



Comparing the Health Status and Health Care Utilization of Children in
Georgia's Foster Care System to Other Georgia Medicaid Children

Prepared for the Georgia Health Foundation

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Executive Summary

Research studies have shown that children in foster care have greater mental health, developmental, and physical health needs due to abuse and neglect. The Georgia Health Policy Center, with support from the Georgia Health Foundation, initiated this analysis to determine if national findings applied to the health care experiences of Georgia foster children in comparison to other Medicaid children. Analytic questions included areas of demographics, health conditions, service utilization, costs, and quality indicators using Georgia Medicaid data for the years 2000, 2001, and 2002.

- Overall, Georgia foster children are older than other Medicaid children, while all other demographic characteristics are similar.
- Foster children are three times more likely than Medicaid children to have a mental health diagnosis. Over half of foster children have such a diagnosis. The rate for other Medicaid children is also high at 34.7 percent, or over one in three. This finding may serve as a cautionary note regarding the provision of mental health services to Medicaid children.
- More foster children have abuse diagnoses, while more Medicaid children have diagnoses of pregnancy and substance abuse. Diagnoses of special health care needs are about equal in both populations.
- More foster children experience outpatient visits, EPSDT screenings, and dental visits, while more Medicaid children experience inpatient admissions and emergency visits and show evidence of prescription drug claims. National studies predict more foster children experience inpatient stays and emergency room visits. The Georgia data may indicate positive utilization of preventive services by foster children.
- Among children who use a given service, foster children experience *more* outpatient visits, EPSDT screenings, dental visits, and prescription drug utilization. Both groups experience inpatient admissions about equally. Medicaid children visit the emergency room more often.
- Of those who use health care services, Medicaid children have higher inpatient costs, while foster children have higher outpatient and prescription drug costs.
- The number of foster children and other Medicaid children who visited a physician over three years is about equal, but more foster children visited a specialist over three years. About equal numbers of foster children and other Medicaid children with special health care needs visited a physician at least once in three years.
- More foster children showed evidence of a lapse in mental health prescription drug use over three years, and some children in each group showed evidence of mental health prescription drug use without a mental health diagnosis.

The results for the foster children described in this analysis, in comparison to the general Medicaid child population, are encouraging in many areas, particularly in preventive care. The greatest concerns for policy makers may be the high proportions of mental health diagnoses, lapses in prescription drug claims for mental health conditions, and the presence of mental health drug claims in the Medicaid data without an associated mental health diagnosis. It is hoped that this analysis will serve as a source of information for improved foster care program development at the state level.

Background

Georgia's foster care program provides temporary homes for children of neglect or abuse. The program is administered by the Georgia Department of Human Resources' Division of Family and Children Services (DFACS). Of the 16,119 children in state care as of May 2004:

- 25% were under the age of four;
- 50% were younger than nine years old;
- 14% were placed with relatives;
- 57% percent were living in foster homes;
- 10% were living in group homes; and,
- 4% were housed in residential institutions¹.

According to a 2001 study by Mathematica Policy Research, Inc. that examined the health care utilization and Medicaid costs² of foster children in California, Florida, and Pennsylvania:

- Children in foster care represent between one and three percent of Medicaid children but between four and eight percent of Medicaid expenditures; and,
- Between 65 and 80 percent of foster children had at least one outpatient visit in the year of study (Rosenbach, 2001).

The researchers also found that between 23 and 38 percent of foster children in these states had a mental health diagnosis as compared with between four and seven percent of all Medicaid children. Foster children were also more likely to have had an inpatient hospital stay, an emergency room visit, an outpatient visit, and a dental visit than other Medicaid children.

Simms, in an October 2000 paper in the journal *Pediatrics*, states that children enter foster care in a poor state of health and with psychological difficulties brought on by multiple problems. He also points out that while many foster children improve, there is a subset of children whose health care needs are not met. Psychological or emotional problems may get even worse.

The Georgia Health Policy Center, with support from the Georgia Health Foundation, initiated this analysis to determine if, in fact, the experiences of Georgia foster children were similar to those examined in national studies. This analysis is intended to answer the following questions:

- What, if any, are the demographic differences between foster children and other Medicaid children in terms of age, race, gender, and geography?
- What are the health conditions of foster children compared with other Medicaid children, particularly in terms of special health care needs, substance abuse, mental health conditions, pregnancy, and child abuse, and does being a foster child have an effect on the likelihood of having one of these conditions?
- How does the health care service use of foster children compare with other Medicaid children in terms of inpatient admissions, outpatient visits, prescription drug use,

¹ http://www.gov.state.ga.us/summit_fl/statistics.shtml

² Foster children are automatically eligible for Medicaid reimbursement.

emergency room visits, and dental services, and does being a foster child affect the likelihood of using each service type?

- How do the health care costs of foster children compare with other Medicaid children for the above listed service types?
- How do the health care experiences of foster children compare with other Medicaid children in terms of physician visits, lapses in medication use for mental health conditions, physician visits for children with special health care needs, duplicate vaccinations due to incomplete medical histories, and access to specialists?

It is hoped that this analysis will prove useful as a source of information for future program improvement and foster care policy formulation in Georgia.

Methods

The study's analytic base is drawn from Georgia Medicaid claims of children age birth through 16 years³ with continuous eligibility from January 2000 through December 2002. Continuous eligibility is required for analytic purposes to measure health care utilization over time. The maximum age for inclusion is 16 to allow for three years of claims observations through age 18. A total of 165,796 children, of which 7,227⁴ were foster children, had continuous Medicaid eligibility from January 2000 through December 2002.

Demographic profiles of Georgia foster children and other Medicaid children are illustrated in Table 1.

Table 1
Selected Demographics of Georgia Foster Children and Other
Medicaid Children with Continuous Eligibility
2000 - 2002

		Foster Children (n = 7,227) %	Other Medicaid Children (n = 158,569) %	Statistical Significance ⁵
Age	0 - 2	3.2	17.7	*
	3 - 5	12.4	20.5	*
	6 - 12	59.4	43.9	*
	13 - 16	25.1	17.9	*
Gender	Female	51.9	51.5	
	Male	48.1	48.5	
Race	White	34.3	26.6	*
	African-American	57.5	66.3	*
	Other	8.2	7.1	*
Region	Rural	37.0	43.9	*
	Urban	63.0	56.1	*

³ Children through age 21 are eligible for foster care, while children up to age 18 are eligible for Medicaid. Age 18 was selected as the upper age limit for this study to ensure similar comparisons of foster children with other Medicaid children.

⁴ Although the absolute number of foster children changes from year to year, the foster children with continuous eligibility from 2000 to 2002 represent approximately 38 percent of the annual foster child census.

⁵ Throughout this report, the presence of statistical significance ($p > .01$ unless otherwise stated) is designated by an asterisk.

In general, foster children tend to be older (above age five), while Medicaid children are younger (up to age 5). Gender proportions are approximately equal. Foster children are less likely to be African-American than other Medicaid children; children on Medicaid as a result of foster care are more likely to come from urban areas.

For analytic purposes, all other Medicaid children's records were matched against the foster child records to ensure matching demographics. After that process, 21,668 Medicaid children met the demographic criteria of the foster children.⁶ Approximately 295 foster children who appeared in the eligibility file did not have any Medicaid claims from 2000 to 2002. These records were excluded, leaving a total of 6,932 foster child records (Table 2).

Table 2
Selected Demographics of Georgia Foster Children and a Sample of Medicaid Children with Continuous Eligibility 2000 - 2002

		Foster Children (n = 6,932) %	Medicaid Children (n = 21,668) %
Age	0 - 2	3.3	3.2
	3 - 5	12.6	12.4
	6 - 12	59.4	59.4
	13 - 16	24.7	25.1
Gender	Female	51.9	52.1
	Male	48.1	47.9
Race	White	34.1	34.3
	African-American	58.2	57.5
	Other	7.6	8.2
Region	Rural	37.7	37.0
	Urban	62.3	63.0

Because administrative claims data are not ideal for research purposes, especially when comparing results to national benchmarks, definitions of analytic variables must be clearly delineated within the context of the analysis. Health condition clusters were defined from the International Classification of Diseases - Ninth Edition, Clinical Modification (ICD-9-CM) as illustrated in Table 3.

⁶ PeachCare children were excluded from the analysis, as it is well documented that PeachCare children are very different from foster children or Medicaid children along socio-demographic dimensions.

Table 3
Health Conditions and Associated ICD-9-CM Codes

Health Condition Clusters	Diagnoses	ICD-9-CM Codes	
Special Health Care Needs ⁷	HIV/AIDS	042	
	Perinatal Conditions	765-766, 770-771	
	Congenital Anomalies	744-747, 749-751, 754, 758	
	Malignant Neoplasms		142, 147, 155, 158, 170-171, 189, 190-192, 196, 197, 200-208
			250, 277
	Diabetes and Cystic Fibrosis		282
		Hereditary Anemias	330-331, 343-344
		Cerebral Degeneration	345
		Epilepsy	359
		Muscular Dystrophy	369, 389
Blindness, Hearing Loss		741	
Mental Health ⁸	Organic Mental Illness and Psychoses	292-296, 299	
	Mental Retardation	317-319	
	Neurotic and Non-Psychotic Mental Disorders	300-302, 306-310, 312-316	
	Drug Dependence and Non-Dependent Use of Drugs		304-305
Alcohol Dependence		303	
Pregnancy	Pregnancy	650-659	
Abuse	Abuse	995.5	

Inpatient admissions, EPSDT screenings, dental visits, emergency room visits, and prescription drugs are tabulated as they appear in the Medicaid claims data. Outpatient visits include only those contacts with direct patient care providers. Emergency room visits do not include visits that resulted in inpatient admissions.

Descriptive statistics were derived using SAS v.8.2 software. Significance of difference testing for health conditions and service utilization was performed using the chi-square analysis. Significance of difference testing for cost was performed using the t-test. Logistic regression was performed using a binary logit model to establish odds ratio estimates of the effect of foster care status on the probability of manifesting a particular health condition or of using a particular Medicaid service while controlling for region, race, sex, age, and health conditions.

⁷ Adapted from E. Shenkman, et al. "Children with Special Health Care Needs in the Healthy Kids Program: A Preliminary Examination." Institute for Child Health Policy, Tallahassee, FL, April 1996.

⁸ Some definitions of special health care needs include mental health conditions and abuse. Because those conditions are analyzed separately in this analysis, they are not included in the special health care needs definition.

Diagnoses

As illustrated in Table 4, a significantly larger proportion of foster children exhibit mental health conditions and child abuse diagnoses, while other Medicaid children have a higher proportion of pregnancy diagnoses. There are no significant differences between foster children and other Medicaid children in diagnoses for special health care needs and substance abuse.

Table 4
Selected Health Conditions of Georgia Foster Children and Other Medicaid Children
2000 - 2002

	Foster Children (n = 6,932) %	Medicaid Children (n = 21,668) %	Statistical Significance
Special Health Care Needs	13.5	14.2	
Mental Health	60.4	34.7	*
Substance Abuse	1.3	1.5	
Pregnancy	1.1	3.2	*
Child Abuse	3.4	0.9	*

The high proportion of Georgia children with at least one mental health diagnosis both in foster care and in Medicaid was of concern and might indicate an artifact of the project's analytic need to follow only patients with three years of continuous eligibility. The Mathematica analysis found that mental health diagnoses were present in 23 percent of the foster children in California and 38 percent in Pennsylvania - proportions somewhat lower than in the current analysis. To re-test our finding, we first examined the single year proportion of mental health diagnoses for foster children and other Medicaid children for the years 2000, 2001, and 2002. Forty-five percent of foster children and 23 percent of Medicaid children exhibited a mental health diagnosis in each of the three years tested.

We then tested the single year proportion of mental health diagnoses in *all* foster care children (N = 17,818) with Medicaid claims and the universe of other Medicaid children (N = 838,833) for the year 2000. In this test, 50 percent of foster children and nine percent of Medicaid children had at least one mental health diagnosis.

We also examined mental health diagnoses over time. Over three years, the number of non-foster care Medicaid children with mental health diagnoses age 0 - 2, 3 - 5, and 6 - 12 increased, while the mental health diagnoses in children age 13 - 16 decreased. The results for foster children were similar, except the number of foster children age 6 - 12 with mental health diagnoses also decreased over the three years. This increase of diagnoses over time is consistent with Simms's earlier findings.

As shown in Table 5, mental health diagnoses were more than three times as likely to appear in foster children as in other Medicaid children. The Mathematica analysis found that four to six times more foster children had a mental health diagnosis than the general Medicaid population. Foster children were almost four times as likely to have a diagnosis of child abuse. The odds

ratio⁹ for pregnancy could not be calculated due to small numbers of pregnancies in the foster child population.

Table 5
Logistic Regression Analysis of Health Conditions¹⁰: Georgia Foster Children versus Other Medicaid Children 2000 - 2002

	Odds Ratio	95% Confidence Interval
Special Health Care Needs	0.943	(0.871 - 1.020)
Mental Health	3.015*	(2.848 - 3.192)
Substance Abuse	0.903	(0.714 - 1.142)
Pregnancy	N/A	N/A
Child Abuse	3.731*	(3.083 - 4.514)

*Significant at the .01 level.

Utilization

Table 6 displays selected service use over three years. All results are significant at the .01 level. More Medicaid children, on average, had at least one inpatient admission, one prescription, and at least one emergency room visit over three years. More foster children had at least one dental visit, EPSDT¹¹ visit, or outpatient visit. It should be noted that as a condition of participation, Medicaid children must choose a primary care physician through Georgia Better Health Care (GBHC). The same requirement does not apply to foster children.

Table 6
Georgia Foster Children and Other Medicaid Children Using at Least One Health Care Service 2000 - 2002

	Foster Children %	Medicaid Children %	Statistical Significance
Inpatient Admission	6.4	7.7	*
Emergency Visit	39.7	55.9	*
Dental Visit	76.7	71.9	*
EPSDT	59.7	55.3	*
Outpatient Visit	96.6	95.2	*
Rx	89.0	90.5	*

⁹ Odds ratios indicate the chances of a particular event occurring after controlling for other factors.

¹⁰ Controlling for race, age, gender, and region.

¹¹ EPSDT - Early and Periodic Screening, Diagnostic, and Treatment - is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. In Georgia, the EPSDT program is called Health Check.

Table 7 displays the effect of foster care status on the odds of using selected Medicaid services. All results are consistent with those in Table 6; however, the outpatient visit variable is statistically significant at the .05 level rather than the .01 level. Foster status, in fact, appears to be a predictor of service utilization.

Table 7
Logistic Regression Analysis of Service Utilization¹²: Georgia Foster Children
Versus Other Medicaid Children
2000 - 2002

	Odds Ratio	95% Confidence Interval
Inpatient Admission	0.738*	(0.655 - 0.831)
Emergency Visit	0.483*	(0.456 - 0.512)
Dental Visit	1.205*	(1.129 - 1.286)
EPSDT	1.141*	(1.076 - 1.210)
Outpatient Visit	0.854 ¹³	(0.735 - 0.992)
Rx	0.636*	(0.579 - 0.698)

*Significant at the .01 level.

Table 8 details units of service use for those children who used selected Medicaid services from 2000 to 2002. Among foster children and other Medicaid children who experienced inpatient stays, the median number of claims is equal. In contrast, the medians reveal twice as many EPSDT visits in the foster child population, more than 50 percent more outpatient visits, and one-third more dental visits. Other Medicaid children experienced twice as many ER visits.

Table 8
Utilization of Services by Georgia Foster Children and Other Medicaid Children
2000 - 2002

	Foster Children			Medicaid Children		
	Percent Using Service	Median Units per Recipient	Range	Percent Using Service	Median Units per Recipient	Range
Inpatient Stay	6.4	1.0	(1 - 22)	7.7	1.0	(1 - 45)
Emergency Visit	39.7	1.0	(1 - 30)	55.9	2.0	(1 - 48)
Dental Visit	76.7	4.0	(1 - 25)	71.9	3.0	(1 - 30)
EPSDT	59.7	2.0	(1 - 11)	55.3	1.0	(1 - 13)
Outpatient Visit	96.6	23.0	(1 - 553)	95.2	13.0	(1 - 835)
Rx	89.0	16.0	(1 - 608)	90.5	13.0	(1 - 437)

¹² Controlling for age, race, gender, region, special health care needs, and mental health, substance abuse, pregnancy, and abuse diagnoses.

¹³ Significant at $p < .05$.

Costs

Table 9 illustrates the costs of selected services used by foster children and other Medicaid children over three years. Outpatient costs include all costs not captured by inpatient stays and prescription drugs. The results are consistent with Table 8 and might indicate that utilization is driving cost. Foster children have higher outpatient and prescription drug costs. The higher outpatient costs in the foster child population may be driven by higher outpatient mental health costs.

Table 9
Costs of Georgia Foster Children and Other Medicaid Children Using Selected Services
2000 - 2002

	Foster Children		Medicaid Children		Statistical Significance
	Median Cost per Recipient \$	Range \$	Median Cost per Recipient \$	Range \$	
Inpatient Cost	4,117	(50 - 268,698)	4,508	(30 - 309,411)	
Outpatient Cost	2,560	(1 - 288,034)	1,689	(5 - 524,940)	*
Rx Cost	535	(2 - 531,635)	356	(0 - 367,300)	*

Quality Indicators: Vaccinations

Measurements of quality from administrative claims data must be interpreted with caution. Due to the repetitive nature of childhood vaccinations, one must be careful in determining whether or not a particular vaccine was erroneously administered more than once. For example, the Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine is administered at two, four, and six months, again between 12 and 18 months, and again after four years. Certain vaccines may be administered as catch-up immunizations if the recommended range of administration is missed at the appropriate time. Finally, children eligible for Medicaid may receive vaccinations outside the Medicaid reimbursement system.

Therefore, we can only determine the percent of children in each age group who received more than the recommended dose for a particular vaccine. The cause may be due to duplicate vaccinations or catch up vaccinations from a previously missed period, but the Medicaid claims data do not allow us to discriminate among these possible causes. For example, in Table 10, we know that seven percent of foster children in the three to five age group and six percent of Medicaid children in the same age group received more than one DTaP vaccine.¹⁴ We cannot determine if the children who received more than one did so due to duplicate vaccines or catch up vaccines from a previous period. None of the comparisons in Table 10 are statistically significant at the .01 level, indicating that there are no significant differences between the two populations on this measure.

¹⁴ One DTaP vaccine is recommended between the ages of four and six.

Table 10
Georgia Foster Children and Other Medicaid Children Exceeding Recommended Vaccine
Administrations within Selected Age Groups
2000 - 2002

Age	Foster Children				Medicaid Children			
	DTaP %	Hib ¹⁵ %	IPV ¹⁶ %	MMR ¹⁷ %	DTaP %	Hib %	IPV %	MMR %
0 - 2	0.4	1	1	8	1.5	1	2	6
3 - 5	7	5	6	4	6	5	5	4
6 - 12	0.1	.5	0.1	0.2	0.1	0.4	0.1	0.2

Quality Indicators: Access to Physicians and Specialists

To test whether or not foster children had the same access to physician and specialist visits, we measured utilization over three years. The frequencies of regular physician and specialist visits are displayed in Table 11.

Table 11
Georgia Foster Children and Other Medicaid Children
With Physician and Specialist Visits
2000 - 2002

	Foster Children			Medicaid Children		
	Percent with Visits	Median Visits per Recipient	Range	Percent with Visits	Median Visits per Recipient	Range
Physician Visits	97.1	12	(1 - 248)	97.5	11	(1 - 299)
Specialist Visits	90.8	9	(1 - 481)	85.9	7	(1 - 780)

Foster children received, on average, more physician visits over three years (12) than did other Medicaid children (11), although the finding is not statistically significant. Foster children also received more specialist visits - a finding that is statistically significant at the .01 level and consistent with what one might expect as a result of the diagnoses observed in Table 4.

Quality Indicators: Access to Physicians by Children with Special Health Care Needs

As previously reported, there is no significant difference between foster children and other Medicaid children in the proportion of children with special health care needs for the years 2000

¹⁵ Haemophilus influenzae type b (Hib) conjugate vaccine.

¹⁶ Inactivated Poliovirus.

¹⁷ Measles, Mumps, and Rubella vaccine.

to 2002. However, one of the concerns of this analysis was whether or not foster children with special health care needs had the same access to physicians as other Medicaid children with special health care needs. The results of that analysis are presented in Table 12.

Table 12
Physician Visits of Georgia Foster Children and Medicaid Children with
Special Health Care Needs
2000 -2002

	Foster Children			Medicaid Children		
	Percent with Visits	Median Visits per Recipient	Range	Percent with Visits	Median Visits per Recipient	Range
Physician Visits	99.6	21	(1 - 193)	99.1	19	(1 - 263)

Foster children with special health care needs visited a physician office significantly more often than other Medicaid children between the years 2000 and 2002 (21 visits versus 19.) However, whether or not that number of visits is an appropriate level of care is beyond the scope of this analysis.

Quality Indicators: Lapses in Prescription Drug Use

Because there may be disruption in routine preventive care in the foster child population due to frequently changing or stressed home environments, foster children with mental health needs might experience gaps in mental health medication use. One cannot determine from Medicaid claims data whether or not prescription drugs were actually consumed. One can only determine whether or not Georgia Medicaid paid a claim for a particular drug or class of drug. Determining whether or not there is a lapse in those paid claims is also problematic.

For example, a prescription might be filled on the first day of a given month and refilled on the 30th of the month for consumption in the following month. The claims data will show two prescriptions filled in one month (possibly construed as duplicate prescriptions) and no prescription filled in the next month (possibly construed as a lapse.) For the purposes of this analysis, a lapse is defined once a prescription drug appears in the claims data, is followed by two full months with no claim for the same class of drug, and is followed by a fourth month where a mental health drug reappears.

Using this algorithm, Medicaid claims data were tested for prescription drug lapses. The results are presented in Table 13.

Table 13
Lapses in Mental Health Drug Use of Foster Children and Other Medicaid
Children Prescribed Mental Health Drugs
2000 - 2002

	Foster Children		Medicaid Children		Statistical Significance
	Number	Percent	Number	Percent	
Lapse	1,029	32	1,825	27	*
No Lapse	2,221	68	4,827	73	*

A slightly higher percentage of foster children who use mental health drugs experience lapses in use. Previously, it was shown that foster children have more outpatient visits, more preventive screenings, and more visits to physicians and specialists, yet here it is observed that lapses in mental health prescription drug use may be problematic. While the limitations inherent in the data prevent this analysis from being definitive, the observations made here may be reason for foster care program managers and mental health workers to focus on whether or not the regular use of mental health drugs, once prescribed, might be improved.

Discussion

Demographically, foster children in Georgia differ from the larger non-foster care population of Medicaid children mostly in age, with foster children tending to be older and Medicaid children younger. Health programs targeted at pre-teens and teenagers within the foster care system may prove valuable in light of the developmental challenges young adults face.

Georgia foster children are diagnosed with special health care needs and substance abuse problems in roughly the same proportions as other Medicaid children. Fewer foster children are diagnosed with pregnancy - a particularly encouraging indicator considering the older ages of the foster child population. Both mental health conditions and abuse are manifested in the foster child population in greater proportions than in other Medicaid children - a finding that mirrors national studies. While the proportion of mental health conditions in the foster child population is not surprising, it indicates that any reduction in mental health services to foster children might place foster children at even greater risk than they are currently.

Health care utilization in the foster child population is encouraging. A higher proportion of foster children received dental visits, outpatient visits, and EPSDT screenings than other Medicaid children. This was achieved even though foster children are not required to choose a primary care physician as are other Medicaid children.

A smaller proportion of foster children was admitted to a hospital or visited an emergency room over the three years. Those foster children that did use selected services had fewer emergency room visits and more outpatient visits, dental visits, EPSDT screenings, and prescription drug claims. Understanding why the foster child population uses preventive services more frequently may benefit the overall population of Medicaid children.

Costs of inpatient stays were higher in the Medicaid child population, although the difference was not statistically significant. Costs of outpatient visits and prescription drugs were significantly higher in the foster child population. We believe this is most likely due to the higher proportion of mental health diagnoses in the foster child population.

About the same proportion of foster children visited physicians and significantly more visited specialists over three years. The concern that foster children lack access to specialists appears to be unfounded. Foster children with special health care needs also visited physicians more frequently than Medicaid children with special health care needs, but again the difference was not significant.

Lapses in mental health prescription drug use were difficult to measure using Medicaid claims data, and an analysis-specific algorithm was created to define a prescription drug lapse. Using that algorithm, a higher proportion of foster children experienced lapses in mental health drug use, indicating the importance of a focus on mental health within the foster care population. A sub-analysis of mental health drug utilization revealed that about five percent of the foster child population and nine percent of the other Medicaid children showed evidence of a mental health drug claim without a corresponding mental health related diagnosis. While it is possible that the drugs manifested in the claims data may have indications for use other than for mental health conditions, further investigation may be warranted.

Conclusion

This analysis was undertaken to identify the health conditions and service utilization of Georgia's foster children compared with other Medicaid children. It does not extend to the question of whether or not health care services are adequately utilized. Reference studies have identified foster children as being at risk for high rates of mental health problems, abuse, and lack of access to regular physician visits and specialist visits, especially for children with special health care needs. While administrative claims data can provide important clues to areas warranting further investigation, they are not designed for research. This analysis, still, has increased our understanding of how Georgia foster children manage within the Medicaid system.

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