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# Timely Health Service Utilization of Older Foster Youth by Insurance Type

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A B S T R A C T

**Purpose:** To evaluate the impact of a policy change for older foster care youth from a fee-for-service (FFS) Medicaid program to health maintenance organization (HMO) providers on the timeliness of first well-child visits (health care physicals).
**Methods:** A three-year retrospective study using linked administrative data collected by the Michigan Departments of Human Services and Community Health of 1,657 youth, ages 10-20 years, who were in foster care during the 2009–2012 study period was used to examine the odds of receiving a timely well-child visit within the recommended 30-day time frame controlling for race, age, days from foster care entry to Medicaid enrollment, and number of foster care placements.
**Results:** Youth entering foster care during the HMO period were more likely to receive a timely well-child visit than those in the FFS period (odds ratio, 2.46; 95% confidence interval, 1.84–3.29; $p < .0001$) and days to the first visit decreased from a median of 62 days for those who entered foster care during the FFS period to 29 days for the HMO period. Among the other factors examined, more than 14 days to Medicaid enrollment, being non-Hispanic black and having five or more placements were negatively associated with receipt of a timely first well-child visit.
**Conclusions:** Those youth who entered foster care during the HMO period had significantly greater odds of receiving a timely first well-child visit; however, disparities in access to preventive health care remain a concern for minority foster care youth, those who experience delayed Medicaid enrollment and those who experienced multiple placements.


**IMPLICATIONS AND CONTRIBUTION**

This study assesses service access by type of Medicaid coverage. Findings indicate that the state's change from fee-for-service to health maintenance organization for foster youth in Medicaid found a greater proportion of children receiving timely well-child visits under health maintenance organization period than during the fee-for-service period.

Health insurance and utilization of preventive health care services are vital to the promotion of the health of adolescents, including the approximately 400,000 U.S. youth in foster care [1] and provide the primary means of preventing and mitigating health problems [2]. Foster care youth are a medically vulnerable population [3–5] for which a high percent suffer from physical health conditions (87%–95%) [6], and many experience multiple morbidities (>50%) [6]. Access to primary care providers that can provide timely preventive services (i.e., a health care physical) is

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**What's known on the subject:** Preventive health screenings, shown to be effective in reducing negative health outcomes and costs, are recommended for all children entering foster care. These services are predominantly covered through Medicaid health plans, including both fee-for-service and managed care programs.

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critical for this population as they are often suffering from undiagnosed and untreated health care problems that exacerbate over their time in foster care placement and during their transition out of care. Health systems oriented toward primary care have lower costs and better population health outcomes [7]. Foster youth are expensive consumers of health care treatments. Although youth in foster care account for 8% of expenditures within the Medicaid program, they represent <3% of all enrollees [8]. Early identification and management of health care conditions at the onset of foster care entry is critical. In attempt to decrease the unmet health needs of this vulnerable population and assure no gap in health care coverage, federal guidelines [9] have been established that require states to conduct a comprehensive health assessment within 30–60 days of initial placement in foster care [4–6,10]. However, the most effective method to provide timely care remains unclear [11,12].

Within the foster care population, several subgroups are at particular risk, including older youth, minorities, and those with multiple placements [13,14]. Older youth have special health concerns, including an increased likelihood of engagement in risky behavior [15–17]. These older foster youth have been the focus of major federal policies implemented to increase access and utilization of preventive and treatment-based health care services (Section 2004 of the Patient Protection and Affordable Care Act, Title II, of the Fostering Connections to Success and Increasing Adoptions Act, and Title II, Section 201 of the *Child and Family Services Improvement and Innovation Act*) [1,18,19]. In addition to these federal policies, class action lawsuits in several states have challenged state agencies to modify their current practices to ensure adequate and timely health care for this high-risk group [20].

Despite the adoption of these policies and court decisions, there is evidence that children in foster care do not receive routine health care in a timely manner and, therefore, have gaps in care and continue to suffer from untreated health problems throughout the time they are placed in foster care [3–5,20]. One barrier to access to care among these youth is a lack of placement stability. Frequent moves among foster homes or moves out of and back into foster care contribute to children receiving less timely care and care from many different physicians [21]. Additionally, minority children experience disparities in health outcomes, timely access to care, and use of services [22]. As children of color are overrepresented in our nation's foster care system [13], they are especially at risk for not receiving the health care they need in a timely manner. Improvements in health care access and utilization are currently being examined by several states as one system-level reform initiative that could improve the health care of this vulnerable population [23].

Any improvement in health care for foster care youth likely will involve Medicaid because all children placed in foster care in the United States have been served under the Medicaid program for several decades [24]. In an effort to control costs and improve access to care, state governments have enrolled Medicaid recipients in privately owned and operated health management organizations (HMOs) [25]. HMOs have historically shared some of the burden of financial risk for the health care of children in their programs, and they have an incentive to provide effective services in an efficient manner by offering access to primary care providers and a network of specialists [26]. Although most children in Medicaid are covered by an HMO plan, many states have exempted certain populations from managed care, including foster youth and other children with special health care needs and instead covered them through a Medicaid fee-for-service (FFS) plan [11]. States like Colorado have wavered in selecting a mandatory managed health care plan for foster youth and currently provide managed care to this population as a voluntary option [27].

Despite the lack of unanimous agreement on the adoption of HMO Medicaid for this population, Public Act 131 of 2009, Section 1772, required that Michigan change health insurance coverage for foster youth from FFS to a managed care system [28]. Michigan's policy also includes a standard of promptness for enrollment of all children placed in foster care in Medicaid within 14 calendar days of acceptance of the child welfare case [28] and receive their first well-child visit within 30 days [28] to ensure no gap in health care coverage and maintenance of any ongoing health concern and reduction of inappropriate use of the emergency department [29]. To address this policy, Michigan began transitioning foster care youth to managed care in November 2010 and completed the transition by September 1, 2011.

Understanding how to best ensure this vulnerable population has health care with no gaps in coverage is particularly important now given the estimated 400,000 foster care youth in the United States that will be impacted by the Affordable Care Act (ACA) [30]. There are no provisions in the ACA, however, that restrict the type of Medicaid plan (FFS vs. HMO) states would need to adopt to serve this population [18,30]. Although some evidence suggests FFS may serve foster care children, including older youth, better [11]; studies on the general population have found that children obtain increased access to more preventive health services when insured by HMOs [11,31,32]. The effects of this type of policy change on the health care access and service utilization of foster care youth remains unknown.

States are currently implementing policy changes in health care coverage to improve timely health care access and service utilization despite a lack of clear evidence regarding the likely outcome of these changes [11,12]. To address this gap in the literature, this study examined whether Michigan's change from FFS to HMO Medicaid was associated with older youth obtaining a well-child visit in a timely manner after initial foster care entry, as mandated by child welfare policy.

## Methods

This study was a retrospective examination of two secondary, linked data sets (child welfare administrative data and Medicaid claims and encounter data) of older foster care youth who had active foster care cases in the state of Michigan from November 1, 2009, to September 1, 2012. All foster youth in the sample were matched to their Medicaid records. Data linking was conducted using Medicaid ID number. These dates were chosen to coincide with the state change in Medicaid policy from FFS to HMO over an approximately 3-year period. To be included in the analysis, youth had to (1) be between 10 and 20 years of age; (2) enter foster care initially during one of the three study periods; (3) spend at least 30 days continuously in foster care after entry; and (4) not be on Medicaid before foster care entry. Continuous enrollment in Medicaid was not a requirement for this study.

Child welfare and Medicaid records were matched based on the identifiers of patient name, date of birth, and Medicaid identification number. After matching occurred, identifiers were removed before analysis. Wayne State University and Western Michigan University human subjects institutional review boards