor the Medicaid claims demonstrated receipt of a particular required element by a sampled child, that element was counted as not received.

We followed up with foster care program officials in the five States regarding every child for whom we determined at least one required element was missing. State officials either provided additional documentation showing that the child did receive the element(s) in question, or declined to submit additional documentation. If additional documentation showed that the element(s) were received, we counted those element(s) as received.

Comparing States' Protocols to Professional Practice Guidelines

We selected professional practice guidelines from AACAP guidance documents for comparison with the five States' requirements for oversight regarding psychotropic medication. Specifically, we selected professional practice guidelines related to (1) screening, assessment, psychiatric evaluations, and treatment planning; and (2) medication monitoring. We then assessed the extent to which State requirements incorporated these professional practice guidelines. For example, regarding treatment planning and medication monitoring, we assessed whether States' protocols required inclusion of elements such as assessment for risk of nonadherence, information on adverse effects, assessment strategies, starting dose and timing of dose changes in the medication list.

APPENDIX C: State-by-State Compliance With Psychotropic Medication Requirements

This appendix contains five State-by-State summaries of compliance for selected foster care requirements regarding psychotropic medications.

We reviewed foster care case file documentation and Medicaid claims data representing healthcare services and mental health services received by the sampled children during the review period. We determined whether any of those documents or claims represented evidence that a State-required criteria of treatment planning and medication monitoring was provided.

Each State establishes its own foster care requirements (i.e., protocols) for oversight of psychotropic medications. Each State's requirements are unique; therefore, the criteria that we used to assess consistency with the requirements in each selected State is unique to that State. Additionally, we included a determination for each State of whether each sampled child received medication monitoring by a prescribing professional.



Iowa

Compliance with State-Specific Requirements Based on Foster Care Case File and Medicaid Claims Review



TREATMENT PLANNING

Iowa requires that a treatment plan be developed for the child in foster care.

- 30 percent of children in foster care did not receive a treatment plan



MEDICATION MONITORING

Iowa requires caseworkers to visit children in foster care monthly to: determine whether children are receiving necessary medical care and whether the program plan is providing appropriate and sufficient services; inquire of the foster family the effectiveness of the medications; and document the child's medications, why they were prescribed, and whether they meet the child's needs. We also included a determination of whether each sampled child received medication monitoring by a prescribing professional.

- Children in foster care did not receive the following State-required medication monitoring criteria, as applicable:*
- 41 percent of children did not have evidence that the caseworker documented whether the child was receiving necessary medical care in their case files
- 33 percent of children did not have evidence that the caseworker documented whether the program plan was providing appropriate and sufficient services in their case files
- 83 percent of children did not have evidence that the caseworker inquired of the foster family the effectiveness of the medications in their case files
- 84 percent of children did not have evidence that the caseworker documented the reason the medication was prescribed in their case files
- 72 percent of children did not have evidence that the caseworker documented whether the medication was meeting the child's needs in their case files
- 48 percent of children in foster care did not receive medication monitoring by a prescribing professional



HIGHLIGHT OF RELATED STATE PRACTICES

Iowa requires caseworkers to conduct multiple tasks related to medication monitoring during their monthly visits with children in foster care. Tasks include determining whether a child is receiving necessary medical care, inquiring of the foster family the effectiveness of a medication, and determining whether the medication meets the child's needs.

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.

*The figures in this exhibit represent the occurrence of this activity at least once during the review period. However, we note Iowa protocol directs caseworker to complete these tasks monthly.



Maine

Compliance with State-Specific Requirements Based on Foster Care Case File and Medicaid Claims Review



TREATMENT PLANNING

Maine requires that a treatment plan be developed for the child in foster care.

- 28 percent of children in foster care did not receive a treatment plan



MEDICATION MONITORING

Maine requires that children in foster care's medication plans be reviewed quarterly by the treatment provider. Additionally, for children prescribed antipsychotic medication, Maine requires the caseworker to participate in medical or psychiatric appointments where medications are initially discussed and a determination is made to proceed or not, and then at least every 3 months following. We also included a determination of whether each sampled child received medication monitoring by a prescribing professional.

- 26 percent of children in foster care had a medication plan that was not reviewed quarterly by the treatment provider
- For children prescribed antipsychotic medications, 59 percent of children in foster care did not have a caseworker who participated in initial medical or psychiatric appointments and then at least every 3 months following*
- 11 percent of children in foster care did not receive medication monitoring by a prescribing professional



HIGHLIGHT OF RELATED STATE PRACTICES

Maine requires caseworkers to conduct certain tasks when a prescribing professional considers antipsychotic medications as a course of treatment for a child in foster care. Caseworkers must provide the child with a discussion guide on antipsychotic medications, complete a medication consent form, review the child's case with the prescribing professional, and participate in the initial appointment to discuss the medication and then every three months following.

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.

*This estimate is based on a sample size of 39 children. The 95-percent confidence interval for this estimate is 45 percent to 72 percent.



New Hampshire

Compliance with State-Specific Requirements Based on Foster Care Case File and Medicaid Claims Review



TREATMENT PLANNING

New Hampshire requires that a treatment plan be developed for the child in foster care. The treatment plan must include an assessment summary, diagnosis, goals or desired outcomes, incremental steps to goal achievement, interventions, an evaluator's name or signature, and a date.

- 23 percent of children in foster care did not receive a treatment plan
- 76 percent of children in foster care did not receive all State-required treatment planning criteria, as follows:
 - 6 percent of children did not have an assessment summary in their treatment plan
 - 38 percent of children did not have a diagnosis in their treatment plan
 - 3 percent of children did not have goals or desired outcomes in their treatment plan
 - 7 percent of children did not have incremental steps to goal achievement in their treatment plan
 - 6 percent of children did not have interventions in their treatment plan
 - 57 percent of children did not have the evaluator's name/signature/date in their treatment plan



MEDICATION MONITORING

We included a determination of whether each sampled child received medication monitoring by a prescribing professional.

- 22 percent of children in foster care did not receive medication monitoring by a prescribing professional



HIGHLIGHT OF RELATED STATE PRACTICES

New Hampshire employs public health nurse coordinators to assist caseworkers by coordinating healthcare visits, exams and treatment for children in foster care, reviewing healthcare histories, and documenting care planning activities.

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.



North Dakota

Compliance with State-Specific Requirements Based on Foster Care Case File and Medicaid Claims Review



TREATMENT PLANNING

North Dakota requires that a treatment plan be developed for the child in foster care. The plan must include goals or objectives, action steps, information about prescribed medications, documentation of treatment progress, and evidence that the treatment plan was developed by a multidisciplinary team.*

- 7 percent of children in foster care did not receive a treatment plan
- 38 percent of children in foster care did not receive all State-required treatment planning criteria, as follows:
 - 2 percent of children did not have goals or objectives in their treatment plan
 - 8 percent of children did not have action steps for meeting specified goals in their treatment plan
 - 11 percent of children did not have information about prescribed medications in their treatment plan
 - 11 percent of children did not have documentation of treatment progress in their treatment plan
 - 27 percent of children did not receive a treatment plan developed by a multidisciplinary team



MEDICATION MONITORING**

We included a determination of whether each sampled child received medication monitoring by a prescribing professional.

- 2 percent of children in foster care did not receive medication monitoring by a prescribing professional



HIGHLIGHT OF RELATED STATE PRACTICES

North Dakota requires multidisciplinary participation in Child & Family Team meetings for children in foster care. The teams are tasked with reviewing case plans, determining levels of care, writing permanency plans, and developing local policies related to foster care.

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.

*North Dakota protocol does not define the disciplines included in a multidisciplinary team. For this review, we considered this requirement met with evidence of participation by at least two disciplines including: Guardian Ad Litem (GAL), Independent Living Coordinator, social worker, caseworker, practitioner, and therapist.

**North Dakota medication monitoring requirements applied to children in foster care in certain circumstances (e.g., residential treatment facilities and therapeutic foster care). These requirements were not applicable to a significant number of sampled children; therefore, we cannot project compliance with these requirements.



Virginia

Compliance with State-Specific Requirements Based on Foster Care Case File and Medicaid Claims Review



TREATMENT PLANNING

Virginia requires that a treatment plan be developed for the child in foster care. The plan must include the child's strengths and needs, health status including any allergies or health conditions, names and addresses of the child's medical and mental health providers, and a list of the child's medications including psychotropic drugs.

- 7 percent of children in foster care did not receive a treatment plan
- 52 percent of children in foster care did not receive all State-required treatment planning criteria, as follows:
 - 12 percent of children did not have strengths and needs in their treatment plan
 - 25 percent of children did not have health status in their treatment plan
 - 42 percent of children did not have the names and addresses of their medical and mental health providers in their treatment plan
 - 29 percent of children did not have a list of their medications including psychotropic drugs in their treatment plan



MEDICATION MONITORING

We included a determination of whether each sampled child received medication monitoring by a prescribing professional.

- 3 percent of children in foster care did not receive medication monitoring by a prescribing professional



HIGHLIGHT OF RELATED STATE PRACTICES

Virginia's Department of Social Services revised the State's foster care manual in July 2015. Updates included requirements for caseworkers to discuss psychotropic medications with the child and guardian, identify the person in the home responsible for administering and monitoring the medication, communicate the importance of medication adherence, monitor the child's behavior, and report any side effects.

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.

APPENDIX D: Statistical Estimates and Confidence Intervals

Exhibit D-1 contains:

- sample sizes (the number of sample children where we obtained useable outcomes);
- point estimates (made using the outcomes determined on the basis of the number of sample children reviewed, or the sample size); and
- 95-percent confidence intervals (estimates of the error in the point estimates; 95 percent is a strong level of confidence).

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

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Five States combined statistics			
Percent of children in foster care treated with psychotropic medications that did not receive treatment planning or medication monitoring	589	33.9%	29.8%–38.3%
Percent of children who did not receive a treatment plan	589	19.5%	15.9%–23.6%
Percent of children who did not receive medication monitoring	589	22.9%	19.2%–27.0%
Percent of children who did not receive treatment planning and medication monitoring	589	8.4%	6.0%–11.7%
In States with specific treatment plan requirements, percent of children who received a treatment plan that did not receive all State-required treatment planning criteria	308	52.0%	44.4%–59.6%
Iowa's specific requirements			
Percent of children who did not receive a treatment plan	116	30.2%	22.7%–38.9%
Percent of children who did not have evidence that the caseworker documented whether the child was receiving necessary medical care in their case files	116	40.5%	32.2%–49.5%
Percent of children who did not have evidence that the caseworker documented whether the program plan was providing appropriate and sufficient services in their case files	116	32.8%	25.0%–41.6%

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**Exhibit D-1: Point Estimates, Sample Sizes, and Confidence Intervals
(continued)**

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Iowa's specific requirements			
Percent of children who did not have evidence that the caseworker inquired of the foster family the effectiveness of the medications in their case files	116	82.8%	75.0%–88.5%
Percent of children who did not have evidence that the caseworker documented the reason the medication was prescribed	116	83.6%	76.0%–89.2%
Percent of children who did not have evidence that the caseworker documented whether the medication was meeting the child's needs	116	72.4%	63.8%–79.6%
Percent of children who did not receive medication monitoring by a prescribing professional	116	48.3%	39.5%–57.1%
Maine's specific requirements			
Percent of children who did not receive a treatment plan	120	27.5%	21.0%–35.1%
Percent of children who did not have their medication plan reviewed quarterly by their treatment provider	120	25.8%	19.5%–33.4%
Percent of children prescribed antipsychotic medication who had no evidence that the caseworker participated in medical or psychiatric appointments where medications were initially discussed and a determination is made to proceed or not, and then at least every 3 months following*	39	59.0%	44.9%–71.7%
Percent of children who did not receive medication monitoring by a prescribing professional	120	10.8%	6.8%–16.8%
New Hampshire's specific requirements			
Percent of children who did not receive a treatment plan	124	23.4%	18.6%–29.0%
Percent of children who did not receive all State-required treatment planning criteria	95	75.8%	69.2%–81.3%
Percent of children who did not have an assessment summary in their treatment plan	95	6.3%	3.6%–10.8%
Percent of children who did not have a diagnosis in their treatment plan	95	37.9%	31.3%–44.9%
Percent of children who did not have goals or desired outcomes in their treatment plan	95	3.2%	1.4%–6.8%

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**Exhibit D-1: Point Estimates, Sample Sizes, and Confidence Intervals
(continued)**

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
New Hampshire's specific requirements			
Percent of children who did not have incremental steps to goal achievement in their treatment plan	95	7.4%	4.4%–12.0%
Percent of children who did not have interventions in their treatment plan	95	6.3%	3.6%–10.8%
Percent of children who did not have the evaluator's name/signature/date in their treatment plan	95	56.8%	49.8%–63.7%
Percent of children who did not receive medication monitoring by a prescribing professional.	124	21.8%	17.1%–27.3%
North Dakota's specific requirements			
Percent of children who did not receive a treatment plan	118	6.8%	4.1%–11.1%
Percent of children who did not receive all State-required treatment planning criteria	110	38.2%	31.7%–45.2%
Percent of children who did not receive goals or objectives in their treatment plan	110	1.8%	0.6%–5.0%
Percent of children who did not receive action steps for meeting specified goals in their treatment plan	110	8.2%	5.1%–12.9%
Percent of children who did not receive information about prescribed medications in their treatment plan	110	10.9%	7.3%–16.1%
Percent of children who did not receive documentation of treatment progress in their treatment plan	110	10.9%	7.3%–16.1%
Percent of children who did not receive a treatment plan developed by a multidisciplinary team	110	27.3%	21.5%–33.9%
Percent of children who did not receive medication monitoring by a prescribing professional	118	1.7%	0.6%–4.7%

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**Exhibit D-1: Point Estimates, Sample Sizes, and Confidence Intervals
(continued)**

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Virginia's specific requirements			
Percent of children who did not receive a treatment plan	111	7.2%	3.7%–13.6%
Percent of children who did not receive all State-required treatment planning criteria	103	51.5%	42.1%–60.7%
Percent of children who did not receive strengths or needs of the child in their treatment plan	103	11.7%	6.8%–19.2%
Percent of children who did not receive a health status, including any allergies or health conditions in their treatment plan	103	25.2%	17.9%–34.3%
Percent of children who did not receive the names and addresses of child's medical and mental health providers in their treatment plan	103	41.7%	32.8%–51.2%
Percent of children who did not receive a list of the child's medications including psychotropic drugs in their treatment plan	103	29.1%	21.3%–38.4%
Percent of children who did not receive medication monitoring by a prescribing professional	111	2.7%	0.9%–7.8%

Source: OIG analysis of State foster care case files and Medicaid claims for children in foster care, 2017.

*We are unable to reliably project the frequency estimates for this item because of the small number of sample occurrences.

APPENDIX E: State Demographics Regarding Children in Foster Care Treated With Psychotropic Medications

For each State, Exhibit E-1 represents the population of children in foster care,⁴⁶ the number and percentage of children in foster care who were treated with psychotropic medications,⁴⁷ and total Medicaid FFS expenditures for psychotropic medications for children in foster care in FY 2013. These figures are based on MSIS eligibility and prescription drug claims data. For States that cover medications through managed care, the exhibit does not reflect the amounts the managed care organizations (MCOs) paid for psychotropic medications for children in foster care.⁴⁸ States such as Arizona and Hawaii do not have FFS expenditures for these drugs because they were all covered through managed care.

Exhibit E-1: State Demographics Regarding Children in Foster Care Treated with Psychotropic Medications and Related Medicaid Expenditures*

State	Population of Children in Foster Care	Number of Children in Foster Care Treated with Psychotropic Medications	Percentage of Children in Foster Care Treated with Psychotropic Medications	Total Medicaid FFS Expenditures for Psychotropic Medications for Children in Foster Care
Alabama	11,709	2,897	24.7%	\$4,851,356
Alaska	4,175	672	16.1%	\$1,204,665
Arizona	24,731	4,257	17.2%	\$0
Arkansas	9,857	2,470	25.1%	\$3,415,546
California	147,806	20,064	13.6%	\$44,581,405
Colorado	21,155	4,871	23.0%	\$9,116,770
Connecticut	5,674	1,532	27.0%	\$3,345,982
Delaware	2,254	719	31.9%	\$1,465,037
District of Columbia	4,671	613	13.1%	\$1,026,092
Florida	65,198	11,228	17.2%	\$16,510,753
Georgia	33,033	9,408	28.5%	\$12,021,956
Hawaii	5,912	571	9.7%	\$0
Idaho**	5,024	1,102	21.9%	\$1,515,443
Illinois	53,898	10,109	18.8%	\$10,733,426
Indiana	23,912	6,844	28.6%	\$14,371,841
Iowa	13,951	4,981	35.7%	\$7,135,849

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Exhibit E-1: State Demographics Regarding Children in Foster Care Treated with Psychotropic Medications and Related Medicaid Expenditures* (continued)

State	Population of Children in Foster Care	Number of Children in Foster Care Treated with Psychotropic Medications	Percentage of Children in Foster Care Treated with Psychotropic Medications	Total Medicaid FFS Expenditures for Psychotropic Medications for Foster Children
Kansas	18,319	4,292	23.4%	\$3,230,278
Kentucky	18,257	5,657	31.0%	\$494,659
Louisiana	13,407	4,017	30.0%	\$5,584,262
Maine	3,527	1,155	32.7%	\$1,600,692
Maryland	16,030	4,450	27.8%	\$9,441,087
Michigan	18,884	4,190	22.2%	\$10,193,641
Minnesota	12,446	3,597	28.9%	\$4,094,907
Mississippi	7,294	1,891	25.9%	\$3,187,730
Missouri	34,817	9,847	28.3%	\$26,130,684
Montana	4,861	1,249	25.7%	\$2,336,576
Nebraska	13,606	3,882	28.5%	\$7,118,577
Nevada	12,100	1,829	15.1%	\$3,431,784
New Hampshire	2,614	944	36.1%	\$1,741,581
New Jersey	27,856	3,871	13.9%	\$387,902
New Mexico	6,450	1,189	18.4%	\$53,857
New York	54,099	9,068	16.8%	\$9,671,915
North Carolina	23,121	7,004	30.3%	\$16,393,851
North Dakota	2,734	1,021	37.3%	\$1,184,934
Ohio	35,029	9,196	26.3%	\$23,575,138
Oklahoma	11,120	2,267	20.4%	\$3,150,116
Oregon	23,331	4,468	19.2%	\$4,812,840
Pennsylvania	54,349	11,387	21.0%	\$1,377,212
Rhode Island**	4,875	979	20.1%	\$178,257
South Carolina	14,087	3,630	25.8%	\$3,794,339
South Dakota	4,709	1,304	27.7%	\$2,480,728
Tennessee	24,455	6,418	26.2%	\$11,017,546
Texas	88,609	23,991	27.1%	\$35,762,195
Utah	10,862	3,212	29.6%	\$7,954,880
Vermont	2,950	933	31.6%	\$1,915,196

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Exhibit E-1: State Demographics Regarding Children in Foster Care Treated with Psychotropic Medications and Related Medicaid Expenditures* (continued)

State	Population of Children in Foster Care	Number of Children in Foster Care Treated with Psychotropic Medications	Percentage of Children in Foster Care Treated with Psychotropic Medications	Total Medicaid FFS Expenditures for Psychotropic Medications for Foster Children
Virginia	14,999	5,584	37.2%	\$11,959,404
Washington	27,538	5,035	18.3%	\$7,008,379
West Virginia	10,950	3,138	28.7%	\$4,163,156
Wisconsin	18,290	4,557	24.9%	\$7,289,062
Wyoming	3,805	875	23.0%	\$1,542,474
Total:	1,073,340	238,465	22.2%	\$365,555,960

Source: OIG analysis of MSIS eligibility and prescription drug claims data, 2016.

*Massachusetts is not included in this exhibit because its MSIS eligibility files for FY 2013 were incomplete. The Massachusetts eligibility data included only approximately 1,500 unique identifiers for children in foster care. The population of children in foster care in Massachusetts is known to be significantly higher than 1,500.

**Indicates that complete FY 2013 data was not available in MSIS at the time of data collection; therefore, FY 2012 data was used.

APPENDIX F: Agency Comments



ADMINISTRATION FOR CHILDREN & FAMILIES

Office of the Assistant Secretary | 330 C Street, S.W., Suite 4034
Washington, D.C. 20201 | www.acf.hhs.gov

07/27/2018

Ms. Suzanne Murrin
Deputy Inspector General for Evaluation and Inspections
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Murrin:

I am writing to you concerning the Office of Inspector General's (OIG) draft report: *Treatment Planning and Medication Monitoring were Lacking for Children in Foster Care Receiving Medication (Report OEI-07-15-00380)*. ACF concurs with some of the OIG's recommendations but not others for the reasons set forth below.

Recommendation 1:

ACF develop a comprehensive strategy to improve State's compliance with requirements related to treatment planning and medication monitoring for psychotropic medications.

ACF Response:

We appreciate the OIG's examination of several states with respect to issues in the implementation of their protocols for the appropriate use and monitoring of psychotropic medications.

As far as establishing a strategic plan specific to this requirement, ACF has a well-established approach to program implementation. No approach can guarantee that compliance issues will not arise. Our approach includes a regulated mechanism to identify and correct any compliance issues. OIG's recommendation would require statutory and regulatory changes to implement.

ACF currently collects administrative data but views data on treatment planning and medication monitoring to be outside the scope of what can be reliably and consistently reported to an administrative data set. The statute requires any data reported to our administrative data set be both reliable and consistent across the reporting population.

We will assess opportunities to continue to provide technical assistance in this area as well as ensure states are reporting on this requirement through the Child and Family Services Plans and its annual updates.

Recommendation 2:

ACF should assist States in strengthening their requirements for oversight of psychiatric medications by incorporating suggested professional practice guidelines for monitoring children at the individual level.

ACF Response:

We are amenable to assessing what additional technical assistance and best practice guidance to provide to states. Let me first highlight how our current technical assistance is structured. The Child Welfare Information Gateway (Information Gateway) develops, disseminates and maintains publications, website pages, general information and guidance on a variety of child welfare topics, including those focused on effectively addressing ongoing challenges related to ensuring the appropriate use of psychotropic medications for children in foster care. The Capacity Building Center for States (Center) seeks to support State and territorial child welfare agencies in building capacity to better serve youth by undertaking efforts and promoting best practices, including those related specifically to psychotropic medication use for children in foster care and accompanying topics such as health and mental health, well-being, continuity of care, and successful transitions to adulthood. Services are available to respond to state-specific needs related to the oversight of psychotropic medications for children in foster care and may involve policy and procedure development, consultation and training design, as well as support for the implementation of related efforts. To date, no state has engaged the Center specifically around this area of need.

We do continue, however, to highlight resources for states as they are developed and as they come to our attention. In July/August 2018 the Information Gateway will spotlight new information on mental health of children and youth in foster care, specifically an article titled, “Improving the Use of Psychotropic Medication for Children in Foster Care: A Resource Center,” by the Center for Health Care Strategies, Inc.

In conclusion, ACF believes that while we have statutory and regulatory constraints that prevent us from fully implementing all of OIG’s recommendations, we will take full advantage of our technical assistance resources to be responsive to OIG’s findings in this report. Please direct any follow-up inquiries to Scott Logan of our Office of Legislative Affairs and Budget at (202) 401-4529.

Sincerely,

A handwritten signature in blue ink, appearing to read "Steven Wagner", with a horizontal line extending to the right.

Steven Wagner
Acting Assistant Secretary
for Children and Families

ACKNOWLEDGMENTS

Jamila Murga served as the team leader for this study, and Dana Squires and Abbi Warmker served as lead analysts. Others in the Office of Evaluation and Inspections who conducted the study include Cody Johnson, Katie Fry, Lesta Newberry, Anna Pechenina, and Andrea Staples. Office of Evaluation and Inspections central office staff who provided support include Althea Hosein and Seta Hovagimian.

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

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the healthcare industry concerning the anti-kickback statute and other OIG enforcement authorities.

ENDNOTES

- ¹ ACF, *Managing Psychotropic Medications for Children and Youth in Foster Care*, 2012. Accessed at <http://www.acf.hhs.gov/blog/2012/08/managing-psychotropic-medications-for-children-and-youth-in-foster-care> on April 1, 2016.
- ² Centers for Disease Control, *Psychotropic Medication Use Among Adolescents: United States, 2005-2010*, 2013. Accessed at <https://www.cdc.gov/nchs/data/databriefs/db135.pdf> on July 5, 2017.
- ³ National Institute of Mental Health, *Mental Health Medications*, 2016. Accessed at <http://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml> on March 31, 2016.
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- ⁵ National Institute of Mental Health, *Mental Health Medications*, 2016. Accessed at <http://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml> on March 31, 2016.
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- ⁷ Ibid.
- ⁸ American Academy of Pediatrics (AAP), "Health Care Issues for Children and Adolescents in Foster Care and Kinship Care," *Pediatrics*, Vol. 136, No. 4, 2015. Accessed at <http://pediatrics.aappublications.org/content/136/4/e1142> on October 26, 2017.
- ⁹ Michael Naylor, et al, "Psychotropic Medication Management for Youth in State Care: Consent, Oversight, and Policy Considerations," *Child Welfare*, Vol. 86, No. 5, 2007, pp. 175-192.
- ¹⁰ AAP, *Fostering Health: Health Care for Children and Adolescents in Foster Care 2nd Edition*, 2005. Accessed at <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Fostering-Health.aspx> on September 15, 2017.
- ¹¹ Ibid.
- ¹² ACF, Information Memorandum ACYF-CB-IM-12-03, 2012. Accessed at <https://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf> on August 24, 2017.
- ¹³ Michael Naylor, et al, "Psychotropic Medication Management for Youth in State Care: Consent, Oversight, and Policy Considerations," *Child Welfare* Vol. 86, No. 5, 2007, pp. 175-192.
- ¹⁴ AACAP, "Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents," *J. Am. Acad. Child Adolesc. Psychiatry*, Vol. 48, No. 9, 2009, pp. 961-973. Accessed at [http://www.jaacap.com/article/S0890-8567\(09\)60156-8/pdf](http://www.jaacap.com/article/S0890-8567(09)60156-8/pdf) on March 9, 2016.
- ¹⁵ Ibid.
- ¹⁶ OIG, *Second-Generation Antipsychotic Drug Use Among Medicaid-Enrolled Children: Quality-of-Care Concerns* (OEI-07-12-00320), March 2015. Accessed at <https://oig.hhs.gov/oei/reports/oei-07-12-00320.pdf> on October 31, 2017.
- ¹⁷ In all States, nearly all children in foster care are eligible for Medicaid services. According to section 1902(a)(10)(A)(i)(I) of the Social Security Act (the Act), children in foster care who are eligible for assistance payments through Title IV-E of the Act are mandatorily eligible for Medicaid. Children in foster care who are not eligible under Title IV-E usually qualify for Medicaid through other eligibility categories established by each State. Because most children in foster care are eligible for Medicaid, Medicaid pays for healthcare services for almost all children in foster care.
- ¹⁸ These expenditures only reflect fee-for-service (FFS) Medicaid payments reflected in Medicaid Statistical Information System (MSIS) data for fiscal year (FY) 2013. This was the most recent complete data available at the time of State selection.
- ¹⁹ The Act, § 422(b)(15)(A)(1)(v).
- ²⁰ Each State is required to submit its health services oversight and coordination plan as part of its CFSP to ACF every 5 years (45 CFR § 1357.15). The most recent plans available during the period of our review cover FYs 2015 through 2019.
- ²¹ ACF, Program Instruction ACYF-CB-PI-12-05, 2012. Accessed at <http://www.acf.hhs.gov/sites/default/files/cb/pi1205.pdf> on July 30, 2015.
- ²² Ibid.
- ²³ Ibid.
- ²⁴ Michael Naylor, et al, "Psychotropic Medication Management for Youth in State Care: Consent, Oversight, and Policy Considerations," *Child Welfare* Vol. 86, No. 5, 2007, pp. 175-192.
- ²⁵ Ibid.

²⁶ The compliance reviews assess State compliance with Federal requirements and the outcomes of the child welfare system. These reviews do not specifically determine whether children in foster care received treatment consistent with States' requirements. ACF, *Child and Family Service Reviews Fact Sheet*. Accessed at https://www.acf.hhs.gov/sites/default/files/cb/cfsr_general_factsheet.pdf on September 15, 2017.

²⁷ "Substantial conformity" is determined by the State agency's ability to meet various standards and criteria, including its capacity to deliver services leading to improved outcomes for children and families. 45 CFR § 1355.34.

²⁸ 45 CFR § 1355.34.

²⁹ 45 CFR § 1355.35(a).

³⁰ If the State fails to successfully complete a program improvement plan, ACF has the authority to withhold a certain amount of Federal funding for the year under review and each subsequent year until the State either successfully completes a program improvement plan or is found to be operating in substantial conformity. 45 CFR § 1355.33 – 1355.36.

³¹ ACF, *CFSR Round 3 Onsite Review Instrument and Instructions*, 2016. Accessed at https://www.acf.hhs.gov/sites/default/files/cb/cfsr_r3_osri.pdf on November 14, 2017.

³² ACF, Information Memorandum ACYF-CB-IM-12-03, 2012. Accessed at <https://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf> on August 24, 2017.

³³ The recommendations described in this evaluation are not an exhaustive list of all professional recommendations. We have selected recommendations that are relevant to the scope of this study.

³⁴ AACAP, *A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents*, 2012. Accessed at http://www.aacap.org/app_themes/aacap/docs/press/guide_for_community_child_serving_agencies_on_psychotropic_medications_for_children_and_adolescents_2012.pdf on October 30, 2017.

³⁵ Ibid.

³⁶ AACAP, "Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents," *J. Am. Acad. Child Adolesc. Psychiatry*, Vol. 48, No. 9, 2009, pp. 961-973.

³⁷ Ibid.

³⁸ We used eligibility and prescription drug files from the MSIS to calculate the total children enrolled in foster care in each State, and the total children who had at least one Medicaid-paid claim for a psychotropic medication in FY 2013. We used FY 2012 data for Idaho and Rhode Island because complete FY 2013 files were not available.

³⁹ ACF, Program Instruction (ACYF-CB-PI-12-05), April 11, 2012, p. 13. Accessed at <http://www.acf.hhs.gov/sites/default/files/cb/pi1205.pdf> on July 30, 2015.

⁴⁰ States are not mandated to establish requirements consistent with AACAP guidance. Therefore, our analysis does not conclude that States are in error, or have failed to meet requirements, where their requirements are not consistent with AACAP guidance.

⁴¹ Children may receive healthcare from sources such as schools, free health clinics, or a parent's private insurance. Additionally, some of the Medicaid claims data provided for our review included Medicaid Managed Care capitated payments, which did not consistently provide detail regarding the services received by those children.

⁴² GAO, *HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions* (GAO-12-270T), 2011. Accessed at <http://www.gao.gov/new.items/d12270t.pdf> on October 31, 2017.

⁴³ ACF, Program Instruction (ACYF-CB-PI-12-05), April 11, 2012, p. 13. Accessed at <http://www.acf.hhs.gov/sites/default/files/cb/pi1205.pdf> on July 30, 2015.

⁴⁴ We define evaluation and management services as office visits, hospital visits, and consultations provided by qualified healthcare professionals authorized to perform such services within the scope of their practice.

⁴⁵ States are required to develop a case plan for each child in foster care. The case plan must include information such as the child's health records, medical problems, and medications. The Act, § 422(a)(8)(A)(ii), § 475(5), and § 475(1)(C).

⁴⁶ The figures for the population of children in foster care in each State represent the total unique children that were eligible for Medicaid because of their foster care status at any point during FY 2013.

⁴⁷ We considered any child who had at least one Medicaid-paid claim for a psychotropic medication while in foster care to have been treated with psychotropic medications.

⁴⁸ Medicaid managed care is a type of healthcare delivery system that provides Medicaid health benefits and services to enrollees through contracted arrangements between State Medicaid agencies and MCOs. MCOs receive a set payment per member per month from the State Medicaid agency for these services. FFS is a type of healthcare delivery system in which healthcare providers are paid for each service provided to Medicaid enrollees.