Elevance Health | Public Policy Institute

Data Brief

Healthcare Quality and Access for Children and Youth in Foster Care by Delivery System

September 2025

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Overview

Under Title IV-E of the Social Security Act, children and youth in foster care are automatically eligible for Medicaid, which provides essential coverage for preventive, behavioral, and developmental services. As states have shifted from fee-for-service (FFS) models to managed care, research on the effectiveness of different delivery systems for this population has been limited.

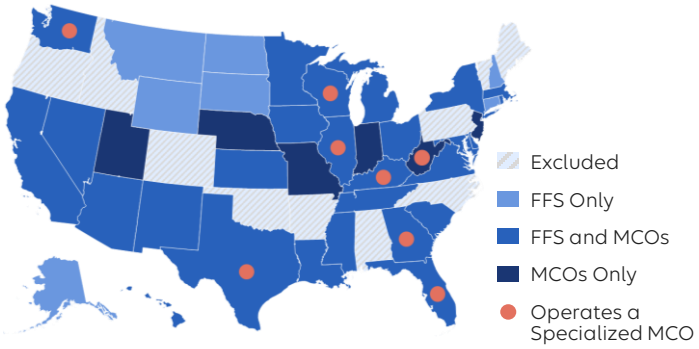
This study helps address this knowledge gap by comparing care quality and service use for children and youth in foster care (CYFC) across FFS, general managed care organizations (MCOs), and specialized MCOs designed specifically for CYFC. These findings offer insight into how Medicaid delivery models influence care for children and youth with unique health and social needs.

Methods

This study analyzed 2021–2022 Transformed Medicaid Statistical Information System (T-MSIS) data covering over 530,000 CYFC in 40 states and DC. CYFC were categorized by delivery system—FFS, general MCO, or specialized MCO—based on enrollment (Exhibit 1).

Twenty-one quality and utilization measures, drawn from the Medicaid Child Core Set and other validated sources, were used to compare access and care quality (Exhibit 2). Results were examined across demographic, medical, and behavioral health factors.

Exhibit 1: States Contributing Cases to the Study, by Delivery System



Note. FFS = Fee-for-Service. MCO = Managed Care Organization.

Exhibit 2: Quality and Utilization Measures Used to Compare Medicaid Managed Care and Fee-For-Service Performance for Children and Youth in Foster Care

Quality Measures – Primary & Medical Care (7 metrics)	Quality Measures – Behavioral Health Care (8 metrics)	Utilization Measures (6 metrics)

• **WCV:** Well-Child Visits for Younger Children (12-30 months; 2 metrics)
  ◦ % receiving at least 1 WCV
  ◦ Average number of visits
• **WCV:** Children and Adolescents (% Receiving at least 1 WCV)
• **OEV:** Oral Evaluation, Dental Services (% Receiving at least 1 oral evaluation visit)
• **PPC:** Prenatal Care and Postpartum Care (2 metrics)
• **AMR:** Asthma Medication Ratio
	• **FUH:** Follow-Up After Hospitalization for Mental Health, 7-day rate
	• **FUH:** 30-day rate
	• **FUM:** Follow-Up After Emergency Department Visit for Mental Health, 7-day rate
	• **FUM:** 30-day rate
	• **FUA:** Follow-Up After Emergency Department Visit for Substance Use, 7-day rate
	• **FUA:** 30-day rate
	• **ADD:** Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication, Initiation Rate
	• **APP:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
		• **Inpatient Utilization:** Access (% with any visits within the year)
		• **Inpatient Utilization:** Length of Stay
		• **All Cause Readmission:** Access (observed % of unplanned readmissions within 30 days)
		• **Residential Utilization:** Access (% with any visits within the year)
		• **Residential Utilization:** Length of Stay
		• **Emergency Department (ED) Utilization:** Access (% with any visits within the year)

This report was commissioned by the Elevance Health Public Policy Institute and conducted by KNG Health Consulting.

Results

Medical and Preventive Care. Both specialized and general MCOs outperformed FFS across most medical and preventive quality measures. CYFC in managed care were more likely to receive well-child visits, dental care, postpartum care, and asthma treatment (Exhibit 3).

Behavioral Health. Specialized MCOs consistently delivered the strongest performance, including higher rates of timely follow-up after mental health hospitalizations and ED visits, appropriate ADHD follow-up, and use of first-line psychosocial care with antipsychotic prescriptions (Exhibit 4).

Utilization Patterns. CYFC in managed care had fewer inpatient admissions and shorter hospital stays, despite having more complex health needs (Exhibit 5). CYFC in FFS had the highest all cause readmission rates.

Although CYFC in managed care had higher ED use than in FFS (Exhibit 6), this may reflect case mix differences and greater triage of youth with chronic conditions, particularly mental health. Specialized MCOs still outperformed FFS on all ED follow-up quality measures.

Exhibit 3: Medical and Preventive Care Quality Measure Rates, by Delivery System

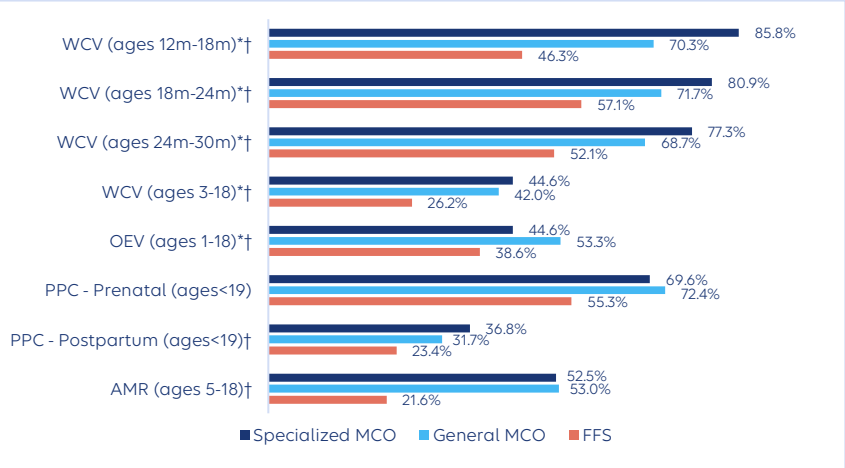
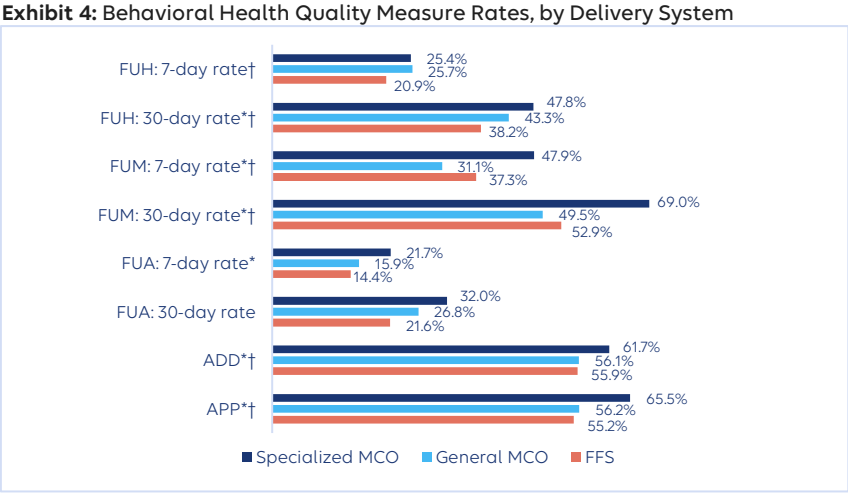


Exhibit 4: Behavioral Health Quality Measure Rates, by Delivery System



Note. * p-value <0.05 is for an F-test of significant differences in performance rate by specialized MCO vs. general MCO. † p-value <0.05 is for an F-test of significant differences in performance rate by specialized MCO, general MCO, and FFS.

Exhibit 5: Average Inpatient Length of Stay, by Delivery System

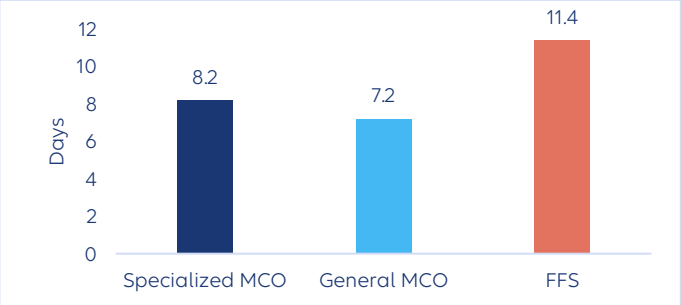
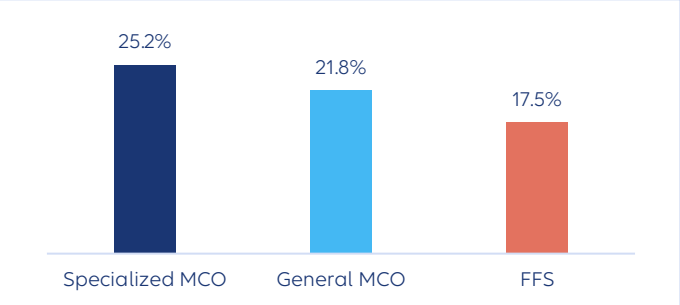


Exhibit 6: Proportion of CYFC with at Least One Emergency Department Visit, by Delivery System



Note. P-value is <0.05 in length of stay by specialized MCO vs. general MCO only. P-value is <0.001 in length of stay by specialized MCO, general MCO, and FFS. P-value is <0.001 in utilization rate by specialized MCO vs. general MCO only. P-value is <0.001 in utilization rate by specialized MCO, general MCO, and FFS.

Conclusion

Medicaid managed care—particularly specialized MCOs tailored for CYFC—provides higher quality care and better coordination than FFS models. These findings highlight the promise of specialized managed care in meeting the complex needs of CYFC, suggesting that expanding access to such models could improve long-term outcomes. Continued investment in data collection, quality measurement, and cross-system collaboration will be critical for assessing and advancing care for this population.

This data brief includes information from a larger analysis conducted by KNG Health Consulting and commissioned by the Elevance Health Public Policy Institute. For the complete paper, scan the QR code on page one or visit www.elevancehealthppi.com.