Health Care Oversight and Coordination Plan

Plan Overview

Section 422(b)(15)(A) of the Social Security Act requires states to develop a plan for the ongoing oversight and coordination of health care services for children in foster care. States must develop the plan in coordination with the state title XIX (Medicaid) agency, and in consultation with pediatricians and other experts in health care, and experts in and recipients of child welfare services.

Virginia has endeavored through the last CFSP period to strengthen both the provision of health care services and the state's ability to provide oversight and coordination. For example, the implementation of the psychotropic medication oversight protocol represented several years of effort to develop mechanisms to capture and review data regarding the prescription of psychotropic medications, and to improve coordination between DMAS and VDSS. However, limitations in OASIS continue to create significant barriers to comprehensive oversight, especially in terms of meaningful data sharing with DMAS. Additionally, inconsistent practice at the LDSS level is an ongoing concern. Turnover, vacancies, and staff with limited child welfare experience affect the degree to which children in foster care receive all the health care services that are available to them and continue to pose a challenge to the implementation of the psychotropic medication protocol. Consistent, accurate, and timely documentation, as well as availability of records, also affect both VDSS's and DMAS's ability to evaluate the degree to which children in care in Virginia receive health care services as expected.

Director of Foster Care Health and Safety

VDSS was required to establish a Director of Foster Care Health and Safety. VDSS had developed a job description that specified that candidates will be licensed medical professionals, ideally physicians with prescribing privileges, familiarity with the effects of trauma, and experience working with children. This position will be responsible for identifying LDSS that fail to provide foster care services in a manner that complies with applicable laws and regulations that ensure the health, safety, and well-being of all children in foster care. Among other responsibilities, the director will ensure that LDSS remedy any failures in practice (e.g., the provision of physical, mental, and behavioral health screenings and services, and oversight of psychotropic medication use) and track health outcomes for children in care. VDSS anticipates that under the director, the advisory committee for the health plan will be re-assessed and re-invigorated, perhaps through the re-establishment of a separate health plan advisory committee, which would facilitate more direct input from pediatricians and other experts in health care.

The position was posted for recruitment on July 12, 2019. After several months during which no applications for the position were received, VDSS made an adjustment to increase the potential starting salary to the maximum amount funded by the budget allocation. VDSS continued to advertise and recruit for this position when the COVID-19 pandemic began in March 2020. VDSS conducted several interviews with promising candidates, but all applicable candidates expressed interest only as a part-time position. VDSS was in the process of exploring the possibility of modifying the job description to allow for a candidate to, at least, begin in the position on a part time rather than full time basis, when the Governor declared a State of Emergency and instituted a hiring freeze.

Once the hiring freeze was lifted, DFS began re-evaluating the criteria and position given the previous difficulties in hiring full-time staff. Currently, VDSS is considering revising the requirements.

(**Permanency Strategy 3.4**). The revised minimum requirements would shift the requirements from a licensed physician to one that directs overall health and safety of children in care statewide. Responsibilities would include: establishing multi-disciplinary teams to review cases of children with complex medical or mental health needs; leading efforts around guidance changes to support kinship placements and less dependence on congregate care; reestablish the Health Planning Advisory Committee to receive and provide input and direction on health and developmental policy, services, and needs relative to children in foster care; and to direct the operations of process improvements to improve overall outcomes for children in foster care.

The process of revising the responsibilities and requirements of the position is underway and will need to be reviewed and approved by human resources. Once that is completed, recruitment can begin. It is estimated that VDSS can begin recruitment for the position in mid 2025.

Due to the challenges associated with hiring a licensed physician within the established salary range for the position, VDSS recommends that a physician, be employed on a part-time or as needed basis to consult on medical decisions involving children in foster care, to serve on the Health Planning Advisory Committee; and to review the use of psychotropic medications for children in care.

Health Plan Advisory Committee

There have been no formal meetings of the advisory committee for the health plan due to the establishment of the Safe and Sound Taskforce which is now overseeing decisions initially led by the committee (See **Collaboration section** of CFSP). VDSS has also continued to use CWAC to provide input into policy decisions related to the health care of children in foster care. Additionally, VDSS routinely partners with various stakeholders to ensure the health needs of children in foster care continue to be met.

As issues arise regarding identifying placements due to health needs, the taskforce comes together to address them. For example, children with diabetes are often denied placements due to the challenges providers have with meeting their medical needs. The taskforce has been able to pull together providers and DBHDS licensing to attempt to overcome the barriers to serving these children. The CWAC committee has also provided an avenue to gain valuable feedback from stakeholders around the issue of addressing the high acuity behavioral health needs of children in foster care and identifying placements to meet their needs.

Technical Assistance

Internal Supports

The foster care omnibus bill in 2019 established two additional regional consultant positions in each regional office, permitting VDSS to significantly increase the level of technical assistance, support, and ongoing case work review at the LDSS level. There are now three permanency consultant positions and a resource family consultant position in all five regional offices, who provide technical assistance support and ongoing casework reviews at the LDSS level. The regional consultants support LDSS through regular, intentional provision of technical assistance towards improving health care services for children in foster care. It is anticipated that this targeted attention, in combination with the use of COMPASS|Mobile, will result in more accurate and timely data becoming available.

Improving Timely Health Care for Children and Youth

The working relationship between DMAS and VDSS is positive and collaborative. Virginia was one of 12 states selected by the Centers of Medicare and Medicaid Services (CMS) to participate in the Improving Timely Health Care for Children and Youth in Foster Care Affinity Group. The selection was based on the partnership between DMAS and VDSS and the readiness to bring data, experiences, stakeholders, and creativity to bear to improve timely access to health care services for children and youth in foster care. DMAS and VDSS were co-leads on the group which also includes representatives from the various MCOs. The aim of the work by this group was to establish more effective workflows that will increase the percentage of children entering foster care who receive their initial medical exam within 30 days of entering foster care. The group established two tests of change that were implemented. One included a "warm hand-off" from the LDSS to the MCO so that the MCO was aware of new members more promptly and was reaching out within a couple of days of the child entering foster care to assist in scheduling appointments. A second test of change included one of the MCO's employing a care manager that was housed in the LDSS. Again, this aided in the MCO being made aware of new members more promptly, enabling them to provide support in making appointments and ensuring medical needs are met.

The affinity group started in late summer 2021 and received targeted technical assistance from CMS for a period of 12 months with the option to continue for an additional 12 months. The affinity group completed their work in August of 2023 and was one of the states chosen to present at a webinar spotlighting states who participated in the affinity group. This experience was valuable in that DMAS and VDSS continued to maintain a strong partnership and worked collaboratively to improve the rate in which children received their initial physical exam after entering foster care. VDSS and DMAS will continue to use the information from these two small tests of change to impact practice more broadly as VDSS develops the new CCWIS system and moves toward automating processes.

DMAS/Foster Care Partnership

The ongoing DMAS/Foster Care Partnership provides opportunities for increased collaboration with various stakeholders to improve overall access to health care for children in and aging out of foster care. The group includes representatives from DMAS, VDSS, LDSS, OCS, VCOY, and LCPA. The purpose of the Foster Care Partnership is to improve collaboration among all individuals involved in the treatment and care of youth in foster care in Virginia, as well as to focus on actionable goals related to improving health care services for youth in foster care. The areas of focus are divided up into action groups. This year, the action groups were created based on cross-sector discussions around current needs of youth in foster care. The groups factored in results and recommendations of the 2021–2022 Child Welfare Focus Study.

In 2023, DMAS hosted six Foster Care Partnership meetings, and eight Action Group meetings. Two Action Groups identified new focus areas based on discussion and feedback:

- A joint DMAS and MCO action group to plan, develop, and implement an updated statewide training about Medicaid and managed care for youth in foster care, and
- A joint DMAS, DSS, and MCO action group to improve service utilization for youth in foster care.

The Foster Care Partnership was set to reconvene in July 2024 once the new MCOs have been established (See MCO Re-Procurement section); however due to delays in the procurement process, the new MCOs were not established The new MCOs are set to be in place in the summer of 2025 and at that time the partnership meetings will resume and new priorities will be identified.

DMAS Technical Assistance

In March and April 2023, DMAS and the contracted MCOs hosted two 90-minute statewide webinars focused on Medicaid and Managed Care for Youth in Foster Care, which were attended by 415 foster care stakeholders/professionals around the state. In June 2023, DMAS kicked off the first of a series of mini-trainings to follow up on areas of interest during the statewide webinars. The mini-trainings included Magellan of Virginia sharing about Medicaid residential treatment services processes and procedures.

Additionally, DMAS and the MCOs worked together on several one-time or ad hoc projects last year to support collaboration with DSS and youth in foster care:

- Foster Care Awareness Month: In May 2023, Anthem hosted a Comfort Cases packing party, all MCOs collaborated to provide a "wellness room" for a week for The Petersburg LDSS. The MCOs also hosted additional training and awareness activities in partnership with our stakeholders.

- Foster Care College Support Project: In August 2023, DMAS, contracted MCOs, and the Office of the Secretary of Health and Human Resources (OSHHR) provided support, gifts, and resources to 16 Medicaid members enrolled in foster care and attending a four year university in the fall of 2023. This was a voluntary project to support the health, well-being, and independence of youth in foster care transitioning into adulthood.

- Foster Care Newsletter : In May 2023 DMAS launched the first quarterly Foster Care Newsletter email to keep VDSS partners and stakeholders up to date about resources, events and trainings along with any changes or news related to Medicaid that may impact youth in the child welfare system. Three newsletters went out in 2023 to the Foster Care Partnership mailing distribution list of over 400 stakeholders.

The assistance that was provided by the MCOs was a tremendous support throughout 2023. The delays in the procurement of the Foster Care Specialty Plan that lasted throughout 2024 made it impossible for the MCO to participate in similar efforts in 2024.

Cardinal Care

As part of the 2021 Appropriations Act, DMAS was directed to merge their two managed care programs, Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus), in a manner that links seamlessly with the fee-for-service program. DMAS' strategy to achieve these legislative directives was implemented in phases, including the initial phase to rebrand as Cardinal Care in January 2023. DMAS worked closely with the CMS to receive federal approval to consolidate the two managed care waivers and contracts. DMAS received approval from CMS to consolidate the Medallion 4.0 and CCC Plus programs under Cardinal Care Managed Care effective October 1, 2023.

Cardinal Care is the brand that encompasses all DMAS health coverage programs, including Medicaid and Family Access to Medical Insurance Security (FAMIS), and includes both managed care and fee-for-service delivery systems. Cardinal Care, as a single program, delivers health care based on the individual member's needs at a given point of time, without switching between programs or MCOs if their needs change. With the retirement of Medallion 4.0 and CCC Plus, providers maintain and adhere to only one contract and credentialing process for each of the health plans in which they participate as network providers.

Under Cardinal Care, youth in foster care continue to receive an enhanced level of care management. The Cardinal Care Managed Care contract includes an enhanced and responsive model of care to provide access to care management services based on the member's needs and health risks. Youth in foster care receive one of the three mandatory levels of care management intensity (low, moderate, or high). Mandatory high intensity populations include:

- Youth in foster care or former foster care for three months after child welfare Medicaid enrollment, or a new foster care home;
- Youth in foster care three months prior to aging out; and
- Former foster care youth for the first three months after aging out of the child welfare system.

MCO Re-Procurement and Foster Care Specialty Plan

DMAS attempted to procure its MCO contracts for Cardinal Care and anticipated a summer 2024 implementation. Due to delays in the procurement process, this has been delayed until summer 2025. The current procurement reflects DMAS' goals to improve MCO accountability in service delivery and member access with particular focus on behavioral health and maternal and child health, including foster care members. Cardinal Care will emphasize enhanced expectations for performance and quality improvement, member engagement, use of new technology and new payment models.

The procurement will include a provision for one MCO to administer a single specialty plan for the child welfare member populations. Through the Foster Care Specialty Plan, DMAS will select one MCO that will operate statewide and work collaboratively with DMAS, the DSS, and OCS.

DMAS plans to enroll all children and youth in foster care in the Foster Care Specialty Plan. It is anticipated that youth in adoption assistance and former foster care members will be auto assigned to the Foster Care Specialty Plan but may elect to enroll in another health plan.

As new technologies and processes are developed, the relationship between DMAS and VDSS will continue to evolve but will remain the cornerstone of efforts to improve health outcomes (**Strategic Plan Permanency 3**). DMAS contracts with an External Quality Review Organization (EQRO), which conducts (as an optional external quality review (EQR) task under the CMS Medicaid guidelines) an annual focused study that provides quantitative information about children and adolescents placed in foster care and receiving medical services through Medicaid managed-care service delivery. Information from this annual study will continue to be used to determine the extent to which children in foster care are receiving the expected preventive and therapeutic medical care. In addition to the more general plan to continue to improve health care and oversight for children in foster care over the next five years previously outlined, Virginia is also making efforts in specific areas.

Child Welfare Focused Study

The SFY 2023-2024 Child Welfare Focused Study demonstrated that children in foster care have higher rates of appropriate health care utilization than a comparable population for most study indicators in measurement year MY 2023. Study findings show that differences in the rate between children in foster care and control groups were greatest among the dental study indicators (Annual Dental Visit; Preventive Dental Services; Oral Evaluation, Dental Services; and Topical Fluoride for Children—Dental or Oral Health Services by 15.5, 16.3, 16.8, and 11.9 percentage points, respectively), the use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics measure (by 13.8 percentage points) and the engagement of SUD treatment (16.5 percentage points) (. The follow up care for prescribed ADHD medication at 6 months and 9 months was slightly lower for children in foster care. Rate

differences between children in foster care and control groups across study indicators persisted even after matching on many demographic and health characteristics.

Healthcare Utilization Study Indicator Results for Children in Foster Care and Controls

Measure	Children in Foster Care Rate	Controls Rate	*p*
Primary Care			
Child and Adolescent Well-Care Visits	62.7%	55.2%	<0.001*
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	65.6%	52.5%	0.02*
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	83.5%	79.2%	0.28
Oral Health			
Annual Dental Visit	72.1%	56.6%	<0.001*
Preventive Dental Services	67.1%	50.8%	<0.001*
Oral Evaluation, Dental Services	66.3%	49.5%	<0.001*
Topical Fluoride for Children—Dental or Oral Health Services	33.4%	21.5%	<0.001*
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	57.7%	58.9%	0.86
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up	76.7%	66.7%	0.33
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing	36.4%	38.5%	0.69
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	86.3%	72.5%	0.07
Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up	76.1%	66.0%	0.06
Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up	88.8%	81.3%	0.08
Follow-Up Care for Children Prescribed ADHD Medication—Three-Month Follow-Up	91.8%	88.2%	0.32
Follow-Up Care for Children Prescribed ADHD Medication—Six-Month Follow-Up	94.0%	95.8%	0.49
Follow-Up Care for Children Prescribed ADHD Medication—Nine-Month Follow-Up	95.5%	99.3%	0.06

Substance Use			
Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment	33.9%	28.1%	0.57
Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment	19.6%	3.1%	0.05*
Respiratory Health			
Asthma Medication Ratio	77.1%	77.8%	0.93
Service Utilization			
Ambulatory Care Visits	86.8%	88.0%	0.16
Emergency Department Visits	26.7%	36.7%	<0.001*
Inpatient Visits	6.0%	4.8%	0.03*
Behavioral Health Encounters—Total	68.5%	56.1%	<0.001*
Behavioral Health Encounters—ARTS	3.9%	1.8%	<0.001*
Behavioral Health Encounters—CMH Services	33.1%	19.3%	<0.001*
Behavioral Health Encounters—RTC Services	9.2%	4.6%	<0.001*
Behavioral Health Encounters—Therapeutic Services	2.2%	1.5%	0.06
Behavioral Health Encounters—Traditional Services	65.8%	53.8%	<0.001*
Overall Service Utilization	89.7%	91.8%	0.004*

** Indicates that the rates were statistically different between the children in foster care and controls.*
P-values were calculated using Chi-square tests and Fisher's exact tests to quantify the relationship between foster care status and numerator compliance. Measure rates and p-values presented in this table are not adjusted for demographic and health characteristics.
Denominators vary by study indicator; please refer to Appendix A: Study Indicators for indicator-specific technical specifications.

Although the DMAS Child Welfare Focus Study continues to find that children in foster care are receiving many services at a higher rate than a comparable population, there are areas where improvement is needed. VDSS and DMAS will continue to work together to ensure that children are receiving services as expected and data are available to effectively monitor service provision.

How Health Needs Identified through Screenings will be Monitored and Treated, Including Emotional Trauma Associated with a Child's Maltreatment and Removal from Home

Virginia continues to utilize family engagement, FPMs, the foster care service plan, FAPT, the individualized family services plan, and utilization management to inform decision-making, service planning, implementation, and monitoring of services identified during screenings and assessments. The LDSS service worker continues to play a central and essential role in managing services for the child or youth in foster care.

Information on a wraparound approach and intensive care coordination is addressed in the foster care chapter of the VDSS *Child and Family Services Manual*. DBHDS, DMAS, and/or OCS provide training on these two approaches and implementing systems of care. This service is also frequently recommended in meetings when youth at risk of displacement are staffed.

In 2022, VDSS established the Office of Trauma and Resilience Policy (OTRP) to better support the implementation of trauma-informed practice and services in social service agencies across Virginia. Virginia Helping Everyone Access Linked Systems (HEALS) is a model of service delivery that has been developed to assist service providers in better linking systems of care and providing support and care to children, youth, and families impacted by trauma and/or victimization. The ORTPs support the Virginia HEALS project which includes checklists for agencies to assess the degree to which they are trauma-informed and a brief screening tool, the Screening for Experiences and Strengths (SEAS.) This tool is widely available for use by LDSS after completing a short training course. Additionally, training on trauma-informed care is mandated for all foster care service workers.

CANS Assessment

Virginia's CANS assessment is the mandatory uniform assessment instrument for all children age birth to 18 and their families in foster care and/or who receive services funded by the CSA (§ 2.2-5209 Code of Virginia). The local FAPT uses the CANS to help plan, make decisions, and manage services at both an individual and system of care level. The CANS helps:

- Identify the strengths and needs of the child, youth, and family;
- Enhance communication among participants working with the child, youth, and family;
- Identify children and youth who require and are referred for in-depth assessments, including assessments for health and behavioral health needs;
- Guide and inform service planning with the child, youth, and family;
- Capture data to track progress on child and family outcomes; and
- Identify service gaps and promote resource development.

The CANS assessment is mandated for all children in foster care on an at least annual basis, regardless of whether they are receiving CSA services.

Additionally, the Virginia CANS includes items related to trauma and child welfare. The child welfare version of the CANS adds disruptions in caregiving as a form of trauma that a child may experience and requires that the trauma module is completed for all children in foster care. Guidance directs LDSS to utilize the trauma module, as well as various behavioral indicators captured in the CANS, as a screening tool to determine when a child in foster care should be referred for additional trauma assessment and/or services. The CANS online system provides a child-specific report, to make possible the evaluation of a child's progress over time, and a permanency planning report, to make possible the evaluation of a family's or caretaker's progress over time.

Children and Youth with Special Healthcare Needs

Children in foster care are classified in Virginia Medicaid as children and youth with special health care needs (CYSHCN), as defined by Health Resources and Services Administration (HRSA) and CMS. Health plans have designated foster care coordinators responsible for ensuring that children in foster care receive health assessments and medical, dental, and behavioral health visits. Health plans refer members for further diagnosis and treatment, or follow-up of all correctable abnormalities uncovered or suspected during screenings. Plans provide other medically necessary health care, diagnostic services, treatment, and measures as needed to correct or ameliorate defects and physical, mental, and substance use illnesses and conditions discovered, or determined as necessary to maintain the child's current level of functioning or prevent the child's medical condition from getting worse. Plans coordinate the unique needs of children in the foster care system and those who were adopted, through the provision of trauma-informed case management services to coordinate care efforts for children.

As Virginia continues the implementation of FFPSA, issues previously identified relative to inconsistent availability, accessibility, and quality service across all communities in Virginia continue to be an area of focus. VDSS will continue to explore opportunities to partner with DBHDS, OCS, DJJ, and DMAS towards improving the adequacy of Virginia's service array.

A Schedule for Initial and Follow-Up Health Screenings That Meet Reasonable Standards of Medical Practice

VDSS has incorporated a schedule for medical, dental, and EPSDT screening activities that is consistent with DMAS recommendations for all children in foster care guidance. These appointments are documented in OASIS, permitting the monitoring of compliance with the expectations by LDSS supervisors and VDSS. Due dates for medical appointments have been incorporated into the reminders that are generated through COMPASS|Mobile. The reminders are displayed on the FSS dashboard 30 days prior to the due date to ensure that appointments are scheduled timely. DMAS EPSDT screenings occur according to the American Academy of Pediatrics policy statements and clinical guidelines. Another resource for preventive health guidelines provided to the LDSS is the AAP compatible "*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*."

MCOs are required to make every reasonable effort to assure that foster care children receive a visit to their assigned primary care provider within 30 days of enrollment in the health plans. They also educate and inform members who are not complying with the EPSDT periodicity and immunization schedule. As noted above, this was the focus of the Foster Care Affinity Group and the two small tests of change that were implemented showed improved rates of children receiving their exam timely. Additionally, receipt of data through DMAS confirms that children in foster care are generally receiving medical and dental exams consistent with the standards that DMAS and VDSS have established.

How Medical Information for Children will be Updated and Appropriately Shared, Which May Include Developing and Implementing an Electronic Health Record

VDSS continues to defer to larger efforts in Virginia to implement electronic medical records (EMRs) as described in this plan rather than create a separate electronic health record for children in foster care. In the interim, until the EMR for children in Medicaid is established, OASIS has been revised to permit LDSS service workers to gather known health information on the child and the child's birth family from health care providers, caregivers, MCOs, and other entities in one place. The worker can then appropriately share this information with caregivers and health care providers.

Virginia can identify children in foster care or children receiving adoption assistance in the Medicaid Management Information System (MMIS). This allows the aggregate reporting of data, divided by MCO region, on children in foster care. Two aid categories are now used to identify youth in foster care and youth receiving adoption assistance. VDSS also uses data available in OASIS and reports in SafeMeasures® to monitor agency practices and child indicators.

The implementation of COMPASS|Mobile has had a significant effect on the availability of medical information for children in foster care. Service workers have access to historical information as needed during appointments and can update the official case record while in the doctor's office. More readily available, accurate, timely, and comprehensive medical information can then be appropriately shared.

As a result of an increase in youth in foster care who are experiencing behavioral health crises boarding in emergency rooms for extended periods of time while an appropriate acute bed is being located, a small work group is continuing to look at how to 'flag' Medicaid recipients who are in foster care experiencing these extended stays. This workgroup continues to meet, and the number of children and youth brought to VDSS' attention has reduced.

LDSS have been encouraged to elevate these situations to the Safe and Sound Taskforce so that the taskforce can begin supporting the agency on identifying and supporting the child's next foster care placement, in the event they cannot return to their pre-emergency room placement. The workgroup is negotiating concerns about confidentiality and data sharing between the many hospitals in Virginia, DMAS, the LDSS, and VDSS.

Steps to Ensure Continuity of Health Care Services, Which May Include Establishing a Medical Home for Every Child in Care

A major element of Virginia's health care oversight plan is that the MCOs are responsible for ensuring continuity of health care services. The MCO contract with DMAS requires that the MCOs have a primary care network that includes contracting with all area health departments, major hospitals, CSBs, federally qualified health centers and rural health clinics, and the top 50 percent of utilized primary-care providers, OB/GYNs, and pediatricians in both rural and urban areas.

The MCOs' pediatric and adult primary care providers and specialists must be clinically qualified to provide or arrange for the provision of appropriate health care services. The MCO shall submit to DMAS prior to signing the initial contract, upon revision or on request, referral guidelines that demonstrate the conditions under which the PCPs will make the arrangements for referrals to specialty care networks.

Health plans conduct health assessments for each child within 60 days of enrollment into the health plan. Health plans also provide care coordination for CYSHCN among the multiple providers, agencies, advocates, and funding sources serving CYSHCN.

Health plans assure the availability of providers who are experienced in serving children and youth with special needs and provide a medical home that is accessible, comprehensive, coordinated, and compassionate. To ensure there is no interruption of any covered services for enrollees, health plans have policies and procedures to ensure transition of care for all enrollees.

The Oversight of Prescription Medicines, Including Protocols for the Appropriate Use of and Monitoring of Psychotropic Medications

VDSS has continued to work towards reducing the unnecessary or inappropriate prescription of psychotropic medication to children in foster care through two primary strategies. The first involves raising awareness and improving LDSS practice regarding the monitoring of psychotropic medication prescribed to children in foster care. The second involves partnering with DMAS to incorporate the medical review of psychotropic prescriptions, when appropriate, through requirements established in their contracts with the MCOs. VDSS plans to continue to improve the oversight of psychotropic medication for youth in foster care through activities identified in **Permanency Strategy 3.4**.

LDSS staff have been supported in making the connection between the need for better assessment and treatment of trauma and the risk of over-prescription, as well the importance of understanding the worker's role in asking questions, empowering the birth parents to be involved in making decisions, and advocating for treatment that is conservative and considers side effects through enhancements to foster care guidance. The VDSS LTD has developed an eLearning course that serves as an orientation to the effects of trauma on children, as well as an in-person course that focuses on the provision of trauma-

informed child welfare services. Additionally, foster care policy requires the screening of all children in foster care for trauma, utilizing the trauma module of the CANS tool.

VDSS implemented the Psychotropic Medication Oversight Protocol in July 2019 as part of the 2020-2024 CFSP Permanency Strategy 5.3. Workers complete a consent protocol that requires information to be obtained from the prescriber describing the medication being prescribed, its intended use, and potential side effects. The information is then entered into a consent form that verifies required activities such as information that has been provided to the caregiver responsible for providing the medication to the child, that birth parent(s) were involved in decision-making, that youth are involved in decision-making, and under what circumstances the LDSS will monitor more closely and/or consider obtaining a second opinion. Foster care guidance and the psychotropic-medication oversight protocol can be found at http://dss.virginia.gov/family/fc/index.cgi.

The consent form is provided to a psychotropic Medication Consenter (PMC) at the LDSS. This person or persons are selected by the LDSS director and certified through the completion of the required VDSS training course. With the implementation of the protocol, each LDSS was required to establish at least one PMC. The person(s) designated as the PMC are required to complete CWSE4050: Psychotropic Medications and the Child Welfare Systems and CWSE4051: Psychotropic Medication Consenter. The PMC for each agency must review and approve, or deny, the prescription of psychotropic medication to children in foster care. VDSS anticipates that the protocol module will be periodically updated. The regional practice consultants maintain a list of the PMCs designated for each agency to ensure that each LDSS has a trained consenter at all times.

VDSS LTD also offers another course related to psychotropic medications. CWSE4050: Psychotropic Medications and Child Welfare System teaches practical approaches to working with medical professionals on the monitoring of psychotropic medications, key questions to ask and critical information to bring to the attention of the physician or psychiatrist prescribing the medications, how to express professional disagreement in a helpful manner that is in the best interest of the child, suggest alternative treatments to medication, and how to support foster parents advocating for the child in their care. This course is required for all foster care service workers and is a prerequisite for becoming a PMC.

CWSE4050: Psychotropic Medications and the Child Welfare System was added to the mandatory training for new foster care workers in July 2019. In 2022, 298 FSS, supervisors, or directors completed that course and 72 completed VDSS- CWSE-4051: Psychotropic Medication Consenter. In 2023, 384 FSS', supervisors, or directors completed VDSS- CWSE4050 and 56 completed VDSS- CWSE-4051. In 2024, 329 completed VDSS-CWSE 4050 and 48 completed CWSE-4051.

Regional permanency practice consultants are provided a list of individuals who have completed the CWSE4051 course quarterly to help support monitoring of the LDSS's compliance for this requirement. . The average percentage of children prescribed psychotropic medication has decreased slightly over this past year. Reducing the use of psychotropic medications will continue to be a focus in the strategic plan (**Permanency Strategy 3**).

	Psychotropic Medication Found	No Psychotropic Medication Found	Total Children
Measurement Period	# (%)	# (%)	#
CY2023 Monthly Average	1,582 (31.50%)	3,439 (68.48%)	5,022
CY2024 Monthly Average	1,536 (29.13%)	3,737 (70.87%)	5,274

Finally, the health screens in OASIS have been revised to include the ability to enter data regarding prescriptions and to indicate whether the prescribed medication is a psychotropic medication. This information is now available in a report in SafeMeasures®, which makes it possible for LDSS supervisors, regional permanency consultants, and home office staff to monitor the incidence of psychotropic medication use. This data is available in a report that permits monitoring of psychotropic medication prescribing at the agency level.

As it pertains to DMAS, MCO health plans provide pharmacological management, including prescription and review of medication, when performed with psychotherapy services. Health plans have established drug utilization review (DUR) boards that comply with the DUR program standards as described in section 1927(g) of the Social Security Act and 42 CFR 456, subpart K, including prospective DUR, retrospective DUR, educational program, and the DUR board. Health plans, as well as the fee-for-service delivery system, require service authorization for atypical and typical antipsychotics prescribed to all members under the age of eighteen.

As mentioned previously, DMAS contracts with an EQRO, which conducts (as an optional external quality review (EQR) task under the CMS Medicaid guidelines) an annual focused study that provides quantitative information about children and adolescents placed in foster care and receiving medical services through Medicaid managed-care service delivery. The study includes specific indicators addressing utilization of antipsychotic medications, children's receipt of ongoing care following hospitalization for mental illness, and the prevalence of children prescribed antidepressant medications or medications for ADHD. The "*Healthcare Utilization Study Indicator Results for Children in Foster Care and Controls"* chart above outlines the results of this study.

Guidance in ACYF-CB-PI-20-02 Reflected in VDSS Psychotropic Medication Protocols

The guidance included in ACYF-CB-PI-20-02, which is reflected in the VDSS psychotropic medication protocols including the following:

- **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 medication.**

  MCOs have established policies and procedures in place to ensure children in foster care receive assessments and medical, dental, and behavioral health visits. A fully completed assessment addresses health care needs, including mental health, interventions received, and any additional services required, including referrals to other resources and programs. EPSDT-required medical screenings include a comprehensive health and developmental history, including assessments of both physical and mental health development. Pharmacy services for children are reviewed in accordance with EPSDT requirements to cover drugs when medically necessary, based on a case-by-case review of the individual child's needs, such as for off-label use.

- **Informed and shared decision-making (consent and assent) and methods for ongoing communication between the prescriber, the child, the child's caregivers, other healthcare providers, the child welfare worker, and other key stakeholders.**

The psychotropic medication oversight protocol includes a comprehensive consent document to be completed by the service worker that addresses how consent/assent is to be obtained with the youth/child, how birth parents are to be involved in the decision-making, how caregivers are to receive information about prescriptions and provide information to the prescriber regarding changes in behavior or mood and any potential side effects and that information about medical conditions and medications are to be shared with prescribers of psychotropic medication, and how information about psychotropic medication is to be shared with health care providers addressing other issues.

- **Effective medication monitoring at both the client and agency level.**

  At the client level, the psychotropic medication oversight protocol creates a process through which the FSS and director designated PMC are aware of all psychotropic medications prescribed and monitor their use with all children in the custody of the agency. Although OASIS allows for the entry of psychotropic medication information, there is no mechanism available to require that the fields are filled out or updated each time a prescription changes. Thus, VDSS has concerns that the data available from OASIS does not completely reflect the current psychotropic medication usage by children in foster care.

  To help alleviate these concerns, additional regional office capacity for technical assistance was added in 2020 and case reviews facilitate increased agency oversight as needed. The reviews conducted by QAA for item 18 of the CFSR take into account whether or not the LDSS is adhering to the psychotropic medication protocol. The new Director of Health and Safety will be tasked with developing a plan for identifying when agency practice is failing to meet the health and safety needs of children in foster care and/or when the rate of psychotropic medication prescription differs significantly from other LDSS.

- **Availability of mental health expertise and consultation regarding both consent and monitoring issues by a board-certified or board-eligible child and adolescent psychiatrist at both the agency and individual case level.**

  The psychotropic medication oversight protocol identifies situations when the LDSS should consider seeking a second opinion or accessing a consultation with a child and adolescent psychiatrist over a primary-care physician. The mechanism for accessing this level of mental health expertise is to contact the foster care coordinator through the child's MCO. Contact information for the MCO care coordinators is available on the VDSS intranet site.

  The health plan's community-based mental health providers (public and private) must meet any applicable DBHDS certification and licensing standards. Behavioral health providers shall meet DMAS' qualifications as outlined in 12 VAC 30-130-5000, et. al. and DMAS' most current behavioral health provider manuals, including the manuals for community mental health rehabilitative services, mental health clinics, and psychiatric services providers.

  At the LDSS level, the new Director of Health and Safety will be responsible for identifying and intervening with LDSS that are in need of mental health expertise and consultation regarding consent and monitoring issues.

- **Mechanisms for sharing accurate and up-to-date information related to psychotropic medications to clinicians, child welfare staff, and consumers, including both data sharing mechanisms (e.g., integrated information systems) and methods for sharing educational materials.**

  VDSS has significantly enhanced a dedicated intranet webpage where information about the MCO foster care points of contact and links to verified web sources where information about usual doses, purposes, and potential side effects, as well as other resources, are available. The enhancement permits FSS, supervisors, and PMCs to more readily access information necessary to monitor the utility of any psychotropic medications prescribed and identify any potential side effects.

  VDSS will continue to work at making improvements in psychotropic medication oversight. The implementation of the Foster Care Specialty MCO will provide the opportunity to work more closely with the MCO to address the overuse of psychotropic medications. The new Director of Health and Safety for foster care will oversee the development of additional enhancements to the psychotropic medication oversight protocol, full implementation of the protocol, and a case review process for youth congregate care placements and/or prescribed psychotropic medication. Per ACYF-CB-PI-12-02, an agency-level review process utilizing existing data, case review data, and CFSR data will also be formalized.

  Additionally, VDSS will work with the DMAS Foster Care Collaboration group in developing strategies for communicating the protocol to target audiences, including:

  - Front-line workers (VDSS FSS, FAPT and CSB case managers, clinicians, managed care managers);
  - Caregivers/providers where child lives (foster care parents, treatment foster care and residential treatment providers, etc.);
  - Prescribers of psychotropic medications (child and adolescent psychiatrists, nurse practitioners, primary care providers in public and private sectors);
  - Youth; and,
  - Birth parents.

- **How the state actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children.**

  Foster care guidance directs LDSS to ensure that children in care receive regular preventive healthcare. When a child requires care for an illness, caregivers access primary care providers through the child's assigned MCO. Complex medical or behavioral needs that require the involvement of or consultation with a specialist are addressed through referrals and care coordination provided by the MCO.

  Health plans conduct health assessments for each child within 60 days of enrollment in the health plan. Health plans also provide care coordination for CYSHCN among the multiple providers, agencies, advocates, and funding sources serving CYSHCN.

- **The procedures and protocols the state has established to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or**

behavioral disorders, medically fragile conditions, or developmental disabilities, and placed in settings that are not foster family homes as a result of the inappropriate diagnoses.

In accordance with the requirements of the FFPSA, VDSS enhanced procedures established in guidance to ensure that children in foster care are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities leading to placement in settings that are not foster family homes as a result. Although the work to address monitoring and prevention of over-prescription of psychotropic medication had not previously included a focus on the prevention of inappropriate diagnoses, the psychotropic medication oversight protocol and the eLearning include information addressing the risks of inappropriate diagnoses and guidance around the worker's responsibility to intervene, as well as strategies do so. Guidance for workers on preventing misdiagnosis of children in foster care is included in Section 12.11.7 of Foster Care Guidance. The full psychotropic medication oversight protocol is embedded in Virginia's Foster Care Guidance in Section 12.11.8.

As VDSS's capacity to conduct case reviews expanded over the last few years, additional technical assistance and targeted review of diagnoses, the related use of congregate care placements, and use of psychotropic medications was also expanded and will continue throughout the next five year strategic plan.

- **Steps to ensure that the components of the transition plan development process required under section 475(5)(H) of the act that relate to the health care needs of youth aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under state law, and to provide the child with the option to execute such a document, are met.**

  Youth in foster care who were receiving Virginia Medicaid at the age of 18 are eligible for Medicaid up to age 26. VDSS continues to coordinate with DMAS and LDSS to implement provisions of the ACA. At age 18, these youth are automatically evaluated for Medicaid in one of two eligibility categories and automatically enrolled into the up-to-age-26 category should they exit care. They then maintain their eligibility to age 26.

  Beginning at age 14, youth in foster care participate in the development of a transition plan that, among other things, addresses their health and well-being needs. As they get closer to their 18th birthday, focus is placed on ensuring their continued eligibility for Medicaid, maintaining needed health care services, and providing education about designating a health care power of attorney. Foster care guidance directs LDSS to encourage and assist the youth in seeking counsel from an attorney to address any questions. The current 90-day transition plan, which is completed with the youth approximately 90 days before their eighteenth birthday, includes the following items for the youth:

  - I understand that during the 90 days before I turn age 18, I will finalize my plans for successfully transitioning from foster care to adulthood. This plan for successful transition will include the names of adult(s) who have agreed to help me during this transition and in the future. It will also address my specific needs, including housing, health insurance, education, local opportunities for mentors and continuing support services, workforce supports, employment services, and any other needs I identify.
  - I understand the importance of identifying someone to make health care treatment decisions on my behalf, if I become unable to make them and if I do not have or want a relative to make these decisions. I can identify a health care power of attorney using the form on the Virginia Department of Health's website, titled "Virginia Advance Medical Directive."

http://www.vdh.virginia.gov/OLC/documents/2008/pdfs/2005%20advanced%20directive%20form.pdf

Additionally, in the plan for successful transition section of the 90-day transition plan, the following information is reviewed and collected:

Health Care and Insurance (e.g., contact information, policy numbers)	
I have health insurance:	Yes No
Name of insurance company:	
Policy ID #:	
Phone number of insurance provider:	
Date of last medical exam:	Date of next medical exam:
Date of last dental exam:	Date of next dental exam:

I have identified someone to make health care treatment decisions on my behalf if I become unable to make them (a health proxy/ healthcare power of attorney) using the form on the Virginia Department of Health's website, titled "Virginia Advance Medical Directive.",. Yes No (circle one)

The foster care guidance includes directions for the LDSS to provide additional information to youth who request it during the transition-planning process.

Health plans are required to establish a process to notify youth in foster care who are approaching age 17 of the Medicaid programs that provide continued health care coverage. The health plans assist in care coordination during this transitional period. The transition plan includes provisions for convening a comprehensive treatment team meeting to discuss the services and supports the enrollee will need post-separation. If the services are not covered by Medicaid, the plan provides information for the enrollee, or their authorized representative, about any community programs that may be able to meet their needs. The necessary referrals are then made.

VDSS remains committed to ensuring the health and safety of all children in foster care. The partnership between DSS and DMAS will be critical to this continued work and past collaboration has been extremely beneficial. DMAS has established the Foster Care Specialty Plan so that one MCO will be responsible for the children in foster care. This will allow for expertise in working with this population, ensuring that the unique needs of children in foster care are met and partnerships continue.