Commonwealth of Virginia
Department of Medical Assistance Services

Access Monitoring Review Plan
June 2021

Table of Contents

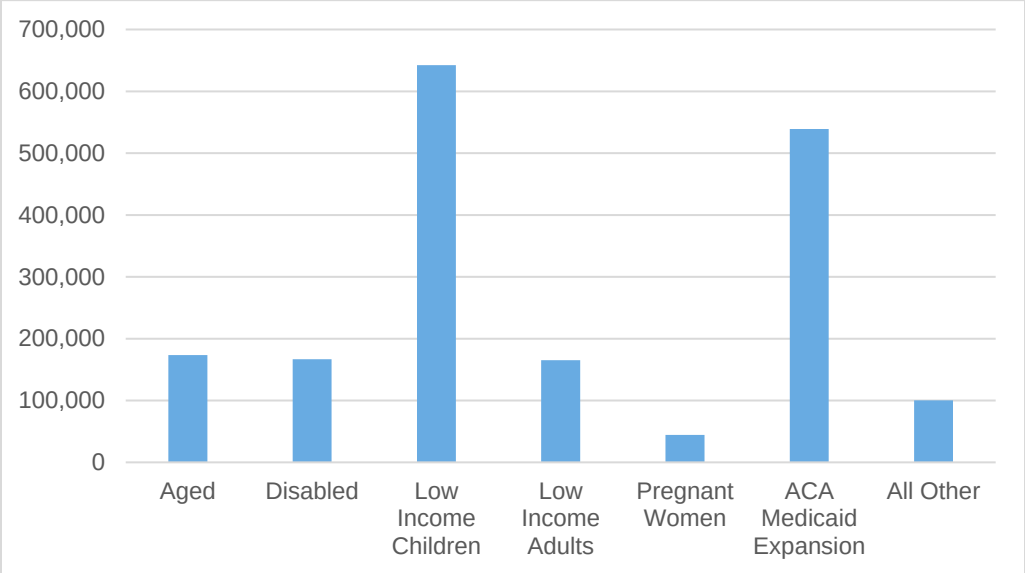
Virginia Access Monitoring Review Plan Overview

In November 2015, the Centers for Medicare and Medicaid Services (CMS) promulgated federal regulations that created requirements for states to monitor access to Medicaid services in a Medicaid fee-for-service (FFS) environment[1]. Under these requirements, states must develop an access monitoring review plan, which must be published for public review and comment and submitted to CMS. In accordance with these requirements, the Virginia Department of Medical Assistance Services (DMAS) has prepared the access monitoring review plan contained herein.

The Virginia Medicaid program provides healthcare coverage for low-income individuals, including children, pregnant women, individuals with disabilities, the elderly, parents and other adults. The Virginia Department of Medical Assistance Services is the single state agency that administers the Medicaid program in the Commonwealth of Virginia. The mission of the Virginia Medicaid program is to provide access to a comprehensive system of high quality and cost effective health care services to qualifying Virginians.

DMAS provides Medicaid coverage to individuals through managed care and fee-for-service delivery models. The managed care delivery system, known as Medallion 4.0. and CCC Plus (higher risk and older members), covers Medicaid members through six commercial health plans. Virginia has been increasing its use of the managed care program, and as of November 2019, 90% of Medicaid enrollees are in managed care. During state fiscal year (SFY) 2020, the Virginia Medicaid program provided coverage to approximately 1.6 million enrolled members, and total Medicaid spending was approximately $12.7 billion. Figures 1 through 4 illustrate Virginia's Medicaid total enrollment and expenditures for SFY 2020.

Figure 1. Total Medicaid Enrollment by Eligibility Category



[1] 42 C.F.R 447.203, 42 C.F.R 447.204, and 42 C.F.R 447.205. See also the Centers for Medicare and Medicaid Services (CMS) Final Rule: Federal Register Vol. 80, No. 211, November 2, 2015.

Figure 2. Total Medicaid Expenditures by Eligibility Category

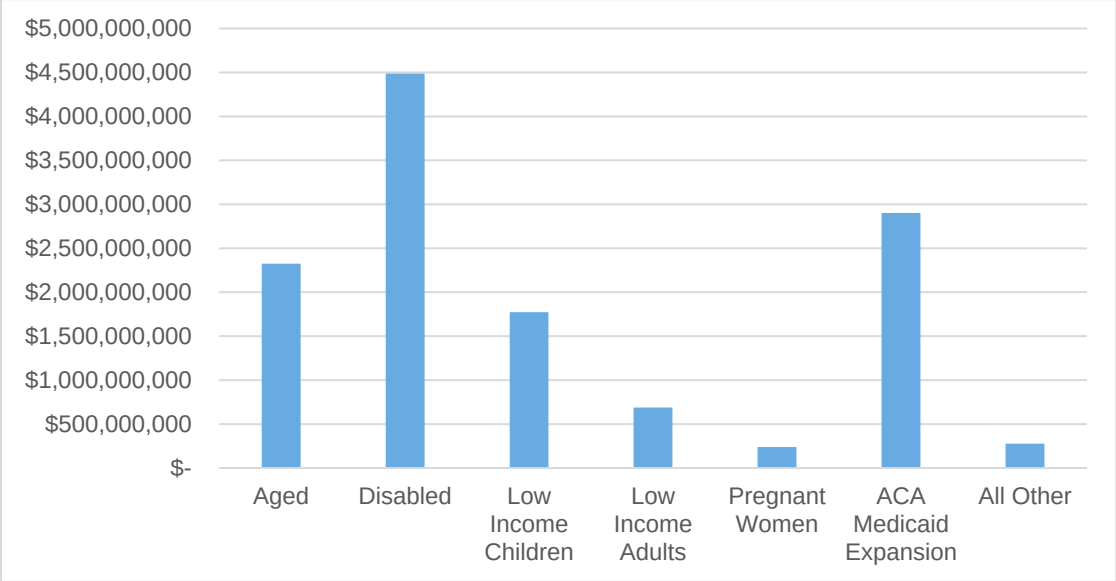


Figure 3. Comparison of Total Medicaid Enrollment and Expenditures by Eligibility Category

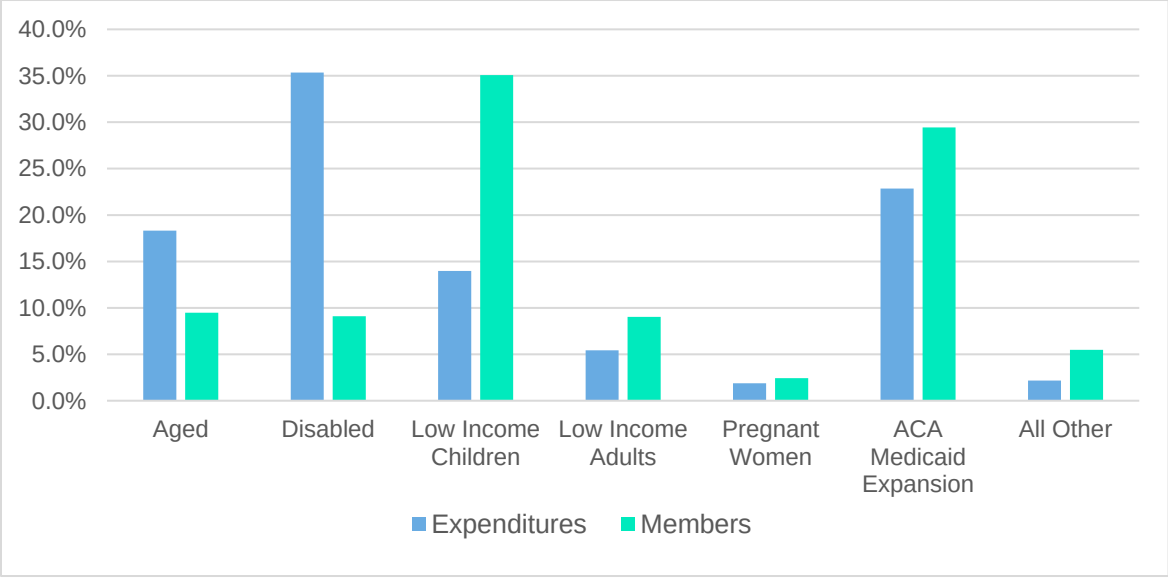


Figure 4. Total Medicaid Enrollment and Expenditure Data for SFY 2020

	Enrollment	Expenditures
Aged	173,587	$2,325,576,928
Disabled	166,651	$4,486,093,957
Low Income Children	642,380	$1,773,765,065
Low Income Adults	165,318	$688,585,434
Pregnant Women	44,421	$238,223,795
ACA Medicaid Expansion	539,161	$2,900,843,689
All Other	100,332	$276,661,576
TOTALS	1,831,850	$12,689,750,446

The Medicaid eligibility categories above are defined as follows:

Figure 5. Medicaid Eligibility Categories

Eligibility Category	Definition
ACA	Affordable Care Act Medicaid Expansion for Low Income Adults
Aged	Adults 65 and older under 80% of the Federal Poverty Limit (FPL) or needing Long Term Care
Disabled	Individuals under 65 determined disabled under 80% FPL or needing Long Term Care
Low Income Children	Children up to age 19 with family incomes below 143% FPL
Low Income Adults	Low income caretaker adults- FPL maximum varies by locality, approximately 33%
Pregnant Women	Members enrolled due to pregnancy; incomes under 143% FPL
Plan First (included in All Other)	Members under 200% FPL, benefits limited to family planning services
Foster Care (included in All Other)	Foster Care and Adoption Assistance children
QMB Only (included in Aged)	Qualified Medicare Beneficiaries, under 135% FPL, benefits limited to Medicare premiums, or to Medicare premiums, co-pays and deductibles

Virginia has a population of 8.5 million people, making it the 12th most populous state in the United States.[2] With 81 acute care hospitals, including seven critical access hospitals and a children's hospital, and a network of 211 federally qualified health center (FQHC) and rural health clinic (RHC) sites, there are numerous options for Medicaid members to receive health care services.

[2] United States Census Bureau. POPESTIMATE2019, "nst-est2019-alldata" retrieved from https://www.census.gov/data/datasets/time-series/demo/popest/2010s-national-total.html#par_textimage_401631162.

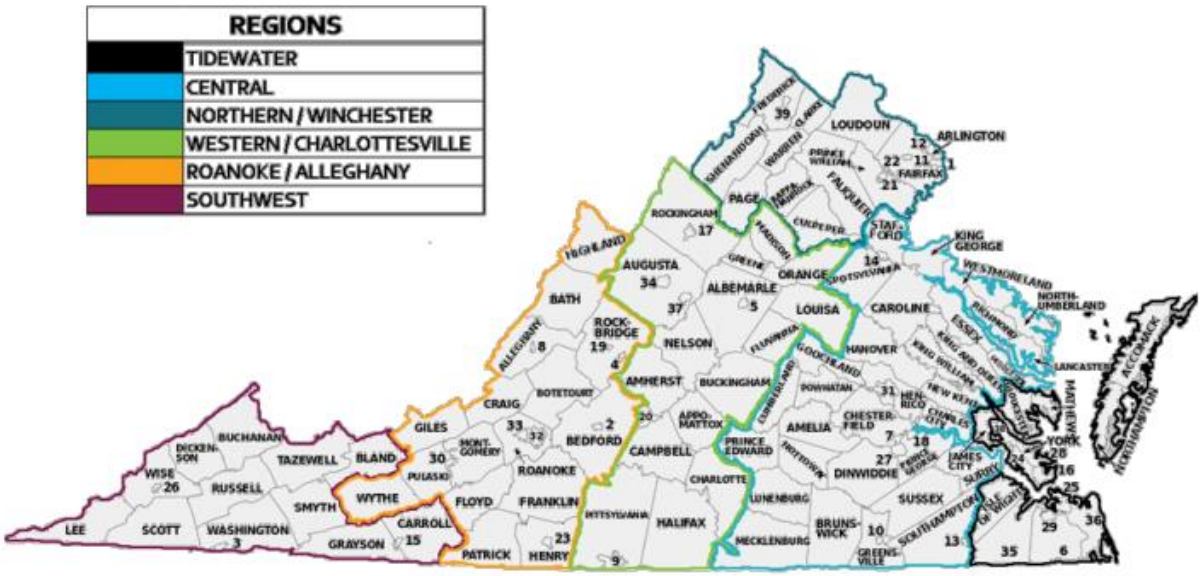
Virginia is committed to ensuring its enrolled members have adequate access to health care services. A key component of DMAS' strategic plan is ensuring adequate provider network access by monitoring and analyzing utilization, provider caseloads, reimbursement rates, and Medicaid population groups.

Member access to care can be measured and analyzed in a variety of ways. Using the metrics and data sources described in this plan, DMAS will measure and monitor indicators of healthcare access to ensure that its Medicaid FFS members have access to care that is comparable to the general population. The methodology employed in this plan will consist of evaluating trends in provider availability and participation in the Medicaid program, trends in utilization of services by Medicaid members, and member and provider feedback. Through the FFS monitoring plan and subsequent updates to the plan, DMAS anticipates that the access monitoring analysis, metrics, data sources, and other factors will evolve over time. Separate access monitoring and provider network sufficiency requirements are present in a managed care environment and under home and community based services waiver programs, and these issues are not addressed in this plan.

Because members located in different areas may have different experiences accessing health care services, this plan will analyze access to care by geographic region. Specifically, the plan will analyze access to care for the regions utilized by the Virginia Medicaid program for Managed Long-term Supports and Services (MLTSS) and the managed care program, Medallion 4.0. These regions are illustrated in Figure 6[3]. The localities comprising these regions are listed in Appendix A.

[3] Virginia Department of Medical Assistance Services. 2020–2022 Quality Strategy. Retrieved from https://www.dmas.virginia.gov/media/2966/2020-2022-dmas-quality-strategy.pdf.

Figure 6. Virginia Healthcare Service Regions Map



In accordance with 42 CFR 447.203, Virginia developed this access monitoring review plan (AMRP) for the following service categories provided under a fee-for-service (FFS) arrangement:

- Primary care services
- Physician specialist services
- Behavioral health services
- Pre- and post-natal obstetric services, including labor and delivery
- Home health services

The plan describes data that will be used to measure access to care for members in FFS. The plan considers the availability of Medicaid providers, utilization of Medicaid services and the extent to which Medicaid members' healthcare needs are fully met. The plan was developed during the months of July and August 2016 and posted on the Virginia Regulatory Town Hall website under General Notices, found at the following address: http://townhall.virginia.gov/L/EditNotice.cfm?GNid=new from August 29, 2016 to September 29, 2016, as well as being posted on the DMAS website, http://www.dmas.virginia.gov/ to allow for public inspection and feedback.

Member Population

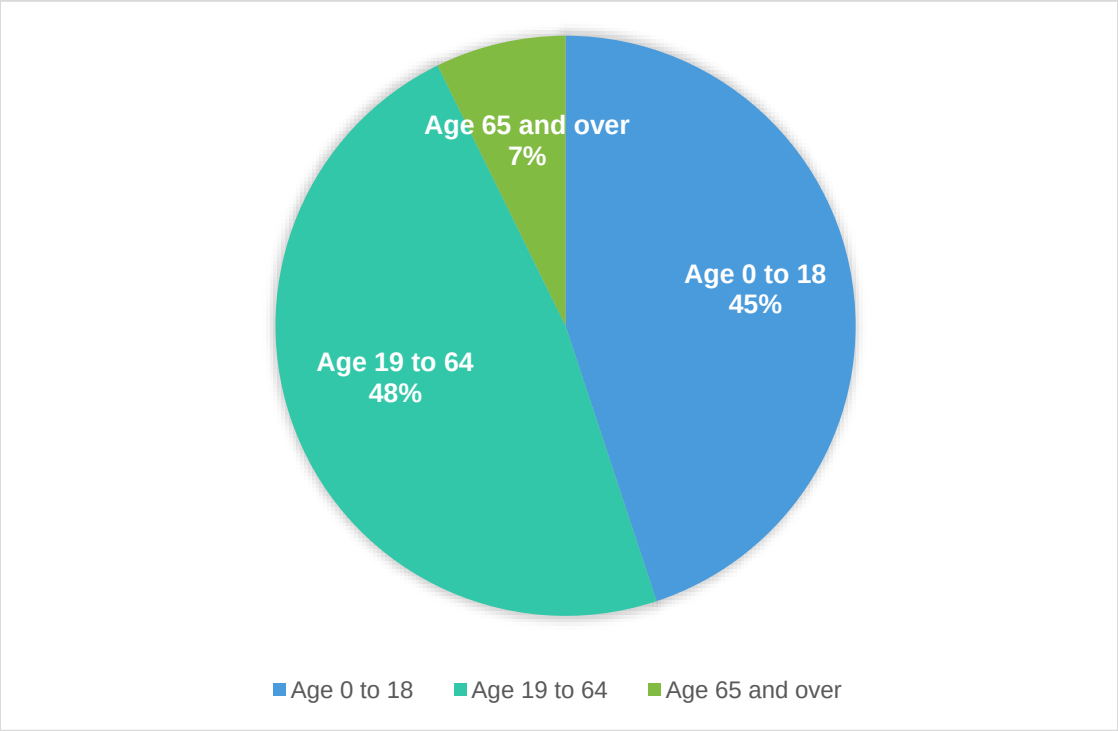
During SFY 2020, the Virginia Medicaid program provided coverage to approximately 1.6 million enrolled members across all delivery systems. Approximately 90% of Medicaid members are enrolled in the managed care program, Medallion 4.0 or CCC Plus. Members enrolled in the managed care program consist of members that are aged and/or disabled and low income

families and children. Members enrolled in the FFS program are primarily individuals in one or more of the following categories:

- Family planning services only (limited benefit)
- Dually eligible for Medicare and Medicaid coverage
- Private insurance as a primary payer
- In a home and community based waiver program.

Characteristics of the total member population are illustrated in the figures below and on the following pages. Figure 7 illustrates the distribution of Medicaid members by age. A majority of members are 19 to 64 with Medicaid expansion, with the next largest group in the 18 years of age or younger age range.

Figure 7. Medicaid Members by Age Group



Figures 8 through 10 illustrate trends in the total member population from SFY 2018 to SFY 2020. These figures illustrate trends in member enrollment in total and by age group as well as the trend in cost per member by eligibility category.

Figure 8: Change in Total Medicaid Enrollment by SFY

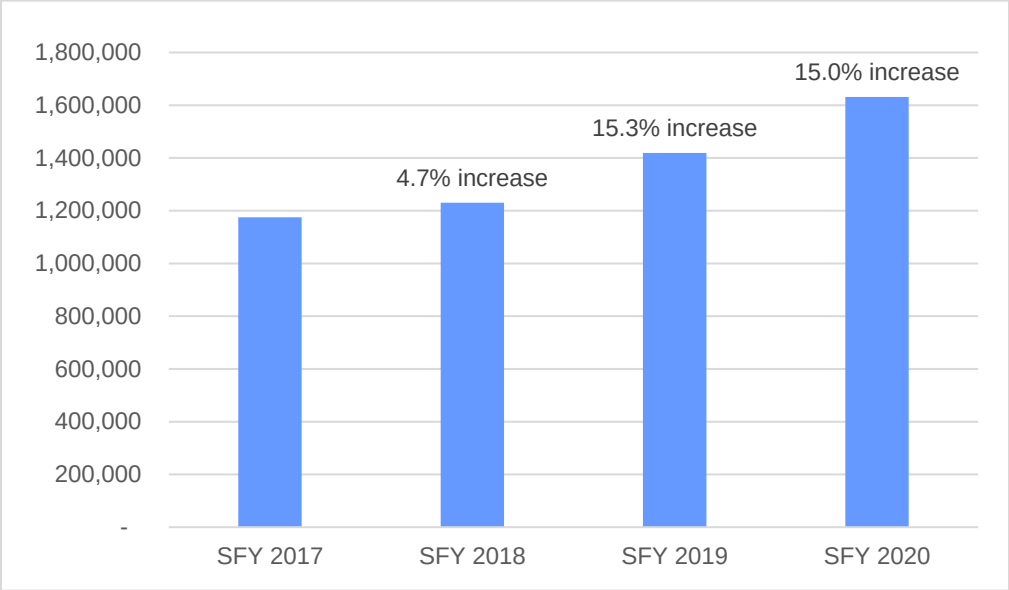


Figure 9: Total Medicaid Enrollment by Age Group and SFY

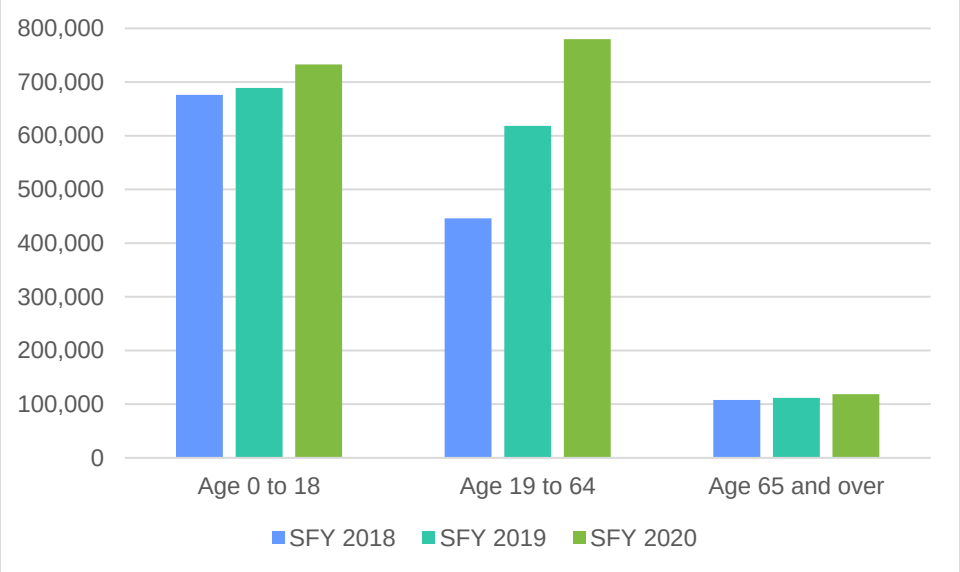
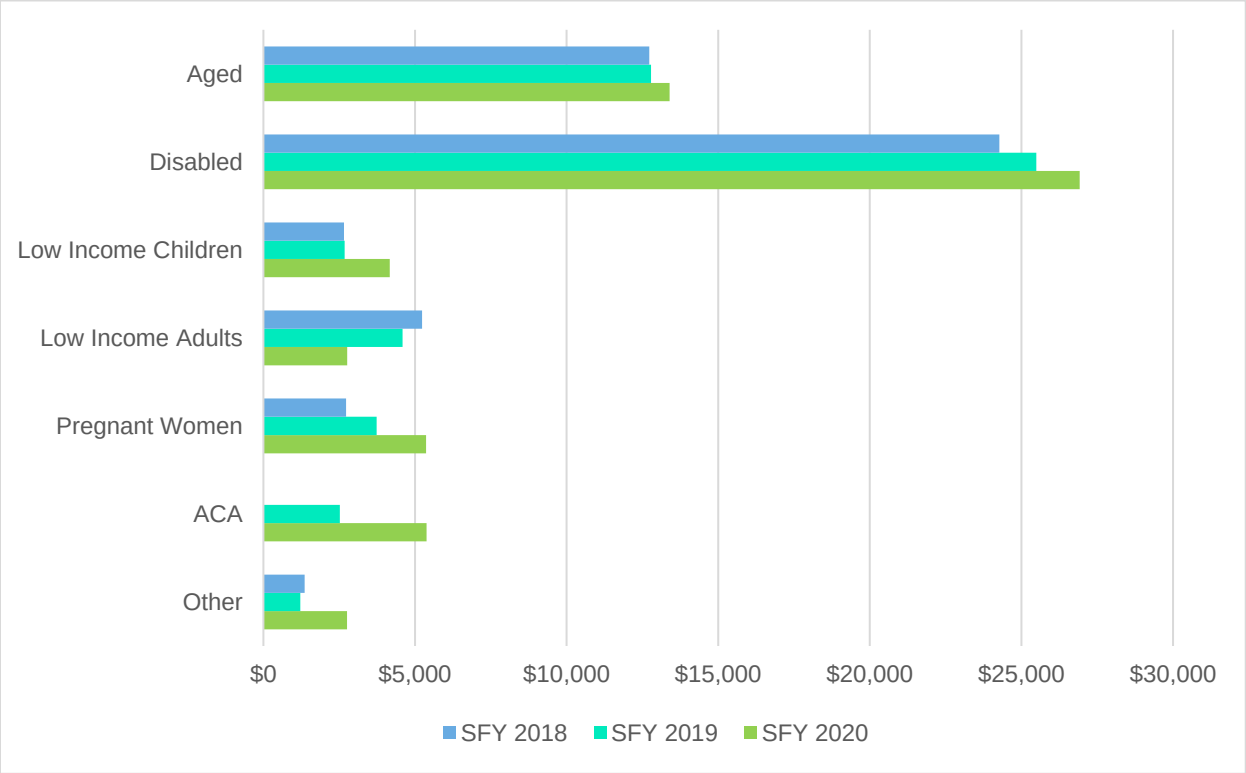


Figure 10: Cost per Member by Eligibility Group and SFY



Notable facts from this data are as follows:

- Overall Medicaid enrollment increased over the 3 year period by 29%. There was a 1% increase in enrollment in SFY 2018, followed by a 26% increase in SFY 2019 and a 2% increase in SFY 2020. Virginia implemented Medicaid expansion beginning January 1, 2019.
- The largest enrollment growth occurred in the 19 to 64 age group, increasing by 85% over 3 years compared to 29% growth across the entire Medicaid population.
- Aged and disabled members have the highest cost per member but the smallest growth in Medicaid enrollment over the 3 year period. Virginia implemented Medicaid expansion in 2019, with total SFY 2020 expenditures of $2.9B.

Access concerns raised by members

Members have numerous options for obtaining assistance relating in accessing services. Members are advised to call their local Department of Social Services agencies for questions related to eligibility or obtaining services. All notices provided to enrollees inform them that they should contact the local agency and also provides either the local agency phone number or the local eligibility worker's direct phone number. The local agency will address the concern and develop a response in house (if applicable) or refer the caller to the appropriate resource for resolving the concern. Managed care enrollees are provided with MCO information advising them of whom or where to call for questions or issues related to their health plan.

If the caller's issue is not resolved through the local agency, the local agency may escalate the inquiry directly to DMAS, or arrive at DMAS via the enrollee's request for assistance from their local or national legislators, the Governor, or CMS. DMAS has a system set up to address such concerns, typically within five business days of receipt.

Member perceptions of access to care

DMAS conducts an annual survey of member satisfaction and experiences for children receiving services under the Family Access to Medical Insurance Security (FAMIS) program, Virginia's children's health insurance program. The survey is conducted as required by the Children's Health Insurance Program Reauthorization Act (CHIPRA) and in accordance with the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey of the U.S. Agency for Healthcare Research and Quality. CAHPS surveys are overseen by states but are conducted by contracted vendors. Beginning in 2015, the CAHPS survey in Virginia is conducted by the Health Services Advisory Group (HSAG). Below are selected survey questions relevant to member access and the responses to these questions obtained through the 2020 CAHPS survey.[4] For these questions regarding obtaining needed care and obtaining care quickly, respondents selected from the following response categories: Never, Sometimes, Usually, or Always. It is important to note that the majority of FAMIS members are enrolled in managed care. However, because a small percentage of FAMIS members are enrolled in the FFS program, DMAS believes it is informative to include the results of the FAMIS CAHPS survey in this monitoring plan.

[4] Health Services Advisory Group. 2020 FAMIS Program Member Satisfaction Report (October 2020).

Figure 11: 2015 CAHPS Survey Responses

CAHPS Survey Measure and Question	Survey Response
Measure: Getting needed care	89.0% "Usually/Always"
Question 1: In the last 6 months, how often was it easy to get the care, tests, or treatment your child needed?	
Question 2: In the last 6 months, how often did you get an appointment for your child to see a specialist as soon as you needed?	
Measure: Getting care quickly	90,8% "Usually/Always"
Question 1: In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?	
Question 2: In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?	

Provider Feedback

There are multiple mechanisms available for providers to submit feedback to DMAS regarding the FFS Medicaid program. The state maintains a provider helpline that is staffed from 8 a.m. to 5 p.m., Monday through Friday in order to provide assistance with claims and billing, member eligibility, covered services and limitations, and state regulations, memos, and other communications. A provider enrollment services helpline is also available for new providers to obtain assistance with Medicaid provider enrollment applications and other provider enrollment issues. DMAS also maintains an online web portal through which providers can access information and conduct certain activities in a secure fashion, including claims submission, claim status inquiries, member eligibility inquiries, provider payment history, remittance advice messages, and provider enrollment information. In addition to the web portal, providers can also access similar information through an automated voice response system that is available 24 hours a day, 7 days a week. Numerous other provider support systems are available, such the EDI helpdesk, pharmacy helpdesk as well as the helplines available from the contracted managed care organizations. The primary provider feedback mechanisms are illustrated in the table below:

Figure 12: Provider Feedback Mechanisms

Topic / Issue	Contact Name / Number
Provider Helpline (8am-5pm, Mon-Fri) • Assistance with claims status and adjudication inquires • Assistance with Member eligibility, covered services and limitations • Assistance with regulations, Memos and other communications • Assistance with claims and billing instructions	Virginia Medicaid Provider Helpline Phone (In-State) - 800-552-8627 Phone (Out of State) 804-786-6273
Provider Enrollment Services (8am-5pm, Mon-Fri) • Online application submittal • Paper application submittals • Application status tracking • All other Provider Enrollment inquiries	Virginia Medicaid Provider Enrollment Helpdesk Phone - 804-270-5105 or 888-829-5373 Fax - 804-270-7027 or 888-335-8476 Email: Va.Medicaid.ProviderEnrollment@conduent.com
Web Systems (8am-5pm, Mon-Fri) • Web Registration (new and registered providers) • Web User Management (user maintenance - passwords, roles, etc.) • Provider Profile Maintenance • Claims Direct Data Entry (DDE) • Web Portal technical issues • All other Web Portal inquiries	Virginia Medicaid Web Support Helpdesk Phone - 866-352-0496 (or) via Email at virginiamedicaid.providerhelpline@conduent.com
Medicall - Automated Voice Response System (24 hours a day x 7 days a week) Automated Provider access to the following Information: • Member Eligibility • Claim Status • Claim Payments • Status on Service Authorizations • Service Limits Information • Pharmacy Prescriber ID Information	Automated Services Phone (Richmond Area) - 800-772-9996 Phone (USA) - 800-884-9730
Electronic Data Interchange (EDI) for Claim Submissions (8am-5pm, Mon-Fri) • Electronic File Set-up • File Testing • EDI Customer Support	Virginia Medicaid EDI Helpdesk Phone - 866-352-0766 Fax - 888-335-8460
Point of Service (POS) Pharmacy Support (24 hours a day x 7 days a week) • POS Transmission Issues • Drug service authorizations • Preferred Drug List (PDL) • ProDUR and RetroDUR	Virginia Medicaid Pharmacy Helpdesk Phone - 800-774-8481

Previous reports have included responses to DMAS' biannual provider satisfaction survey. However, Virginia has been increasing its use of the managed care program, and as of November 2019, 90% of Medicaid enrollees are in managed care. As such, responses to more recent surveys relate primarily to the managed care delivery system, rather than fee for service. Therefore, we have not included them in the current report.

Access Monitoring Methodology

The state's analysis of access to care for the FFS population includes an analysis of the core services required by CMS, services the state has elected to analyze that are not required by CMS, and services for which rates are reduced or restructured. This access monitoring review plan contains an analysis of the following services:

- Core services[5]
  - Primary care services
  - Physician specialist services
  - Behavioral health services
  - Pre- and post-natal obstetric services
  - Home health services
  - Telemedicine services
- Services for which rates are reduced or restructured
  - Inpatient hospital services
  - Outpatient hospital services

The methodology for evaluating access to these services is a data-driven analyses that compares recent historical data as a baseline to subsequent years' data. The analysis evaluates these trends on a statewide basis and by MLTSS geographic region, and in some cases, by population. This approach facilitates the evaluation of trends and patterns over time, across geographic regions, and by population age group. The overview section of this report contains more information regarding MLTSS regions. For this analysis, adults are members 19 years of age and above, and pediatrics are members under the age of 19 (except for the analysis of obstetric services, which uses a different definition as described in that section).

The availability of providers of these services and the utilization of these services by Medicaid members are indicators of Medicaid members' ability to access services. The analysis conducted under this plan measures the availability of providers and the utilization of services by Medicaid FFS members by analyzing provider participation in the Medicaid program and trends in member utilization. The FFS data for this analysis is derived from the state's Medicaid

[5] In the state's previous access monitoring review plan, the state indicated that future access monitoring review plans would include an analysis of transportation services. However, the state has determined that an analysis of FFS transportation services would not be informative because the majority of transportation services are or will soon be covered under managed care or waiver programs.

Management Information System (MMIS) for a three year period comprising SFY 2018 to SFY 2020. Claims data consists of claims with dates of service during SFY 2018 through SFY 2020. This time frame provides a baseline of SFY 2018 data for comparison to SFY 2019 and 2020 and represents complete claims periods that are not impacted by paid claims lag (claims that have not been filed and/or paid).

It important to note that member enrollment in the FFS program is not static. Members enroll and dis-enroll, and members may temporarily be enrolled in the FFS program before being transitioned to a Medicaid managed care organization. For this analysis, the number of FFS members was determined by analyzing FFS enrollment as of the end of each state fiscal year. Therefore, the FFS data in this analysis is based on members enrolled in the FFS program as of the end of state fiscal years 2018, 2019, and 2020.

FFS member enrollment has declined due to the state's ongoing emphasis and focus on expanding the managed care program. For example, almost all elderly and disabled members have moved to managed care as of SFY 2019. Therefore, rather than analyzing raw provider and service volume counts, Provider Measure 1 calculates provider participation on a 1,000 members basis, and Utilization Measure 1 calculates service volume on a per-member basis. In areas with very low utilization, such as home health, Provider Measure 1 is presented as provider participation on a per 100 members basis.

Analysis of Primary Care Services

The state's analysis of primary care services for the FFS population evaluates access to services provided by primary care physicians, federally qualified health centers, rural health clinics (RHCs), and dentists. For purposes of this analysis, primary care physician services consist of pediatric primary care services, pediatric preventive care services, and adult preventive and primary care services as defined in the DMAS reimbursement methodology for physician services (refer to the Rate Comparison section below for further details). FQHC and RHC services consist of services provided by those provider types, and dental services consist of services billed to the Medicaid FFS program through Current Dental Terminology (CDT) procedure codes.

Availability of Providers

Provider availability is analyzed using the following measures:

Provider Measure 1: Number of available providers per 1,000 members.

Measure: Number of available primary care providers per 1,000 members by state fiscal year, statewide, and by region.

Methodology: Identify available primary care providers from SFY 2018 (baseline) to SFY 2020. Available providers are defined as providers with at least one Medicaid FFS claim during the period analyzed. Identify the number of members receiving at least one primary care service from SFY 2018 to SFY 2020. Calculate the ratio of available primary care providers per 1,000 members. Data is analyzed on a statewide basis and by MLTSS region. For providers with multiple service locations, each service location is counted separately. This measure identifies trends in provider participation.

Data source: MMIS FFS claims, provider, and member data

Results: The figure below illustrates the number of available providers per 1,000 members on a statewide basis and by MLTSS region. Total available primary care providers per 1,000 members increased by 20% between SFY 2018 and 2020.

Figure 13: Available Primary Care Providers per 1,000 Members

Physicians			
Region	**SFY 2018**	**SFY 2019**	**SFY 2020**
Central	152	220	310
Charlottesville Western	151	217	325
Northern & Winchester	177	244	287
Roanoke/Alleghany	172	231	327
Southwest	86	137	210
Tidewater	160	219	319
Statewide	151	214	298
Change from Baseline		63	147
Percent Change from Baseline		42%	97%
FQHCs and RHCs			
Region	**SFY 2018**	**SFY 2019**	**SFY 2020**
Central	11	14	26
Charlottesville Western	4	5	7
Northern & Winchester	17	20	21
Roanoke/Alleghany	8	10	13
Southwest	9	15	35
Tidewater	4	6	12
Statewide	8	10	14
Change from Baseline		2	6
Percent Change from Baseline		28%	79%

Dental Providers			
Region	SFY 2018	SFY 2019	SFY 2020
Central	5	5	13
Charlottesville Western	7	6	14
Northern & Winchester	8	8	20
Roanoke/Alleghany	4	4	14
Southwest	3	3	7
Tidewater	8	6	19
Statewide	6	6	16
Change from Baseline		0	10
Percent Change from Baseline		-6%	167%
All Primary Care Providers			
Region	SFY 2018	SFY 2019	SFY 2020
Central	86	103	103
Charlottesville Western	88	103	110
Northern & Winchester	95	102	97
Roanoke/Alleghany	101	112	123
Southwest	47	60	70
Tidewater	92	100	111
Statewide	86	98	102
Change from Baseline		12	17
Percent Change from Baseline		14%	20%

Provider Measure 2: Provider patient load.

Measure: Number of members per available primary care provider by state fiscal year, statewide, and by region.

Methodology: Identify available primary care providers from SFY 2018 (baseline) to SFY 2020. Available providers are defined as providers with at least one Medicaid FFS claim during the period analyzed. Identify the number of members receiving at least one primary care service from SFY 2018 to SFY 2020. Calculate the ratio of members per available provider. Data is analyzed on a statewide basis and by MLTSS region. For providers with multiple service locations, each service location is counted separately. This measure identifies trends in patient load (members per provider).

Data source: MMIS FFS claims, provider, and member data

Results: The figure below illustrates the primary care provider patient load on a statewide basis and by MLTSS region. Total primary care patient load decreased by 18% between SFY 2018 and 2020.

Figure 14: Primary Care Provider Patient Load

Physicians			
Region	**SFY 2018**	**SFY 2019**	**SFY 2020**
Central	7.3	5.0	3.6
Charlottesville Western	8.4	5.8	3.9
Northern & Winchester	6.4	4.6	3.9
Roanoke/Alleghany	7.3	5.3	3.8
Southwest	12.5	7.9	5.0
Tidewater	5.86.9	5.0	3.4
Statewide	7.4	5.2	3.8
Change from Baseline		-2.2	-3.6
Percent Change from Baseline		-30%	-49%
FQHCs and RHCs			
Region	**SFY 2018**	**SFY 2019**	**SFY**
Central	111.1	88.3	51.6
Charlottesville Western	226.5	160.5	136.4
Northern & Winchester	69.9	60.4	59.8
Roanoke/Alleghany	116.8	103.9	69.4
Southwest	122.5	70.7	27.2
Tidewater	229.9	162.1	87.6
Statewide	128.0	99.0	71.4
Change from Baseline		-29.0	-56.6
Percent Change from Baseline		-23%	-44%
Dental Providers			
Region	**SFY 2018**	**SFY 2019**	**SFY 2020**
Central	219.9	225.6	74.6
Charlottesville Western	172.5	174.1	77.8
Northern & Winchester	165.9	162.5	59.1
Roanoke/Alleghany	222.9	246.8	57.1
Southwest	332.2	304.0	116,6
Tidewater	121.5	156.4	58.4
Statewide	175.7	185.2	65.5
Change from Baseline		9.5	-110.2
Percent Change from Baseline		5%	-63%
All Primary Care Providers			
Region	**SFY 2018**	**SFY 2019**	**SFY 2020**
Central	12.6	10.4	10.1
Charlottesville Western	13.7	11.3	10.1
Northern & Winchester	12.8	11.6	12.1
Roanoke/Alleghany	10.8	9.6	7.9
Southwest	21.3	16.3	13.2
Tidewater	11.2	10.4	9.9
Statewide	12.7	10.9	10.4
Change from Baseline		-1.7	-2.2
Percent Change from Baseline		-14%	-18%

Utilization of primary care services

Utilization of primary care services is analyzed using the following measures:

Utilization Measure 1: Volume of services per member.

Measure: Volume of primary care services on a per-member basis by state fiscal year, statewide and by region, and by population type.

Methodology: Identify the volume of primary care services (number of FFS paid claims) from SFY 2018 (baseline) to SFY 2020. Identify the number of members receiving at least one primary care service from SFY 2018 to SFY 2020. Calculate the ratio of primary care services per member. Data is analyzed on a statewide basis, by MLTSS region, and between adult and pediatric populations. This measure identifies trends in primary care service volume.

Data source: MMIS FFS claims, provider, and member data

Results: The figures below illustrate the volume of primary care services per member on a statewide basis and by MLTSS region for the adult and pediatric populations. Between SFY 2018 and 2020, primary care service volume per member decreased by 19% for adult members and by 11% for pediatric members.

Figure 15: Primary Care Service Volume per Member - Adults

Region	SFY 2018	SFY 2019	SFY 2020
Central	7.7	7.1	6.0
Charlottesville Western	8.0	7.5	6.3
Northern & Winchester	6.4	5.5	5.2
Roanoke/Alleghany	7.7	7.1	5.7
Southwest	4.9	4.5	4.4
Tidewater	7.8	7.3	6.4
Statewide	7.1	6.6	5.7
Change from Baseline		-0.5	-1.3
Percent Change from Baseline		-7%	-19%

Figure 16: Primary Care Service Volume per Member - Pediatrics

Region	SFY 2018	SFY 2019	SFY 2020
Central	7.3	7.4	6.3
Charlottesville Western	6.9	6.1	5.4
Northern & Winchester	8.1	8.2	7.3
Roanoke/Alleghany	5.3	5.4	4.3
Southwest	5.2	4.9	3.7
Tidewater	6.5	6.7	6.1
Statewide	6.8	6.8	6.1
Change from Baseline		0.0	-0.7
Percent Change from Baseline		0%	-11%

Utilization Measure 2: Percentage of members utilizing services.

Measure: Percentage of members utilizing primary care services by state fiscal year, statewide and by region, and by population type.

Methodology: Identify the number of members receiving at least one primary care service and divide by the total number of members, from SFY 2018 (baseline) to SFY 2020. Primary care services are defined as services provided by a primary care provider as defined in this plan (primary care physician, FQHC, RHC, or dentist). Data is analyzed on a statewide basis, by MLTSS region, and between adult and pediatric populations. This measure identifies trends in member utilization.

Data source: MMIS FFS claims, provider, and member data

Results: The figures below illustrate the percentage of members that utilized primary care services on a statewide basis and by MLTSS region for the adult and pediatric populations. Between SFY 2018 and 2020, the percentage of members utilizing primary care services decreased by 55% for adult members and increased by 21% for pediatric members.

Figure 17: Percentage of Members Utilizing Primary Care Services - Adults

Region	SFY 2018	SFY 2019	SFY 2020
Central	106%	42%	54%
Charlottesville Western	129%	45%	55%
Northern & Winchester	107%	39%	516%
Roanoke/Alleghany	113%	44%	49%
Southwest	1556%	45%	45%
Tidewater	106%	43%	54%
Statewide	117%	43%	53%
Change from Baseline		-74%	-64%
Percent Change from Baseline		-63%	-55%

Figure 18: Percentage of Members Utilizing Primary Care Services - Pediatrics

Region	SFY 2018	SFY 2019	SFY 2020
Central	169%	155%	218%
Charlottesville Western	158%	143%	180%
Northern & Winchester	185%	168%	236%
Roanoke/Alleghany	158%	146%	160%
Southwest	188%	185%	186%
Tidewater	138%	139%	182%
Statewide	169%	157%	205%
Change from Baseline		-12%	36%
Percent Change from Baseline		-7%	21%

Rate Comparison

This analysis compares Medicaid FFS rates for primary care services to Virginia Medicare rates. Medicare rate data is a readily-available source of other payer reimbursement rates. A rate source for other payers, such as an all-payer database, is not readily available. Rates for primary care physician services are compared for pediatric primary care, pediatric preventative care, and adult primary care. Rates for dental services are not compared at this time due to the unavailability of other payer dental rates; however, the state will continue to study this issue and look for ways to compare Medicaid dental rates to other payers. Rates for FQHCs and RHCs are compared using the average Medicaid per-visit rate, which is compared to the Medicare FQHC prospective payment system (PPS) rate for Virginia and the Medicare RHC per-visit payment limit. It is important to note that a direct comparison of Medicaid and Medicare FQHC/RHC payment rates is difficult because of the differences in reimbursement methodologies and because of the differences between Medicaid and Medicare covered services in the FQHC and RHC setting.

Primary care physician services

DMAS reimburses physicians through a fee schedule that is based on a Resource Based Relative Value Scale (RBRVS) methodology. Under this methodology, each physician service is assigned relative value units (RVUs) that, when applied to a conversion factor, determine the fee schedule payment rate. Virginia's physician fee schedule RVUs are based on the RVUs developed by CMS for the Medicare program, with adjustments for budget neutrality. Each year, DMAS analyzes Medicaid rates as a percentage of Medicare rates for primary care service categories, and results are illustrated in the table below.

Figure 19: Medicaid rates for primary care physician services as a percentage of Medicare rates[6]

Service Category	Percentage of Medicare Rates SFY 2019	SFY 2020	SFY 2021
Pediatric Primary Care	75%	75%	74%
Pediatric Preventive Care	71%	70%	70%
Adult Preventive and Primary Care	66%	69%	69%

In a 2017 study, the Urban Institute, a research organization focusing on economic and social policy, compared Medicaid physician fee schedule rates between states and against Medicare rates. From the data collected in this analysis, the researchers computed a Medicaid fee index and a Medicaid-to-Medicare fee index. The Medicaid fee index expressed the relationship of each state's rates to a national average. The Medicaid-to-Medicare fee index expressed each state's rates to Medicare rates. The table below shows Virginia's indices under these two metrics (data from a 2016 survey). Virginia's primary care physician rates were 1.11 times the national average and 84% of Medicare (above the national average).

Figure 20: Urban Institute 2016 Medicaid fee index and Medicaid-to-Medicare fee index[7]

State	Medicaid Fee Index - Primary Care	Medicaid to Medicare Fee Index - Primary Care
United States	1.00	0.66
Virginia	1.11	0.84

FQHCs and RHCs

DMAS reimburses FQHCs and RHCs on the basis of an alternative payment methodology. Under the alternative payment methodology, FQHCs and RHCs receive a cost-based per-visit rate for patient visits. On an annual basis, a settlement is calculated to ensure providers receive the greater of the alternative payment rate or the payment rate they would have received under a FQHC/RHC prospective payment system (PPS) methodology. Because FQHC/RHC providers receive reimbursement in an amount that is at least equal to payment at a Medicaid PPS payment rate, the state believes that Medicaid reimbursement is sufficient to ensure that members do not experience issues accessing FQHC and RHC services.

For purposes of comparing to Medicare, the table below illustrates the average Medicaid FQHC and RHC payment rate compared to the FQHC Medicare prospective payment system (PPS) rate for Virginia (taking into account the Medicare geographic adjustment factor for Virginia) and the Medicare RHC upper payment limit rate.

[6] DMAS analysis of Medicaid and Medicare reimbursement rates.
[7] Urban Institute. Medicaid Physician Fees after the ACA Primary Care Fee Bump March 5, 2017. Retrieved from https://www.urban.org/research/publication/medicaid-physician-fees-after-aca-primary-care-fee-bump.

Figure 21: FQHC and RHC rate comparison

Medicare FQHC PPS Base Rate for VA	Average Medicaid FQHC Payment Rate	Medicaid to Medicare Percentage
$ 176.45	$ 168.29	95%
Medicare RHC Upper Payment Limit	**Average Medicaid RHC Per-Visit Rate**	**Medicaid to Medicare Percentage**
$ 87.52	$ 83.81	96%

Analysis of Physician Specialist Services

The state's analysis of physician specialist services for the FFS population evaluates access by utilizing the Current Procedural Terminology (CPT) code from MMIS claims data to identify physician specialist services and the providers of those services. For purposes of this analysis, physician specialist services consist of radiology, surgery, and oncology services as defined in the DMAS reimbursement methodology for physician services (refer to the Rate Comparison section below for further details).

Availability of Providers

Provider availability is analyzed using the following measures:

Provider Measure 1: Number of available providers per 1,000 members.

Measure:	Number of available physician specialists per 1,000 members by state fiscal year, statewide, and by region.
Methodology:	Identify available physician specialists from SFY 2018 (baseline) to SFY 2020. Available physician specialists are defined as physicians with at least one Medicaid FFS claim for specialist services during the period analyzed. Identify the number of members receiving at least one specialist service from SFY 2018 to SFY 2020. Calculate the ratio of available physician specialists per 1,000 members. Data is analyzed on a statewide basis and by MLTSS region. For providers with multiple service locations, each service location is counted separately. This measure identifies trends in provider participation.
Data source:	MMIS FFS claims, provider, and member data
Results:	The figure below illustrates the number of available providers per 1,000 members on a statewide basis and by MLTSS region. Total available physician specialists per 1,000 members increased by 96% between SFY 2018 and 2020.

Figure 22: Available Physician Specialists per 1,000 Members

Region	SFY 2018	SFY 2019	SFY 2020
Central	140	195	302
Charlottesville Western	128	178	288
Northern & Winchester	210	267	304
Roanoke/Alleghany	180	254	351
Southwest	56	92	158
Tidewater	141	192	265
Statewide	146	201	286
Change from Baseline		55	140
Percent Change from Baseline		37%	96%

Provider Measure 2: Provider patient load.

Measure: Number of members per available physician specialist by state fiscal year, statewide, and by region.

Methodology: Identify available physician specialists from SFY 2018 (baseline) to SFY 2020. Available physician specialists are defined as physicians with at least one Medicaid FFS claim for specialist services during the period analyzed. Identify the number of members receiving at least one physician specialist service from SFY 2018 to SFY 2020. Calculate the ratio of members per available physician specialist. Data is analyzed on a statewide basis and by MLTSS region. For providers with multiple service locations, each service location is counted separately. This measure identifies trends in patient load (members per provider).

Data source: MMIS FFS claims, provider, and member data

Results: The figure below illustrates the physician specialist patient load on a statewide basis and by MLTSS region. Total physician specialist patient load decreased by 49% between SFY 2018 and 2020.

Figure 23: Physician Specialist Patient Load

Region	SFY 2018	SFY 2019	SFY 2020
Central	7.6	5.4	3.5
Charlottesville Western	9.6	7.1	4.5
Northern & Winchester	5.1	3.8	3.4
Roanoke/Alleghany	7.0	4.9	3.4
Southwest	15.9	10.0	5.8
Tidewater	7.5	5.4	3.9
Statewide	7.3	5.3	3.7
Change from Baseline		-2.0	-3.6
Percent Change from Baseline		-28%	-49%

Utilization of physician specialist services

Utilization of physician specialist services is analyzed using the following measures:

Utilization Measure 1: Volume of services per member.

Measure: Volume of physician specialist services on a per-member basis by state fiscal year, statewide and by region, and by population type.

Methodology: Identify the volume of physician specialist services (number of FFS paid claims) from SFY 2018 (baseline) to SFY 2020. Identify the number of members receiving at least one specialist service from SFY 2018 to SFY 2020. Calculate the ratio of physician specialist services per member. Data is analyzed on a statewide basis, by MLTSS region, and between adult and pediatric populations. This measure identifies trends in physician specialist service volume.

Data source: MMIS FFS claims, provider, and member data

Results: The figures below illustrate the volume of physician specialist services per member on a statewide basis and by MLTSS region for the adult and pediatric populations. Between SFY 2018 and 2020, physician specialist service volume per member decreased by 18% for adult members and increased by 11% for pediatric members.

Figure 24: Physician Specialist Service Volume per Member - Adults

Region	SFY 2018	SFY 2019	SFY 2020
Central	4.8	4.4	4.0
Charlottesville Western	5.3	5.1	4.4
Northern & Winchester	3.9	3.2	3.0
Roanoke/Alleghany	5.1	4.3	3.6
Southwest	2.2	2.0	2.1
Tidewater	4.1	3.6	3.6
Statewide	4.3	3.8	3.5
Change from Baseline		-0.4	-0.8
Percent Change from Baseline		-10%	-18%

Figure 25: Physician Specialist Service Volume per Member - Pediatrics

Region	SFY 2018	SFY 2019	SFY 2020
Central	3.3	3.6	3.8
Charlottesville Western	5.8	5.7	6.2
Northern & Winchester	3.1	3.4	3.9
Roanoke/Alleghany	3.1	3.2	3.2
Southwest	1.9	2.1	2.5
Tidewater	3.2	3.6	2.9
Statewide	3.4	3.6	3.7
Change from Baseline		0.3	0.4
Percent Change from Baseline		7%	11%

Utilization Measure 2: Percentage of members utilizing services.

Measure: Percentage of members utilizing physician specialist services by state fiscal year, statewide and by region, and by population type.

Methodology: Identify the number of members receiving at least one physician specialist service and divide by the total number of members, from SFY 2018 (baseline) to SFY 2020. Data is analyzed on a statewide basis, by MLTSS region, and between adult and pediatric populations. This measure identifies trends in member utilization.

Data source: MMIS FFS claims and member data

Results: The figures below illustrate the percentage of members that utilized physician specialist services on a statewide basis and by MLTSS region for the adult and pediatric populations. Between SFY 2018 and 2020, the percentage of members utilizing physician specialist services decreased by 33% for adult members and 12% for pediatric members.

Figure 26: Percentage of Members Utilizing Physician Specialist Services - Adults

Region	SFY 2018	SFY 2019	SFY 2020
Central	19%	6%	4%
Charlottesville Western	19%	6%	4%
Northern & Winchester	16%	5%	5%
Roanoke/Alleghany	20%	6%	4%
Southwest	20%	5%	2%
Tidewater	17%	5%	4%
Statewide	19%	6%	4%
Change from Baseline		-13%	-15%
Percent Change from Baseline		-69%	-79%

Figure 27: Percentage of Members Utilizing Physician Specialist Services - Pediatrics

Region	SFY 2018	SFY 2019	SFY 2020
Central	12%	10%	9%
Charlottesville Western	12%	10%	8%
Northern & Winchester	10%	8%	8%
Roanoke/Alleghany	13%	9%	9%
Southwest	12%	10%	8%
Tidewater	9%	8%	7%
Statewide	11%	9%	8%
Change from Baseline		-2%	-3%
Percent Change from Baseline		-19%	-26%

Rate Comparison

This analysis compares Medicaid FFS rates for physician specialist services to Medicare rates. Medicare rate data is a readily-available source of other payer reimbursement rates. A rate source for other payers, such as an all-payer database, is not readily available.

DMAS reimburses physicians through a fee schedule that is based on a Resource Based Relative Value Scale (RBRVS) methodology. Under this methodology, each physician service is assigned relative value units (RVUs) that, when applied to a conversion factor, determine the fee schedule payment rate. Virginia's physician fee schedule RVUs are based on the RVUs developed by CMS for the Medicare program, with adjustments for budget neutrality. For SFY 2020, the state's analysis of Medicaid rates as a percentage of Medicare rates for physician specialist services are illustrated in the table below.

Figure 28: Medicaid physician specialist rates as a percentage of Medicare rates

Service Category	% of Medicare
Physician specialist services	
Radiology	81%
Surgery	82%
Oncology and Nuclear Medicine	81%

Analysis of Behavioral Health Services

The state's analysis of behavioral health services for the FFS population evaluates access by utilizing the Current Procedural Terminology (CPT) code from MMIS claims data to identify behavioral health services and the practitioners of those services (e.g., psychiatrists, psychologists, etc.). This analysis is based on the definition of behavioral health services from the DMAS reimbursement methodology for practitioner services (refer to the Rate Comparison section below for further details).

Availability of Providers

Provider availability is analyzed using the following measures:

Provider Measure 1: Number of available providers per 1,000 members.

Measure: Number of available behavioral health practitioners per 1,000 members by state fiscal year, statewide, and by region.

Methodology: Identify available behavioral health practitioners from SFY 2018 (baseline) to SFY 2020. Available behavioral health practitioners are defined as practitioners with at least one Medicaid FFS claim or Administrative Services Only (ASO) contract encounter for behavioral health services during the period analyzed. Identify the number of members receiving at least one behavioral health service from SFY 2018 to SFY 2020. Calculate the ratio of available behavioral health practitioners per 1,000 members. Data is analyzed on a statewide basis and by MLTSS region. For providers with multiple service locations, each service location is counted separately. This measure identifies trends in provider participation.

Data source: MMIS FFS claims, provider, and member data

Results: The figure below illustrates the number of available providers per 1,000 members on a statewide basis and by MLTSS region. Total available behavioral health practitioners per 1,000 members increased by 2% between SFY 2018 and 2020.

Figure 29: Available Behavioral Health Practitioners per 1,000 Members

Region	SFY 2018	SFY 2019	SFY 2020
Central	365	400	417
Charlottesville Western	338	381	377
Northern & Winchester	405	435	404
Roanoke/Alleghany	318	390	325
Southwest	260	274	203
Tidewater	335	340	296
Statewide	336	367	345
Change from Baseline		30	8
Percent Change from Baseline		9%	2%

Provider Measure 2: Provider patient load.

Measure: Number of members per available behavioral health practitioner by state fiscal year, statewide, and by region.

Methodology: Identify available behavioral health practitioners from SFY 2018 (baseline) to SFY 2020. Available behavioral health practitioners are defined as practitioners with at least one Medicaid FFS claim or ASO

encounter for behavioral health services during the period analyzed. Identify the number of members receiving at least one behavioral health service from SFY 2018 to SFY 2020. Calculate the ratio of members per available behavioral health practitioner. Data is analyzed on a statewide basis and by MLTSS region. For providers with multiple service locations, each service location is counted separately. This measure identifies trends in patient load (members per provider).

Data source: MMIS FFS claims, provider, and member data

Results: The figure below illustrates the behavioral health practitioner patient load on a statewide basis and by MLTSS region. Total behavioral health practitioner patient load decreased by 2% between SFY 2018 and 2020.

Figure 30: Behavioral Health Practitioner Patient Load

Region	SFY 2018	SFY 2019	SFY 2020
Central	3.5	2.9	2.9
Charlottesville Western	2.9	2.7	2.6
Northern & Winchester	2.5	2.4	2.7
Roanoke/Alleghany	3.0	2.6	3.1
Southwest	3.7	3.5	4.5
Tidewater	3.0	3.1	3.4
Statewide	3.1	2.8	3.0
Change from Baseline		-0.2	-0.1
Percent Change from Baseline		-8%	-2%

Utilization of behavioral health services

Utilization of behavioral health services is analyzed using the following measures:

Utilization Measure 1: Volume of services per member.

Measure: Volume of behavioral health services on a per-member basis by state fiscal year, statewide and by region, and by population type.

Methodology: Identify the volume of behavioral health services (number of FFS paid claims) from SFY 2018 (baseline) to SFY 2020. Identify the number of members receiving at least one behavioral health service from SFY 2018 to SFY 20205. Calculate the ratio of behavioral health services per member. Data is analyzed on a statewide basis, by MLTSS region, and between adult and pediatric populations. This measure identifies trends in behavioral health service volume.

Data source: MMIS FFS claims, provider, and member data

Results: The figures below illustrate the volume of behavioral health services per member on a statewide basis and by MLTSS region for the adult and pediatric populations. Between SFY 2018 and 2020, behavioral health

service volume per member increased by 154% for adult members and increased by 25% for pediatric members.

Figure 31: Behavioral Health Service Volume per Member - Adults

Region	SFY 2018	SFY 2019	SFY 2020
Central	5.7	6.3	11.7
Charlottesville Western	4.7	7.5	11.1
Northern & Winchester	12.7	20.5	31.0
Roanoke/Alleghany	6.5	8.4	14.6
Southwest	4.0	3.7	13.0
Tidewater	5.7	10.8	17.1
Statewide	6.4	9.1	16.3
Change from Baseline		2.7	9.9
Percent Change from Baseline		42%	154%

Figure 32: Behavioral Health Service Volume per Member - Pediatrics

Region	SFY 2018	SFY 2019	SFY 2020
Central	10.3	12.8	12.7
Charlottesville Western	6.3	8.8	6.5
Northern & Winchester	7.0	6.7	8.4
Roanoke/Alleghany	4.7	8.5	6.8
Southwest	4.7	5.3	9.4
Tidewater	8.2	10.1	9.2
Statewide	7.3	9.2	9.1
Change from Baseline		1.9	1.8
Percent Change from Baseline		26%	25%

Utilization Measure 2: Percentage of members utilizing services.

Measure: Percentage of members utilizing behavioral health services by state fiscal year, statewide and by region, and by population type.

Methodology: Identify the number of members receiving at least one behavioral health service and divide by the total number of members, from SFY 2018 (baseline) to SFY 2020. Data is analyzed on a statewide basis, by MLTSS region, and between adult and pediatric populations. This measure identifies trends in member utilization.

Data source: MMIS FFS claims and member data

Results: The figures below illustrate the percentage of members that utilized behavioral health services on a statewide basis and by MLTSS region for the adult and pediatric populations. Between SFY 2018 and 2020, the percentage of members utilizing behavioral health services decreased by 75% for adult members and 28% for pediatric members.

Figure 33: Percentage of Members Utilizing Behavioral Health Services - Adults

Region	SFY 2018	SFY 2019	SFY 2020
Central	4%	1%	1%
Charlottesville Western	5%	2%	1%
Northern & Winchester	4%	1%	1%
Roanoke/Alleghany	5%	2%	1%
Southwest	6%	2%	2%
Tidewater	4%	1%	1%
Statewide	4%	1%	1%
Change from Baseline		-3%	-3%
Percent Change from Baseline		-69%	-75%

Figure 34: Percentage of Members Utilizing Behavioral Health Services - Pediatrics

Region	SFY 2018	SFY 2019	SFY 2020
Central	5%	4%	4%
Charlottesville Western	7%	5%	5%
Northern & Winchester	4%	3%	2%
Roanoke/Alleghany	6%	4%	4%
Southwest	6%	6%	6%
Tidewater	5%	4%	4%
Statewide	5%	4%	4%
Change from Baseline		-1%	-1%
Percent Change from Baseline		-24%	-28%

Rate Comparison

This analysis compares Medicaid FFS rates for behavioral health practitioner services to Medicare rates. Medicare rate data is a readily-available source of other payer reimbursement rates. A rate source for other payers, such as an all-payer database, is not readily available.

DMAS reimburses behavioral health practitioners through a fee schedule that is based on a Resource Based Relative Value Scale (RBRVS) methodology. Under this methodology, each service is assigned relative value units (RVUs) that, when applied to a conversion factor, determine the fee schedule payment rate. Virginia's physician fee schedule RVUs are based on the RVUs developed by CMS for the Medicare program, with adjustments for budget neutrality. For SFY 2020, the state's analysis of Medicaid rates as a percentage of Medicare rates for behavioral health services are illustrated in the table below.

Figure 35: Medicaid behavioral health services rates as a percentage of Medicare rates

Service Category	% of Medicare
Behavioral health services	94%

Analysis of Pre- and Post-natal Obstetric Services

The state's analysis of pre- and post-natal obstetric services for the FFS population evaluates access by utilizing the Current Procedural Terminology (CPT) code from MMIS claims data to identify obstetric services and the practitioners of those services, such as obstetricians. This analysis is based on the definition of obstetric services from the DMAS reimbursement methodology for practitioner services (refer to the Rate Comparison section below for further details).

Availability of Providers

Provider availability is analyzed using the following measures:

Provider Measure 1: Number of available providers per 1,000 members.

Measure: Number of available obstetric practitioners per 1,000 members by state fiscal year, statewide, and by region.

Methodology: Identify available obstetric practitioners from SFY 2018 (baseline) to SFY 2020. Available obstetric practitioners are defined as practitioners with at least one Medicaid FFS claim for obstetric services during the period analyzed. Identify the number of members receiving at least one obstetric service from SFY 2018 to SFY 2020. Calculate the ratio of available obstetric practitioners per 1,000 members. Member data for this analysis is limited to females over the age of 11. Data is analyzed on a statewide basis and by MLTSS region. For providers with multiple service locations, each service location is counted separately. This measure identifies trends in provider participation.

Data source: MMIS FFS claims, provider, and member data

Results: The figure below illustrates the number of available providers per 1,000 members on a statewide basis and by MLTSS region. Total available obstetric practitioners per 1,000 members increased by 103% between SFY 2018 and 2020.

Figure 36: Available Obstetric Practitioners per 1,000 Members

Region	SFY 2018	SFY 2019	SFY 2020
Central	48	66	109
Charlottesville Western	32	44	74
Northern & Winchester	50	64	80
Roanoke/Alleghany	71	92	149
Southwest	53	46	90
Tidewater	40	53	86
Statewide	46	60	93
Change from Baseline		14	47
Percent Change from Baseline		32%	103%

Provider Measure 2: Provider patient load.

Measure: Number of members per available obstetric practitioner by state fiscal year, statewide, and by region.

Methodology: Identify available obstetric practitioners from SFY 2018 (baseline) to SFY 2020. Available obstetric practitioners are defined as practitioners with at least one Medicaid FFS claim for obstetric services during the period analyzed. Identify the number of members receiving at least one obstetric service from SFY 2018 to SFY 2020. Calculate the ratio of members per available obstetric practitioner. Member data for this analysis is limited to females over the age of 11. Data is analyzed on a statewide basis and by MLTSS region. For providers with multiple service locations, each service location is counted separately. This measure identifies trends in patient load (members per provider).

Data source: MMIS FFS claims, provider, and member data

Results: The figure below illustrates the obstetric practitioner patient load on a statewide basis and by MLTSS region. Total obstetric practitioner patient load decreased by 51% between SFY 2018 and 2020.

Figure 37: Obstetric Practitioner Patient Load

Region	SFY 2018	SFY 2019	SFY 2020
Central	21.7	15.7	9.8
Charlottesville Western	34.5	25.4	14.8
Northern & Winchester	20.4	15.7	12.6
Roanoke/Alleghany	15.6	11.7	7.0
Southwest	15.9	17.8	9.2
Tidewater	25.8	19.6	11.8
Statewide	22.2	16.8	10.9
Change from Baseline		-5.4	-11.3
Percent Change from Baseline		-24%	-51%

Utilization of obstetric services

Utilization of obstetric services is analyzed using the following measures:

Utilization Measure 1: Volume of services per member.

Measure: Volume of obstetric services on a per-member basis by state fiscal year, statewide and by region, and by population type.

Methodology: Identify the volume of obstetric services (number of FFS paid claims) from SFY 2018 (baseline) to SFY 2020. Identify the number of members receiving at least one obstetric service from SFY 2018 to SFY 2020.

Calculate the ratio of obstetric services per member. Member data for this analysis is limited to females over the age of 11. Data is analyzed on a statewide basis, by MLTSS region, and between adult and pediatric populations. This measure identifies trends in obstetric service volume.

Data source: MMIS FFS claims, provider, and member data

Results: The figures below illustrate the volume of obstetric services per member on a statewide basis and by MLTSS region for the adult and pediatric populations. Between SFY 2018 and 2020, obstetric service volume per member decreased by 14% for adult members and 5% for pediatric members.

Figure 38: Obstetric Service Volume per Member - Adults

Region	SFY 2018	SFY 2019	SFY 2020
Central	3.2	2.7	2.8
Charlottesville Western	3.8	3.3	3.2
Northern & Winchester	2.6	2.5	2.5
Roanoke/Alleghany	3.4	3.0	2.9
Southwest	2.2	1.9	1.8
Tidewater	3.9	3.2	3.1
Statewide	3.8	2.8	2.7
Change from Baseline		-0.4	-0.5
Percent Change from Baseline		-13%	-14%

Figure 39: Obstetric Service Volume per Member - Pediatrics

Region	SFY 2018	SFY 2019	SFY 2020
Central	2.4	2.4	2.3
Charlottesville Western	2.7	2.8	2.6
Northern & Winchester	2.0	1.8	1.9
Roanoke/Alleghany	3.9	3.0	3.2
Southwest	1.8	1.5	1.4
Tidewater	2.5	2.7	2.7
Statewide	2.5	2.4	2.3
Change from Baseline		-0.1	-0.1
Percent Change from Baseline		5%	-5%

Utilization Measure 2: Percentage of members utilizing services.

Measure: Percentage of members utilizing obstetric services by state fiscal year, statewide and by region, and by population type.

Methodology: Identify the number of members receiving at least one obstetric service and divide by the total number of members, from SFY 2018 (baseline) to SFY 2020. Member data for this analysis is limited to females over the age of 11. Data is analyzed on a statewide basis, by MLTSS region, and

between adult and pediatric populations. This measure identifies trends in member utilization.

Data source: MMIS FFS claims and member data

Results: The figures below illustrate the percentage of members that utilized obstetric services on a statewide basis and by MLTSS region for the adult and pediatric populations. Between SFY 2018 and 2020, the percentage of members utilizing obstetric services decreased by 68% for adult members and 22% for pediatric members.

Figure 40: Percentage of Members Utilizing Obstetric Services - Adults

Region	SFY 2018	SFY 2019	SFY 2020
Central	22%	8%	7%
Charlottesville Western	16%	6%	4%
Northern & Winchester	22%	9%	10%
Roanoke/Alleghany	15%	6%	4%
Southwest	9%	3%	2%
Tidewater	22%	8%	6%
Statewide	20%	7%	6%
Change from Baseline		-12%	-14%
Percent Change from Baseline		-62%	-68%

Figure 41: Percentage of Members Utilizing Obstetric Services - Pediatrics

Region	SFY 2018	SFY 2019	SFY 2020
Central	4%	3%	3%
Charlottesville Western	4%	3%	2%
Northern & Winchester	2%	2%	3%
Roanoke/Alleghany	3%	3%	2%
Southwest	1%	1%	1%
Tidewater	4%	3%	3%
Statewide	3%	3%	3%
Change from Baseline		-1%	-1%
Percent Change from Baseline		-19%	-22%

Rate Comparison

This analysis compares Medicaid FFS rates for obstetric practitioner services to Medicare rates. Medicare rate data is a readily-available source of other payer reimbursement rates. A rate source for other payers, such as an all-payer database, is not readily available.

DMAS reimburses obstetric practitioners through a fee schedule that is based on a Resource Based Relative Value Scale (RBRVS) methodology. Under this methodology, each service is assigned relative value units (RVUs) that, when applied to a conversion factor, determine the

fee schedule payment rate. Virginia's physician fee schedule RVUs are based on the RVUs developed by CMS for the Medicare program, with adjustments for budget neutrality. For SFY 2021, the state's analysis of Medicaid rates a percentage of Medicare rates for obstetric services are illustrated in the table below.

Figure 42: Medicaid obstetric services rates as a percentage of Medicare rates[8]

Service Category	Percentage of Medicare Rates SFY 2019	SFY 2020	SFY 2021
Obstetric services	87%	87%	86%

In a 2017 study, the Urban Institute, a research organization focusing on economic and social policy, compared Medicaid physician fee schedule rates between states and against Medicare rates. From the data collected in this analysis, the researchers computed a Medicaid fee index and a Medicaid-to-Medicare fee index. The Medicaid fee index expressed the relationship of each state's rates to a national average. The Medicaid-to-Medicare fee index expressed each state's rates to Medicare rates. The table below shows Virginia's indices under these two metrics (data from 2016). Virginia's rates for obstetric care were 1.08 times the national average and 103% of Medicare (above the national average).

Figure 43: Urban Institute 2016 Medicaid fee index and Medicaid-to-Medicare fee index[9]

State	Medicaid Fee Index - Obstetric Care	Medicaid to Medicare Fee Index - Obstetric Care
United States	1.00	0.81
Virginia	1.08	1.03

Analysis of Home Health Services

The state's analysis of home health services for the FFS population evaluates access to services provided by home health agency (HHA) providers.

Availability of Providers

Provider availability is analyzed using the following measures:

Provider Measure 1: Number of available providers per 100 members.

[8] DMAS analysis of Medicaid and Medicare reimbursement rates.
[9] Urban Institute. Medicaid Physician Fees after the ACA Primary Care Fee Bump March 5, 2017. Retrieved from https://www.urban.org/research/publication/medicaid-physician-fees-after-aca-primary-care-fee-bump.

Measure: Number of available HHA providers per 100 members by state fiscal year, statewide, and by region.

Methodology: Identify available HHA providers from SFY 2018 (baseline) to SFY 2020. Available HHA providers are defined as HHA providers with at least one Medicaid FFS claim during the period analyzed. Identify the number of members receiving at least one HHA service from SFY 2018 to SFY 2020. Calculate the ratio of available HHA providers per 1,000 members. Data is analyzed on a statewide basis and by MLTSS region. For providers with multiple service locations, each service location is counted separately. This measure identifies trends in provider participation.

Data source: MMIS FFS claims, provider, and member data

Results: The figure below illustrates the number of available providers per 100 members on a statewide basis and by MLTSS region. Total available HHA providers per 1,000 members increased by 103% between SFY 2018 and 2020.

Figure 44: Available HHA Providers per 1,000 Members

Region	SFY 2018	SFY 2019	SFY 2020
Central	8	10	14
Charlottesville Western	7	9	15
Northern & Winchester	18	24	37
Roanoke/Alleghany	7	6	18
Southwest	17	31	111
Tidewater	8	13	13
Statewide	9	12	18
Change from Baseline		3	9
Percent Change from Baseline		32%	103%

Provider Measure 2: Provider patient load.

Measure: Number of members per available HHA provider by state fiscal year, statewide, and by region.

Methodology: Identify available HHA providers from SFY 2018 (baseline) to SFY 2020. Available HHA providers are defined as HHA providers with at least one Medicaid FFS claim during the period analyzed. Identify the number of members receiving at least one HHA service from SFY 2018 to SFY 2020. Calculate the ratio of members per available HHA provider. Data is analyzed on a statewide basis and by MLTSS region. For providers with multiple service locations, each service location is counted separately. This measure identifies trends in patient load (members per provider).

Data source: MMIS FFS claims, provider, and member data

Results: The figure below illustrates HHA provider patient load on a statewide basis and by MLTSS region. Total HHA provider patient load decreased by 51% between SFY 2018 and 2020.

Figure 45: HHA Provider Patient Load

Region	SFY 2018	SFY 2019	SFY 2020
Central	12.2	9.9	7.0
Charlottesville Western	14.7	11.6	7.1
Northern & Winchester	5.0	3.6	2.3
Roanoke/Alleghany	15.9	16.0	5.6
Southwest	5.6	3.2	1.1
Tidewater	14.7	8.5	7.6
Statewide	11.1	8.4	5.4
Change from Baseline		-2.7	-5.7
Percent Change from Baseline		-25%	-51%

Utilization of home health services

Utilization of home health services is analyzed using the following measures:

Utilization Measure 1: Volume of services per member.

Measure: Volume of HHA services on a per-member basis by state fiscal year, statewide and by region, and by population type.

Methodology: Identify the volume of HHA services (number of FFS paid claims) from SFY 2018 (baseline) to SFY 2020. Identify the number of members receiving at least one HHA service from SFY 2018 to SFY 2020. Calculate the ratio of HHA services per member. Data is analyzed on a statewide basis, by MLTSS region, and between adult and pediatric populations. This measure identifies trends in home health service volume.

Data source: MMIS FFS claims, provider, and member data

Results: The figures below illustrate the volume of HHA services per member on a statewide basis and by MLTSS region for the adult and pediatric populations. Between SFY 2018 and 2020, HHA service volume per member decreased by 29% for adult members and increased by 46% for pediatric members.

Figure 46: HHA Service Volume per Member - Adults

Region	SFY 2018	SFY 2019	SFY 2020
Central	3.9	3.1	2.6
Charlottesville Western	2.9	2.6	3.0
Northern & Winchester	3.3	3.0	1.9
Roanoke/Alleghany	7.3	5.3	5.0
Southwest	3.54	3.6	5.3
Tidewater	5.4	5.1	3.4
Statewide	4.6	4.0	3.3
Change from Baseline		-0.7	-1.3
Percent Change from Baseline		-14%	-29%

Figure 47: HHA Service Volume per Member - Pediatrics

Region	SFY 2018	SFY 2019	SFY 2020
Central	2.3	2.2	1.7
Charlottesville Western	2.0	1.5	1.1
Northern & Winchester	0.7	2.0	4.0
Roanoke/Alleghany	10.7	3.5	2.2
Southwest	0.3	0.0	0.0
Tidewater	2.0	2.6	2.3
Statewide	3.3	2.2	1.8
Change from Baseline		-1.1	-1.5
Percent Change from Baseline		-34%	-46%

Utilization Measure 2: Percentage of members utilizing services.

Measure: Percentage of members utilizing HHA services by state fiscal year, statewide and by region, and by population type.

Methodology: Identify the number of members receiving at least one HHA service and divide by the total number of members, from SFY 2018 (baseline) to SFY 2020. Data is analyzed on a statewide basis, by MLTSS region, and between adult and pediatric populations. This measure identifies trends in member utilization.

Data source: MMIS FFS claims and member data

Results: The figures below illustrate the percentage of members that utilized HHA services on a statewide basis and by MLTSS region for the adult and pediatric populations. Between SFY 2018 and 2020, the percentage of members utilizing HHA services decreased by 86.7% for adult members and 6.3% for pediatric members.

Figure 48: Percentage of Members Utilizing HHA Services - Adults

Region	SFY 2018	SFY 2019	SFY 2020
Central	0.5%	0.1%	0.1%
Charlottesville Western	0.7%	0.2%	0.1%
Northern & Winchester	0.3%	0.1%	0.0%
Roanoke/Alleghany	1.0%	0.3%	0.1%
Southwest	1.0%	0.2%	0.1%
Tidewater	0.9%	0.2%	0.2%
Statewide	0.7%	-0.2%	0.1%
Change from Baseline		-0.5%	-0.6%
Percent Change from Baseline		-74.0%	-86.7%

Figure 49: Percentage of Members Utilizing HHA Services - Pediatrics

Region	SFY 2018	SFY 2019	SFY 2020
Central	0.3%	0.4%	0.5%
Charlottesville Western	0.2%	0.2%	0.2%
Northern & Winchester	0.1%	0.0%	0.0%
Roanoke/Alleghany	0.2%	0.1%	0.1%
Southwest	0.1%	0.0%	0.0%
Tidewater	0.1%	0.1%	0.0%
Statewide	0.2%	0.2%	0.2%
Change from Baseline		0.0%	0.0%
Percent Change from Baseline		-11.9%	-6.3%

Rate Comparison

This analysis compares Medicaid FFS HHA rates to Medicare HHA rates. Medicare rate data is a readily-available source of other payer reimbursement rates. A rate source for other payers, such as an all-payer database, is not readily available.

A direct rate comparison for home health services is difficult because of the differences between the Medicare and Virginia Medicaid reimbursement methodologies. Under Medicare's reimbursement system, HHAs are reimbursed through a 60-day episode rate, whereas under the Virginia Medicaid reimbursement methodology, payment is made through per-visit rates. However, the Medicare methodology does contain per-visit rates for low utilization episodes, which are defined as episodes with four or fewer visits. The rate comparison below utilizes the calendar year 2021 Medicare low-utilization per-visit rates for HHAs submitting quality data compared to the 7/1/2020 effective Medicaid per-visit rates by HHA discipline. The Medicaid reimbursement methodology contains separate rates for the initial assessment, follow-up, and comprehensive visits for certain disciplines. Furthermore, the Medicaid rates are different for the three HHA peer groups in Virginia. The HHA peer groups are the Virginia Department of Health HHAs (VDOH), non-Department of Health HHAs in northern Virginia (NOVA), and non-

Department of Health HHAs in the rest of the state. The various Medicaid rate segments are compared to Medicare by discipline in the figure below.

Figure 50: HHA rate comparison

Medicaid HHA Assessment Rates				
Discipline	**Peer Group**	**Medicare Rate**	**Medicaid Rate**	**Medicaid to Medicare Percentage**
Skilled Nursing	VDOH	$152.63	$165.58	108%
	NOVA	$152.63	$162.42	106%
	Rest of State	$152.63	$126.64	83%
Physical Therapy	VDOH	$166.83	$155.67	93%
	NOVA	$166.83	$141.50	85%
	Rest of State	$166.83	$148.57	89%
Occupational Therapy	VDOH	$167.98	$159.96	95%
	NOVA	$167.98	$138.72	83%
	Rest of State	$167.98	$141.64	84%
Speech Therapy	VDOH	$181.34	$167.60	92%
	NOVA	$181.34	$150.49	83%
	Rest of State	$181.34	$134.14	74%
Medicaid HHA Follow-Up Rates				
Discipline	**Peer Group**	**Medicare Rate**	**Medicaid Rate**	**Medicaid to Medicare Percentage**
Skilled Nursing	VDOH	$134.42	$150.58	112%
	NOVA	$134.42	$147.42	110%
	Rest of State	$134.42	$111.64	83%
Physical Therapy	VDOH	$146.95	$140.67	96%
	NOVA	$146.95	$126.50	86%
	Rest of State	$146.95	$133.57	91%
Occupational Therapy	VDOH	$147.95	$144.96	98%
	NOVA	$147.95	$123.72	84%
	Rest of State	$147.95	$126.64	86%
Speech Therapy	VDOH	$159.71	$152.60	96%
	NOVA	$159.71	$135.49	85%
	Rest of State	$159.71	$119.14	75%
Medicaid HHA Comprehensive Rates				
Discipline	**Peer Group**	**Medicare Rate**	**Medicaid Rate**	**Medicaid to Medicare Percentage**
Skilled Nursing	VDOH	$134.42	$275.91	205%
	NOVA	$134.42	$270.16	201%
	Rest of State	$134.42	$204.58	152%
Home Health Aid	VDOH	$69.11	$85.45	124%
	NOVA	$69.11	$98.56	143%

Analysis of Telemedicine Services

The state's analysis of telemedicine services for the FFS population evaluates access to services provided by telemedicine providers.

Availability of Providers

Provider availability is analyzed using the following measures:

Provider Measure 1: Number of available providers per 1000 members.

Measure: Number of available telemedicine providers per 1000 members by state fiscal year, statewide, and by region.

Methodology: Identify available telemedicine providers from SFY 2018 (baseline) to SFY 2020. Available telemedicine providers are defined as providers with at least one Medicaid FFS telemedicine claim during the period analyzed. Identify the number of members receiving at least one telemedicine service from SFY 2018 to SFY 2020. Calculate the ratio of available telemedicine providers per 1,000 members. Data is analyzed on a statewide basis and by MLTSS region. For providers with multiple service locations, each service location is counted separately. This measure identifies trends in provider participation.

Data source: MMIS FFS claims, provider, and member data

Results: The figure below illustrates the number of available providers per 1000 members on a statewide basis and by MLTSS region. Total available telemedicine providers per 1,000 members increased by 106% between SFY 2018 and 2020.

Figure 51: Available Telemedicine Providers per 1,000 Members

Region	SFY 2018	SFY 2019	SFY 2020
Central	104	188	353
Charlottesville Western	309	353	393
Northern & Winchester	93	167	273
Roanoke/Alleghany	149	262	339
Southwest	162	500	112
Tidewater	235	125	400
Statewide	152	265	313
Change from Baseline		113	161
Percent Change from Baseline		74%	106%

Provider Measure 2: Provider patient load.

Measure: Number of members per available telemedicine provider by state fiscal year, statewide, and by region.

Methodology: Identify available telemedicine providers from SFY 2018 (baseline) to SFY 2020. Available telemedicine providers are defined as providers with at least one Medicaid FFS telemedicine claim during the period analyzed. Identify the number of members receiving at least one telemedicine service from SFY 2018 to SFY 2020. Calculate the ratio of members per available telemedicine provider. Data is analyzed on a statewide basis and by MLTSS region. For providers with multiple service locations, each service location is counted separately. This measure identifies trends in patient load (members per provider).

Data source: MMIS FFS claims, provider, and member data

Results: The figure below illustrates telemedicine provider patient load on a statewide basis and by MLTSS region. Total telemedicine provider patient load decreased by 53% between SFY 2018 and 2020.

Figure 52: Telemedicine Provider Patient Load

Region	SFY 2018	SFY 2019	SFY 2020
Central	5.8	3.9	2.8
Charlottesville Western	4.4	4.2	3.5
Northern & Winchester	5.9	5.3	3.6
Roanoke/Alleghany	10.5	5.1	2.8
Southwest	7.2	2.4	8.4
Tidewater	3.1	3.0	2.6
Statewide	6.9	3.9	3.2
Change from Baseline		-3.0	-3.6
Percent Change from Baseline		-44%	-53%

Utilization of telemedicine services

Utilization of telemedicine services is analyzed using the following measures:

Utilization Measure 1: Volume of services per member.

Measure: Volume of telemedicine services on a per-member basis by state fiscal year, statewide and by region, and by population type.

Methodology: Identify the volume of telemedicine services (number of FFS paid claims) from SFY 2018 (baseline) to SFY 2020. Identify the number of members receiving at least one telemedicine service from SFY 2018 to SFY 2020. Calculate the ratio of telemedicine services per member. Data is analyzed on a statewide basis, by MLTSS region, and between adult and

pediatric populations. This measure identifies trends in home health service volume.

Data source: MMIS FFS claims, provider, and member data

Results: The figures below illustrate the volume of telemedicine services per member on a statewide basis and by MLTSS region for the adult and pediatric populations. Between SFY 2018 and 2020, telemedicine service volume per member decreased by 18% for adult members and increased by 88% for pediatric members.

Figure 53: Telemedicine Service Volume per Member - Adults

Region	SFY 2018	SFY 2019	SFY 2020
Central	1.2	1.8	1.6
Charlottesville Western	3.0	1.9	1.6
Northern & Winchester	1.4	1.3	1.9
Roanoke/Alleghany	2.9	2.2	1.7
Southwest	1.5	2.1	1.7
Tidewater	1.1	0.5	1.2
Statewide	1.9	1.9	1.6
Change from Baseline		0.0	-0.3
Percent Change from Baseline		-2%	-18%

Figure 54: Telemedicine Service Volume per Member - Pediatrics

Region	SFY 2018	SFY 2019	SFY 2020
Central	0.2	0.4	3.5
Charlottesville Western	1.3	4.0	9.8
Northern & Winchester	0.2	2.7	2.7
Roanoke/Alleghany	11.4	14.0	6.1
Southwest	4.0	0.8	10.2
Tidewater	0.1	0.0	3.8
Statewide	2.6	2.3	4.9
Change from Baseline		-0.2	2.3
Percent Change from Baseline		-9%	88%

Procedures for Rate Reductions or Restructurings

Federal regulations for Medicaid access to care contain special provisions for analyzing access to care when Medicaid reimbursement rates are reduced, or when rates are restructured in such a manner that access could be diminished. In these instances, states must ensure that an analysis of access has been conducted on the impacted services within 12 months prior to submitting a state plan amendment to CMS to reduce or restructure reimbursement rates. The state's access monitoring review plan must continue to monitor access for the impacted services on an annual basis for a period of at least 3 years after the implementation of the reduced or restructured rates.

DMAS plans to modify the reimbursement methodology for inpatient hospital services and outpatient hospital services, specialized care, and outpatient rehabilitation to incorporate an inflationary rate adjustment.

In accordance with federal requirements, these services are included in the access monitoring plan and will be reviewed at least annually for not less than a 3 year period. The sections below contain the analysis for inpatient hospital and outpatient hospital.

Analysis of Inpatient Hospital Services

The state's analysis of inpatient hospital services for the FFS population evaluates access to inpatient services provided by hospital providers.

Availability of Providers

Provider availability is analyzed using the following measures:

Provider Measure 1: Number of available providers per 1,000 members.

Measure:	Number of available inpatient hospital providers per 1,000 members by state fiscal year, statewide, and by region.
Methodology:	Identify available inpatient hospital providers from SFY 2018 (baseline) to SFY 2020. Available inpatient hospital providers are defined as hospital providers with at least one Medicaid FFS inpatient claim during the period analyzed. Identify the number of members receiving at least one inpatient hospital service from SFY 2018 to SFY 2020. Calculate the ratio of available inpatient hospital providers per 1,000 members. Data is analyzed on a statewide basis and by MLTSS region. For providers with multiple service locations, each service location is counted separately. This measure identifies trends in provider participation.
Data source:	MMIS FFS claims, provider, and member data
Results:	The figure below illustrates the number of available providers per 1,000 members on a statewide basis and by MLTSS region. Total available inpatient hospital providers per 1,000 members increased by 61% between SFY 2018 and 2020.

Figure 55: Available Inpatient Hospital Providers per 1,000 Members

Region	SFY 2018	SFY 2019	SFY 2020
Central	3.2	4.6	5.6
Charlottesville Western	2.9	4.3	5.5
Northern & Winchester	1.7	2.0	2.1
Roanoke/Alleghany	5.1	7.6	9.5
Southwest	9.8	20.5	25.8
Tidewater	4.2	5.7	7.4
Statewide	3.2	4.3	5.1
Change from Baseline		1.2	1.9
Percent Change from Baseline		36%	61%

Provider Measure 2: Provider patient load.

Measure: Number of members per available inpatient hospital provider by state fiscal year, statewide, and by region.

Methodology: Identify available inpatient hospital providers from SFY 2018 (baseline) to SFY 2020. Available inpatient hospital providers are defined as hospital providers with at least one Medicaid FFS inpatient claim during the period analyzed. Identify the number of members receiving at least one inpatient hospital service from SFY 2018 to SFY 2020. Calculate the ratio of members per available inpatient hospital provider. Data is analyzed on a statewide basis and by MLTSS region. For providers with multiple service locations, each service location is counted separately. This measure identifies trends in patient load (members per provider).

Data source: MMIS FFS claims, provider, and member data

Results: The figure below illustrates inpatient hospital provider patient load on a statewide basis and by MLTSS region. Total inpatient hospital provider patient load decreased by 38% between SFY 2018 and 2020.

Figure 56: Inpatient Hospital Provider Patient Load

Region	SFY 2018	SFY 2019	SFY 2020
Central	320	226	183
Charlottesville Western	388	261	202
Northern & Winchester	590	509	469
Roanoke/Alleghany	207	137	108
Southwest	87	41	33
Tidewater	250	185	140
Statewide	319	233	197
Change from Baseline		-85	-121
Percent Change from Baseline		-27%	-38%

Utilization of inpatient hospital services

Utilization of inpatient hospital services is analyzed using the following measures:

Utilization Measure 1: Volume of services per member.

Measure: Volume of inpatient hospital services on a per-member basis by state fiscal year, statewide and by region, and by population type.

Methodology: Identify the volume of inpatient hospital services (number of FFS paid claims) from SFY 2018 (baseline) to SFY 2020. Identify the number of members receiving at least one inpatient hospital service from SFY 2018 to SFY 2020. Calculate the ratio of inpatient hospital services per member. Data is analyzed on a statewide basis, by MLTSS region, and between adult and pediatric populations. This measure identifies trends in inpatient hospital service volume.

Data source: MMIS FFS claims, provider, and member data

Results: The figures below illustrate the volume of inpatient hospital services per member on a statewide basis and by MLTSS region for the adult and pediatric populations. Between SFY 2018 and 2020, inpatient hospital service volume per member decreased by 11% for adult members and remained unchanged for pediatric members.

Figure 57: Inpatient Hospital Service Volume per Member - Adults

Region	SFY 2018	SFY 2019	SFY 2020
Central	1.4	1.4	1.2
Charlottesville Western	1.4	1.3	1.2
Northern & Winchester	1.1	1.1	1.1
Roanoke/Alleghany	1.5	1.5	1.2
Southwest	1.0	1.0	0.9
Tidewater	1.4	1.3	1.2
Statewide	1.3	1.2	1.1
Change from Baseline		<0.1	-0.1
Percent Change from Baseline		-3%	-11%

Figure 58: Inpatient Hospital Service Volume per Member - Pediatrics

Region	SFY 2018	SFY 2019	SFY 2020
Central	1.0	1.1	1.1
Charlottesville Western	1.2	1.2	1.2
Northern & Winchester	1.1	1.1	1.0
Roanoke/Alleghany	1.1	1.1	1.1
Southwest	0.8	0.8	0.9
Tidewater	1.2	1.2	1.1
Statewide	1.1	1.1	1.1
Change from Baseline		0.0	0.0
Percent Change from Baseline		1%	0%

Utilization Measure 2: Percentage of members utilizing services.

Measure: Percentage of members utilizing inpatient hospital services by state fiscal year, statewide and by region, and by population type.

Methodology: Identify the number of members receiving at least one inpatient hospital service and divide by the total number of members, from SFY 2018 (baseline) to SFY 2020. Data is analyzed on a statewide basis, by MLTSS region, and between adult and pediatric populations. This measure identifies trends in member utilization.

Data source: MMIS FFS claims and member data

Results: The figures below illustrate the percentage of members that utilized inpatient hospital services on a statewide basis and by MLTSS region for the adult and pediatric populations. Between SFY 2018 and 2020, the percentage of members utilizing inpatient hospital services decreased by 63% for adult members and 4% for pediatric members.

Figure 59: Percentage of Members Utilizing Inpatient Hospital Services - Adults

Region	SFY 2018	SFY 2019	SFY 202000
Central	15%	5%	6%
Charlottesville Western	14%	4%	4%
Northern & Winchester	24%	9%	10%
Roanoke/Alleghany	14%	4%	4%
Southwest	9%	2%	2%
Tidewater	11%	4%	4%
Statewide	16%	5%	6%
Change from Baseline		-10%	-10%
Percent Change from Baseline		-66%	-63%

Figure 60: Percentage of Members Utilizing Inpatient Hospital Services - Pediatrics

Region	SFY 2018	SFY 2019	SFY 2020
Central	9%	8%	9%
Charlottesville Western	8%	7%	6%
Northern & Winchester	17%	15%	17%
Roanoke/Alleghany	7%	5%	6%
Southwest	3%	2%	3%
Tidewater	7%	6%	6%
Statewide	10%	9%	10%
Change from Baseline		-1%	-0.4%
Percent Change from Baseline		-13%	-4%

Rate Comparison

This analysis compares Medicaid FFS inpatient hospital reimbursement to estimated Medicare inpatient hospital reimbursement. A rate source for other payers, such as an all-payer database, is not readily available.

The Medicare program and the Virginia Medicaid program reimburse inpatient hospital services under different methodologies. Under both systems, inpatient hospital stays are assigned to diagnosis related groups (DRGs) for classification and payment purposes. However, the Medicare Severity (MS) DRG system used by the Medicare program and the All Payer Refined (APR) DRG system used by the Medicaid program are different classifications systems. Furthermore, there are other significant differences between the two reimbursement methodologies as it pertains to hospital rates and various other components of the reimbursement system (e.g., outlier payments, direct/indirect medical education, etc.).

Because of the limitations described above, a direct comparison of Medicare and Medicaid rates is not feasible. Therefore, the comparison below is based on the state's Medicare upper payment limit (UPL) demonstrations for inpatient hospital services. Federal regulations require that states demonstrate on an annual basis that Medicaid reimbursement for inpatient hospital services does not exceed a reasonable estimate of what the Medicare program would pay for those services on an aggregate basis by hospital ownership type. The information below is derived from the state fiscal year 20217 inpatient hospital UPL demonstrations.

Figure 61: Medicaid inpatient hospital reimbursement as a percentage of estimated Medicare reimbursement

Hospital Type	% of Medicare
State Owned Hospitals	100%
Non State Owned Hospitals	100%
Total	100%

Analysis of Outpatient Hospital Services

The state's analysis of outpatient hospital services for the FFS population evaluates access to outpatient services provided by hospital providers.

Availability of Providers

Provider availability is analyzed using the following measures:

Provider Measure 1: Number of available providers per 1,000 members.

Measure: Number of available outpatient hospital providers per 1,000 members by state fiscal year, statewide, and by region.

Methodology: Identify available outpatient hospital providers from SFY 2018 (baseline) to SFY 2020. Available outpatient hospital providers are defined as hospital providers with at least one Medicaid FFS outpatient claim during the period analyzed. Identify the number of members receiving at least one outpatient hospital service from SFY 2018 to SFY 2020. Calculate the ratio of available outpatient hospital providers per 1,000 members. Data is analyzed on a statewide basis and by MLTSS region. For providers with multiple service locations, each service location is counted separately. This measure identifies trends in provider participation.

Data source: MMIS FFS claims, provider, and member data

Results: The figure below illustrates the number of available providers per 1,000 members on a statewide basis and by MLTSS region. Total available outpatient hospital providers per 1,000 members increased by 73% between SFY 2018 and 2020.

Figure 62: Available Outpatient Hospital Providers per 1,000 Members

Region	SFY 2018	SFY 2019	SFY 2020
Central	1.4	2.1	2.8
Charlottesville Western	1.3	1.7	2.0
Northern & Winchester	1.3	1.9	2.2
Roanoke/Alleghany	2.4	3.3	4.2
Southwest	2.5	3.3	4.1
Tidewater	1.7	2.5	2.9
Statewide	1.6	2.3	2.8
Change from Baseline		0.7	1.2
Percent Change from Baseline		43%	73%

Provider Measure 2: Provider patient load.

Measure: Number of members per available outpatient hospital provider by state fiscal year, statewide, and by region.

Methodology: Identify available outpatient hospital providers from SFY 2018 (baseline) to SFY 2020. Available outpatient hospital providers are defined as hospital providers with at least one Medicaid FFS outpatient claim during the period analyzed. Identify the number of members receiving at least one outpatient hospital service from SFY 2018 to SFY 2020. Calculate the ratio of members per available outpatient hospital provider. Data is analyzed on a statewide basis and by MLTSS region. For providers with multiple service locations, each service location is counted separately. This measure identifies trends in patient load (members per provider).

Data source: MMIS FFS claims, provider, and member data

Results: The figure below illustrates outpatient hospital provider patient load on a statewide basis and by MLTSS region. Total outpatient hospital provider patient load decreased by 43% between SFY 2018 and 2020.

Figure 63: Outpatient Hospital Provider Patient Load

Region	SFY 2018	SFY 2019	SFY 2020
Central	715	488	369
Charlottesville Western	997	745	618
Northern & Winchester	791	534	464
Roanoke/Alleghany	422	303	234
Southwest	391	296	236
Tidewater	633	417	369
Statewide	650	455	373
Change from Baseline		-195	-277
Percent Change from Baseline		-30%	-43%

Utilization of outpatient hospital services

Utilization of outpatient hospital services is analyzed using the following measures:

Utilization Measure 1: Volume of services per member.

Measure: Volume of outpatient hospital services on a per-member basis by state fiscal year, statewide and by region, and by population type.

Methodology: Identify the volume of outpatient hospital services (number of FFS paid claims) from SFY 2018 (baseline) to SFY 2020. Identify the number of members receiving at least one outpatient hospital service from SFY 2018 to SFY 2020. Calculate the ratio of outpatient hospital services per member. Data is analyzed on a statewide basis, by MLTSS region, and between adult and pediatric populations. This measure identifies trends in outpatient hospital service volume.

Data source: MMIS FFS claims, provider, and member data

Results: The figures below illustrate the volume of outpatient hospital services per member on a statewide basis and by MLTSS region for the adult and

pediatric populations. Between SFY 2018 and 2020, outpatient hospital service volume per member increased by 5% for adult members and decreased by 5% for pediatric members.

Figure 64: Outpatient Hospital Service Volume per Member - Adults

Region	SFY 2018	SFY 2019	SFY 2020
Central	3.1	3.2	3.2
Charlottesville Western	4.1	4.3	4.3
Northern & Winchester	2.3	2.2	2.0
Roanoke/Alleghany	2.9	2.8	2.8
Southwest	2.4	2.5	2.7
Tidewater	3.2	3.3	3.6
Statewide	3.0	3.1	3.1
Change from Baseline		0.1	0.1
Percent Change from Baseline		4%	5%

Figure 65: Outpatient Hospital Service Volume per Member - Pediatrics

Region	SFY 2018	SFY 2019	SFY 2020
Central	1.8	1.8	1.8
Charlottesville Western	2.1	2.0	2.0
Northern & Winchester	1.7	1.6	1.6
Roanoke/Alleghany	1.7	1.5	1.5
Southwest	1.5	1.4	1.3
Tidewater	2.0	1.8	1.7
Statewide	1.8	1.7	1.7
Change from Baseline		-0.1	-0.1
Percent Change from Baseline		-4%	-5%

Utilization Measure 2: Percentage of members utilizing services.

Measure: Percentage of members utilizing outpatient hospital services by state fiscal year, statewide and by region, and by population type.

Methodology: Identify the number of members receiving at least one outpatient hospital service and divide by the total number of members, from SFY 2018 (baseline) to SFY 2020. Data is analyzed on a statewide basis, by MLTSS region, and between adult and pediatric populations. This measure identifies trends in member utilization.

Data source: MMIS FFS claims and member data

Results: The figures below illustrate the percentage of members that utilized outpatient hospital services on a statewide basis and by MLTSS region for the adult and pediatric populations. Between SFY 2018 and 2020, the percentage of members utilizing outpatient hospital services decreased by 70% for adult members and by 31% for pediatric members.

Figure 66: Percentage of Members Utilizing Outpatient Hospital Services - Adults

Region	SFY 2018	SFY 2019	SFY 2020
Central	53%	18%	17%
Charlottesville Western	69%	20%	19%
Northern & Winchester	44%	12%	12%
Roanoke/Alleghany	56%	19%	17%
Southwest	67%	18%	16%
Tidewater	51%	17%	18%
Statewide	56%	18%	16%
Change from Baseline		-38%	-39%
Percent Change from Baseline		-69%	-70%

Figure 67: Percentage of Members Utilizing Outpatient Hospital Services - Pediatrics

Region	SFY 2018	SFY 2019	SFY 2020
Central	24%	20%	19%
Charlottesville Western	23%	18%	15%
Northern & Winchester	20%	16%	16%
Roanoke/Alleghany	19%	15%	13%
Southwest	21%	16%	12%
Tidewater	23%	17%	15%
Statewide	23%	18%	16%
Change from Baseline		-5%	-7%
Percent Change from Baseline		-23%	-31%

Rate Comparison

This analysis compares Medicaid FFS outpatient hospital reimbursement to estimated Medicare outpatient hospital reimbursement. A rate source for other payers, such as an all-payer database, is not readily available.

The Medicare program and the Virginia Medicaid program reimburse outpatient hospital services under different methodologies. Medicare reimburses outpatient hospital services using the ambulatory payment classification (APC) system, while the Virginia Medicaid program uses the enhanced ambulatory patient groups (EAPGs) system. One of the key differences is in the area of service “bundling” or “packaging”, i.e., services that are included in the bundled payment rate under one system may be excluded under the other system and reimbursed under a separate payment methodology or fee schedule.

Because of the limitations described above, a direct comparison of Medicare and Medicaid rates is not feasible. Therefore, the rate comparison below is based on the state’s Medicare upper payment limit (UPL) demonstrations for outpatient hospital services. Federal regulations require that states demonstrate on an annual basis that Medicaid reimbursement for outpatient hospital

services does not exceed a reasonable estimate of what the Medicare program would pay for those services on an aggregate basis by hospital ownership type. The information below is derived from the state fiscal year 2020 State Owned Hospitals and state fiscal year 2021 Non State Owned Hospitals outpatient hospital UPL demonstrations.

Figure 68: Medicaid outpatient hospital reimbursement as a percentage of estimated Medicare reimbursement

Hospital Type	% of Medicare
State Owned Hospitals	100%
Non State Owned Hospitals	100%
Total	100%

Periodic Plan Updates

DMAS will update the access monitoring review plan at least triennially to incorporate more recent data as well as feedback from members, providers, and other stakeholders. DMAS will also evaluate whether additional measures or other data sources should be incorporated into the update analysis. Service categories subject to rate reductions or restructurings will be updated annually.

Appendix A: Managed Long-term Supports and Services (MLTSS) Regions[10]

CENTRAL REGION					
007	AMELIA	101	KING WILLIAM	177	SPOTSYLVANIA
025	BRUNSWICK	103	LANCASTER	179	STAFFORD
033	CAROLINE	111	LUNENBURG	181	SURRY
036	CHARLES CITY	115	MATHEWS	183	SUSSEX
041	CHESTERFIELD	117	MECKLENBURG	193	WESTMORELAND
049	CUMBERLAND	119	MIDDLESEX	570	COLONIAL HEIGHTS
053	DINWIDDIE	127	NEW KENT	595	EMPORIA
057	ESSEX	133	NORTHUMBERLAND	620	FRANKLIN CITY
075	GOOCHLAND	135	NOTTOWAY	630	FREDERICKSBURG
081	GREENSVILLE	145	POWHATAN	670	HOPEWELL
085	HANOVER	147	PRINCE EDWARD	730	PETERSBURG
087	HENRICO	149	PRINCE GEORGE	760	RICHMOND CITY
097	KING AND QUEEN	159	RICHMOND COUNTY		
099	KING GEORGE	175	SOUTHAMPTON		
CHARLOTTESVILLE WESTERN REGION					
003	ALBEMARLE	079	GREENE	540	CHARLOTTESVILLE
009	AMHERST	083	HALIFAX	590	DANVILLE
011	APPOMATTOX	109	LOUISA COUNTY	660	HARRISONBURG
015	AUGUSTA	113	MADISON	680	LYNCHBURG
029	BUCKINGHAM	125	NELSON	780	SOUTH BOSTON
031	CAMPBELL	137	ORANGE	790	STAUNTON
037	CHARLOTTE	143	PITTSYLVANIA	820	WAYNESBORO
065	FLUVANNA	165	ROCKINGHAM		
NORTHERN & WINCHESTER REGION					
013	ARLINGTON	107	LOUDOUN	510	ALEXANDRIA
043	CLARKE	139	PAGE	600	FAIRFAX CITY
047	CULPEPER	153	PRINCE WILLIAM	610	FALLS CHURCH
059	FAIRFAX COUNTY	157	RAPPAHANNOCK	683	CITY OF MANASSAS
061	FAUQUIER	171	SHENANDOAH	685	MANASSAS PARK
069	FREDERICK	187	WARREN	840	WINCHESTER
ROANOKE/ALLEGHANY REGION					
005	ALLEGHANY	091	HIGHLAND	560	CLIFTON FORGE
017	BATH	121	MONTGOMERY	580	COVINGTON
019	BEDFORD COUNTY	141	PATRICK	678	LEXINGTON
023	BOTETOURT	155	PULASKI	690	MARTINSVILLE
045	CRAIG	161	ROANOKE COUNTY	750	RADFORD
063	FLOYD	163	ROCKBRIDGE	770	ROANOKE CITY
067	FRANKLIN COUNTY	197	WYTHE	775	SALEM
071	GILES	515	BEDFORD CITY		
089	HENRY	530	BUENA VISTA		
SOUTHWEST REGION					
021	BLAND	105	LEE	191	WASHINGTON
027	BUCHANAN	167	RUSSELL	195	WISE
035	CARROLL	169	SCOTT	520	BRISTOL
051	DICKENSON	173	SMYTH	640	GALAX
077	GRAYSON	185	TAZEWELL	720	NORTON
TIDEWATER REGION					
001	ACCOMACK	199	YORK	735	POQUOSON
073	GLOUCESTER	550	CHESAPEAKE	740	PORTSMOUTH
093	ISLE OF WIGHT	650	HAMPTON	800	SUFFOLK
095	JAMES CITY COUNTY	700	NEWPORT NEWS	810	VIRGINIA BEACH
131	NORTHAMPTON	710	NORFOLK	830	WILLIAMSBURG

[10] Virginia Department of Medical Assistance Services. Financial Reports: 2020 Virginia Medicaid and CHIP Data Book. Retrieved from https://www.dmas.virginia.gov/open-data/financial-reports/.