Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

Transparency in Medicaid Managed Care for Children and Youth in Foster Care

by Andy Schneider, Allie Corcoran, and Emma Hurler

Contents

Key Findings

- In 2018, six states—Arizona, Florida, Georgia, Tennessee, Texas, and Washington—contracted with Medicaid managed care organizations to furnish services on a statewide basis exclusively to children and youth in foster care and other vulnerable populations (MCO/FCs).
- None of the Medicaid agency websites in these states posted all of the minimum data elements required by federal regulations, and none of them posted information sufficient to enable stakeholders to assess the performance of the MCO/FCs for enrolled foster care children and youth.
- Although information on the race and ethnicity of children and youth in foster care is collected by state child welfare agencies, the state Medicaid agency websites did not present data on the provision or quality of services disaggregated by race and ethnicity. This lack of transparency makes it extremely challenging to identify and address heath inequities.

Executive Summary

Children and youth in foster care are among the most vulnerable populations covered by Medicaid. When children and youth enter the child welfare system, they are often not up to date on routine care, and many have unrecognized and untreated medical needs. In addition, the experience of removal from a child's biological family, even when necessary for their safety, creates trauma which in turn generates additional health needs. Adverse events in early childhood including neglect, abuse, and toxic stress, can have long-lasting effects on children's physical and mental health, especially if they go unaddressed. Given their circumstances, children and youth in foster care require access to a broad range of health and behavioral health services and extensive care coordination. As the nation's health insurer for children and youth whose foster care families receive assistance under Title IV-E of the Social Security Act, Medicaid has a particularly important role to play in protecting the health of individual children and youth as well as improving the well-being of the foster care population generally.

In 40 states and the District of Columbia, state Medicaid programs contract with managed care organizations (MCOs) to furnish covered services to Medicaid beneficiaries. In some of these states, children and youth in foster care are not enrolled in MCOs but continue to receive services through fee-for-service (FFS) Medicaid. In other states, children and youth in foster care are enrolled in MCOs along with other Medicaid-eligible children and adults. And in some states, the Medicaid agencies currently contract with a single MCO to furnish services to all foster care children in the state. Because these MCOs focus on the foster care population, rather than enrolling a range of beneficiary groups, we refer to them as MCO/FCs.

Six states—Arizona, Florida, Georgia, Tennessee, Texas, and Washington—contracted with MCO/FCs to furnish services to children and youth in foster care in calendar year 2018. To assess how MCO/FCs performed for their enrollees in that year, we searched the websites of the Medicaid agencies, child welfare agencies, and MCO/FCs in each of these states. We conducted our scan between December 2020 and May 2021; this paper presents the results. A companion paper presents the results of a scan of the websites of 56 MCOs in 13 states for information on their performance for enrolled children and pregnant women during calendar year 2018.[1]

In this scan, we were able to locate enrollment data for each of the MCO/FCs, but those data were not disaggregated by race or ethnicity. We were unable to find any measures of performance with respect to Medicaid's comprehensive pediatric health benefit—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services—which is of particular importance to a high-need population like those in the child welfare system. Finally, we searched for evidence of performance on quality measures during 2018 and found substantial results for only four of the six MCO/FCs that were operational that year. None of the quality measures we were able to find were disaggregated by race or ethnicity.

In short, much of the information one would need to assess how well each of the six MCO/FCs performed for foster care youth in FY 2018 was not publicly available. We are not able to draw any conclusions about the performance of these MCO/FCs, and we cannot make any meaningful comparisons between their performance and that of their MCO/FC peers in other states.

Medicaid has a particularly important role to play in protecting the health of individual children and youth as well as improving the well-being of the foster care population generally.

One premise of the MCO/FC model is that enrolling foster care children and youth in MCOs that specialize in the management of health and related services for this population will produce better outcomes than leaving them in uncoordinated fee-for-service (FFS) arrangements. Another is that enrolling them in MCO/FCs will produce better outcomes than enrolling them in MCOs that manage services for all Medicaid beneficiaries. The pervasive lack of transparency about the performance of individual MCOs/FCs and MCOs generally makes it impossible for the public and policymakers to evaluate either premise. It also increases the risk that MCO/FCs, and the state agencies with which they contract, will not be held accountable in the event of poor performance.

Children and youth in foster care are a critically vulnerable group. More data are needed to hold Medicaid MCOs accountable for ensuring their access to needed physical and behavioral health services. In particular:

1. State Medicaid agencies that contract with an MCO/FC should maintain a child health dashboard that contains enrollment and performance information specific to that MCO/FC. At a minimum, the performance data should include EPSDT screenings and treatment, Child Core Set metrics, and all other information required to be posted by federal regulations. All enrollment and performance data should be disaggregated by race and ethnicity.
2. The Centers for Medicare & Medicaid Services (CMS) should add a child health dashboard as a measure to the State Administrative Accountability pillar of its Medicaid & CHIP Scorecard. The dashboard should present performance information on EPSDT services and Child Core Set metrics disaggregated by race and ethnicity for individual MCO/FCs as well as individual MCOs to enable comparison of performance from state to state.

Health Needs of Children and Youth in Foster Care

Approximately 673,000 children are served by the foster care system over the course of a year, and there are 424,000 children in care at any point in time.[2] The American Academy of Pediatrics (AAP) classifies these children categorically as children with special health care needs.[3] Many have unaddressed health needs when entering the child welfare system as a result of previous neglect, abuse, or trauma. More than one-quarter of children in foster care have a mental health diagnosis and they are more likely to experience developmental delays and speech/language disorders than their peers.[4] Fetal alcohol syndrome, a condition in which early diagnosis and therapeutic services are critical, is common among foster care children, but often not recognized or misdiagnosed.[5] Children with a history of foster care are 1.5 times more likely to report oral health problems as compared to their counterparts.[6]

AAP recommends that, at minimum, all children and youth entering foster care are given a comprehensive screening within 72 hours of placement. Young children, children who are victims of abuse, and children with chronic conditions should be seen within 24 hours.[7] AAP advises that pediatricians screen carefully for undiagnosed prenatal alcohol syndrome, signs of abuse or sex trafficking, and mental health conditions including suicide risk.[8] In addition, children and youth in foster care should have more frequent visits than other children (monthly for the first six months of life, every three months between six months and 24 months, and every six months after that) and may require longer visits.[9] When vaccination records are incomplete or missing, children should also be brought up-to-date with the AAP recommended immunization schedule.[10]

Children and youth in foster care face enormous challenges in accessing appropriate care. Chief among them is being moved in and out of the home and from foster care placement to foster care placement, which can result in needed medical or behavioral care being interrupted, uncoordinated, or not accessed at all. This makes effective care management, including a unified electronic health record for each child in foster care, particularly important.[11]

Any use of antipsychotics in children should be a last resort. Once prescribed, the regimen requires careful monitoring for side effects and continual coordination between providers and caregivers.[12] Unfortunately, the fragmented nature of foster children's interaction with the system means that psychotropics are often inappropriately substituted for intensive trauma-informed counseling and not well-monitored.[13]

Medicaid for Children and Youth in Foster Care

Medicaid is the nation's health insurer for children and youth in foster care. Those whose families are receiving payments under Title IV-E of the Social Security Act are automatically eligible for Medicaid in every state. Medicaid coverage entitles these children to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, which are particularly important for a population with significant medical and behavioral health needs.[14]

State Medicaid programs vary in how they deliver EPSDT and other services to children and youth in foster care. Some use the fee-for-service delivery system; others enroll them in MCOs along with other Medicaid populations; and some enroll them in MCO/FCs, which enroll only foster care and other highly vulnerable child populations. In 2018, the Medicaid and CHIP Payment and Access Commission (MACPAC) estimated that 44 percent of Title IV-E children were enrolled in managed care plans; however, that share has likely grown as more states opt to move the population from FFS to managed care.[15] Currently, nine states enroll their foster care children and youth in MCO/FCs (Arizona, Florida, Georgia, Illinois, Kentucky, Tennessee, Texas, Washington, and West Virginia).

State Medicaid agencies contract with MCOs and MCO/FCs to organize networks of providers that are capable of furnishing covered services to enrollees and to ensure that those services are available and accessible to enrollees when needed. The agencies pay MCOs and MCO/FCs under these contracts on a risk basis—i.e., a fixed amount per member per month for each enrollee, whether the enrollee uses services or not. These fixed amounts, or capitation payments, vary with the likelihood that a group of enrollees, such as infants under age one or children between ages one and five, will use services; in the case of a high-needs population like children and youth in foster care, these monthly capitation payments will likely be higher than those for children and youth who are not in the child welfare system.

Within limits, MCOs and MCO/FCs can retain revenues and, in some cases, earn profits from monthly capitation payments that are not paid out to network providers for furnishing covered services. This creates a financial incentive to withhold approval for needed services.

One check on this incentive is that the MCO or MCO/FC is required to report information on its performance to the state Medicaid agency. Two types of performance information are particularly important to children and youth in foster care: the provision of EPSDT services and quality measures from the CMS Child Core Set. In each case, both the MCO/FC and the state Medicaid agency have this information for the enrolled foster care population (see boxes on page 8 and 9). This performance information enables the state Medicaid agency to assess and, where indicated, improve the performance of the MCO or MCO/FC for foster care children and youth. The collection, reporting, and validation of the data are paid for entirely with state and federal Medicaid funds.

Additionally, state child welfare agencies are required to track metrics such as placement permanency and reunification for children in care and report the outcomes to the national Adoption and Foster Care Analysis and Reporting System (AFCARS).[16] MCO/FCs can either facilitate or complicate access to health-based interventions such as trauma-informed mental health care that promote stability and reunification.[17] Consequently, although not the only drive of placement stability and reunification, the performance of MCO/FCs could well have an impact on these important metrics.

Currently, nine states enroll their foster care children and youth in MCO/FCs: Arizona, Florida, Georgia, Illinois, Kentucky, Tennessee, Texas, Washington, and West Virginia.

Health Equity for Children and Youth in Foster Care

Black and American Indian/Alaska Native children are overrepresented in the foster care population.[18] This overrepresentation makes all MCOs, and especially MCO/FCs, a critical point for achieving equity: they can either furnish the children with the services that they need or they can be yet another point of systemic failure. Plan selection of certain providers, limited networks, and prior authorization practices may restrict children's access to their established care team and to providers they trust, which can be especially harmful for children of color.[19] It is estimated that children who identify as LGBTQ+ are disproportionately represented in the foster care population, with around 30 percent of foster care youth (roughly between ages 10 and 20) identifying as LGBTQ+.[20] These children may enter the foster care system for reasons unrelated to their identity, but they may also enter the system because they face rejection, neglect, and/or abuse from their origin family. LGBTQ+ children may fear backlash from disclosing their sexual orientation or gender identity to foster placements or caseworkers, underscoring the need for providers who affirm their identity.

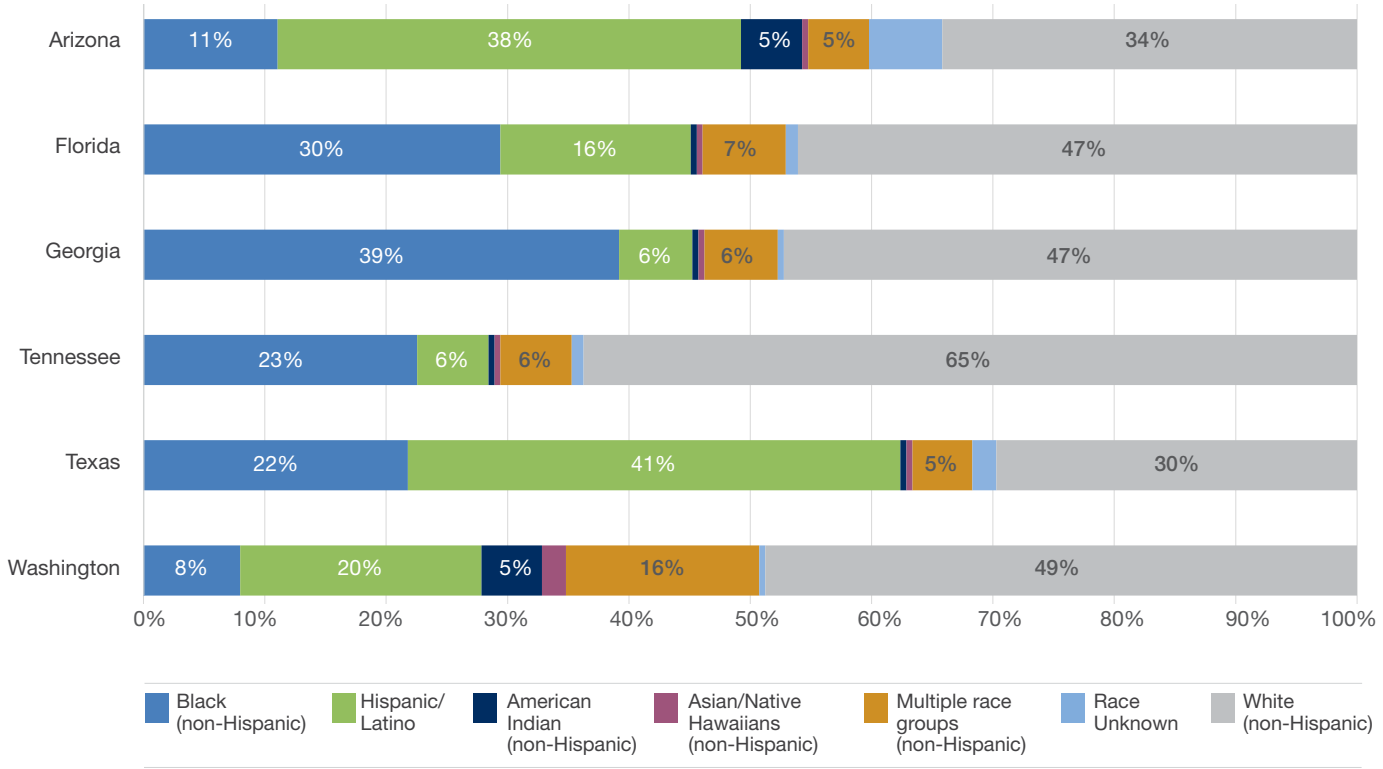
Plan selection of certain providers, limited networks, and prior authorization practices may restrict children's access to their established care team and to providers they trust, which can be especially harmful for children of color.

The States and MCO/FCs We Scanned

Our scan focused on the six MCO/FCs that were operating in calendar year (CY) 2018: Comprehensive Medical and Dental Plan (Arizona); Sunshine State Health Plan (Florida); Amerigroup Georgia Families 360° (Georgia); TennCare Select (Tennessee); Superior Health Plan (Texas); and Apple Health Core Connections (Washington). We selected this performance year because it was the most recent for which data was available at the time of the scan.[21]

In line with the national trend, Black non-Latino children were overrepresented as a share of the foster care population in all six states in 2018 (see Appendix B). And, in five of the six states—Arizona, Florida, Georgia, Texas, and Washington—the majority of the foster care population in 2018 were children of color (see figure 1). As a result, the MCO/FCs that enroll only this population have an opportunity to manage the care of these children and youth in a way that addresses unmet needs, reduces racial and ethnic disparities, promotes health equity, and improves outcomes such as family reunification. On the other hand, limiting enrollment to foster care children and youth runs the risk of exacerbating racial disparities for children of color, separating them from trusted providers, and denying them access to the services they need.

Figure 1. Composition of State Foster Care Programs by Race/Ethnicity, 2018



Note: Numbers may not sum due to rounding.

Source: Annie E. Casey Foundation Child Trends analysis of 2018 Adoption and Foster Care Analysis and Reporting System (AFCARs) data (March 2020), available at https://datacenter.kidscount.org/data/tables/6246-children-in-foster-care-by-race-and-hispanic-origin?loc=1&loct=1#detailed/2/4,11-12,15,19,44-45,49-50/false/37/2638,2601,2600,2598,2603,2597,2602,1353/12992,12993.

In some states, enrollment in the MCO/FC is mandatory for foster care and adoption assistance children; in others, voluntary. As of 2018, enrollment was mandatory in four of the states we scanned and optional in two.[22]

As of 2021, in five of the states, the MCO/FC contract with the state Medicaid agency was held by a subsidiary of a national insurer: Anthem, Centene, or CVS/Aetna. In each case, that insurer also operates an MCO that enrolls both child and adult Medicaid beneficiaries in the state. With the exception of Tennessee, the state Medicaid agencies contract with the MCO/FC on a risk basis.[23] In four of the states, the contract is separate from the main MCO risk contract with the insurer; in the remaining two states the arrangement is an amendment to the main risk contract.

The parent company with the largest footprint among the six MCO/FCs is Centene, which operates subsidiaries in Florida, Texas, and Washington that collectively enroll approximately 98,000 children.[24] Centene is a publicly traded company (#24 among the Fortune 500 in 2021) that operated 38 MCOs in 28 states as of July 2021. It is the nation's largest Medicaid managed care company, whether measured by enrollment (14 million Medicaid beneficiaries in July 2021) or Medicaid revenues ($74.8 billion in 2020).[25] The company's Texas subsidiary, Superior Health Plan, was a subject of the award-winning Dallas Morning News investigative series "Pain & Profit," which documented the withholding of needed services from children with disabilities by MCOs in Texas.[26]

What Performance Information We Looked For

We are not aware of any generally accepted set of measures for answering the question: How well is an MCO/FC performing for foster care children and youth? Our search focused on data elements that we believe are the minimum necessary to answer that question. Some of these data elements are required to be posted by federal regulation; others are not. These elements fall into four broad categories.

First, what is each MCO/FC's role for foster care children and youth (and the other child populations that may also be enrolled)? How many are enrolled? What is the age distribution (e.g., <1, 1-5, etc.)? What is their demographic profile?

Second, we tried to gather information about the structure of each MCO/FC that is required to be posted on the website of either the state Medicaid agency or individual MCO/FC. This information includes MCO/FC management, the MCO/FC's accreditation status, and the risk contract between the MCO/FC and the state Medicaid agency. These data elements are among those that federal Medicaid managed care regulations require.[27]

Third, we wanted to know whether foster care children and youth enrolled in the MCO/FC are receiving the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to which they are entitled. We looked for the same data elements that the state Medicaid agencies report annually to CMS on Form-416 (see Box).[28] We also sought to determine whether there were any differences in access to these services based on race or ethnicity.

Collected and Cleaned: EPSDT Services and CMS Form-416

Children enrolled in Medicaid are entitled to the comprehensive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit package. In order to monitor access to EPSDT services, states are required to report to CMS:

- The number of children provided child health screening services
- The number of children referred for corrective treatment as a result of the screenings
- The number of children receiving dental services

CMS collects this information from states on CMS-416, the Annual EPSDT Participation Report. In order to complete the form, Medicaid agencies in managed care states have to obtain encounter data on the number of children receiving these screenings and services from each MCO. In other words, MCOs are already required to collect this data, and state agencies are already cleaning the data by removing duplicative entries, incomplete information, and correcting formatting errors. All that remains is for the state Medicaid agencies to post the data.[29]

Finally, we wanted to know what results each MCO produced for foster care children as measured by the metrics in the CMS Child Core Set (see Box).[30] We examined a subset of measures from the Core Set that, in our judgment, reflect the health care needs of foster care children and youth. Seven of these relate to primary and preventive care; six to behavioral health; and one to maternal health (see Appendix D). Again, we looked for whether these metrics varied by race and ethnicity.

Collected and Cleaned: Child Core Set

The Child Core Set are metrics chosen by CMS in consultation with input from a national committee of experts to evaluate access to and quality of care for Medicaid and CHIP beneficiaries. The measures cover a variety of domains including preventative care, oral health, and behavioral health. The standard metrics in the Set allow for comparisons both over time and between states, though there are limitations.[31]

Currently, it is optional for state agencies to report the metrics on an aggregate, statewide basis to CMS, but reporting on all measures will become mandatory starting in fiscal year 2024.[32] As with the EPSDT metrics, this means that managed care states are already collecting the records from their MCOs and are cleaning the data to ensure accuracy and consistency across MCO and FFS records before they combine the datasets to find the statewide rate.

Some measures included in the Set, such as use of first-line psychosocial care for children and adolescents on antipsychotics, are particularly pertinent to monitoring access and treatment of foster care youth. However, the overall Set is designed with the entire child population in mind and does not address measures specific to foster youth such as comprehensive risk-screening, reducing outplacement, and reducing placement turnover.

There are data elements relevant to MCO/FC performance that we did not examine. These include information on the adequacy of the MCO/FC's provider network for pediatric and behavioral health services; denials of services; the disposition of grievances, appeals, and state fair hearings involving children and foster care families; and sanctions or administrative penalties or corrective action plans imposed on MCO/FCs for violations of contract requirements. We also did not search for information relating to the MCO/FC's financial performance, such as the annual medical loss ratio report to the state Medicaid agency or the annual financial filing with the state insurance department.

The Performance Information We Found

Our scan of the websites of the six state Medicaid agencies and their individual MCO/FCs did not yield enough information to enable us to assess how well each MCO/FC performed for its enrollees in CY 2018. Here's what we were able to find.

Enrollment

We found enrollment data for each MCO/FC, although the years for which those data were available varied (see Appendix A). In the case of those MCO/FCs that enrolled populations other than foster care youth, such as youth in the juvenile justice system, we were unable to find enrollment breakouts by subpopulation. None of the state agency or MCO/FC websites disaggregated the enrollment data by race or ethnicity.

Racial and Ethnic Disparities

In an effort to measure and address racial and ethnic disparities in the child welfare system, federal regulations require that child welfare agencies record the race and ethnicity of children in the Adoption and Foster Care Analysis and Reporting System.[33] These data, analyzed by the Annie E. Casey Foundation and presented in Figure 1, show that all six states with MCO/FCs we scanned have high shares of Black and/or Latino children. Even though these data are already collected by the state's child welfare agency, none of the state Medicaid agency websites we looked at posted MCO/FC enrollment disaggregated by race and ethnicity.

Federal Transparency Requirements

Federal regulations require that state Medicaid agencies post their contracts with MCOs.[34] As shown in Appendix C, only two of the six states we scanned—Tennessee and Washington—post the actual contracts with their MCO/FCs on the Medicaid agency website. Three states—Florida, Georgia, and Texas—post what appear to be template contracts. In every state, the contract is between MCO/FC and the state Medicaid agency, not the state child welfare agency.[35]

Federal regulations also require that state Medicaid agencies post information about the ownership and management of each MCO/FC (and its subcontractors).[36] However, full information on plan ownership and management was only available for Tennessee (and, even then, the information was only posted on the Department of Insurance website as opposed to the Medicaid agency website). Georgia and Washington posted partial information.[37] Arizona, Florida, and Texas made no information on plan ownership and management available, although the Florida Agency for Health Care Administration does post a detailed list of MCO subcontractors.[38]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services for Children

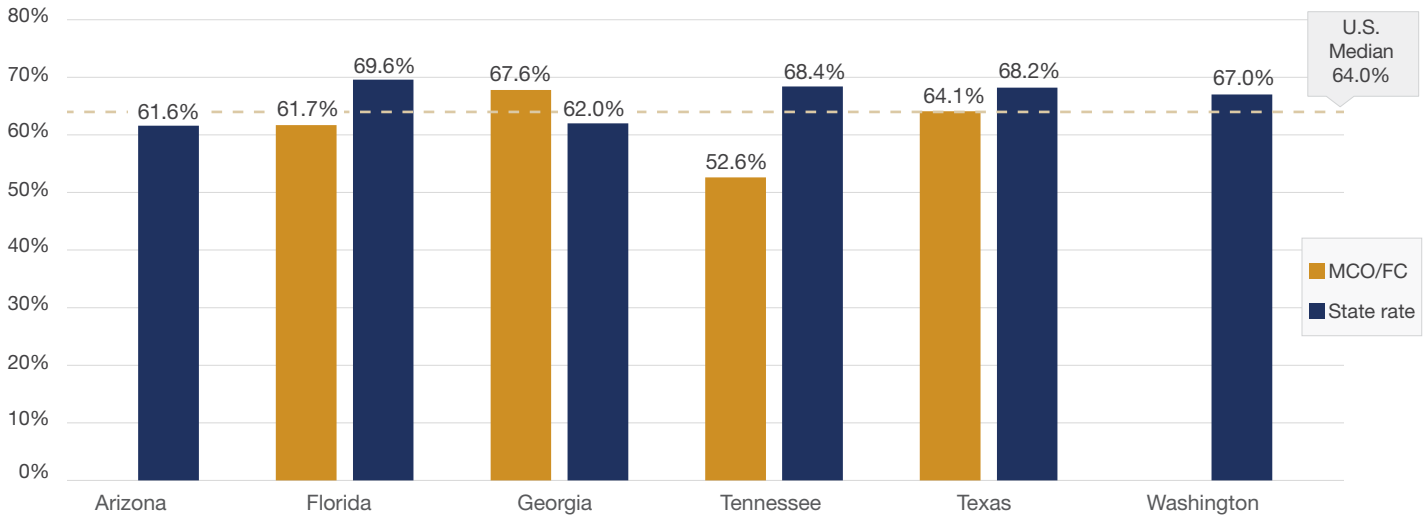
We could not find any EPSDT performance information for any of the six MCO/FCs during CY 2018. We were unable to determine how many screenings each MCO/FC's network providers conducted, how many of the children screened were referred for corrective treatment, or whether they received that treatment.

Child Health Quality Metrics

In all of the states we scanned other than Washington, MCO/FC-specific performance data for CY 2018 were available in the Annual Technical Report (ATR) prepared by the Medicaid agency's External Quality Review Organization (EQRO) and posted on the agency's website.[39] Appendix D provides detail about MCO/FC performance on Child Core Set quality measures in relation to state and U.S. median rates in CY 2018.

The limited data available show mixed results; consider the data on the Tennessee MCO/FC and the Texas MCO/FC. In Tennessee, the MCO/FC performed the worst on well-child visits in the first 15 months (52.6 percent) when compared to the state average (68.4 percent), the U.S. median (64.0 percent), and each of the other MCO/FCs (see Figure 2). In Texas, on the other hand, the MCO/FC significantly outperformed the state rate and the national median on use of first-line psychosocial care for children and adolescents on antipsychotics (see Figure 3).

Figure 2. Well Child Visits in the First 15 Months of Life

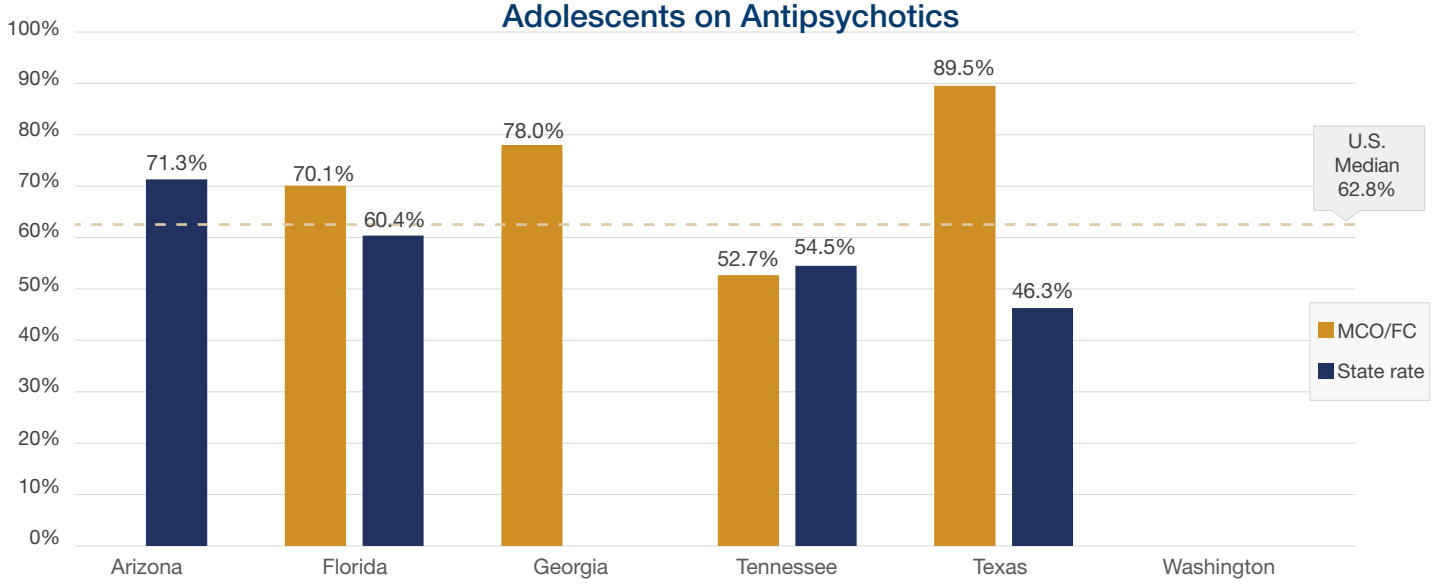


Note: Higher rates are better for this measure.

Data reflects performance year 2018.

Source: Georgetown Center for Children and Families analysis of 2019 Child Core Set Report and state 2020 External Quality Review Annual Technical Reports.

Figure 3. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics



Note: Higher rates are better for this measure.

Data reflects performance year 2018.

Source: Georgetown Center for Children and Families analysis of 2019 Child Core Set Report and state 2020 External Quality Review Annual Technical Reports.

Despite the availability of some Child Core Set metrics in all states, significant data gaps remain. Only Florida breaks out enrollment by age; in all the other states, it is impossible to gauge the performance of the MCO/FC for younger children or older youth in foster care. Georgia reported its MCO/FC's performance on depression screening and follow-up, while the other states did not. None of the states reported quality data disaggregated by race, ethnicity, sexual orientation, or gender identity, even though children of color and LGBTQ+ youth are disproportionately represented in the foster care population.

Child Welfare Dashboards

The findings above reflect our examination of state Medicaid agency and MCO websites. We also looked at the websites of the child welfare agencies in these states. In four states (Arizona, Georgia, Florida, and Texas), the agencies maintain data dashboards all of which contain substantive information about the agency's own performance in managing their programs. However, with the exception of Florida, the dashboards did not contain information about the performance of the MCO/FCs in which foster care children and youth are enrolled (see Appendix E). The Arizona agency's dashboard presents the percentage of children and youth in foster care receiving services, but does not describe the services or present quality metrics.[40] The Texas agency makes demographics of the children and youth it serves available monthly by region and service level, but does not present any information on the MCO/FC's performance.[41] The Georgia agency's dashboard presents child demographics (age, race, and sex) for all children served by the agency, as well as for children in foster care; once again, no quality information on the MCO/FC is included.[42] Florida's data dashboard was the only one to present data on the provision of medical and dental services, highlighting the metrics "Children Receiving Dental Services" and "Children Receiving Medical Services."[43] These metrics are presented as the percentage of children in out-of-home care who received a medical or dental service, and are disaggregated by age, sex, race, and placement.

Discussion

Given the limited amount of information available on state agency or MCO/FC websites, we are unable to draw any conclusions about how well the six MCO/FCs performed for children and youth in foster care in 2018. The Child Core Set quality measures available on each MCO/FC are limited and not consistent from state to state, and no state provides any plan-specific data on whether children and youth in foster care are receiving the EPSDT services to which they are entitled.

The absence of any performance data disaggregated by race or ethnicity prevents us from assessing how effectively MCO/FCs are addressing racial and ethnic disparities in access or health outcomes. These findings are consistent with the lack of transparency we observed in our companion paper looking more broadly at Medicaid managed care services for children.[44] This lack of transparency is especially unfortunate given the increasing interest on the part of state Medicaid agencies in enrolling vulnerable foster care children and youth in managed care.

Conclusion

The delivery system through which foster care children and youth receive their Medicaid coverage matters. The choices among delivery systems—FFS, MCO, MCO/FC—are state-specific.[45] State policymakers and stakeholders evaluating these choices would benefit greatly from data on the performance of both MCOs and MCO/FCs for foster care children and youth. Unfortunately, in the states we reviewed, the publicly available data are inadequate to that task. The state and MCO/FC websites did not enable us to understand how the MCO/FCs are performing and how their performance compares to that of MCOs or the FFS delivery system.

This is an avoidable error. State Medicaid agencies and MCO/FCs have the data necessary to assess performance; they simply need to make those data available to the public. We have two recommendations to promote transparency of this information:

State Medicaid agencies that contract with an MCO/FC should maintain a child health dashboard that contains enrollment and performance information specific to that MCO/FC. At a minimum, the performance data should include EPSDT screenings and treatment, Child Core Set metrics, and all information required to be posted by federal regulations. All enrollment and performance data should be disaggregated by race and ethnicity.

The Centers for Medicare & Medicaid Services (CMS) should add a child health dashboard as a measure to the State Administrative Accountability pillar of its Medicaid & CHIP Scorecard. The dashboard should present performance information on EPSDT services and Child Core Set metrics disaggregated by race and ethnicity for individual MCO/FCs and as well as individual MCOs to enable comparison of performance from state to state.

This brief was written by Andy Schneider, Allie Corcoran, and Emma Hurler. The authors would like to thank Joan Alker, Julia Buschmann and Ema Bargeron of the Center for Children and Families for their contributions. Design and layout provided by Nancy Magill.

The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high-quality, affordable health coverage for America's children and families. CCF is based in the McCourt School of Public Policy's Health Policy Institute.

Methodology

Data Sources

We searched the websites of state Medicaid agency websites, state insurance departments, state child welfare agencies, and individual MCO/FCs for data about the performance of the MCO/FCs for children and youth in foster care and other high-risk populations. In some cases, state agency websites referred us to external websites, such as that of the National Committee for Quality Assurance (NCQA). We cross-checked our findings relating to MCO/FC contractors, parent companies, and overall MCO/FC quality rankings with the information presented on the Kaiser Family Foundation's Medicaid Managed Care Market Tracker.

The quality measures presented in this paper reflect MCO/FC performance during calendar year (CY) 2018 (Healthcare Effectiveness Data and Information Set 2019). These rates were the most recent data available at the beginning of our scan in December 2020. In order to permit comparison of MCO/FC performance with the performance of other MCOs we scanned, we present (CY) 2018 performance data for all six MCO/FCs. CY 2019 (HEDIS) results may have become available during the course of our scan.

Data Collection

The six states included in this scan (Arizona, Florida, Georgia, Tennessee, Texas, and Washington) are states where foster care children and youth were enrolled in MCOs that primarily or exclusively managed health care services for them on a statewide basis in 2018. Four of these (Arizona, Georgia, Tennessee, and Texas) are states where CCF provides ongoing technical assistance to child health advocates.

The list of data elements for which we searched can be found on this report's page on CCF's website. In our view, these elements are the minimum necessary for advocates and the public to make an informed assessment about the performance of an individual MCO/FC for children. There are additional data elements that could inform this assessment for which we did not search. These include additional MCO/FC-specific information: the resolution of grievances, appeals, and state fair hearings relating to denials of care; performance improvement projects; sanctions and administrative penalties imposed; and financial performance (e.g., Medical Loss Ratios).

We limited our search to publicly accessible websites. We did not review the minutes of meetings of state Medical Care Advisory Committees. While we validated the availability of information, we did not attempt to validate the accuracy of the information that we found. We did not file Public Records Act requests with state Medicaid agencies, child welfare agencies, or insurance departments for the performance data we were seeking. We also did not file Freedom of Information Act requests for this information with CMS.

Limitations

This scan was limited to six MCO/FCs operating in six states in CY 2018. These findings, therefore, do not necessarily apply to MCO/FCs that operate in other Medicaid managed care states or the District of Columbia. We excluded states that contract with MCO/FCs below the state-level (for example, Wisconsin).

We limited the collected data elements to those we consider most relevant to the performance of individual MCOs for children in foster care. It is possible that, had we searched for all potential performance data, we would have uncovered more information to assess the performance of individual MCOs, thereby affecting our judgments regarding transparency in the six states that we did scan.

We looked for EPSDT and Child Core Set data only for one year (CY 2018). Therefore, we are not able to present trends in MCO/FC performance on EPSDT and Child Core Set quality measures from year to year.

Finally, as noted above, caution should be exercised in comparing MCO/FC performance across states, even for the one year for which we found measure data. The demographic profile and health status of the children in foster care enrolled in these MCOs, as well as the provider networks that MCOs are able to assemble to furnish services to these populations, may vary significantly from state to state.

Appendix A. Populations Served and Enrollment Information

State Plan	Parent Firm	Population	Mandatory Enrollment in MCO/FC[a]	Enrollment (date)[b]	Enrollment by Race/ Ethnicity	Enrollment Breakouts	Enrollment Available	Foster Children (FFY 2020)[c]
Arizona Mercy Care DCS Comprehensive Health Plan	Department of Child Safety and Aetna/CVS	Children and youth placed in out-of-home care; youth in juvenile justice system	Yes	13,600 (9/2020)	–	–	Monthly	13,300
Florida Sunshine State Health Plan	Centene	Foster care youth under the age of 21; Medicaid agency has the discretion to extend eligibility to young adults in extended foster care under age 26	Yes	37,800 (9/2020)	–	By age (<1, 1-13; 14+); by region (11)	Monthly	24,600
Georgia Amerigroup 360°	Anthem	Foster care youth; adoption assistance youth; youth in juvenile justice system	Yes	28,700 (6/2020)	–	By region (6)	Monthly[d]	12,900
Tennessee TennCare Select	BlueCross BlueShield of Tennessee	Foster care children, children receiving SSI, children receiving services in a nursing facility or intermediate care facility for individuals with intellectual disabilities, other beneficiaries if other plans do not have capacity	No	52,400 (9/2020)	–	–[e]	Monthly	9,300
Texas Superior Health Plan	Centene	Foster care children under the age of 22; adoption assistance youth; former foster care children under 21	Yes	36,400 (8/2020)	–	By region (14)	Quarterly	31,400
Washington Apple Health Core Connections	Centene	Foster care children; adoption assistance; former foster care youth under age 26 (if enrolled on 18th birthday)	No	24,000 (2018)	–	–	Yearly	10,900

[a] Reflects information presented in Center for Medicaid and Medicare Services, "Managed Care: Profiles & Program Features," (Baltimore: Center for Medicaid and Medicare Services, 2018), available at https://www.medicaid.gov/medicaid/managed-care/profiles-program-features/index.html.

[b] Figures rounded to the nearest hundred. Enrollment for Washington sourced from the latest document available at the time of the scan, the 2019 External Quality Review Annual Technical Report.

[c] This column shows the number of foster care children in the state on September 30, 2019 rounded to the nearest hundred. This is a point-in-time statistic, meant to give a general ballpark for the number of children in foster care at the start of FFY 2020.

[d] There is a significant data lag for the enrollment statistics in Georgia. As of 1/18/2021, the latest report available was from June 2020.

[e] Tennessee's monthly enrollment report divides TennCare Select beneficiaries into "High" and "Low" categories, but offers no explanation as to what this division means.

Appendix B. Race and Ethnicity of All Children and Foster Care Children

	All Children	Foster Care Children
Arizona		
American Indian/Alaskan Native (non-Hispanic)	5%	5%
Asian/Native Hawaiian/Pacific Islander (non-Hispanic)	3%	<0.5%
Black (non-Hispanic)	5%	11%
Other/Two or More Races (non-Hispanic)	4%	5%
White (non-Hispanic)	39%	34%
Hispanic/Latino	45%	38%
Florida		
American Indian/Alaskan Native (non-Hispanic)	<0.5%	<0.5%
Asian/Native Hawaiian/Pacific Islander (non-Hispanic)	3%	<0.5%
Black (non-Hispanic)	20%	30%
Other/Two or More Races (non-Hispanic)	5%	7%
White (non-Hispanic)	41%	47%
Hispanic/Latino	32%	16%
Georgia		
American Indian/Alaskan Native (non-Hispanic)	<0.5%	<0.5%
Asian/Native Hawaiian/Pacific Islander (non-Hispanic)	4%	<0.5%
Black (non-Hispanic)	33%	39%
Other/Two or More Races (non-Hispanic)	5%	6%
White (non-Hispanic)	43%	47%
Hispanic/Latino	15%	6%
Tennessee		
American Indian/Alaskan Native (non-Hispanic)	<0.5%	<0.5%
Asian/Native Hawaiian/Pacific Islander (non-Hispanic)	2%	<0.5%
Black (non-Hispanic)	19%	23%
Other/Two or More Races (non-Hispanic)	5%	6%
White (non-Hispanic)	65%	65%
Hispanic/Latino	10%	6%
Texas		
American Indian/Alaskan Native (non-Hispanic)	<0.5%	<0.5%
Asian/Native Hawaiian/Pacific Islander (non-Hispanic)	4%	<0.5%
Black (non-Hispanic)	12%	22%
Other/Two or More Races (non-Hispanic)	3%	5%
White (non-Hispanic)	31%	30%
Hispanic/Latino	49%	41%
Washington		
American Indian/Alaskan Native (non-Hispanic)	1%	5%
Asian/Native Hawaiian/Pacific Islander (non-Hispanic)	8%	2%
Black (non-Hispanic)	4%	8%
Other/Two or More Races (non-Hispanic)	10%	16%
White (non-Hispanic)	56%	49%
Hispanic/Latino	21%	20%

Note: Shares of population should be read as an approximation. Given that the two estimates come from different data sources, it is not possible to calculate statistical significance between the shares. Share of foster care children whose race is unknown is 6 percent or below and is not included in presentation.

Sources: For all children: Georgetown Center for Children and Families analysis of 2018 U.S. Census Bureau American Community Survey Public Use Mircodata (PUMS). For foster care children: Annie E. Casey Foundation Child Trends analysis of 2018 Adoption and Foster Care Analysis and Reporting System (AFCARs) data (March 2020), available at https://datacenter.kidscount.org/data/tables/6246-children-in-foster-care-by-race-and-hispanic-origin?loc=1&loct=1#detailed/2/4,11-12,15,19,44-45,49-50/false/37/2638,2601,2600,2598,2603,2597,2602,1353/12992,12993.

Appendix C. Company and Contracting Structure

State MCO/FC	Parent Firm	Parent Firm Operates Non-Foster Care MCO in State	Risk Contract Posted	Ownership and Management of MCO/FC Available
Arizona Mercy Care DCS Comprehensive Health Plan	Department of Child Safety (and Aetna/CVS)*	✓	No* (amendment)	No
Florida Sunshine State Health Plan	Centene	✓	Template (amendment)	No
Georgia Amerigroup 360 °	Anthem	✓	Template (stand-alone)	✓**
Tennessee TennCare Select	BlueCross BlueShield of Tennessee	✓	✓ (stand-alone)	✓
Texas Superior Health Plan	Centene	✓	Template (stand-alone)	No
Washington Apple Health Core Connections	Centene	✓	✓ (stand-alone)	✓**

* During the performance year assessed, the MCO/FC was operated by the Department of Child Safety. The Aetna/CVS arrangement is as of 2021. Arizona's contract between the MCO/FC and the state was not available from the state; however, an outdated contract is available from the Commonwealth Fund's Medicaid Managed Care Database at https://www.commonwealthfund.org/medicaid-managed-care-database#/states/AZ.

** Indicates that partial information is available.

Appendix D. Foster Care-Specific MCO Quality Metrics Compared to National and State Median, CY 2018[a]

Quality Measure	US Median	Mercy Care DCS CHP[b]	AZ	Sunshine State Health Plan	FL	Amerigroup 360°	GA	TennCare Select	TN	Superior Health Plan	TX	Apple Health Core Connections	WA
Primary and Preventive Care													
Childhood Immunization Status: Combination 3	68.8%	–	–	79.1%	73.3%	77.9%	72.2%	67.2%	72.3%	58.6%	68.8%	–	70.0%
Adolescent Immunization Status: Combination 1	78.6%	–	–	65.7%	74.1%	86.6%	86.9%	67.9%	75.1%	82.8%	77.2%	–	76.0%
Well-Child Visits in the First 15 Months of Life (6 or More)	64.0%	–	61.6%	61.7%	69.6%	67.6%	62.0%	52.6%	68.4%	64.1%	68.2%	–	67.0%
Well-Child Visits in 3rd, 4th, 5th, and 6th Years	69.0%	72.6%	61.8%	84.0%	77.9%	80.4%	68.3%	76.8%	73.6%	89.4%	77.7%	–	67.7%
Adolescent Well Care	50.6%	72.4%	41.5%	64.0%	60.2%	60.5%	52.8%	49.6%	57.3%	73.1%	67.5%	–	46.6%
Weight Assessment for Children and Adolescents: BMI Percentile Documentation	69.7%	–	–	89.9%	87.8%	83.5%	–	83.1%	80.0%	17.8%	73.8%	–	72.2%
Depression Screening and Follow-up	–	–	–	–	–	19.0%	–	–	–	–	–	–	–
Behavioral Health													
Follow-Up Care for Children Prescribed ADHD Medication Initiation Phase	48.6%	–	58.8%	50.8%	40.6%	44.4%	–	42.0%	45.0%	51.0%	37.4%	–	42.8%
Follow-Up Care for Children Prescribed ADHD Medication Continuation and Maintenance Phase	58.6%	–	66.0%	61.5%	54.3%	49.5%	–	59.7%	58.3%	56.5%	51.8%	–	50.8%
Follow-Up within 7 days after Hospitalization for Mental Illness: Ages 6-17	41.9%	–	69.5%	–	41.3%	45.2%	–	39.2%	48.7%	55.6%	35.4%	–	72.6%
Follow-Up within 30 days after Hospitalization for Mental Illness: Ages 6-17	66.3%	–	85.8%	–	61.1%	70.3%	–	58.6%	70.0%	80.4%	58.5%	–	88.1%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Ages 1-17	62.8%	–	71.3%	70.1%	60.4%	78.0%	–	52.7%	54.5%	N/A for 1-17	46.3%	–	–
Use of Multiple Concurrent Antipsychotics in Children and Adolescents[c]	2.6%	–	1.0%	1.3%	2.1%	3.4%	–	3.5%	2.6%	2.3%	2.0%	--	2.4%
Maternal Health													
Timeliness of Prenatal Care	80.7%	–	–	64.9%	83.2%	62.1%	67.2%	76.6%	83.0%	58.9%	88.1%	–	80.6%

[a] Measures were selected from the Child Core Set to represent three critical areas of care for foster care youth. Currently, it is optional for states to report Child Core Set metrics (on an aggregate state level) to CMS; reporting will become mandatory in 2024. We looked for plan-level performance data on these measures in each state's EQRO Annual Technical Report (ATR). The performance results in this table come from the 2020 ATRs, which reflect HEDIS 2019 measures, which in turn reflect data collected for calendar year 2018. National median and state-level performance data are as reported by CMS in the 2020 Child Core Set, which reflects FFY 2019 reporting, which in turn reflects data collected during calendar year 2018. Some state-level measures may reflect performance for both Medicaid and CHIP populations. Though Apple Health Core Connections (Washington) was established by CY 2018, the EQRO ATR does not include any quality data for the plan for that year.

[b] Effective April 1, 2021, Arizona's MCO/FC merged with Mercy Care, an Aetna/CVS subsidiary. Data included in the chart reflects performance prior to merger when the Arizona Department of Child Safety was wholly responsible for the MCO/FC.

[c] Lower percentages indicate better performance.

Appendix E. Elements Contained in Data Dashboards on State Child Welfare Agency Websites

State	Demographics of children in foster care	Demographics of children enrolled in MCO/FC	HEDIS measure rates	EPSDT
Arizona	–[a]	–	–	–
Georgia	✓	–	–	–
Florida	–	–	–	✓[b]
Texas	✓[c]	–	–	–

[a] Arizona makes the demographics of children in foster care available in a monthly report on the Department of Child Safety's website.

[b] The measures available were "Children Receiving Dental Services" and "Children Receiving Medical Services," which are not EPSDT metrics but do measure the provision of services that are similar to EPSDT.

[c] Texas presents child demographics for each region and authorized service level in its monthly enrollment reports on the Department of Family and Protective Services website.

Endnotes

[1] Corcoran, A., et al., " Transparency in Medicaid Managed Care: Findings from a 13-State Scan" (Washington, D.C.: Georgetown Center for Children and Families, September 2021), available at https://ccf.georgetown.edu/2021/09/09/transparency-in-medicaid-managed-care-findings-from-a-13-state-scan/.

[2] Administration on Children, Youth and Families, Children's Bureau, "Trends in Foster Care and Adoption: FY 2010 -FY 2019," U.S. Department of Health and Human Services, October 16, 2020, available at https://www.acf.hhs.gov/sites/default/files/documents/cb/trends_fostercare_adoption_10thru19.pdf.

[3] Council on Foster Care, Adoption, and Kinship Care; Committee on Adolescence; Council on Early Childhood, "Health Care Issues for Children and Adolescents in Foster Care and Kinship Care," *Pediatrics* 136, no. 4 (October 2015): e1131-e1140, available at https://pediatrics.aappublications.org/content/136/4/e1131.

[4] Keefe, R., et al., "Mental Health Diagnoses of Children in Foster Care: A Comparison Study between Foster and Non-Foster Children Covered by Medicaid," *Pediatrics* 146, no. 1 (meeting abstract) (July 2020), available at https://doi-org.ezproxy.library.wisc.edu/10.1542/peds.146.1_MeetingAbstract.508-a; Bilaver, L., Havlicek, J., and Davis, M., "Prevalence of Special Health Care Needs Among Foster Youth in a Nationally Representative Survey," *JAMA Pediatrics* 174, no. 7 (May 2020): 727-729, available at https://jamanetwork.com/journals/jamapediatrics/fullarticle/2765817.

[5] Chasnoff, I., Wells, A., and King, L., "Misdiagnosis and Missed Diagnoses in Foster and Adopted Children with Prenatal Alcohol Exposure," *Pediatrics* 135, no. 2 (February 2015): 264-270, available at https://pediatrics.aappublications.org/content/135/2/264?ijkey=9e33747ca31f3cd9815077c21ce950f14c006819&keytype2=tf_ipsecsha.

[6] Sarvas, E., et al., "Oral Health Needs Among Youth with a History of Foster Care: A Population-Based Study," *The Journal of the American Dental Association* 152, no. 8 (June 2021), available at https://www.sciencedirect.com/science/article/abs/pii/S0002817721001677.

[7] Council on Foster Care, Adoption, and Kinship Care; Committee on Adolescence; Council on Early Childhood, op cit.

[8] Jones, V. et al., "Pediatrician Guidance in Supporting Families of Children who are Adopted, Fostered, or in Kinship Care," *Pediatrics* 146, no. 6 (December 2020), available at https://pediatrics.aappublications.org/content/146/6/e2020034629; Council on Foster Care, Adoption, and Kinship Care; Committee on Adolescence; Council on Early Childhood, op cit.

[9] Council on Foster Care, Adoption, and Kinship Care; Committee on Adolescence; Council on Early Childhood, op cit.

[10] Ibid.

[11] Jones, V. et al., op cit.

[12] Ibid.

[13] Butler, J., Reck, J., and Hensley-Quinn, M., "Evidence-Based Policymaking Is an Iterative Process: A Case Study of Antipsychotic Use among Children in the Foster Care System" (National Academy for State Health Policy, February 2019), available at https://www.nashp.org/wp-content/uploads/2019/02/Antipsychotic-Meds-Foster-Kids-Brief-1.pdf.

[14] Centers for Medicare and Medicaid Services, "EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents" (Baltimore: Centers for Medicare and Medicaid Services, June 2014), available at https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf.

[15] Medicaid and CHIP Payment and Access Commission, "Report to Congress on Medicaid and CHIP" (Washington, D.C.: Medicaid and CHIP Payment and Access Commission, March 2018), available at https://www.macpac.gov/wp-content/uploads/2018/03/Report-to-Congress-on-Medicaid-and-CHIP-March-2018.pdf.

[16] Information about the AFCARS reporting system can be found at https://www.acf.hhs.gov/cb/data-research/adoption-fostercare.

[17] Barnett, E. R., "Children's Behavioral Health Needs and Satisfaction and Commitment of Foster and Adoptive Parents: Do Trauma-Informed Services Make a Difference?," *Psychological Trauma: Theory, Research, Practice, and Policy* 11, no. 1 (2019): 73-81, available at https://doi.org/10.1037/tra0000357.

[18] Administration for Children and Families, Children's Bureau, "Child Welfare Practice to Address Racial Disproportionality and Disparity" (Washington, D.C.: U.S. Department of Health and Human Services, April 2021), available at https://www.childwelfare.gov/pubPDFs/racial_disproportionality.pdf. In Arizona, a state with an MCO/FC included in this scan, data from the child welfare agency show that while approximately 5.2 out of every 1,000 children are in foster care, the numbers are vastly different for children of color: 12.5 out of every 1,000 American Indian children and 16.9 out of every 1,000 African-American children living in the state are in foster care. Preliminary data estimated for state fiscal year 2021. Arizona Department of Child Safety, "Monthly Operational Report," State of Arizona (July 2021), available at https://dcs.az.gov/reports.

[19] Stevens, G. and Shi, L., "Effect of Managed Care on Children's Relationships with their Primary Care Physicians," *Archives of Pediatric and Adolescent Medicine* 156, no. 4 (2002), available at https://jamanetwork.com/journals/jamapediatrics/fullarticle/191765.

[20] This estimate comes from a recent report from the Administration for Children and Families which in turn summarizes data from three studies of foster care youth spanning the following age brackets: 10-18, 12-21, and 13-20. For more information, see Administration for Children and Families, Children's Bureau, "Supporting LGBTQ+ Youth: A Guide for Foster Parents" (Washington, D.C.: U.S. Department of Health and Human Services, June 2021), available at https://jamanetwork.com/journals/jamapediatrics/fullarticle/191765.

[21] For accompanying examination of MCOs in 13 states that enroll a broader population of children, see Corcoran, A., et al., "Transparency in Medicaid Managed Care: Findings from a 13-State Scan" (Washington, D.C.: Georgetown Center for Children and Families, September 2021), available at https://ccf.georgetown.edu/2021/09/09/transparency-in-medicaid-managed-care-findings-from-a-13-state-scan/.

[22] Center for Medicaid and Medicare Services, "Managed Care: Profiles & Program Features" (Baltimore: Center for Medicaid and Medicare Services, 2018), available at https://www.medicaid.gov/medicaid/managed-care/profiles-program-features/index.html.

[23] BlueCross BlueShield of Tennessee is reimbursed on a non-risk, non-capitated basis (or a partial risk basis for some services) and receives fees for its administrative costs. In Arizona, the Department of Child Safety (DCS) is compensated on a capitated basis.

[24] Given that not all states report eligibility in the same way or with the same frequency, this number is an estimate based on the enrollment from state reports from September 2020 (Florida), August 2020 (Texas) and the end of 2018 (Washington). Note that Centene makes a concerted effort to present itself as a leader in care management for foster care youth; there is a dedicated section on the Centene website listing their plans that serve children in foster care across the United States (including plans that are not specifically tailored to meet the needs of foster children alone). Centene Corporation, "Centene Foster Care," September 2021, available at https://www.centenefostercare.com/.

[25] Corcoran, A., "Medicaid Managed Care: 2021 Results for the 'Big Five' at Q2," Say Ahh! Health Policy Blog (August 2021), available at https://ccf.georgetown.edu/2021/08/18/medicaid-managed-care-2021-results-for-the-big-five-at-q2/; and Schneider, A. and Corcoran, A., "Medicaid Managed Care: 2020 Results for the 'Big Five,'" SayAhh! Health Policy Blog (February 2021), available at https://ccf.georgetown.edu/2021/02/23/medicaid-managed-care-2020-results-for-the-big-five/.

[26] The series won an award for investigative reporting from the Nieman Foundation at Harvard. Nieman Foundation, "'Pain and Profit' by The Dallas Morning News wins Worth Bingham Prize for Investigative Journalism" Harvard University (April 2019), available at https://nieman.harvard.edu/news/2019/04/pain-and-profit-by-the-dallas-morning-news-wins-worth-bingham-prize-for-investigative-journalism/.

[27] 42 *C.F.R.* 438.332(c)(1); 438.364(c)(2)(i); 438.602(g).

[28] Centers for Medicare and Medicaid Services, "Instructions for Completing Form CMS-416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report" (Baltimore: Centers for Medicare and Medicaid Services), available at https://www.medicaid.gov/medicaid/benefits/downloads/cms-416-instructions.pdf.

[29] At least one state Medicaid agency posts MCO-specific EPSDT performance data for all children. "MCO External Quality Review Annual Technical Reports," District of Columbia Department of Health Care Finance, available at https://dhcf.dc.gov/page/mco-external-quality-review-annual-technical-reports.

[30] "Children's Health Care Quality Measures," Centers for Medicare and Medicaid Services, available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html.

[31] Center for Medicaid and CHIP Services, "Criteria for Using the Child and Adult Core Set Measures to Assess Trends in State Performance in Medicaid and the Children's Health Insurance Program" (Baltimore: Centers for Medicaid and Medicare Services, November 2019), available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/methods-brief.pdf.

[32] "State Readiness to Report Mandatory Core Set Measures," Medicaid and CHIP Payment and Access Commission, March 2020, available at https://www.macpac.gov/publication/state-readiness-to-report-mandatory-core-set-measures/; and, §1139A of the Social Security Act.

[33] 45 *C.F.R.* 1355, Appendix A.

[34] 42 *C.F.R.* 438.602(g)(1).

[35] For the time period reviewed, the Arizona MCO/FC was operated by the Department of Child Safety. Currently, the state Medicaid Agency contracts with both the Department of Child Safety and the private insurer, Mercy Care (a subsidiary of CVS/Aetna), on a risk basis to operate the MCO/FC. In West Virginia, the MCO/FC launched after the time period included in this scan, is under contract with both the state Medicaid agency and Child Welfare agency.

[36] 42 *C.F.R.* 438.602(g)(3).

[37] Information for Georgia available at Amerigroup Georgia Families 360 website, https://www.myamerigroup.com/ga/your-plan/georgia-families-360-stakeholder-information.html. Information for Washington available at State Department of Insurance website, https://fortress.wa.gov/oic/consumertoolkit/Company/CompanyFinancialStatements.aspx?WAOIC=Ttd7tAycAG5hjFu7z87hMg%253D%253D.

[38] The "Administrative Subcontractors and Affiliates Report" can be accessed from the Agency for Healthcare Administration's Statewide Medicaid Managed Care home page or at https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Adm_Subcontractor_Affilites_Report.pdf.

[39] Comparing the performance of individual MCO/FCs to their state medians helps show how the MCO/FC performs in relation to the MCOs that enroll a broader population of children in the state. Additionally, comparing the performance of the MCO/FC to the U.S. median offers context but should be done with care, given that particular state characteristics can contribute to lower quality scores relative to those of other states and regions. For more information on the external quality review process and interpreting quality metrics, see Machledt, D., "Medicaid External Quality Review: An Updated Overview" (Washington, D.C.: National Health Law Program, November 2020), available at https://healthlaw.org/resource/medicaid-external-quality-review-an-updated-overview/; and, Machledt, D., "Finding and Analyzing Medicaid Quality Measures," (Washington, D.C.: National Health Law Program, January 2021), available at https://healthlaw.org/resource/finding-and-analyzing-medicaid-quality-measures/.

[40] Arizona Health Care Cost Containment System, "Resources for Foster/Kinship/Adoptive Families," State of Arizona (September 2021), available at https://www.azahcccs.gov/Members/AlreadyCovered/MemberResources/Foster/.

[41] Texas Department of Family and Protective Services, "Monthly Data," State of Texas (September 2021), available at https://www.dfps.state.tx.us/About_DFPS/Monthly_Data/default.asp#children-in-care.

[42] Georgia Department of Human Services, "Child Welfare Data: Children Served," State of Georgia (September 2021), available at https://dhs.georgia.gov/division-family-children-services-child-welfare.

[43] Florida Department of Children and Families, "Florida Child Welfare Statistics," State of Florida (September 2021), available at https://www.myflfamilies.com/programs/childwelfare/dashboard/index.shtml.

[44] Corcoran, A. et al., op cit.

[45] For example, in California, the policy choice was between a single statewide MCO/FC, with medical, behavioral health, and dental services fully integrated; a regional MCO/FC; or an MCO that enrolls more beneficiary groups than foster youth and has a county-level service area. The view of some advocates was, "Overall, the accountability of managed care organizations, along with the opportunities for enforcement of access to care and consumer protections, make managed care delivery preferable to FFS for foster children and youth." Lewis, K. and Cohen, C., "Foster Care Model of Care Workgroup: Assessing Different Managed Care Options for Foster Youth in California" (Los Angeles: National Health Law Program, December 2020), available at https://www.dhcs.ca.gov/provgovpart/Documents/NHeLP-Foster-Care-Options.pdf.