Commonwealth of Virginia Department of Medical Assistance Services

2021–22 Child Welfare Focus Study

HSAG HEALTH SERVICES ADVISORY GROUP

VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION • QUALITY • VALUE

Table of Contents

1. Executive Summary

The Commonwealth of Virginia Department of Medical Assistance Services (DMAS) contracted with Health Services Advisory Group, Inc. (HSAG) to conduct the Child Welfare Focus Study in state fiscal year (SFY) 2021–2022 (Contract Year 1). Children in foster care, children receiving adoption assistance, and former foster care members face many barriers to adequate healthcare, and DMAS is committed to improving the quality, access, and timeliness of care for these members.

While the Child Welfare Focus Study has historically been referred to as the Foster Care Focus Study, DMAS requested that the study name be updated to account for the addition of the children receiving adoption assistance and former foster care members study populations in the 2020–2021 report. The 2021–2022 Child Welfare Focus Study assesses healthcare utilization during measurement year (MY) 2021 (i.e., January 1–December 31, 2021) among children in foster care, children receiving adoption assistance, and former foster care members compared to utilization among similar members not in these programs (henceforth referred to as "controls") who were also enrolled with Medicaid managed care organizations (MCOs). Additionally, this year's study assesses timely access to care for members who transitioned into or out of the foster care program and identifies disparities in healthcare utilization and timely access to care based on demographic factors.

Methodology and Study Indicators

For the healthcare utilization analysis, HSAG identified the eligible populations for each child welfare program using the specific program's aid category to determine member enrollment at any point during the measurement period:

- Children in Foster Care—All children enrolled in Medicaid under 18 years of age as of January 1, 2021, and identified by DMAS as enrolled in Medicaid under the aid category "076" for children in foster care.
- Children Receiving Adoption Assistance—All children enrolled in Medicaid under 18 years of age as of January 1, 2021, and identified by DMAS as enrolled in Medicaid under the aid category "072" for children receiving adoption assistance.
- Former Foster Care Members—All members enrolled in Medicaid 19 to 26 years of age as of January 1, 2021, and identified by DMAS as enrolled in Medicaid under the aid category "070" for former foster care members.

Selected study indicators assess demographic characteristics among the eligible populations for any length of Medicaid enrollment during the measurement period. For study indicators assessing healthcare utilization, the eligible populations were limited to members enrolled in the Medallion 4.0 or Commonwealth Coordinated Care Plus (CCC Plus) managed care programs with any MCO or a combination of MCOs during the measurement year, with enrollment gaps totaling no more than 45 days. This approach ensured that these members were continuously enrolled and covered by Medicaid for study indicators assessing healthcare utilization. Additionally, HSAG matched this group of continuously enrolled members to controls meeting the same age and enrollment criteria and sharing similar demographic and health characteristics to determine the final study populations and controls.

For the timely access to care analysis, HSAG worked with DMAS to develop custom measure specifications to assess timely access to primary and dental care for members who were newly enrolled in the foster care program during the measurement year and timely access to primary, dental, and behavioral healthcare for members who aged out of the foster care program during the year prior to the measurement year. These members were continuously enrolled in Medallion 4.0 or CCC Plus managed care programs with any MCO or a combination of MCOs during the follow-up period for assessing timely care. These populations were not matched to controls.

Study data included administrative claims and encounters, as well as demographic, eligibility, and enrollment data to examine services received by members for MY 2021.

Healthcare Utilization Analysis

To determine the extent to which children in foster care, children receiving adoption assistance, and former foster care members who were continuously enrolled with one or more MCOs throughout the study period utilized healthcare services, HSAG assessed 20 measures, representing 34 study indicators, across six domains, as displayed in Table 1-1.

Table 1-1—Healthcare Utilization Measure Indicators

Measure and Indicators
Primary Care[1-1]
Child and Adolescent Well-Care Visits (WCV)
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+)^ and Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+)^
Oral Health
Annual Dental Visit (ADV)
Preventive Dental Services (PDENT-CH)
Oral Evaluation, Dental Services (OEV-CH)
Topical Fluoride for Children—Dental or Oral Health Services, Dental Services, and Oral Health Services (TFL-CH)
Behavioral Health
Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment (AMM)*
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up (FUH)
Follow-Up After Emergency Department (ED) Visit for Mental Illness—30-Day Follow-Up (FUM)

[1-1] Historically, the Primary Care domain was assessed using the *Children and Adolescents' Annual Access to PCPs* (*CAP*) measure; however, the measure was retired for MY 2020. Therefore, the *Child and Adolescent Well-Care Visits* (*WCV*) measure and the *Well-Child Visits in the First 30 Months of Life* (*W30*) measure were introduced to assess primary care for MY 2020.

Measure and Indicators
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing (APM)^
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)^
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—One-Month Follow-Up, Two-Month Follow-Up, Three-Month Follow-Up, Six-Month Follow-Up, and Nine-Month Follow-Up (ADD)^
Substance Use
Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence—30-Day Follow-Up (FUA)
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment and Engagement of AOD Treatment (IET)
Respiratory Health
Asthma Medication Ratio (AMR)
Service Utilization
Ambulatory Care Visits
ED Visits
Inpatient Visits
Behavioral Health Encounters—Addiction and Recovery Treatment Services (ARTS), Community Mental Health (CMH) Services, Residential Treatment Center (RTC) Services, Therapeutic Services, Traditional Services, and Total
Overall Service Utilization

^Indicates these measure indicators were not calculated for the former foster care members as the measure indicators are not applicable to members 19 to 26 years of age.
**Indicates these measure indicators were only calculated for the former foster care members as the measure indicators are only applicable to members 18 years of age and older.*

Timely Access to Care Analysis

To determine the extent to which children newly enrolled in foster care and members who aged out of the foster care program who were continuously enrolled with one or more MCOs throughout the follow-up period utilized healthcare services in a timely manner, HSAG assessed three measures, representing 10 study indicators, as displayed in Table 1-2.

Table 1-2—Timely Access to Care Measure Indicators

Measure and Indicators
Timely Access to Care for New Foster Care Members—Timely Access to Primary Care for New Foster Care Members, Timely Access to Dental Care for New Foster Care Members, Timely Access to Primary Care or Dental Care for New Foster Care Members, and Timely Access to Primary Care and Dental Services for New Foster Care Members

Measure and Indicators
Timely Access to Care for Members Who Aged Out of Foster Care—Timely Access to Primary Care for Members Who Aged Out of Foster Care, Timely Access to Dental Care for Members Who Aged Out of Foster Care, Timely Access to Primary Care or Dental Care for Members Who Aged Out of Foster Care, and Timely Access to Primary Care and Dental Care for Members Who Aged Out of Foster Care
Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care—Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care and Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care with a Behavioral Health Diagnosis

Appendix A presents detailed descriptions of each study indicator, including references to the Centers for Medicare & Medicaid Services' (CMS') Core Set of Adult Health Care Quality Measures for Medicaid and Core Set of Children's Health Care Quality Measures for Medicaid and Children's Health Insurance Program (Adult and Child Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year (FFY) 2022 Reporting and the custom measure specifications for the service utilization and timely access to care measures.

Health Disparities Analysis

HSAG assessed health disparities among members in child welfare programs based on key demographic factors (i.e., race, age, gender, MCO, and region) for both the healthcare utilization measures and the timely access to care measures. For the healthcare utilization measures, HSAG also assessed health disparities among each group of controls and compared results to the study populations. HSAG identified health disparities using logistic regression models that predict numerator compliance and compare the results of each demographic stratification to a reference group. HSAG excluded comparisons for which disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model). The reference groups consisted of members in any other stratification (e.g., the reference group for members in Tidewater was all other members not in the Tidewater region). A health disparity was defined as a demographic stratification whose rate was significantly higher or lower than the reference group rate. Significant rate differences were defined by a *p*-value of less than 0.05.

Findings

Healthcare Utilization Findings

Table 1-3 contains the healthcare utilization study indicator results for the children in foster care study population and the matched controls with *p*-values indicating whether the rate differences between children in foster care and controls are statistically significant.

Table 1-3—Healthcare Utilization Study Indicator Results for Children in Foster Care and Controls

Measure	Children in Foster Care Rate	Controls Rate	*p*
Primary Care			
Child and Adolescent Well-Care Visits	64.8%	54.7%	<0.001*
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	63.8%	60.0%	0.46
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	79.7%	75.8%	0.31
Oral Health			
Annual Dental Visit	70.6%	52.4%	<0.001*
Preventive Dental Services	64.6%	45.6%	<0.001*
Oral Evaluation, Dental Services	63.5%	44.5%	<0.001*
Topical Fluoride for Children—Dental or Oral Health Services	35.0%	20.8%	<0.001*
Topical Fluoride for Children—Dental Services	28.3%	16.0%	<0.001*
Topical Fluoride for Children—Oral Health Services	2.4%	2.1%	0.43
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	64.2%	59.7%	0.56
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up	92.9%	81.5%	0.25
Metabolic Monitoring for Children and Adolescents on Antipsychotics	38.0%	35.7%	0.67
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	89.2%	68.4%	0.01*
Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up	78.1%	66.4%	0.04*
Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up	88.6%	81.8%	0.13

Measure	Children in Foster Care Rate	Controls Rate	*p*
Follow-Up Care for Children Prescribed ADHD Medication—Three-Month Follow-Up	93.0%	90.2%	0.43
Follow-Up Care for Children Prescribed ADHD Medication—Six-Month Follow-Up	96.5%	96.5%	1.00
Follow-Up Care for Children Prescribed ADHD Medication—Nine-Month Follow-Up	98.2%	97.2%	0.70
Substance Abuse			
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up	0.0%	0.0%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment	40.8%	48.1%	0.51
Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment	25.4%	18.5%	0.48
Respiratory Health			
Asthma Medication Ratio	85.7%	80.2%	0.48
Service Utilization			
Ambulatory Care Visits	88.9%	89.7%	0.33
ED Visits	24.8%	31.5%	<0.001*
Inpatient Visits	4.5%	4.4%	0.82
Behavioral Health Encounters—ARTS	1.9%	0.7%	<0.001*
Behavioral Health Encounters—CMH Services	38.8%	21.7%	<0.001*
Behavioral Health Encounters—RTC Services	4.4%	2.6%	<0.001*
Behavioral Health Encounters—Therapeutic Services	10.4%	5.9%	<0.001*
Behavioral Health Encounters—Traditional Services	67.8%	53.8%	<0.001*

Measure	Children in Foster Care Rate	Controls Rate	*p*
Behavioral Health Encounters—Total	71.0%	57.5%	<0.001*
Overall Service Utilization	92.1%	93.0%	0.18

** Indicates that the rates are statistically different between the children in foster care and controls.*
NC indicates that the p-value could not be calculated since both numerators were zero.
P-values were calculated using Chi-square tests and Fisher's exact tests to quantify the relationship between foster care status and numerator compliance. Measure rates and p-values presented in this table are not adjusted for demographic and health characteristics.
Denominators vary by study indicator; please refer to Appendix A for indicator-specific technical specifications.

Among the 32 study indicators, children in foster care demonstrated rates of healthcare utilization higher than or equal to controls for 28 study indicators, 14 of which were statistically significant. Of note, the rate for children in foster care for one study indicator was significantly lower than the rate for the controls. The children in foster care eligible population included 6,752 children enrolled in Medicaid during MY 2021. Among the eligible population, 3,635 children (53.8 percent) were continuously enrolled with any MCO or combination of MCOs during the measurement year. Finally, 3,436 of the continuously enrolled children in foster care (94.5 percent) were matched to a control member and included in the final study population for comparison to controls. Demographic characteristics of the study population did not differ substantially from the eligible population, except that there were 2.8 percent fewer children two years of age or younger.

Table 1-4 contains the healthcare utilization study indicator results for the children receiving adoption assistance study population and the matched controls with *p*-values indicating whether the rate differences between children receiving adoption assistance and controls are statistically significant.

Table 1-4—Healthcare Utilization Study Indicator Results for Children Receiving Adoption Assistance and Controls

Measure	Children Receiving Adoption Assistance Rate	Controls Rate	*p*
Primary Care			
Child and Adolescent Well-Care Visits	47.1%	48.2%	0.17
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	50.0%	65.3%	0.61
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	71.0%	72.9%	0.82

Measure	Children Receiving Adoption Assistance Rate	Controls Rate	*p*
Oral Health			
Annual Dental Visit	53.2%	50.8%	0.003*
Preventive Dental Services	48.3%	45.0%	<0.001*
Oral Evaluation, Dental Services	47.2%	44.0%	<0.001*
Topical Fluoride for Children—Dental or Oral Health Services	23.7%	19.6%	<0.001*
Topical Fluoride for Children—Dental Services	19.4%	16.2%	<0.001*
Topical Fluoride for Children—Oral Health Services	1.4%	1.2%	0.46
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	59.7%	52.0%	0.25
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up	80.0%	67.4%	0.13
Metabolic Monitoring for Children and Adolescents on Antipsychotics	34.1%	34.6%	0.90
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	59.3%	65.3%	0.41
Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up	51.4%	58.1%	0.12
Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up	62.9%	74.3%	0.005*
Follow-Up Care for Children Prescribed ADHD Medication—Three-Month Follow-Up	73.1%	81.0%	0.03*
Follow-Up Care for Children Prescribed ADHD Medication—Six-Month Follow-Up	86.1%	91.5%	0.05*
Follow-Up Care for Children Prescribed ADHD Medication—Nine-Month Follow-Up	91.0%	94.0%	0.19

Measure	Children Receiving Adoption Assistance Rate	Controls Rate	*p*
Substance Abuse			
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up	0.0%	25.0%	0.40
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment	55.0%	31.9%	0.03*
Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment	10.0%	10.6%	1.00
Respiratory Health			
Asthma Medication Ratio	86.1%	71.4%	0.001*
Service Utilization			
Ambulatory Care Visits	81.4%	83.6%	<0.001*
ED Visits	16.1%	24.1%	<0.001*
Inpatient Visits	2.8%	2.4%	0.12
Behavioral Health Encounters—ARTS	0.4%	0.5%	0.08
Behavioral Health Encounters—CMH Services	14.0%	14.2%	0.76
Behavioral Health Encounters—RTC Services	2.7%	1.9%	<0.001*
Behavioral Health Encounters—Therapeutic Services	5.0%	4.3%	0.03*
Behavioral Health Encounters—Traditional Services	50.3%	42.4%	<0.001*
Behavioral Health Encounters—Total	51.6%	44.9%	<0.001*
Overall Service Utilization	84.1%	86.7%	<0.001*

** Indicates that the rates are statistically different between the children receiving adoption assistance and controls. P-values were calculated using Chi-square tests and Fisher's exact tests to quantify the relationship between adoption assistance status and numerator compliance. Measure rates and p-values presented in this table are not adjusted for demographic and health characteristics.*
Denominators vary by study indicator; please refer to Appendix A for indicator-specific technical specifications.

Among the 32 study indicators, children receiving adoption assistance demonstrated higher rates of healthcare utilization than controls for 15 study indicators, 11 of which were statistically significant. Of note, the rates for children receiving adoption assistance for six study indicators were significantly lower than the rates for the controls. The children receiving adoption assistance eligible population included 8,563 children enrolled in Medicaid during MY 2021. Among the eligible population, 7,321 children (85.5 percent) were continuously enrolled with any MCO or combination of MCOs during the measurement year. Finally, 7,290 of the continuously enrolled children receiving adoption assistance (99.6 percent) were matched to a control member and included in the final study population for comparison to controls. Demographic characteristics of the study population did not differ substantially from the eligible population.

Table 1-5 contains the healthcare utilization study indicator results for the former foster care members study population and the matched controls with *p*-values indicating whether the rate differences between former foster care members and controls are statistically significant.

Table 1-5—Healthcare Utilization Study Indicator Results for Former Foster Care Members and Controls

Measure	Former Foster Care Members Rate	Controls Rate	*p*
Primary Care			
Child and Adolescent Well-Care Visits	19.6%	17.4%	0.37
Oral Health			
Annual Dental Visit	32.1%	27.2%	0.21
Preventive Dental Services	22.5%	20.1%	0.48
Oral Evaluation, Dental Services	24.1%	20.7%	0.34
Topical Fluoride for Children—Dental or Oral Health Services	4.5%	4.2%	0.86
Topical Fluoride for Children—Dental Services	4.1%	3.2%	0.59
Topical Fluoride for Children—Oral Health Services	0.0%	0.0%	NC
Behavioral Health			
Antidepressant Medication Management—Effective Acute Phase Treatment	33.3%	42.1%	0.19
Antidepressant Medication Management—Effective Continuation Phase Treatment	13.5%	20.0%	0.21

Measure	Former Foster Care Members Rate	Controls Rate	*p*
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	26.9%	33.3%	0.50
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up	48.6%	26.7%	0.21
Substance Abuse			
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up	5.0%	14.3%	0.56
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment	49.3%	54.5%	0.42
Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment	16.4%	28.3%	0.03*
Respiratory Health			
Asthma Medication Ratio	69.2%	66.7%	1.00
Service Utilization			
Ambulatory Care Visits	62.3%	66.9%	0.01*
ED Visits	44.3%	38.5%	<0.001*
Inpatient Visits	10.4%	9.6%	0.48
Behavioral Health Encounters—ARTS	5.8%	4.5%	0.08
Behavioral Health Encounters—CMH Services	10.1%	6.3%	<0.001*
Behavioral Health Encounters—RTC Services	5.0%	2.5%	<0.001*
Behavioral Health Encounters—Therapeutic Services	4.1%	2.9%	0.06
Behavioral Health Encounters—Traditional Services	34.2%	30.9%	0.04*
Behavioral Health Encounters—Total	35.6%	31.9%	0.02*
Overall Service Utilization	74.7%	75.4%	0.66

** Indicates that the rates are statistically different between the former foster care members and controls.*

NC indicates that the p-value could not be calculated since both numerators were zero.
P-values were calculated using Chi-square tests and Fisher's exact tests to quantify the relationship between former foster care status and numerator compliance. Measure rates and p-values presented in this table are not adjusted for demographic and health characteristics.
Denominators vary by study indicator; please refer to Appendix A for indicator-specific technical specifications.

Among the 25 study indicators, former foster care members demonstrated higher rates of healthcare utilization than controls for 16 study indicators, five of which were significantly different. Of note, the former foster care rates for two study indicators were significantly lower than the rates for the controls. The former foster care members eligible population included 2,054 members enrolled in Medicaid during MY 2021. Among the eligible population, 1,632 members (79.5 percent) were continuously enrolled with any MCO or combination of MCOs during the measurement year. Finally, 1,627 of the continuously enrolled former foster care members (99.7 percent) were matched to a control member and included in the final study population for comparison to controls. Demographic characteristics of the study population did not differ substantially from the eligible population, except that there were 2.5 percent more male members.

Timely Access to Care Findings

Table 1-6 contains the timely access to care study indicator results for children newly enrolled in foster care and members who aged out of foster care.

Table 1-6—Timely Access to Care Study Indicator Results for Children Newly Enrolled in Foster Care and Members Who Aged Out of Foster Care

Measure	Denominator	Numerator	Rate
Timely Access to Care for New Foster Care Members—Timely Access to Primary Care for New Foster Care Members	1,699	1,464	86.2%
Timely Access to Care for New Foster Care Members—Timely Access to Dental Care for New Foster Care Members	1,699	747	44.0%
Timely Access to Care for New Foster Care Members—Timely Access to Primary Care or Dental Care for New Foster Care Members	1,699	1,534	90.3%
Timely Access to Care for New Foster Care Members—Timely Access to Primary Care and Dental Care for New Foster Care Members	1,699	677	39.9%
Timely Access to Care for Members Who Aged Out of Foster Care—Timely Access to Primary Care for Members Who Aged Out of Foster Care	179	125	69.8%
Timely Access to Care for Members Who Aged Out of Foster Care—Timely Access to Dental Care for Members Who Aged Out of Foster Care	179	62	34.6%
Timely Access to Care for Members Who Aged Out of Foster Care—Timely Access to Primary Care or Dental Care for Members Who Aged Out of Foster Care	179	133	74.3%

Measure	Denominator	Numerator	Rate
Timely Access to Care for Members Who Aged Out of Foster Care—Timely Access to Primary Care and Dental Care for Members Who Aged Out of Foster Care	179	54	30.2%
Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care—Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care	179	58	32.4%
Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care—Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care with a Behavioral Health Diagnosis	142	56	39.4%

Please refer to Appendix A for indicator-specific technical specifications.

The majority of children newly enrolled in foster care and members who aged out of foster care had a timely visit with a primary care provider (PCP) (86.2 percent and 69.8 percent, respectively), while the majority of these members did not have a timely visit with a dental practitioner (44.0 percent and 34.6 percent, respectively). Most members who had a dental care visit also had a primary care visit. Members who aged out of foster care with a behavioral health diagnosis were more likely to have a visit with a mental health practitioner (MHP) compared to members who aged out of foster care who did not have a behavioral health diagnosis (by 7.0 percentage points), and 79.3 percent of members who aged out of foster care had a behavioral health diagnosis.

Health Disparities Findings

Table 1-7 contains the count and percentage of healthcare utilization study indicators for which a health disparity was identified by member characteristic (e.g., age category) for each analysis. A health disparity was defined as a member characteristic whose rate was significantly higher or lower than the reference group rate. This summary table does not include study indicator results for controls for the healthcare utilization analysis; however, these results are discussed in sections 3, 4, and 5.

Table 1-7—Count and Percentage of Study Indicators With a Health Disparity

Disparity Type and Analysis	Count of Study Indicators	Percent of Study Indicators
Age Category*		
Healthcare Utilization: Children in Foster Care	17	64.4%
Healthcare Utilization: Children Receiving Adoption Assistance	14	53.8%
Healthcare Utilization: Former Foster Care Members	1	6.3%
Timely Access to Care	4	100.0%
Sex		
Healthcare Utilization: Children in Foster Care	6	21.4%

Disparity Type and Analysis	Count of Study Indicators	Percent of Study Indicators
Healthcare Utilization: Children Receiving Adoption Assistance	7	25.0%
Healthcare Utilization: Former Foster Care Members	7	29.2%
Timely Access to Care	6	60.0%
Race		
Healthcare Utilization: Children in Foster Care	2	7.1%
Healthcare Utilization: Children Receiving Adoption Assistance	9	32.1%
Healthcare Utilization: Former Foster Care Members	7	29.2%
Timely Access to Care	0	0.0%
Region		
Healthcare Utilization: Children in Foster Care	19	67.9%
Healthcare Utilization: Children Receiving Adoption Assistance	22	78.6%
Healthcare Utilization: Former Foster Care Members	7	29.2%
Timely Access to Care	7	70.0%
MCO		
Healthcare Utilization: Children in Foster Care	13	46.4%
Healthcare Utilization: Children Receiving Adoption Assistance	15	53.6%
Healthcare Utilization: Former Foster Care Members	5	20.8%
Timely Access to Care	7	70.0%

** Only includes study indicators for which there is more than one age category.*

For the healthcare utilization study indicators, the health disparities analysis identified few disparities by sex or race, but there were clear trends among these disparities (e.g., female members were more likely to use certain services like annual dental visits and ED visits). There were more health disparities identified by region and MCO; however, findings varied more across study indicators. Additionally, for children in foster care and children receiving adoption assistance only, 64.4 percent and 53.8 percent of study indicators demonstrated a disparity by age category, respectively. For example, older children were less likely to have a well-care visit. However, some of these disparities may also reflect the relevance of certain services to specific age categories (e.g., older children are more likely to be diagnosed with a behavioral health condition and therefore more likely to use behavioral health services). For the timely access to care study indicators, there were disparities identified for age, sex, region, and MCO, but there were no disparities identified for race.

Study Limitations

Study findings and conclusions may be affected by limitations related to the study design and source data. As such, caveats include, but are not limited to, the following:

- Study indicator rates must be interpreted with caution given the denominator limitations. The covariate balance between the denominator-limited study populations and the denominator-limited controls group may be disrupted when one member in a matched pair qualifies for a study indicator denominator and the other member does not. The smaller the denominators, the greater the risk of imbalance between the study populations and their controls. Covariate balance between the stratification-limited study populations and the stratification-limited controls group may be similarly disrupted when only one member in a matched pair qualifies for a stratification that was matched by propensity score. However, for the SFY 2021–2022 study, all characteristics for which rates were stratified were exact-matched except for member sex, and HSAG found that most covariates were balanced within statewide male and female groups.
- Study indicator results and the accuracy of demographic characteristics (e.g., region, MCO) may be influenced by the accuracy and timeliness of the administrative claims and encounter data used for calculations and must be interpreted within the broader context of the population. Many study indicators are also based on CMS Core Set technical specifications, which may not comprehensively mirror the complete range of clinical practices recommended by AAP for members in the study population (e.g., an enhanced periodicity schedule customized to align with the needs of children in foster care). Furthermore, selected study indicators were originally developed by CMS to assess access to care or the degree to which care adhered to clinical guidelines. These measures were not necessarily developed to assess healthcare utilization. For example, most study indicators do not assess the frequency of service utilization; they only assess whether or not a visit occurred. Findings should be interpreted with respect to the intent of the CMS Core Set technical specifications.
- Methodology changes in MY 2020 may impact trending results for children in foster care. The current study trended study indicator rates for children in foster care across MY 2019, MY 2020, and MY 2021. Since adoption assistance children were included as a study population in MY 2020, they were removed from the pool of members from which controls for children in foster care could be selected. Therefore, while the control pool for MY 2019 included adoption assistance children, the control pool for MY 2020 and MY 2021 did not. Of note, only 1.4 percent of members in the control pool for MY 2019 would have been removed by the methodology change. Additionally, while MY 2019 only assessed members enrolled through Medallion 4.0, the MY 2020 and MY 2021 analyses also included members enrolled through CCC Plus. However, only 22 children in foster care in the study population were enrolled in CCC Plus in MY 2021. Therefore, given that the methodology changes only affect a small proportion of members, HSAG expects impacts on trending to be limited.
- The study populations and controls were limited by several factors, including continuous enrollment and having a comparable match; therefore, study findings are not generalizable to other children in foster care, children receiving adoption assistance, or former foster care members; to other members not in these programs; or to other CMS Core Set measure calculations. However, despite the limitations of the denominators, study indicator results are generalizable to the full study population and controls.
- MY 2020 and MY 2021 findings may be impacted by the onset of the coronavirus disease 2019 (COVID-19) pandemic. Therefore, HSAG recommends exercising caution when interpreting MY 2020 and MY 2021 findings or making comparisons to MY 2019 results, where applicable.

Conclusions and Recommendations

Healthcare Utilization: Children in Foster Care

Children in foster care are children who have been removed from their birth family homes for reasons of neglect, abuse, abandonment, or other issues endangering their health and/or safety.[1-2] While these children are in foster care, the State has custody and therefore primary responsibility for ensuring children receive the appropriate healthcare services. For example, a foster child's service worker must ensure the child meets a schedule of well-child visits and dental examinations based on nationally recognized guidelines.[1-3] This study demonstrated that children in foster care have higher rates of appropriate healthcare utilization than comparable controls for most study indicators in MY 2019, MY 2020, and MY 2021. Study findings show that MY 2021 rate differences between children in foster care and controls were greatest among the dental study indicators (*Annual Dental Visit; Preventive Dental Services; Oral Evaluation, Dental Services;* and *Topical Fluoride for Children—Dental or Oral Health Services* by 18.2, 19.0, 19.0, and 14.2 percentage points, respectively), the *Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics* measure (by 20.4 percentage points), and the *Behavioral Health Encounters—CMH Services* indicator (by 17.1 percentage points). Rate differences between children in foster care and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2021, children in foster care had lower rates compared to controls for only four study indicators: *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment, Ambulatory Care Visits, ED Visits*, and *Overall Service Utilization.* For *Initiation of AOD Treatment*, children in foster care had a higher rate than controls during MY 2019 but a lower rate than controls in MY 2020. However, the rate for children in foster care increased from 29.1 percent to 40.8 percent from MY 2020 to MY 2021, and the gap between children in foster care and controls reduced from 16.7 to 7.3 percentage points. Additionally, the rate for children in foster care for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment* study indicator was lower than controls during MY 2020 but higher than controls during MY 2021, indicating improvement in AOD treatment engagement as well. For the *ED Visits* study indicator, the rate for children in foster care was 6.7 percentage points lower than the rate for controls, which could reflect better management of health conditions for children in foster care. For the *Ambulatory Care Visits* and *Overall Service Utilization* indicators, the rate difference between children in foster care and controls was less than 1 percentage point, and the rates for children in foster care were very high for both indicators.

Among children in foster care, four study indicator rates increased, while 13 study indicator rates decreased from MY 2020 to MY 2021, and seven study indicator rates increased, while eight study indicator rates decreased from MY 2019 to MY 2021. The largest declines from MY 2020 to MY 2021 were for the *Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up* indicator (by 8.7 percentage points), the *Annual Dental Visit* indicator (by 8.5 percentage points), and the *Preventive Dental Services* indicator (by 7.4 percentage points). Among controls for children in foster care, 13 study indicator rates increased, while four study indicator rates decreased from MY 2020

[1-2] Virginia Department of Social Services. Foster Care (FC). Available at: https://www.dss.virginia.gov/family/fc/index.cgi#manuals. Accessed on: Jan 11, 2023.

[1-3] Virginia Department of Social Services. Child and Family Services Manual: Identifying Services to Be Provided. Available at: Child and Family Services Manual.pdf. Accessed on: Jan 11, 2023.

to MY 2021, and eight study indicator rates increased, while nine study indicator rates decreased from MY 2019 to MY 2022. Some declines in rates may be attributable to the COVID-19 pandemic during MY 2020 and MY 2021. For instance, from March 2020 to May 2020, most elective procedures and outpatient visits were cancelled or postponed nationwide.[1-4] Additionally, utilization of ambulatory care services remained below expected rates into early 2021, and rates for Medicaid enrollees were slower to rebound after COVID-19 outbreaks than commercial, Medicare Advantage, and Medicare fee-for-service (FFS) enrollees.[1-5] Despite the nationwide decline in healthcare utilization, six of the MY 2020 to MY 2021 rate declines were by less than 3 percent.

Among children in foster care, 17 study indicators demonstrated disparities across age categories. These disparities were typically seen among the controls as well, and sometimes reflect the relevance of certain services to specific age categories. For example, behavioral health conditions are more likely to be diagnosed later in life, so rates for the *Behavioral Health Encounters* indicators are expected to be higher among older children. However, for other measures, such as *Child and Adolescent Well-Care Visits*, older children were less likely to have a well-care visit despite Virginia state guidelines that children in foster care should have an annual well-child visit up to age 18.[1-6] Additionally, for the *Follow-Up for Hospitalization After Mental Illness—7-Day Follow-Up* indicator, the rate for children in foster care 14 years of age or older was lower than the rate for controls as well as all other age categories. Six study indicators demonstrated disparities between males and females. Female members were more likely to have an annual dental visit, ED visit, inpatient visit, and behavioral health encounter with RTC services, while male members were more likely to have a behavioral health encounter with ARTS or therapeutic services. Only two study indicators demonstrated disparities between racial groups. Black or African American members were more likely to have a behavioral health encounter with ARTS compared to other racial groups, while White members were less likely, and members in the Other racial group were less likely to have a behavioral health encounter with therapeutic services. These disparities were not seen among controls. There were also some disparities identified across regions and MCOs; however, no region or MCO performed consistently better or worse across study indicators.

Based on the findings detailed in this report, HSAG offers the following recommendations related to children in foster care:

- The SFY 2020–2021 study recommended monitoring the *Initiation and Engagement of AOD Abuse or Dependence Treatment* study indicators, since rates for children in foster care were notably lower than the rates for controls during MY 2020. The SFY 2021–2022 study found that rates improved for both measures, such that MY 2021 rates for children in foster care were higher than controls for engagement in AOD treatment, and the gap between children in foster care and controls halved for initiation of AOD treatment. However, rates for both study indicators are still below the MY 2021 national Medicaid 50th percentiles, so DMAS may consider focusing quality improvement efforts

[1-4] Choi SE, Simon L, Basu S, Barrow JR. *Changes in dental care use patterns due to COVID-19 among insured patients in the United States*. Journal of the American Dental Association. 2021. Available at: https://jada.ada.org/article/S0002-8177(21)00417-7/pdf. Accessed on: Jan 11, 2023.

[1-5] Mafi JN, Craff M, Vangala S. *Trends in US Ambulatory Care Patterns During the COVID-19 Pandemic, 2019-2021.* Journal of the American Medical Association. 2022. Available at: https://jamanetwork.com/journals/jama/fullarticle/2788140. Accessed on: Jan 11, 2023.

[1-6] Virginia Department of Social Services. Child and Family Services Manual: Identifying Services To Be Provided. 2021. Available at: https://www.dss.virginia.gov/files/division/dfs/fc/intro_page/guidance_manuals/fc/07_2021/section_12_identifying_services_to_be_provided.pdf. Accessed on: Jan 11, 2023.

toward improving initiation and engagement in AOD abuse or dependence treatment for children in foster care.

- Among children in foster care, 13 study indicator rates decreased from MY 2020 to MY 2021, and eight study indicator rates decreased from MY 2019 to MY 2021. These rates may be impacted by the COVID-19 pandemic. DMAS may consider continuing to monitor these study indicators to ensure that these rates return to pre-pandemic levels.
- SFY 2021–2022 is the first year to introduce a health disparities analysis. The analysis identified few disparities of concern among children in foster care. However, DMAS may consider focusing quality improvement efforts to reduce health disparities toward improving the rate of well-care visits and follow-up visits after hospitalization for mental illness among older children in foster care and improving the rate of annual dental visits among male children in foster care.
- While the current study design provides insight into utilization of healthcare services, it does not assess the quality of care received. DMAS may consider having future studies focus on high-utilization medical conditions that especially impact children in foster care and whether these members are receiving appropriate care for these conditions. For example, a future focus study may assess whether members in this population with asthma are receiving and adhering to appropriate medications.

Healthcare Utilization: Children Receiving Adoption Assistance

Children in the adoption assistance program are children who have been adopted from foster care but who faced additional barriers to adoption compared to other children in foster care, such as special medical conditions and extended time spent in foster care.[1-7] Whereas the State is primarily responsible for ensuring children in foster care receive appropriate healthcare services, the adoptive parents are primarily responsible for children in the adoption assistance program. Furthermore, adoptive parents are not required to ensure the adoption assistance child meets the same medical service requirements as children in foster care, such as a specific schedule of well-child visits.[1-8] The SFY 2021–2022 study was the second study to assess healthcare utilization for children receiving adoption assistance. This study demonstrated that children receiving adoption assistance had higher rates of appropriate healthcare utilization than comparable controls for 47 percent of study indicators in MY 2021 compared to 60 percent of study indicators in MY 2020. Study findings show that children receiving adoption assistance had higher rates than controls for all six Oral Health domain study indicators, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up, Follow-Up After ED Visit for Mental Illness—30-Day Follow*-Up, *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment*, *Asthma Medication Ratio, Inpatient Visits*, and four out of six *Behavioral Health Encounters* study indicators. Rate differences between children receiving adoption assistance and controls across study indicators persisted even after matching on many demographic and health characteristics.

1-7 Virginia Department of Social Services. Adoptive Assistance Screening Tool. Available at: https://dss.virginia.gov/files/division/dfs/ap/intro_page/forms/032-04-0091-06-eng.pdf. Accessed on: Jan 11, 2023.

1-8 Virginia Department of Social Services. Child and Family Services Manual: Adoption Assistance. Available at: https://www.dss.virginia.gov/files/division/dfs/ap/intro_page/manuals/07-01-2019/section_2_adoption_assistance_-July_2019.pdf. Accessed on: Jan 11, 2023.

During MY 2021, children receiving adoption assistance had lower rates compared to controls for the three Primary Care domain study indicators, most Behavioral Health domain study indicators, *Ambulatory Care Visits*, *ED Visits*, and *Overall Service Utilization*. The largest differences were for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* study indicator (by 15.3 percentage points) and the *Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up* study indicator (by 11.4 percentage points). However, for eight study indicators, the rates for children receiving adoption assistance were less than 3 percentage points lower than the controls. Additionally, the *ED Visits* rate for children receiving adoption assistance was 8.0 percentage points lower than controls, which may indicate that health conditions for children receiving adoption assistance are being better managed.

Among children receiving adoption assistance, four study indicator rates increased, while 12 study indicator rates decreased from MY 2020 to MY 2021. The largest declines from MY 2020 to MY 2021 were for the *Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment* study indicator (by 15.0 percentage points) and the *Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up* study indicator (by 8.9 percentage points). The *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* study indicator also declined by 33.0 percentage points; however, the denominator is very small, so rate changes across time are expected to be larger. Among controls for children receiving adoption assistance, nine study indicator rates increased, while nine study indicator rates decreased from MY 2020 to MY 2021. Some declines in rates may be attributable to the COVID-19 pandemic during MY 2020 and MY 2021. Despite the nationwide decline in healthcare utilization, four of the rate declines among children in adoption assistance were by less than 3 percent.

Since children receiving adoption assistance is the largest group among the child welfare populations, and *p*-value calculations are influenced by sample size, statistical tests to identify health disparities were most sensitive for this population. Among children receiving adoption assistance, 14 study indicators demonstrated disparities across age categories. Like the findings for children in foster care, these disparities were typically seen among the controls as well, and sometimes reflect the relevance of certain services to specific age categories. However, for other measures, such as *Child and Adolescent Well-Care Visits* and *Annual Dental Visit*, older children receiving adoption assistance were less likely to have a well-care visit and annual dental visit compared to younger children. Seven study indicators demonstrated disparities between males and females. Female members were more likely to have an annual dental visit and follow-up visits after hospitalizations or ED visits for mental illness, while male members were more likely to have any behavioral health encounter and behavioral health encounters with CMH, therapeutic, or traditional services.

Nine study indicators demonstrated disparities between racial groups. Black or African American members were more likely to have a well-care visit, oral evaluation, topical fluoride treatment, inpatient visit, and any behavioral health encounter except ARTS compared to other racial groups, while White members were less likely to have a well-care visit, oral evaluation, and any behavioral health encounter except ARTS and CMH services. However, White members on antipsychotics were more likely to have metabolic monitoring. Additionally, children receiving adoption assistance in the Other racial group were less likely to have a behavioral health encounter with CMH or traditional services. Some of these disparities were seen among controls. There were also some disparities identified across regions and MCOs. For example, members in the Northern & Winchester region were less likely to have a well-care visit, any of the services in the Oral Health domain (e.g., annual dental visit, preventive dental services), ambulatory care visit, and behavioral health encounter compared to members in other regions, and members enrolled with Aetna and Molina were less likely to have a well-care visit, any of the services in

the Oral Health domain, and an ambulatory care visit compared to members enrolled with other MCOs. Additionally, members enrolled with Aetna were less likely to have a behavioral health encounter.

Based on the findings detailed in this report, HSAG offers the following recommendations related to children receiving adoption assistance:

- The SFY 2021–2022 study found that children receiving adoption assistance had lower rates than controls for the three Primary Care domain study indicators and most Behavioral Health domain study indicators. DMAS may consider focusing quality improvement efforts toward improving utilization of primary care services and behavioral health services, where appropriate, for children receiving adoption assistance.
- SFY 2021–2022 is the second year to include analyses for children receiving adoption assistance. However, considering the impact of the COVID-19 pandemic on healthcare utilization during MY 2020 and MY 2021, the rates for children receiving adoption assistance in MY 2020 and MY 2021 may not be representative of their historical rates. Therefore, DMAS should consider monitoring this population's rates over time to verify appropriate baseline rates, identify areas for improvement, and monitor impacts of program changes.
- SFY 2021–2022 is the first year to introduce a health disparities analysis. The analysis identified disparities in healthcare utilization across age, sex, race, region, and MCO for children receiving adoption assistance. Rates tended to be lower for older, male, and White members, as well as members in the Northern & Winchester region and members enrolled with Aetna and Molina. DMAS may consider focusing quality improvement efforts to reduce health disparities among children receiving adoption assistance toward these subpopulations.
- While the current study design provides insight into utilization of healthcare services, it does not assess the quality of care received. DMAS may consider having future studies focus on high-utilization medical conditions that especially impact children receiving adoption assistance and whether these members are receiving appropriate care for these conditions. For example, a future focus study may assess whether members in this population with asthma are receiving and adhering to appropriate medications.

Healthcare Utilization: Former Foster Care Members

For this study, former foster care members were defined as young adults 19 to 26 years of age who were in foster care and enrolled in Medicaid at the time of their 18th birthday. These members aged out of the foster care program without a permanent home and are eligible to continue receiving Medicaid benefits through age 26. While the State has primary responsibility for the healthcare of children in foster care, and adoptive parents have primary responsibility for the healthcare of children receiving adoption assistance, former foster care members are responsible for their own healthcare. Unlike children in foster care, former foster care members are not required by the State to meet a certain schedule of medical services. Furthermore, this population is more likely to experience barriers to healthcare, such as poverty and homelessness.[1-9] The SFY 2021–2022 study was the second study to assess healthcare utilization for former foster care members. This study demonstrated that former

[1-9] Virginia Department of Social Services. Child and Family Services Manual: Achieving Permanency for Older Youth: Working with Youth 14-17. Available at: https://www.dss.virginia.gov/files/division/dfs/fc/intro_page/guidance_manuals/fc/07_2021/Section_13_achieving_permanency_for_older_youth.pdf. Accessed on: Jan 11, 2023.

foster care members have higher rates of appropriate healthcare utilization than comparable controls for 64 percent of study indicators in MY 2021 compared to 45 percent of study indicators in MY 2020. Study findings show that former foster care members had higher rates than controls for *Child and Adolescent Well-Care Visits*, all Oral Health domain study indicators, *Follow-Up After ED Visit for Mental Illness—30-Day Follow*-Up, *Asthma Medication Ratio, ED Visits, Inpatient Visits*, and all *Behavioral Health Encounters* study indicators. Rate differences between former foster care members and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2021, former foster care members had lower rates compared to controls for the *Antidepressant Medication Management* study indicators, the *Initiation and Engagement of AOD Abuse or Dependence Treatment* study indicators, *Ambulatory Care Visits*, and *Overall Service Utilization*. The largest differences were for the *Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment* study indicator (by 11.9 percentage points), the *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* study indicator (by 9.3 percentage points), and the *Antidepressant Medication Management—Effective Acute Phase Treatment* study indicator (by 8.8 percentage points).

Among former foster care members, all study indicator rates except *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* increased from MY 2020 to MY 2021. However, the *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* study indicator only declined by 0.9 percentage points. Among controls for former foster care members, all study indicator rates except two (i.e., *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up*) also increased from MY 2020 to MY 2021.

Among former foster care members, only the *Overall Service Utilization* study indicator demonstrated disparities across age categories, whereby members 23 to 26 years of age were less likely to have an ambulatory care visit, ED visit, inpatient visit, or behavioral health encounter compared to members 19 to 22 years of age. This disparity was not seen among controls. Seven study indicators demonstrated disparities between males and females. Female members were more likely to have a well-care visit, annual dental visit, ambulatory care visit, ED visit, inpatient visit, any behavioral health encounter, and behavioral health encounters with traditional services.

Seven study indicators demonstrated disparities between racial groups. Black or African American former foster care members were more likely to have an oral evaluation or behavioral health encounter with therapeutic services and less likely to initiate AOD treatment or have an ambulatory care visit compared to members in other racial groups, while White former foster care members were less likely to receive an oral evaluation, topical fluoride treatment, or behavioral health encounter with therapeutic services. Additionally, among members with a diagnosis of major depression who were treated with antidepressant medication, Black or African American members were less likely to remain on an antidepressant medication treatment for at least 12 weeks, while White members were more likely. This finding was not seen among controls. For region and MCO, the only notable finding was that former foster care members in the Tidewater region were less likely to have an annual dental visit, preventive dental services, and oral evaluation compared to members in other regions.

Based on the findings detailed in this report, HSAG offers the following recommendations related to former foster care members:

- The SFY 2021–2022 study found that former foster care members had lower rates than controls for the *Antidepressant Medication Management* study indicators and the *Initiation and Engagement of AOD Abuse or Dependence Treatment* study indicators. DMAS may consider focusing quality improvement efforts toward improving utilization of these services, where appropriate, for former foster care members.
- SFY 2021–2022 is the second year to include analyses for former foster care members. However, considering the impact of the COVID-19 pandemic on healthcare utilization during MY 2020 and MY 2021, former foster care members' rates during MY 2020 and MY 2021 may not be representative of their historical rates. Therefore, DMAS should consider monitoring former foster care members' rates over time to verify appropriate baseline rates, identify areas for improvement, and monitor impacts of program changes.
- SFY 2021–2022 is the first year to introduce a health disparities analysis. The analysis identified disparities in healthcare utilization across age, sex, race, and region among former foster care members. Rates tended to be lower for older, male members, as well as members in the Tidewater region. Racial groups with lower rates differed by study indicator. DMAS may consider focusing quality improvement efforts to reduce health disparities among former foster care members toward these subpopulations.

Timely Access to Care

SFY 2021–2022 is the first year to introduce analyses for timely access to care. Virginia State guidelines require that children in foster care receive a medical examination no later than 30 days after initial placement in foster care.[1-10] Additionally, DMAS' Medallion 4.0 Managed Care Contract encourages MCOs to assist in ensuring that children in foster care receive both a PCP and a dental visit within 30 days of plan enrollment, unless the child's social worker attests that the child has seen a provider within 90 days prior to enrollment.[1-11] DMAS is also working with the Virginia Department of Social Services (VDSS) and the MCOs to meet a goal of statewide improvement in timely initial medical exams. The SFY 2021–2022 study found that 86.2 percent of new foster care members had a visit with a PCP within 30 days after or 90 days prior to entering foster care. Therefore, most children in foster care are receiving timely access to primary care; however, there may be some room for improvement in meeting State guidelines. Additionally, 44.0 percent of new foster care members had a visit with a dental provider within 30 days after or 90 days prior to entering foster care, and most of these children also had a visit with a PCP. Study indicators also assessed timely access to care for members who aged out of foster care. Findings demonstrate that 69.8 percent of members who aged out of foster care in the year prior to the measurement year had a visit with a PCP during the measurement year. Similar to new foster care members, 34.6 percent of members who aged out of foster care had a visit with a dental practitioner during the measurement year, and most of these members also had a visit with a PCP. Additionally, most members who aged out of foster care had a behavioral health diagnosis, and 39.4 percent of these members with a behavioral health diagnosis had a visit with an MHP during the measurement year.

[1-10] Virginia Department of Social Services. Child and Family Services Manual: Identifying Services to Be Provided. Available at: Child and Family Services Manual.pdf. Accessed on: Jan 11, 2023.

[1-11] Commonwealth of Virginia, Department of Medical Assistance Services. Medallion 4.0 Managed Care Services Agreement: Member Eligibility, Enrollment, and General Responsibilities. Available at: https://www.dmas.virginia.gov/media/3583/medallion-4-contract-sfy22-v1.pdf. Accessed on: Jan 11, 2023.

Like the healthcare utilization analysis, HSAG conducted a health disparities analysis for the timely access to care study indicators. Among new foster care members, older children were less likely to have a visit with a PCP and more likely to have a visit with a dental practitioner. Female members who aged out of foster care were more likely to have a visit with a PCP than male members, and for both new foster care members and members who aged out of foster care, female members were more likely to have a visit with a dental practitioner. There were no disparities identified between racial groups, and there were few disparities identified by region and MCO. Of note, members enrolled with VA Premier who aged out of foster care were more likely to have a visit with a dental practitioner and an MHP compared to members enrolled with other MCOs.

Based on the findings detailed in this report, HSAG offers the following recommendations related to timely access to care:

- The study indicator findings identified some opportunities for improvement in timely access to healthcare services for both new foster care members and members who aged out of foster care. For new foster care members, DMAS should continue to monitor the MCOs' monthly reporting on foster care members which includes foster care eligibility dates, date of the member's health risk assessment, whether a care coordinator is assigned, whether a care coordination plan is in place, and the member's service utilization. DMAS should then continue to share the trends, performance, and service utilization identified from the monthly reporting with each MCO in order for MCOs to explain trends or inconsistencies in the data either on a case-by-case basis or by the Compliance Review Committee at the monthly compliance meeting with MCO leadership. DMAS may also consider monitoring who is involved in the development of the care coordination plan (e.g., foster parents) and include that information in the trends shared with the MCOs. For members who age out of foster care, DMAS may consider working with the VDSS to incorporate education about navigating the healthcare system and a recommended schedule for healthcare services (i.e., PCP visits, dental practitioner visits, and MHP visits, as applicable) into the transition plan for youth 14 years of age and older.[1-12]
- While most new foster care members and members who aged out of foster care had a timely visit with a PCP, most members did not have a timely visit with a dental practitioner. DMAS may consider leveraging the strategies that have improved the timeliness of PCP visit rates to improve the timeliness of dental practitioner visit rates.
- The health disparities analysis identified disparities in timely access to care across age, sex, region, and MCO. For example, rates tended to be lower for male members, and among new foster care members, older children were less likely to have a visit with a PCP and more likely to have a visit with a dental practitioner. DMAS may consider focusing quality improvement efforts to reduce health disparities in timely access to care toward these subpopulations.
- SFY 2021–2022 is the first year to introduce analyses for timely access to care, and MY 2021 results may be impacted by the COVID-19 pandemic. DMAS may consider continuing to monitor timely access to care to verify appropriate baseline rates and monitor impacts of quality improvement efforts.

[1-12] Virginia Department of Social Services. Child and Family Services Manual: Fostering Futures. Available at: Child and Family Services Manual.pdf. Accessed on: Jan 11, 2023.

DMAS' Input on Prior Focus Study Recommendations

In addition to the recommendations noted above, DMAS provided the following detailed feedback regarding quality improvement actions or initiatives related to the 2020–2021 Foster Care Focus Study.

Data Recommendations

For the first time during the 2020–21 Foster Care Focus Study, two additional populations (former foster care members and children receiving adoption assistance) were included in addition to children in foster care. These data have availed DMAS the opportunity to compare various outcomes for each individual child welfare population (i.e., foster care, adoption assistance, and former foster care) separately, including those related to behavioral health services, a focus of this study and key program area for DMAS. DMAS has requested that the 2021–2022 study, as well as all future studies, continue to include data from these additional member populations to establish an accurate baseline rate.

DMAS will continue to analyze data and utilize recommendations posed by HSAG to improve access to healthcare services for these newly included groups in order to determine areas of focus and improvement.

Safe and Sound Task Force

Under the leadership of Virginia's Governor Glenn Youngkin and Secretary of Health and Human Resources John Littel, the Safe and Sound Task Force was created. The objective of the task force is to define the problems related to children sleeping in VDSS offices, hotels, or emergency rooms so that DMAS can develop solutions and begin the process of safely and immediately ending this practice.

The Safe and Sound Task Force objectives also include finding safe placements for youth in foster care who are currently displaced or at risk of placement disruption and in Local Department of Social Services (LDSS) custody. This consists of identifying a reservoir of placements for youth who may need them in the future and eventually moving upstream, as well as making and acting on recommendations to address underlying reasons why youth are displaced—addressing the foundational aspects of youth entering foster care.

As part of the broader goals of the Safe and Sound Task Force, the core team implemented a Rapid Response process at the State level to temporarily provide urgent support to youth in foster care who do not have an identified place to safely reside. The Rapid Response is designed to bring together the LDSS, health plans, care team members, providers, and others to identify the placement and care needs of the youth, family support, and youth's ideas/input for placement and to identify a placement for that youth. The local Rapid Response Problem Solving Teams (PST) will develop and/or align with an existing process/team so that Rapid Response meetings can occur in local communities where the youth is known best.

When the task force began its work, the 2021 baseline was 324 children (an average of 27 per month). The current number is an average of three per month, a 90 percent decrease in 90 days. As of July 1, 2022, this in no longer a widespread challenge in Virginia. The task force will continue under this administration to focus on increasing the provision of services to children, families, and those in the community who provide for their well-being.

Community Partnerships

In August 2022, DMAS completed its first full year of hosting the Foster Care Partnership meetings with stakeholders from across the State. These stakeholders included those from the VDSS, the Virginia Commission on Youth, LDSS, Licensed Child Placement Agencies (LCPAs), DMAS MCOs, and the Virginia Office of Children's Services, among others.

Two sub-groups from the partnership also met throughout the year to focus on actionable goals related to improving services for youth in foster care. These action groups are focused on transition planning and increasing utilization of services for the foster care member population. Both action groups were created based on cross-sector and collaborative discussions around current needs of youth in foster care. Additionally, the focus areas of the action groups were chosen based on the results and recommendations of the 2020–2021 Foster Care Focus Study. For the first year of the partnership, the goals established were to share services, roles, and resources available among participating agencies working with youth in foster care. Between the large group, Foster Care Partnership meetings, and each action group, eight peer education sessions were provided. Information shared with the group included:

- MCO case management by United Healthcare
- Virginia's Fostering Futures and Independent Living services by VDSS
- Other independent living programs and transition services by Fostering Acadia (Independent Living/Licensed Child Placing Agency)
- Therapeutic Foster Care (TFC) services by Embrace (Licensed Child Placing Agency)
- Children's Services Act and Family Assessment and Planning Team (FAPT) functions by the Office of Children's Services
- LDSS intake processes by Roanoke and Bedford DSS
- Medicaid behavioral health services/FFS administration by Magellan of Virginia
- Successful transition of older youth in foster care by non-profit agency ProjectLIFE

Another joint goal of both action groups this year was to develop a universal MCO resource document to distribute to LDSS staff and foster families. The purpose of the document was to be an engaging way to provide information about Medicaid managed care for youth in foster care in Virginia. This flyer has been collaboratively developed and will be finalized and distributed by the end of 2022.

It is the goal of DMAS and the Foster Care Partnership to improve service utilization and outcomes for children in foster care, children receiving adoption assistance, and former foster care members through these groups and the larger partnership.

DMAS plans to continue facilitating the Foster Care Partnership and related sub-groups through 2023, with a continued focus on interagency collaboration for improved outcomes and service utilization for youth in foster care, adoption assistance, and former foster care individuals in Virginia. DMAS and the MCOs will specifically be collaborating with LDSS agencies and local Children's Services Act (CSA) Coordinators in the upcoming year. DMAS will be providing statewide trainings and presentations around Medicaid and managed care case management services for these member populations, and will be working with these agencies to enhance intersecting processes and improve service coordination.

Foster Care Affinity Group

During calendar year (CY) 2022, Virginia continued to host the CMS and Children's Bureau's Improving Timely Health Care for Children and Youth in Foster Care Affinity Group to support states in implementing quality improvement (QI) activities to improve timely healthcare services to meet the needs of children in foster care. The Virginia Affinity Group's aim statement is to increase the rate of children entering foster care who receive an initial medical examination within 30 days, according to Virginia State guidelines. The Affinity Group is co-led by DMAS and VDSS, and members also include representation from three MCOs, as well as support and testing teams from LDSS. The Affinity Group meets several times monthly to develop and implement small tests of change, track initial medical examination data for new foster care members, and analyze the success of each test for improving the timeliness of medical utilization upon entering foster care. The project is expected to conclude in December 2023, with the goal of a statewide improvement in timely initial medical exams.

The Virginia team has spent the last year gathering and analyzing data to establish a baseline rate for a sample population; creating a detailed, cross-agency process flow document; and determining the initial areas of focus and test(s) of change to explore. The initial area of focus identified by the team after reviewing the process flow was timely transfer of information about new foster care members from the LDSS agency to the MCOs. The hypothesis for the first improvement test was that notifying the health plans of new foster care members earlier would allow them to begin care coordination efforts sooner, thus improving the timeliness of initial medical care. One MCO began utilizing weekly enrollment reports from DMAS to identify new foster care members earlier than the end-of-month enrollment reports that are currently used by all MCOs. Testing the use of the weekly enrollment report did lead to the identification of new foster care members sooner, and initial data also demonstrated an improvement in the timeliness of initial outreach by the MCO to the new members. However, thus far, the data from this initial test has not yet demonstrated an improvement in the rate of medical examinations within 30 days for those members. The Affinity Group will continue to meet several times per month for the remainder of 2022 and into 2023. The current area of focus is on the intake process at the LDSS level, and the Virginia team is working with several local offices that have volunteered to assist in the process flow development as well as some tests of change. The next tests will be related to timely outreach and scheduling of appointments on the DSS end. The Virginia team will continue to carry out and measure small tests of change in order to identify successful interventions to implement on a wider scale by the end of the project.

Member Outreach

As mentioned previously, in 2022, a flyer was created as an output of the Service Utilization and Transition Planning Action Groups of the Foster Care Partnership that outlined Medicaid and managed care services for youth in foster care and transitioning out. The flyer was created to be distributed, both electronically and physically, to LDSS offices and community partners who work with youth in foster care, foster parents, and former foster care members. The flyer includes information regarding Medicaid coverage for youth, managed care case management services, and information regarding transition to independent living services, including the VDSS Fostering Futures Program. It also includes contact information and information about accessing services.

DMAS' Maternal and Child Health team has participated in several panels and/or provided educational information and training regarding the DMAS Foster Care and Adoption Assistance program, services and benefits available, and managed care case management. These outreach and education opportunities have included a presentation to the Virginia Commission on Youth, a Health Training Day for foster care

youth and young adults transitioning into independent living settings, and the Central Region Independent Living Advocates for Youth, among other things. DMAS will continue making education, awareness, and training an area of focus for this member population and stakeholders who work with them around the State. Continued collaboration and understanding of DMAS' role will improve services and utilization for youth in foster care, adoption assistance members, and former foster care members.

DMAS continues to maintain managed care contract requirements that all MCOs have foster care liaisons with competencies in child welfare to support members in foster care and address foster care-specific inquiries from stakeholders such as LDSS and LCPAs. DMAS also has a dedicated foster care email box to streamline and address inquiries related to foster care and adoption assistance services.

Foster Care and Adoption Assistance Annual Report

In CY 2022, DMAS compiled a 2020–2021 Foster Care and Adoption Assistance Annual Report. This report reviewed program initiatives and updates regarding the DMAS foster care and adoption assistance programs. Included in the report are demographic data provided by HSAG, along with a brief presentation of outcome data provided by HSAG during SFY 2020–2021. The report provided other highlights, accomplishments, and overall DMAS outcomes related to the foster care and adoption assistance member populations, as well as ongoing initiatives such as the Foster Care Partnership, Foster Care Affinity Group, and continued stakeholder engagement.

Medallion 4.0 Program Oversight Efforts

DMAS will soon operate under one unified health program called Cardinal Care. Cardinal Care is a single brand encompassing all health coverage programs for Virginia's two million Medicaid members, expected to go live in early 2023. Cardinal Care will include Medallion 4.0, CCC Plus, Family Access to Medical Insurance Security (FAMIS), and FFS members, and will offer the following:

- Improved overall member experience with Medicaid
- A single system of care for all members
- Reduced transitions between programs or gaps in care as member needs change
- A streamlined enrollment process
- An enhanced model of care to determine intensity and frequency of care coordination for members based on their needs, with youth in foster care and transitioning out of foster care included in high-priority populations. Children in foster care or receiving adoption assistance and former foster care members will be assigned to high intensity care management for the first three months following enrollment into Medicaid or entry into the child welfare system. Children aging out of foster care will also be assigned to high intensity case management for three months prior to when they age out, and three months after aging out. Outside of these mandatory high-intensity periods, children in foster care, children receiving adoption assistance, or former foster care members will remain a "priority population," thereby receiving low, moderate, or high intensity care management at the MCO's discretion.

Providers will also experience the benefits of a consolidated program, such as an easier contracting and credentialing process during provider enrollment and renewal.

Partnership for Petersburg (P4P)

On August 26, 2022, Governor Glenn Youngkin announced the new Partnership for Petersburg initiative, which includes six focus areas: Prepare Petersburg Students for Life, Improve Access to Health Care, Keep Our Community Safe, Keep Petersburg Moving, Foster Business & Economic Growth, and Build Relationships with Community and Faith Leaders. The Commonwealth of Virginia and community partners will work together to improve the health of Petersburg residents by expanding access to screenings, promoting awareness of primary care and prenatal care, and addressing health disparities by connecting Petersburg residents with medical and social services.

2. Overview and Methodology

Overview

Beginning in contract year 2015–2016, DMAS contracted with HSAG to conduct, as an optional EQR task under CMS Medicaid guidelines,[2-1] an annual focus study that provides quantitative information about children and adolescents placed in foster care and receiving medical services through Medicaid MCOs. DMAS takes steps to continually improve the quality and timeliness of care for children in foster care, children receiving adoption assistance, and former foster care members who receive Medicaid benefits. For instance, DMAS co-leads a team with VDSS to evaluate and improve the timeliness of initial medical examinations once a child enters foster care. Additionally, DMAS hosts community partnership meetings with stakeholders, such as Medicaid MCOs, from across Virginia to improve transition planning and increase utilization of services among children in foster care, children receiving adoption assistance, and former foster care members.

In contract year 2021–2022, HSAG conducted the Child Welfare Focus Study to determine the extent to which members in child welfare programs (i.e., children in foster care, children receiving adoption assistance, and former foster care members) received the expected preventive and therapeutic medical care under a managed care service delivery program compared to members not in a child welfare program and receiving Medicaid managed care benefits during MY 2021 (i.e., January 1, 2021–December 31, 2021). While historically the Foster Care Focus Study evaluated healthcare utilization among members in the study populations, for this year's focus study, DMAS requested that HSAG also evaluate timely access to care for members who transitioned into or out of the foster care program. A policy statement published in 2015 by the American Academy for Pediatrics (AAP) outlined a significant number of barriers in providing adequate and timely health services to children in foster care.[2-2] These issues, compounded with the complexities of care for children with histories of trauma and potentially limited healthcare access, make the assessment of preventive and baseline healthcare services critical for a population in the developmental stages of life. Additionally, children in foster care are likely to require services from both physical and behavioral health providers,[2-3] necessitating levels of care coordination and follow-up beyond those expected for most children and adolescents. These physical and behavioral health conditions create additional challenges for youth aging out of the foster care system who are unable to find a permanent home and must navigate the transition into adulthood and adult healthcare.[2-4]

2-1 Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 9: Conducting Focus Studies of Health Care Quality*. Oct 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html. Accessed on: Jan 11, 2023.

2-2 American Academy of Pediatrics. Health care issues for children and adolescents in foster care and kinship care. *Pediatrics*. Oct 2015:136:4. Available at: https://publications.aap.org/pediatrics/article/136/4/e1131/73819/Health-Care-Issues-for-Children-and-Adolescents-in. Accessed on: Jan 11, 2023.

2-3 Deutsch SA, Lynch A, Zlotnik S, et.al. Mental health, behavioral and developmental issues for youth in foster care. *Current Problems in Pediatric and Adolescent Health Care*. 2015; 45:292–297.

2-4 Dworsky A, Courtney M. Addressing the Mental Health Service Needs of Foster Youth During the Transition to Adulthood: How Big is the Problem and What Can States Do? *Journal of Adolescent Health*.2009; 44:1–2.

Additionally, DMAS requested that HSAG evaluate disparities in healthcare utilization and timely access to care based on demographic factors (i.e., age, sex, race, region, and MCO). Federal regulations require state Medicaid agencies to incorporate a plan to identify, evaluate, and reduce health disparities as part of their managed care state quality strategy.[2-5] DMAS' Quality Strategy is committed to monitoring health disparities to inform quality improvement efforts and ensure that Virginia Medicaid members have access to high-quality care. DMAS' Quality Strategy defines health disparities as differences in health outcomes between groups within a population.[2-6] The 2021–22 Child Welfare Focus Study presents study indicator results stratified by member demographics and assesses whether health disparities were statistically significant.

The Child Welfare Focus Study also compares MY 2021 findings to MY 2019 and MY 2020 findings, where applicable. During CY 2018, DMAS transitioned from the Medallion 3.0 program to the Medallion 4.0 program. Due to the program change and changes in the participating MCOs, some members were transitioned to new MCOs during CY 2018. Given that the MCO must work directly with either the social worker or the foster parent on any decisions regarding their medical care, the Medallion transition may or may not have caused delays in enrollment changes, potentially resulting in an impact to the healthcare and coverage for the children in foster care at that time. Additionally, the Medallion 4.0 program began covering and coordinating services, such as Early Intervention and non-traditional behavioral health services, that were previously paid through traditional FFS Medicaid (i.e., "carved out" of managed care). As a result, MY 2019 results presented in this report should be evaluated with caution given that the transitional period may have impacted care during this measurement year.

Methodology

Data Sources

This study examines services received by children in foster care, children receiving adoption assistance, and former foster care members during MY 2021 (i.e., January 1, 2021–December 31, 2021). Additionally, selected study indicators include services occurring up to one year before this measurement year. Appendix A provides detailed information on the measurement period for each study indicator. HSAG received administrative claims and encounters paid through June 30, 2022, as well as demographic, eligibility, and enrollment data, from DMAS in July 2022 for this study. In addition, DMAS supplied HSAG with dental encounter data from the Medicaid dental benefit manager, DentaQuest.

2-5 CMS. CMS External Quality Review (EQR) Protocols. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 23, 2023.

2-6 Commonwealth of Virginia DMAS. 2022–2022 Quality Strategy. Available at: https://www.dmas.virginia.gov/media/2649/2020-2022-dmas-quality-strategy.pdf. Accessed on: Jan 23, 2023.

Healthcare Utilization Analysis

For the healthcare utilization analysis, HSAG identified the eligible populations for each child welfare program using the specific program's aid category to determine member enrollment at any point during the measurement period:

- Children in Foster Care—All children enrolled in Medicaid under 18 years of age as of January 1, 2021, and identified by DMAS as enrolled in Medicaid under the aid category "076" for children in foster care.
- Children Receiving Adoption Assistance—All children enrolled in Medicaid under 18 years of age as of January 1, 2021, and identified by DMAS as enrolled in Medicaid under the aid category "072" for children in the adoption assistance program.
- Former Foster Care Members—All members enrolled in Medicaid 19 to 26 years of age as of January 1, 2021, and identified by DMAS as enrolled in Medicaid under the aid category "070" for young adults formerly in foster care.

To identify each study population for the healthcare utilization indicators, the eligible population for each child welfare program was limited to members who were continuously enrolled in their respective aid category (e.g., aid category "076" for children in foster care) through a single managed care program (i.e., Medallion 4.0 or CCC Plus) with any MCO or combination of MCOs during the measurement year. Continuous enrollment was defined as no more than 45 days without enrollment in a single Medicaid managed care program under the child welfare program's aid category during the measurement year. Medallion 4.0 enrollment was identified by the benefit package prefixes of "0103" or "0143," indicating enrollment in Medallion 3.0 or Medallion 4.0, respectively. CCC Plus enrollment was identified by benefit package prefixes of "0112" and "0114," indicating enrollment in the CCC Program for Dual-Eligibles or CCC Plus, respectively. Limiting to continuously enrolled members at an early step allowed HSAG to better understand the characteristics of the study populations and to identify closely matched controls that supported the continuous enrollment criteria required for the study indicators.

To identify the controls, HSAG first identified members meeting the same age criteria as their respective eligible population (e.g., under 18 years of age for children in foster care) and who were continuously enrolled in Medallion 4.0 or CCC Plus under an aid category other than "076", "072," or "070" over the study period. Continuously enrolled members in the child welfare programs were compared to these continuously enrolled members not in child welfare programs (i.e., the pool of potential controls) to identify demographic and health characteristics that differed between the populations.

Health characteristics were assessed through primary diagnoses in the claims and encounter data. Diagnoses were grouped based on the Clinical Classifications Software (CCS),[2-7] clinical expertise, and historical knowledge of the challenges facing each population. Appendix B provides detailed information on the construction of the health characteristics groups.

Next, HSAG calculated propensity scores for the continuously enrolled members and the pool of potential controls during the study period. To calculate propensity scores, HSAG used a logistic

[2-7] Agency for Healthcare Research and Quality. Clinical Classifications Software (CCS) for ICD-10-PCS (beta version). Available at: https://www.hcup-us.ahrq.gov/toolssoftware/ccsr/ccsr_archive.jsp#ccsr. Accessed on: Jan 11, 2023.

regression model to predict foster care status based on one to two demographic characteristics and seven to 14 population-specific health characteristics. Matching characteristics differed between the study populations, since HSAG only included characteristics that differed meaningfully from controls for each study population. Additionally, HSAG removed characteristics from the final propensity score model that were insignificant during initial propensity score modeling using all characteristics, based on the Wald Chi-square test. Members residing in an unknown managed care geographic region were removed before propensity score calculations because this category was too small for reliable balancing.

For all three populations (i.e., children in foster care, children receiving adoption assistance, and former foster care members), unless otherwise specified, HSAG used the following demographic characteristics as categorical variables for propensity score calculations:

- Sex: Male, Female (Children in Foster Care and Former Foster Care Members only)
- Medicaid Program: Medallion 4.0, CCC Plus

For all three populations, unless otherwise specified, HSAG used the following healthcare characteristics as binary variables for propensity score calculations:

- Diagnosis of Adjustment Disorder
- Diagnosis of Anxiety Disorder
- Diagnosis of ADHD
- Diagnosis of Congenital Anomaly (Children in Foster Care and Adoption Assistance Children only)
- Diagnosis of Developmental Disorder
- Diagnosis of Intentional Self-Harm (Children in Foster Care only)
- Diagnosis of Maltreatment/Abuse (Children in Foster Care only)
- Diagnosis of Mood Disorder
- Diagnosis of Neurological Disorder (Adoption Assistance Children only)
- Diagnosis of Obesity and Metabolic Syndrome (Children in Foster Care only)
- Diagnosis of Other Mental Health Disorders (Children in Foster Care and Children Receiving Adoption Assistance only)
- Diagnosis of Rheumatologic Condition (Children in Foster Care and Former Foster Care Members only)
- Diagnosis of Substance Use Disorder
- ED Visit for Mental Health (Children in Foster Care and Children Receiving Adoption Assistance only)
- Acute Inpatient Visit for Mental Health (Children in Foster Care and Children Receiving Adoption Assistance only)

After calculating propensity scores, the continuously enrolled populations and their comparison groups were exact-matched by the following:

- Age category: Infant (≤ 2 Years), Preschool (3 to 5 Years), Elementary School (6 to 10 Years), Middle School (11 to 13 Years), High School (14 to 17 Years), Young Adult (19 to 22 Years), and Adult (23 to 26 Years)[2-8]
- Continuously Enrolled MCO: Aetna Better Health of Virginia (Aetna); HealthKeepers, Inc. (HealthKeepers); Molina Complete Care (Molina);[2-9] Optima Health (Optima); UnitedHealthcare of the Mid-Atlantic, Inc. (UnitedHealthcare); Virginia Premier Health Plan, Inc. (VA Premier); and More Than One MCO[2-10]
- Region: Central, Charlottesville/Western, Northern & Winchester, Roanoke/Alleghany, Southwest, and Tidewater[2-11, 2-12]
- Race category: White, Black or African American, and Other[2-13]

HSAG exact-matched on age category because age is tied to health risk, likelihood of diagnosis, and healthcare utilization, and because age determined which healthcare claims were used in the health characteristic assessment. HSAG exact-matched on continuously enrolled MCO to improve the covariate balance when stratifying findings by MCO. HSAG exact-matched on region because region is tied to health risk and provider availability. While HSAG has historically included race in the propensity score model, HSAG exact-matched by race for the 2021–2022 Child Welfare Focus Study since this is the first study to stratify study indicator rates by race, and HSAG found that other characteristics were not sufficiently balanced within racial groups without exact matching. The 2021–2022 Child Welfare Focus Study is also the first study to stratify study indicator rates by gender; however, HSAG continued to include gender in the propensity score model instead of exact matching, since HSAG found that other characteristics were sufficiently balanced within gender groups. Please refer to the Health Disparities Analysis section for more information on how rates were stratified.

2-8 Age categories were calculated using the member's age at the beginning of the measurement year (i.e., January 1, 2021).

2-9 In prior year reports, Molina Complete Care was referred to as Magellan Complete Care.

2-10 MCO was assigned based on continuous enrollment. If a member was continuously enrolled with a single MCO during the measurement year with no more than one gap in enrollment of no more than 45 days, then HSAG assigned the MCO as the member's continuously enrolled MCO. Otherwise, HSAG assigned a member's continuously enrolled MCO as More Than One MCO (e.g., members who were continuously enrolled with more than one MCO simultaneously or members who were not continuously enrolled with any single MCO). Using continuous enrollment to determine MCO assignment improves the accuracy of which MCO was responsible for a member's healthcare during the measurement year.

2-11 Regional attribution was based on the demographic file and the SFY 2020–2021 Managed Care Services Agreement provided by DMAS and reflects the managed care regions.

2-12 Commonwealth of Virginia Department of Medical Assistance Services. Medallion 4.0 Managed Care Services Agreement: Jul 1, 2020–Jun 30, 2021. Attachment XII. 405–406. Available at: https://www.dmas.virginia.gov/media/2941/medallion-40-contract-sfy21v3.pdf. Accessed on: Jan 11, 2023.

2-13 Due to the limited number of children in foster care in race categories other than White and Black or African American, other race categories were combined into an "Other" race category. Race categories did not include consideration of ethnicity data.

Finally, HSAG matched the continuously enrolled groups and controls on their propensity scores within exact-matched sub-groups using the greedy 5→1 algorithm.[2-14] Covariate balance between the study populations and their matched controls was assessed by covariate-level Chi-square tests, an omnibus test, and a standardized differences assessment. Statistical tests, like the Chi-square test and the omnibus test, are traditional approaches to balance assessment, which examine individual covariate balance and overall covariate balance, respectively. The standardized differences assessment assesses balance without relying on sample size, which influences the sensitivity of the Chi-square and omnibus tests. Since this study's sample sizes are large and vary across the study populations, a standardized differences assessment helps provide a more reliable estimate of balance than statistical tests alone. Appendix B details the interpretation of the covariate balance tests.

For alignment with other quality initiatives, healthcare utilization measures were based on CMS' Adult and Child Core Set Technical Specifications and Resource Manual for FFY 2021 Reporting or custom measure specifications. The healthcare utilization analysis assessed 20 measures, representing 34 study indicators, across six domains as displayed in Table 2-1.

Table 2-1—Healthcare Utilization Measure Indicators

Measure and Indicators
Primary Care[2-15]
Child and Adolescent Well-Care Visits (WCV)
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+)^ and Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+)^
Oral Health
Annual Dental Visit (ADV)
Preventive Dental Services (PDENT-CH)
Oral Evaluation, Dental Services (OEV-CH)
Topical Fluoride for Children—Dental or Oral Health Services, Dental Services, Oral Health Services (TFL-CH)
Behavioral Health
Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment (AMM)*
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up (FUH)
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up (FUM)

[2-14] Parsons LS. Reducing Bias in a Propensity Score Matched-Pair Sample Using Greedy Matching Techniques. Available at: https://support.sas.com/resources/papers/proceedings/proceedings/sugi26/p214-26.pdf. Accessed on: Jan 11, 2023.

[2-15] Historically, the Primary Care domain was assessed using the *Children and Adolescents' Annual Access to PCPs* (CAP) measure; however, the measure was retired for MY 2020. Therefore, the *Child and Adolescent Well-Care Visits* (WCV) measure and the *Well-Child Visits in the First 30 Months of Life* (W30) measure were introduced to assess primary care for MY 2020.

Measure and Indicators
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing (APM)^
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)^
Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up, Two-Month Follow-Up, Three-Month Follow-Up, Six-Month Follow-Up, and Nine-Month Follow-Up (ADD)^
Substance Use
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up (FUA)
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment and Engagement of AOD Treatment (IET)
Respiratory Health
Asthma Medication Ratio (AMR)
Service Utilization
Ambulatory Care Visits
ED Visits
Inpatient Visits
Behavioral Health Encounters—ARTS, CMH Services, RTC Services, Therapeutic Services, Traditional Services, and Total
Overall Service Utilization

^Indicates these measure indicators were not calculated for former foster care members as the measure indicators are not applicable to members 19 to 26 years of age.
**Indicates these measure indicators were only calculated for former foster care members as the measure indicators are only applicable to members 18 years of age and older.*

When available, HSAG compared MY 2021 study indicator rates to NCQA's Quality Compass®[2-16] national Medicaid health maintenance organization (HMO) percentiles (henceforth referred to as national Medicaid percentiles) to provide additional context for indicator results.

To assess whether indicator rates were statistically different between the study populations and their matched controls, HSAG calculated *p*-values to determine the association between program status (e.g., membership in the foster care program) and numerator compliance. For indicators for which all contingency table cell sizes (i.e., the number of numerator-positive and numerator-negative members for each group) were greater than or equal to 5, HSAG calculated *p*-values using Chi-square tests. For indicators with small contingency table cell sizes, HSAG used Fisher's exact test because Fisher's exact test is more accurate than the Chi-square test when cell sizes are small. A *p*-value less than 0.05 was considered statistically significant.

[2-16] Quality Compass® is a registered trademark of NCQA.

Timely Access to Care Analysis

For the timely access to care analysis, HSAG developed custom measures to determine the extent to which children newly enrolled in the foster care program and children who aged out of the foster care program were able to access healthcare services in a timely manner. Since the measure specifications are specific to experiences in the foster care program, HSAG included all members who met the denominator criteria in the rate calculations (i.e., the denominators were not further limited to specific populations), and these members were not matched to controls. HSAG assessed 3 measures, representing 10 study indicators, as displayed in Table 2-2.

Table 2-2—Timely Access to Care Measure Indicators

Measure and Indicators
Timely Access to Care for New Foster Care Members—Timely Access to Primary Care for New Foster Care Members, Timely Access to Dental Care for New Foster Care Members, Timely Access to Primary Care or Dental Care for New Foster Care Members, and Timely Access to Primary Care and Dental Services for New Foster Care Members
Timely Access to Care for Members Who Aged Out of Foster Care—Timely Access to Primary Care for Members Who Aged Out of Foster Care, Timely Access to Dental Care for Members Who Aged Out of Foster Care, Timely Access to Primary Care or Dental Care for Members Who Aged Out of Foster Care, and Timely Access to Primary Care and Dental Care for Members Who Aged Out of Foster Care
Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care—Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care and Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care with a Behavioral Health Diagnosis

Appendix A presents detailed descriptions of each measure included in the healthcare utilization analysis and the timely access to care analysis, including pertinent references to Adult and Child Core Set technical specifications and/or value sets as well as complete specifications for the custom measures.

Health Disparities Analysis

In order to better understand how member demographic characteristics might have impacted the study indicator rates, HSAG performed an analysis to identify health disparities for the healthcare utilization and timely access to care measures for MY 2021 only. For each demographic characteristic (i.e., age category, sex, race, region, and continuously enrolled MCO, where applicable[2-17]), HSAG calculated study indicator rates for each demographic group (e.g., members in the Tidewater region) and their reference group. The reference group contained all members in any other demographic strata (e.g., the reference group for members in the Tidewater region was all other members not in the Tidewater region). Additionally, HSAG calculated logistic regression models predicting numerator compliance based on a binary indicator for each demographic group among members in each study indicator denominator. The *p*-value for the demographic group's coefficient in the logistic regression model was

[2-17] Some measures only have one group within a demographic characteristic (e.g., there is only one age category included in the *Timely Access to Care for Members Who Aged Out of Foster Care* measure), so a health disparities analysis cannot be performed for that demographic characteristic.

used to identify statistically significant health disparities between the demographic groups and their reference groups. HSAG excluded comparisons for which disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).

For this report, a *p*-value less than 0.05 indicated a health disparity. When analyzing a given demographic group, HSAG classified the stratified rate in one of the following three categories based on the preceding analyses:

- Higher Rate
  - The *p*-value for the coefficient in the logistic regression model was less than 0.05, indicating a health disparity, and the stratified rate for the demographic group was higher than the rate for the reference group.
- Lower Rate
  - The *p*-value for the coefficient in the logistic regression model was less than 0.05, indicating a health disparity, and the stratified rate for the demographic group was lower than the rate for the reference group.
- Similar Rate
  - The *p*-value for the coefficient in the logistic regression model was greater than or equal to 0.05. This means no health disparity was identified when the stratification was compared to the reference group.

3. Healthcare Utilization: Children in Foster Care Findings

Characteristics of the Children in Foster Care Eligible Population and Study Population

This section provides findings describing the demographic characteristics of the 6,752 children in the foster care eligible population and the 3,436 children in the foster care study population. The eligible population consisted of children in foster care younger than 18 years of age as of January 1, 2021, and receiving healthcare coverage from DMAS at any time during MY 2021. Table 3-1 displays the distribution of the children in foster care eligible population by age category, sex, race, region, MCO, and Medicaid program.

Table 3-1—Distribution of Children in Foster Care (n=6,752)

Category	Number	Percent
Age Category		
≤ 2 years	1,502	22.2%
3 to 5 years	1,053	15.6%
6 to 10 years	1,443	21.4%
11 to 13 years	947	14.0%
≥ 14 years	1,807	26.8%
Sex		
Male	3,593	53.2%
Female	3,159	46.8%
Race		
Black or African American	2,194	32.5%
White	4,399	65.2%
Other	159	2.4%
Region		
Central	1,359	20.1%
Charlottesville/Western	1,217	18.0%
Northern & Winchester	970	14.4%
Roanoke/Alleghany	1,131	16.8%
Southwest	845	12.5%
Tidewater	1,165	17.3%
Unknown	65	1.0%
Latest MCO in the Measurement Year		
Aetna	671	9.9%
HealthKeepers	1,836	27.2%

Category	Number	Percent
Molina	416	6.2%
Optima	1,419	21.0%
VA Premier	1,700	25.2%
UnitedHealthcare	520	7.7%
Other*	190	2.8%
Latest Medicaid Program in the Measurement Year		
CCC Plus	89	1.3%
Medallion 4.0	6,461	95.7%
Other**	202	3.0%

**Includes members only enrolled in FFS.*
***Includes members enrolled in FAMIS and members only enrolled in FFS.*

Children in foster care were disproportionately male (53.2 percent) and Black or African American (32.5 percent) compared to the general population in Virginia, which was 49.5 percent male and 20.0 percent Black or African American in 2021.[3-1] Children in foster care were mostly from the Central (20.1 percent), Charlottesville/Western (18.0 percent), and Tidewater (17.3 percent) regions. The region for a small proportion of children in foster care (1.0 percent) was unknown; these children tended to be missing some address information or had an out-of-state address. Children in foster care were most likely to be enrolled with HealthKeepers (27.2 percent), VA Premier (25.2 percent), or Optima (21.0 percent). MCO attribution was Other for 2.8 percent of children in foster care who were only enrolled in FFS during MY 2021.[3-2] Children in foster care were most likely to be enrolled through the Medallion 4.0 program (95.7 percent). The Medicaid program for 3.0 percent of children in foster care was Other, meaning they were enrolled through FAMIS or were only enrolled in FFS during MY 2021.[3-3]

The study population were those in the children in foster care eligible population who were continuously enrolled in either Medallion 4.0 or CCC Plus managed care programs with any MCO or a combination of MCOs during the study period, for whom a match not in a child welfare program could be found. Continuous enrollment was defined as enrollment gaps totaling no more than 45 days. Among the children in foster care eligible population, 50.9 percent (n=3,436) of children met the requirements for the study population, compared to 46.5 percent for MY 2020 and 38.5 percent for MY 2019. The demographic makeup of the study population mirrored the demographic makeup of the foster care eligible population, except that there were 2.8 percent fewer children two years of age or younger. The disproportionate exclusion of infants can be attributed to the inability of children born more than 45 days into the measurement year to meet the continuous enrollment criteria, since these children would have an enrollment gap greater than 45 days.

3-1 United States Census Bureau. Virginia QuickFacts. Available at: https://www.census.gov/quickfacts/VA. Accessed on: Jan 11, 2023.
3-2 Children in foster care may temporarily move to FFS and may not be enrolled with an MCO during the measurement year.
3-3 Children in foster care may temporarily move to FFS and may not be enrolled through a managed care program during the measurement year.

Table B-1 and Table B-4 present the demographic and health characteristics of continuously enrolled children in foster care and the continuously enrolled controls prior to matching (n=3,635). Continuously enrolled children in foster care tended to be older, male, White, less likely to be enrolled with HealthKeepers, and less likely to be enrolled through CCC Plus compared to the continuously enrolled controls. Furthermore, continuously enrolled children in foster care were less likely to live in the Tidewater or Northern & Winchester regions and more likely to live in the Charlottesville/Western, Roanoke/Alleghany, and Southwest regions. In terms of health characteristics, continuously enrolled children in foster care were more likely to have diagnoses for several health conditions, primarily mental illnesses. Additionally, children in foster care were more likely to have ED and acute inpatient visits for mental health than the controls, which may indicate greater severity of mental illness among children in foster care. The higher rate of ED visits and acute inpatient visits may also indicate that children in foster care are more likely to seek care for mental illness through these means, especially if prior access to psychiatric care had been limited prior to entering foster care. The historical Foster Care Focus Study reports demonstrated that rates often differ by member characteristics such as age and MCO, and these findings provided justification for matching children in foster care and the controls.

HSAG was able to match 94.5 percent (n=3,436) of continuously enrolled children in foster care to the controls with similar demographic and health characteristics. Table B-7 and Table B-10 present the demographic and health characteristics of the final study population and their matched controls. Matching successfully balanced all demographic and health characteristics between the study population and the controls.

Appendix B presents detailed descriptions of the demographic and health characteristics of children in foster care and children in the controls prior to matching, as well as covariate balance findings.

Healthcare Utilization Among Children in Foster Care and Controls

This section provides findings from the study indicators used to assess healthcare utilization for the children in foster care study population, as well as findings for the matched controls not enrolled through a child welfare program. The tables displayed in this section also include stratified rates and shading to indicate the results of the health disparities analysis.

Although the controls have been matched to children in foster care on a variety of demographic and health characteristics, HSAG advises caution in comparing the study indicator results between the children in foster care and controls. Due to the different criteria for denominators across measures, one child in a matched pair may be included in a measure calculation while the other child is not. When matched pairs are separated, the distribution of characteristics in the denominator-eligible study population and the denominator-eligible controls may differ from the overall distribution, and balanced covariates are no longer guaranteed. Furthermore, HSAG advises caution in interpreting the *p*-values, as denominator sizes vary by measure, and sample size influences the precision of the *p*-value calculation. When interpreting trending (e.g., comparing measure rates across measurement years), HSAG advises consideration of changes in the study methodology across measurement years, such as the inclusion of the CCC Plus population and the removal of additional aid categories from the control group in MY 2020 (i.e., “072” for Children Receiving Adoption Assistance). However, HSAG expects impacts from these methodology changes to be minimal. The Study Limitations section provides further discussion on methodology changes and trending. Healthcare utilization in MY 2020 and MY 2021 may

also be impacted by the COVID-19 pandemic; however, rate comparisons within MY 2020 and MY 2021 (i.e., to controls) are still reliable.

Primary Care[3-4]

Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+)

Table 3-2 displays the MY 2019, MY 2020, and MY 2021 *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicator measures the percentage of children who turned 15 months old during the measurement year who received six or more well-child visits with a PCP.

Table 3-2—Rates of *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	—	—	65.1%	56.1%	63.8%	60.0%
Sex						
Male	—	—	58.4%	59.5%	66.0%	59.6%
Female	—	—	74.4%	52.7%	61.4%	60.6%
Race						
Black or African American	—	—	66.3%	47.1%	60.0%	48.2%
White	—	—	64.3%	59.6%	64.8%	66.0%
Other	—	—	66.7%	100.0%	100.0%^	75.0%^
Region						
Central	—	—	51.1%	51.5%	51.5%	57.6%
Charlottesville/Western	—	—	73.1%	54.5%	66.7%	73.1%
Northern & Winchester	—	—	69.7%	57.1%	60.0%	57.7%
Roanoke/Alleghany	—	—	56.7%	65.2%	74.5%	51.7%
Southwest	—	—	66.7%	50.0%	73.3%	71.4%
Tidewater	—	—	76.1%	58.3%	58.1%	56.3%

3-4 For MY 2019, the Primary Care domain was assessed using the *Children and Adolescents' Annual Access to PCPs* (CAP) measure; however, the measure was retired for MY 2020. Therefore, the *Child and Adolescent Well-Care Visits* (WCV) measure and the *Well-Child Visits in the First 30 Months of Life* (W30) measure were introduced to assess primary care starting in MY 2020.

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
MCO						
Aetna	—	—	53.3%	37.5%	58.3%	68.4%
HealthKeepers	—	—	73.6%	56.4%	65.9%	60.0%
Molina	—	—	55.6%	44.4%	62.5%	60.0%
Optima	—	—	72.5%	75.7%	76.7%	50.0%
VA Premier	—	—	58.3%	52.8%	58.7%	52.4%
UnitedHealthcare	—	—	52.9%	42.9%	55.0%	84.6%
More Than One MCO	—	—	60.0%	20.0%	100.0%^	75.0%^

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-2 shows that 63.8 percent of children in foster care and 60.0 percent of controls who turned 15 months old during MY 2021 received six or more well-child visits with a PCP, and the difference was not statistically significant (p=0.46). The rates for children in foster care were notably higher than controls for members in the Roanoke/Alleghany region (by 22.8 percentage points) and members enrolled with HealthKeepers and VA Premier (by 5.9 and 6.3 percentage points, respectively). While there were large rate differences for members enrolled with Optima and UnitedHealthcare, these rates had small denominators, so the rates may be less reliable. The children in foster care rate was also notably higher than the control rate for the Black or African American racial group (by 11.8 percentage points) and male members (by 6.4 percentage points).

For all eligible members, the MY 2021 rates for both children in foster care and controls were above the MY 2021 national Medicaid 50th percentile. The rate of well-child visits for children in foster care declined by 1.3 percentage points from MY 2020 to MY 2021, while the rate for controls increased by 3.9 percentage points. There were no disparities identified for the children in foster care members.

Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+)

Table 3-3 displays the MY 2019, MY 2020, and MY 2021 *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child*

Visits indicator measures the percentage of children who turned 30 months old during the measurement year who received two or more well-child visits with a PCP.

Table 3-3—Rates of *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	—	—	77.6%	74.5%	79.7%	75.8%
Sex						
Male	—	—	72.8%	75.2%	81.8%	77.5%
Female	—	—	83.8%	73.3%	76.8%	73.4%
Race						
Black or African American	—	—	79.5%	68.7%	84.0%	78.1%
White	—	—	75.9%	77.9%	76.4%	75.0%
Other	—	—	100.0%	66.7%	100.0%^	50.0%^
Region						
Central	—	—	73.3%	69.7%	86.0%	56.4%
Charlottesville/Western	—	—	92.3%	76.3%	75.0%	85.0%
Northern & Winchester	—	—	75.0%	78.3%	76.9%	74.5%
Roanoke/Alleghany	—	—	52.2%	71.0%	73.7%	82.9%
Southwest	—	—	74.1%	76.0%	77.3%	76.9%
Tidewater	—	—	85.0%	76.2%	88.1%	80.6%
MCO						
Aetna	—	—	69.2%	60.0%	92.9%	85.7%
HealthKeepers	—	—	77.6%	88.2%	74.2%	75.0%
Molina	—	—	75.0%	66.7%	73.7%	70.0%
Optima	—	—	89.7%	80.9%	89.6%	84.6%
VA Premier	—	—	74.5%	69.0%	77.1%	63.8%
UnitedHealthcare	—	—	42.9%	57.9%	63.2%	83.3%
More Than One MCO	—	—	100.0%	0.0%	100.0%^	66.7%^

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.

- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-3 shows that 79.7 percent of children in foster care and 75.8 percent of controls who turned 30 months old during MY 2021 received two or more well-child visits with a PCP, and the difference was not statistically significant (p=0.31). The rates for children in foster care were notably higher than controls for members in the Central and Tidewater regions (by 29.6 and 7.5 percentage points, respectively) and members enrolled with Optima and VA Premier (by 5.0 and 13.3 percentage points, respectively). While there were large rate differences for Aetna and UnitedHealthcare, these rates had small denominators, so the rates may be less reliable. The children in foster care rate was notably higher than the control rate for members in the Black or African American racial group (by 5.9 percentage points).

For all eligible members, the MY 2021 rates for both children in foster care and controls were above the MY 2021 national Medicaid 50th percentile. The rate of well-child visits for children in foster care and controls increased by 2.1 and 1.3 percentage points, respectively, from MY 2020 to MY 2021. There were no disparities identified for the children in foster care members.

Child and Adolescent Well-Care Visits (WCV)

Table 3-4 displays the MY 2019, MY 2020, and MY 2021 *Child and Adolescent Well-Care Visits* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Child and Adolescent Well-Care Visits* indicator measures the percentage of members 3 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetrician/gynecologist (OB/GYN) during the measurement year.

Table 3-4—Rates of *Child and Adolescent Well-Care Visits* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	—	—	68.0%+	48.5%	64.8%+	54.7%
Age Category						
3 to 11 Years	—	—	72.6%	54.7%	68.5%	60.2%
12 to 17 Years	—	—	65.4%	42.4%	63.8%	50.5%
18 to 21 Years	—	—	50.9%	35.6%	45.5%	34.6%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Sex						
Male	—	—	68.0%	48.6%	64.5%	55.4%
Female	—	—	68.1%	48.3%	65.3%	53.8%
Race						
Black or African American	—	—	67.9%	49.8%	66.0%	56.9%
White	—	—	68.4%	47.9%	64.5%	53.5%
Other	—	—	60.0%	46.9%	57.7%	53.1%
Region						
Central	—	—	64.6%	42.5%	61.8%	56.2%
Charlottesville/Western	—	—	67.6%	50.4%	66.2%	50.3%
Northern & Winchester	—	—	68.0%	56.8%	63.6%	58.3%
Roanoke/Alleghany	—	—	64.5%	43.1%	61.3%	54.8%
Southwest	—	—	65.5%	38.9%	63.5%	45.6%
Tidewater	—	—	77.9%	58.5%	71.4%	61.1%
MCO						
Aetna	—	—	57.5%	42.9%	59.5%	49.6%
HealthKeepers	—	—	69.6%	53.5%	65.8%	61.4%
Molina	—	—	63.6%	30.5%	59.5%	46.6%
Optima	—	—	70.4%	51.2%	65.4%	55.2%
VA Premier	—	—	68.5%	44.9%	65.9%	51.2%
UnitedHealthcare	—	—	64.6%	48.8%	63.4%	48.8%
More Than One MCO	—	—	68.3%	53.8%	72.5%	62.7%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-4 shows that 64.8 percent of children in foster care and 54.7 percent of controls had a well-care visit with a PCP or an OB/GYN during MY 2021, and the difference was statistically significant ($p<0.001$). The rates for children in foster care were higher than controls for members across all

stratified rates, with the largest differences in the Southwest region and members enrolled with VA Premier (17.9 and 14.7 percentage points, respectively).

MY 2021 rates for both the children in foster care and controls were above the MY 2021 national Medicaid 50th percentile for all age categories. The rate of well-care visits for children in foster care declined by 3.2 percentage points from MY 2020 to MY 2021, while the rate for controls increased by 6.2 percentage points. For both children in foster care and controls, members in the Tidewater region were significantly more likely to have a well-care visit than all other regions in MY 2021. Additionally, for both children in foster care and controls, members 3 to 11 years of age were significantly more likely to have a well-care visit, but members 18 to 21 years of age were significantly less likely to have a visit in MY 2021.

Oral Health

Annual Dental Visit (ADV)

Table 3-5 displays the MY 2019, MY 2020, and MY 2021 *Annual Dental Visit* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Annual Dental Visit* indicator measures the percentage of members 2 to 20 years of age who had at least one dental visit during the measurement year. Since the children in foster care population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 3-5—Rates of *Annual Dental Visits* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	86.9%+	63.4%	79.1%+	50.0%	70.6%+	52.4%
Age Category						
≤ 2 Years	76.3%	43.5%	67.4%	38.0%	59.1%	38.9%
3 to 5 Years	87.3%	68.6%	82.1%	51.4%	70.4%	53.1%
6 to 10 Years	90.9%	68.0%	82.4%	56.3%	74.0%	59.1%
11 to 13 Years	88.9%	67.2%	82.0%	54.3%	77.5%	56.5%
≥ 14 Years	86.7%	61.4%	78.9%	47.4%	70.2%	50.8%
Sex						
Male	86.2%	61.8%	77.6%	49.6%	68.8%	51.2%
Female	87.8%	65.3%	81.0%	50.6%	72.7%	53.9%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Race						
Black or African American	87.8%	62.9%	78.0%	44.8%	71.2%	53.5%
White	86.4%	63.5%	80.1%	52.5%	70.2%	51.9%
Other	87.3%	66.7%	70.0%	55.9%	70.2%	52.4%
Region						
Central	86.0%	65.2%	78.3%	46.2%	70.0%	53.2%
Charlottesville/Western	83.0%	59.5%	76.8%	52.9%	68.1%	49.5%
Northern & Winchester	89.0%	71.4%	80.6%	57.5%	71.9%	64.4%
Roanoke/Alleghany	86.1%	59.5%	76.9%	45.4%	64.9%	45.2%
Southwest	88.3%	62.1%	81.4%	47.7%	75.7%	53.3%
Tidewater	90.5%	62.4%	81.9%	51.3%	73.9%	50.3%
MCO						
Aetna	81.1%	54.1%	75.7%	43.1%	67.7%	51.6%
HealthKeepers	88.6%	66.2%	77.6%	52.9%	71.2%	55.0%
Molina	82.6%	52.4%	82.9%	39.5%	64.4%	48.4%
Optima	87.3%	61.5%	77.0%	49.7%	68.7%	48.1%
VA Premier	87.3%	67.0%	81.2%	49.8%	71.1%	54.4%
UnitedHealthcare	82.4%	54.6%	80.2%	51.6%	77.7%	50.9%
More Than One MCO	89.1%	66.4%	90.6%	58.3%	79.7%	58.9%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-5 shows that 70.6 percent of children in foster care and 52.4 percent of controls had a dental visit during MY 2021, and the difference was statistically significant ($p<0.001$). The rates for children in foster care were higher than controls for members across all stratified rates, with the largest difference being for the Tidewater region (by 23.6 percentage points) and for members enrolled with UnitedHealthcare (by 26.8 percentage points).

Rates for both the children in foster care and the control members were above the MY 2021 national Medicaid 50th percentile for the 14 years of age and older group, and rates for children in foster care only were higher than the national Medicaid 50th percentiles for all other age groups.[3-5] The rate for children in foster care declined by 8.5 percentage points from MY 2020 to MY 2021, while the rate for controls increased by 2.4 percentage points. For children in foster care, female members were significantly more likely to have a dental visit compared to male members in MY 2021. For both children in foster care and controls, members in the Roanoke/Alleghany region were significantly less likely to have a dental visit compared to all other regions. Children in foster care were significantly more likely to have a dental visit in the Southwest region. Additionally, for children in foster care only, members enrolled with UnitedHealthcare were significantly more likely to have a dental visit than all other MCOs. For both children in foster care and controls, members 6 to 10 years of age were significantly more likely to have a dental visit compared to members in other age categories, while members 2 years of age and younger were significantly less likely. For children in foster care only, members 11 to 13 years of age were significantly more likely to have a dental visit.

Preventive Dental Services (PDENT-CH)

Table 3-6 displays the MY 2019, MY 2020, and MY 2021 *Preventive Dental Services* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Preventive Dental Services* indicator measures the percentage of members 1 to 20 years of age and eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services who received at least one preventive dental service during the measurement year. Since the children in foster care population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 3-6—Rates of *Preventive Dental Services* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	81.7%+	56.5%	72.0%+	42.8%	64.6%+	45.6%
Age Category						
≤ 2 Years	63.7%	32.9%	53.8%	28.3%	50.2%	31.0%
3 to 5 Years	85.5%	66.0%	79.3%	47.5%	68.4%	49.1%
6 to 10 Years	89.4%	65.7%	79.6%	52.6%	70.9%	55.9%
11 to 13 Years	85.7%	62.5%	77.2%	48.7%	71.2%	49.4%

[3-5] Since the national benchmarks have different age stratifications than the age categories in this report, comparisons were made between the age stratifications that were the most similar.

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
≥ 14 Years	80.8%	52.7%	71.3%	38.6%	63.5%	42.5%
Sex						
Male	81.3%	55.5%	70.9%	42.4%	64.1%	44.9%
Female	82.1%	57.7%	73.2%	43.2%	65.1%	46.4%
Race						
Black or African American	83.0%	56.6%	71.8%	38.6%	66.5%	47.5%
White	80.8%	56.2%	72.3%	44.8%	63.5%	44.5%
Other	84.4%	61.4%	64.5%	48.6%	64.8%	48.3%
Region						
Central	80.7%	57.1%	70.4%	39.4%	64.8%	46.7%
Charlottesville/Western	78.3%	53.2%	71.7%	45.0%	60.4%	42.0%
Northern & Winchester	85.5%	64.4%	74.7%	52.2%	65.6%	57.2%
Roanoke/Alleghany	78.4%	52.7%	66.0%	37.0%	57.2%	38.7%
Southwest	83.1%	55.6%	73.0%	40.4%	70.3%	45.8%
Tidewater	85.1%	56.2%	76.2%	43.5%	70.3%	44.3%
MCO						
Aetna	72.2%	50.8%	64.8%	36.7%	62.7%	46.5%
HealthKeepers	84.8%	59.2%	71.3%	45.9%	65.3%	49.4%
Molina	74.7%	38.4%	73.3%	32.3%	56.2%	38.4%
Optima	82.8%	54.3%	70.8%	42.1%	64.4%	40.5%
VA Premier	80.8%	60.3%	74.8%	42.6%	64.0%	46.6%
UnitedHealthcare	77.7%	47.2%	70.2%	45.7%	70.8%	44.6%
More Than One MCO	84.4%	61.9%	79.8%	46.7%	73.8%	54.4%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-6 shows that 64.6 percent of children in foster care and 45.6 percent of controls had at least one preventive dental service during MY 2021, and the difference was statistically significant ($p<0.001$). The children in foster care rates were higher than controls across all stratified rates, with the largest difference being for the Tidewater region (by 26.0 percentage points) and for members enrolled with UnitedHealthcare (by 26.2 percentage points).

MY 2021 national Medicaid benchmarks were not available for this indicator. The rate for children in foster care declined by 7.4 percentage points from MY 2020 to MY 2021, while the rate for controls increased by 2.8 percentage points. For both children in foster care and controls, members in the Charlottesville/Western and Roanoke/Alleghany regions were significantly less likely to have a preventive dental service during MY 2021. For children in foster care only, members in the Southwest and Tidewater regions were significantly more likely to have a preventive dental service compared to members in other regions. Additionally, for both children in foster care and controls, members enrolled with Molina were significantly less likely to have a preventive dental service compared to members enrolled with other MCOs. For children in foster care only, members that had at least one preventive dental service were significantly more likely to be enrolled with UnitedHealthcare than all other MCOs. For both children in foster care and controls, members 6 to 10 years of age were significantly more likely to have a preventive dental service compared to members in other age groups, while members 2 years of age and younger were significantly less likely. For children in foster care only, members 3 to 5 and 11 to 13 years of age were significantly more likely to have at least one preventive dental service compared to members in other age groups.

Oral Evaluation, Dental Services (OEV-CH)

Table 3-7 displays the MY 2019, MY 2020, and MY 2021 *Oral Evaluation, Dental Services* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Oral Evaluation, Dental Services* indicator measures the percentage of enrolled children under 21 years of age who received a comprehensive or periodic oral evaluation within the measurement year. Since the children in foster care population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 3-7—Rates of *Oral Evaluation, Dental Services* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	—	—	—	—	63.5%+	44.5%
Age Category						
≤ 2 Years	—	—	—	—	51.5%	30.2%
3 to 5 Years	—	—	—	—	66.7%	46.9%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
6 to 10 Years	—	—	—	—	68.7%	54.5%
11 to 13 Years	—	—	—	—	68.4%	47.0%
≥ 14 Years	—	—	—	—	63.1%	43.3%
Sex						
Male	—	—	—	—	63.0%	44.0%
Female	—	—	—	—	64.1%	45.1%
Race						
Black or African American	—	—	—	—	65.1%	47.0%
White	—	—	—	—	62.5%	43.0%
Other	—	—	—	—	65.9%	47.7%
Region						
Central	—	—	—	—	65.4%	46.2%
Charlottesville/Western	—	—	—	—	56.8%	39.4%
Northern & Winchester	—	—	—	—	65.5%	56.8%
Roanoke/Alleghany	—	—	—	—	55.6%	36.7%
Southwest	—	—	—	—	69.2%	44.9%
Tidewater	—	—	—	—	69.9%	44.2%
MCO						
Aetna	—	—	—	—	60.6%	45.3%
HealthKeepers	—	—	—	—	65.5%	49.1%
Molina	—	—	—	—	56.2%	36.9%
Optima	—	—	—	—	62.9%	40.1%
VA Premier	—	—	—	—	61.7%	44.4%
UnitedHealthcare	—	—	—	—	71.2%	42.4%
More Than One MCO	—	—	—	—	72.3%	53.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).

+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.

- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-7 shows that 63.5 percent of children in foster care and 44.5 percent of controls received a comprehensive or periodic oral evaluation during MY 2021, and the difference was statistically significant (p<0.001). The rates for children in foster care were notably higher than controls across all stratified rates, with the largest differences being for the Tidewater region (by 25.7 percentage points) and for members enrolled with UnitedHealthcare (by 28.8 percentage points).

MY 2021 national Medicaid benchmarks were not available for this indicator. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both children in foster care and controls, members in the Charlottesville/Western and Roanoke/Alleghany regions were significantly less likely to have an oral evaluation during MY 2021. Children in foster care were significantly more likely to have an oral evaluation in the Southwest and Tidewater regions compared to all other regions. For both children in foster care and controls, members enrolled with Molina were significantly less likely to have an oral evaluation than all other MCOs. For children in foster care only, members enrolled with UnitedHealthcare were significantly more likely to have an oral evaluation compared to members enrolled with other MCOs. For both children in foster care and controls, members 6 to 10 years of age were significantly more likely to have an oral evaluation compared to members in other age groups. For children in foster care only, members 11 to 13 years of age were significantly more likely to have an oral evaluation compared to members in other age groups.

Topical Fluoride for Children—Dental or Oral Health Services (TFL-CH)

Table 3-8 displays the MY 2019, MY 2020, and MY 2021 *Topical Fluoride for Children—Dental or Oral Health Services* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Topical Fluoride for Children—Dental or Oral Health Services* indicator measures the percentage of enrolled children 1 through 20 years of age who received at least two topical fluoride applications as dental or oral health services during the measurement year. Since the children in foster care population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 3-8—Rates of *Topical Fluoride for Children—Dental or Oral Health Services* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	—	—	—	—	35.0%+	20.8%
Age Category						
≤ 2 Years	—	—	—	—	29.5%	20.5%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
3 to 5 Years	—	—	—	—	36.5%	19.9%
6 to 10 Years	—	—	—	—	41.9%	25.8%
11 to 13 Years	—	—	—	—	43.6%	24.4%
≥ 14 Years	—	—	—	—	27.5%	15.4%
Sex						
Male	—	—	—	—	34.5%	19.7%
Female	—	—	—	—	35.7%	22.2%
Race						
Black or African American	—	—	—	—	35.0%	19.3%
White	—	—	—	—	35.1%	21.3%
Other	—	—	—	—	33.3%	28.7%
Region						
Central	—	—	—	—	38.4%	21.9%
Charlottesville/Western	—	—	—	—	30.8%	18.2%
Northern & Winchester	—	—	—	—	41.9%	30.2%
Roanoke/Alleghany	—	—	—	—	24.5%	16.5%
Southwest	—	—	—	—	33.1%	18.4%
Tidewater	—	—	—	—	40.5%	20.1%
MCO						
Aetna	—	—	—	—	30.2%	21.8%
HealthKeepers	—	—	—	—	38.8%	25.1%
Molina	—	—	—	—	30.7%	15.8%
Optima	—	—	—	—	34.6%	18.2%
VA Premier	—	—	—	—	32.6%	19.7%
UnitedHealthcare	—	—	—	—	34.2%	17.6%
More Than One MCO	—	—	—	—	52.5%	24.1%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-8 shows that 35.0 percent of children in foster care and 20.8 percent of controls received at least two topical fluoride applications as dental or oral health services during MY 2021, and the difference was statistically significant ($p<0.001$). Low rates may be due to some topical fluoride treatments not being captured in the administrative data, and the American Dental Association (ADA) only recommends fluoride treatment for people at elevated risk for caries.[3-6] Additionally, the ADA has less strict clinical recommendations for people 6 years of age and older (e.g., people 6 years of age or older can use home-use fluoride treatments instead of receiving fluoride varnish, and two out of three procedure codes in the *Topical Fluoride for Children* specifications are for fluoride varnish).[3-7] The rates for children in foster care were higher than controls across all stratified rates, with the largest difference being for the Tidewater region (by 20.4 percentage points) and for members enrolled with More Than One MCO (by 28.4 percentage points).

MY 2021 national Medicaid benchmarks were not available for this indicator. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both children in foster care and controls, members in the Northern & Winchester region were significantly more likely to receive at least two topical fluoride applications compared to the Roanoke/Alleghany region than all other regions during MY 2021. For children in foster care only, members in the Central and Tidewater regions were significantly more likely to receive at least two topical fluoride applications compared to members in other regions, and significantly less likely in the Charlottesville/Western region. For both children in foster care and controls, members enrolled with HealthKeepers were significantly more likely to receive at least two topical fluoride applications during MY 2021 compared to members enrolled with other MCOs. For children in foster care only, members enrolled with More Than One MCO were significantly more likely to receive at least two topical fluoride applications than all other MCOs. For both children in foster care and controls, members 6 to 10 and 11 to 13 years of age were significantly more likely to receive at least two topical fluoride applications compared to members in other age categories, while members 14 years of age and older were less likely. For children in foster care only, members 2 years of age and younger were significantly less likely to receive at least two topical fluoride applications as dental or oral health services.

Topical Fluoride for Children—Dental Services (TFL-CH)

Table 3-9 displays the MY 2019, MY 2020, and MY 2021 *Topical Fluoride for Children—Dental Services* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Topical Fluoride for Children—Dental Services* indicator measures the percentage of enrolled children 1 through 20 years of age who received at least two topical fluoride applications as dental services within

3-6 American Dental Association. Fluoride: Topical and Systematic Supplements. Available at: https://www.ada.org/resources/research/science-and-research-institute/oral-health-topics/fluoride-topical-and-systemic-supplements. Accessed on: Jan 11, 2023.
3-7 Ibid.

the measurement year. Since the children in foster care population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 3-9—Rates of *Topical Fluoride for Children—Dental Services* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	—	—	—	—	28.3%+	16.0%
Age Category						
≤ 2 Years	—	—	—	—	17.7%	9.1%
3 to 5 Years	—	—	—	—	29.8%	16.7%
6 to 10 Years	—	—	—	—	35.6%	21.3%
11 to 13 Years	—	—	—	—	38.0%	21.4%
≥ 14 Years	—	—	—	—	23.7%	13.0%
Sex						
Male	—	—	—	—	27.8%	15.3%
Female	—	—	—	—	29.0%	16.9%
Race						
Black or African American	—	—	—	—	28.4%	15.0%
White	—	—	—	—	28.5%	16.4%
Other	—	—	—	—	23.0%	20.7%
Region						
Central	—	—	—	—	28.6%	16.7%
Charlottesville/Western	—	—	—	—	24.8%	12.8%
Northern & Winchester	—	—	—	—	35.0%	23.4%
Roanoke/Alleghany	—	—	—	—	19.8%	12.5%
Southwest	—	—	—	—	27.5%	16.5%
Tidewater	—	—	—	—	34.3%	15.4%
MCO						
Aetna	—	—	—	—	23.7%	15.4%
HealthKeepers	—	—	—	—	31.9%	19.6%
Molina	—	—	—	—	23.6%	11.4%
Optima	—	—	—	—	27.6%	13.0%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
VA Premier	—	—	—	—	26.7%	16.0%
UnitedHealthcare	—	—	—	—	28.4%	15.1%
More Than One MCO	—	—	—	—	41.3%	19.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-9 shows that 28.3 percent of children in foster care and 16.0 percent of controls received at least two topical fluoride applications as dental services during MY 2021, and the difference was statistically significant ($p<0.001$). The children in foster care rates were higher than controls for members across all stratified rates, with the largest differences being for the Tidewater region (by 18.9 percentage points) and for members enrolled with More Than One MCO (by 22.3 percentage points).

MY 2021 national Medicaid benchmarks were not available for this indicator. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both children in foster care and controls, members were significantly more likely to receive at least two topical fluoride applications in the Northern & Winchester regions compared to members in other regions during MY 2021, while members in the Charlottesville/Western and Roanoke/Alleghany regions were less likely. For both children in foster care and controls, members enrolled with HealthKeepers were significantly more likely to receive at least two topical fluoride applications compared to members enrolled with other MCOs. For children in foster care only, members enrolled with More Than One MCO were significantly more likely to receive at least two topical fluoride applications than all other MCOs. For both children in foster care and controls, members 6 to 10 and 11 to 13 years of age were significantly more likely to receive at least two topical fluoride applications compared to members in other age categories, while members 2 years of age and younger and 14 years of age and older were significantly less likely.

Topical Fluoride for Children—Oral Health Services (TFL-CH)

Table 3-10 displays the MY 2019, MY 2020, and MY 2021 *Topical Fluoride for Children—Oral Health Services* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Topical Fluoride for Children—Oral Health Services* indicator measures the percentage of enrolled children 1 through 20 years of age who received at least two topical fluoride applications as oral health services

within the measurement year. Since the children in foster care population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 3-10—Rates of *Topical Fluoride for Children—Oral Health Services* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	—	—	—	—	2.4%	2.1%
Age Category						
≤ 2 Years	—	—	—	—	5.9%	8.2%
3 to 5 Years	—	—	—	—	2.7%	0.3%
6 to 10 Years	—	—	—	—	2.0%	0.7%
11 to 13 Years	—	—	—	—	1.5%	0.9%
≥ 14 Years	—	—	—	—	0.6%	1.0%
Sex						
Male	—	—	—	—	2.7%	2.2%
Female	—	—	—	—	2.2%	2.1%
Race						
Black or African American	—	—	—	—	2.0%	1.7%
White	—	—	—	—	2.7%	2.4%
Other	—	—	—	—	2.3%	3.4%
Region						
Central	—	—	—	—	1.8%	1.4%
Charlottesville/Western	—	—	—	—	3.0%	2.7%
Northern & Winchester	—	—	—	—	1.9%	3.1%
Roanoke/Alleghany	—	—	—	—	2.7%	2.1%
Southwest	—	—	—	—	3.3%	1.2%
Tidewater	—	—	—	—	2.1%	2.3%
MCO						
Aetna	—	—	—	—	1.6%	2.2%
HealthKeepers	—	—	—	—	2.3%	2.1%
Molina	—	—	—	—	2.0%	3.5%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Optima	—	—	—	—	2.9%	3.0%
VA Premier	—	—	—	—	2.7%	1.3%
UnitedHealthcare	—	—	—	—	1.2%	1.7%
More Than One MCO	—	—	—	—	5.0%	2.5%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-10 shows that 2.4 percent of children in foster care and 2.1 percent of controls received at least two topical fluoride applications as oral health services during MY 2021, and the difference was not statistically significant (p=0.43). The rates for children in foster care and controls were similar across the stratified rates, except for rates stratified by age category. While the rates for children in foster care were higher than controls for members 3 to 5, 6 to 10, and 11 to 13 years of age (by 2.4, 1.3, and 0.6 percentage points, respectively), the rates for children in foster care 2 years of age and younger and 14 years of age and older were 2.3 and 0.4 percentage points lower than controls, respectively.

MY 2021 national Medicaid benchmarks were not available for this indicator. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both children in foster care and controls, members 2 years of age and younger were significantly more likely to receive at least two topical fluoride applications compared to members in other age categories, while members 14 years of age and older were significantly less likely.

Behavioral Health

Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up (FUH)

Table 3-11 displays the MY 2019, MY 2020, and MY 2021 *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* indicator measures the percentage of discharges for children 6 to 17 years of age who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses for which the member had a follow-up visit within seven days after discharge with a mental health provider. Since the children in foster care

population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 3-11—Rates of *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	38.7%	44.6%	65.6%	59.2%	64.2%	59.7%
Age Category						
3 to 5 Years	100.0%	—	100.0%	0.0%	100.0%^	—
6 to 10 Years	57.9%	45.5%	82.4%	87.5%	81.0%	50.0%
11 to 13 Years	34.4%	45.5%	72.7%	50.0%	71.0%	68.8%
≥ 14 Years	33.3%	44.2%	56.6%	57.7%	51.9%	57.5%
Sex						
Male	42.5%	31.0%	63.2%	61.5%	75.9%	58.8%
Female	36.4%	55.6%	67.3%	58.3%	59.7%	60.0%
Race						
Black or African American	42.6%	21.7%	60.0%	77.8%	60.5%	72.7%
White	34.5%	54.1%	68.4%	55.0%	68.2%	53.8%
Other	100.0%	80.0%	100.0%	—	0.0%^	0.0%^
Region						
Central	34.3%	27.3%	70.6%	70.0%	42.3%	72.7%
Charlottesville/Western	56.3%	42.9%	55.6%	55.6%	55.6%	53.3%
Northern & Winchester	16.7%	57.1%	25.0%	0.0%	93.3%	25.0%
Roanoke/Alleghany	50.0%	70.0%	57.1%	83.3%	73.7%	70.0%
Southwest	28.6%	42.9%	87.5%	62.5%	57.1%	28.6%
Tidewater	34.6%	39.1%	85.7%	50.0%	83.3%	73.3%
MCO						
Aetna	54.5%	0.0%	53.8%	50.0%	50.0%	80.0%
HealthKeepers	28.1%	30.0%	64.3%	63.6%	74.2%	73.9%
Molina	66.7%	50.0%	71.4%	66.7%	71.4%	37.5%
Optima	30.8%	47.4%	81.3%	50.0%	59.3%	50.0%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
VA Premier	47.6%	61.5%	57.9%	61.5%	54.2%	53.3%
UnitedHealthcare	37.5%	100.0%	50.0%	66.7%	50.0%^	0.0%^
More Than One MCO	60.0%	28.6%	33.3%	100.0%	85.7%	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-11 shows that 64.2 percent of children in foster care and 59.7 percent of controls had a follow-up visit within seven days after discharge with a mental health provider during MY 2021, and the difference was not statistically significant (p=0.56). Rates for children in foster care were notably higher than controls for the White racial group (by 14.4 percentage points). While there were large rate differences between children in foster care and controls for members 6 to 10 years of age; male members; members in the Northern & Winchester, Southwest, Tidewater, and Central regions; and members enrolled with Molina, Optima, and Aetna, these rates had small denominators, so rates may be less reliable.

For all eligible members, the MY 2021 rates for both children in foster care and controls were above the MY 2021 national Medicaid 50th percentile. The rate for children in foster care declined from MY 2020 to MY 2021 by 1.4 percentage points, while the rate for controls increased by 0.5 percentage points. For children in foster care only, members in the Northern & Winchester regions were significantly more likely to have a follow-up visit within seven days after discharge with a mental health provider compared to members in other regions in MY 2021, while members in the Central region were less likely. Additionally, children in foster care who were 14 years of age and older were significantly less likely to have a follow-up visit within seven days after discharge with a mental health provider compared to all other age groups.

Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up (FUM)

Table 3-12 displays the MY 2019, MY 2020, and MY 2021 *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* indicator measures the percentage of ED visits for children 6 to 17 years of age with a principal diagnosis of mental illness or intentional self-harm for which the member had a follow-up visit for mental illness within 30 days of the ED visit. Since the children in foster care population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 3-12—Rates of *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	92.6%+	83.9%	87.8%	78.9%	92.9%	81.5%
Age Category						
3 to 5 Years	100.0%	0.0%	100.0%	—	—	—
6 to 10 Years	93.3%	100.0%	100.0%	83.3%	100.0%^	87.5%^
11 to 13 Years	92.3%	62.5%	90.9%	75.0%	80.0%	83.3%
≥ 14 Years	92.0%	95.0%	80.8%	77.8%	92.0%	76.9%
Sex						
Male	90.9%	100.0%	78.9%	88.9%	93.3%	90.9%
Female	93.8%	76.2%	93.3%	70.0%	92.6%	75.0%
Race						
Black or African American	85.7%	70.0%	86.7%	80.0%	93.8%^	100.0%^
White	96.8%	90.5%	87.9%	75.0%	92.0%^	68.8%^
Other	100.0%	—	100.0%	100.0%	100.0%^	100.0%^
Region						
Central	84.6%	62.5%	92.9%	60.0%	100.0%^	100.0%^
Charlottesville/Western	92.3%	100.0%	66.7%	75.0%	88.9%	80.0%
Northern & Winchester	83.3%	75.0%	100.0%	100.0%	100.0%^	66.7%^
Roanoke/Alleghany	100.0%	80.0%	81.8%	100.0%	100.0%^	50.0%^
Southwest	100.0%	100.0%	100.0%	—	100.0%^	—
Tidewater	100.0%	100.0%	85.7%	80.0%	83.3%^	100.0%^
MCO						
Aetna	100.0%	100.0%	100.0%	50.0%	100.0%^	50.0%^
HealthKeepers	100.0%	87.5%	89.5%	100.0%	90.9%	90.0%
Molina	75.0%	—	—	100.0%	100.0%^	100.0%^
Optima	87.5%	100.0%	81.8%	71.4%	83.3%	83.3%
VA Premier	89.5%	80.0%	84.6%	100.0%	90.0%	71.4%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
UnitedHealthcare	100.0%	100.0%	—	—	100.0%^	100.0%^
More Than One MCO	100.0%	0.0%	100.0%	100.0%	100.0%^	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-12 shows that 92.9 percent of children in foster care and 81.5 percent of controls had a follow-up visit for mental illness within 30 days of the ED visit during MY 2021, and the difference was not statistically significant (p=<0.001). While there were large rate differences between children in foster care and controls for members 6 to 10 and 14 years of age and older, members in the Black or African American and White racial groups, members in the Charlottesville/Western region, and members enrolled with VA Premier, these rates had small denominators so the rates may be less reliable.

For all eligible members, the MY 2021 rates for both children in foster care and controls were above the MY 2021 national Medicaid 50th percentile. The rates for children in foster care and controls increased from MY 2020 to MY 2021 by 5.1 and 2.6 percentage points, respectively. There were no disparities identified for children in foster care.

Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing (APM)

Table 3-13 displays the MY 2019, MY 2020, and MY 2021 *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing* indicator measures the percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and who received blood glucose and cholesterol testing. Since the children in foster care population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 3-13—Rates of *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	40.8%+	30.1%	38.3%	27.8%	38.0%	35.7%
Age Category						
≤ 2 Years	—	—	0.0%	—	—	—
3 to 5 Years	41.7%	28.6%	50.0%	0.0%	25.0%	85.7%
6 to 10 Years	34.1%	20.8%	28.9%	15.8%	36.8%	35.6%
11 to 13 Years	50.0%	29.6%	39.0%	35.5%	36.4%	28.1%
≥ 14 Years	39.7%	38.9%	42.4%	36.1%	40.8%	33.3%
Sex						
Male	40.2%	31.5%	41.1%	25.0%	36.2%	36.7%
Female	41.5%	27.8%	34.8%	32.5%	40.0%	34.0%
Race						
Black or African American	37.8%	24.3%	34.7%	15.6%	41.4%	36.4%
White	42.8%	30.0%	40.5%	32.0%	35.4%	36.3%
Other	50.0%	66.7%	25.0%	100.0%	75.0%^	0.0%^
Region						
Central	38.0%	22.7%	39.4%	31.8%	42.3%	34.6%
Charlottesville/Western	35.6%	14.3%	35.3%	25.0%	36.6%	46.4%
Northern & Winchester	46.9%	43.5%	43.8%	30.8%	42.9%	30.0%
Roanoke/Alleghany	39.5%	33.3%	35.3%	21.1%	18.4%	43.8%
Southwest	56.5%	26.1%	41.5%	45.5%	55.9%	46.2%
Tidewater	40.0%	32.4%	36.6%	22.6%	38.2%	21.2%
MCO						
Aetna	47.1%	33.3%	30.8%	60.0%	58.8%	33.3%
HealthKeepers	38.9%	26.0%	28.0%	32.5%	39.8%	26.7%
Molina	33.3%	100.0%	50.0%	33.3%	10.5%	25.0%
Optima	32.8%	26.3%	44.1%	14.8%	36.5%	35.5%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
VA Premier	50.0%	32.6%	45.7%	28.6%	41.3%	57.1%
UnitedHealthcare	57.1%	10.0%	45.5%	16.7%	53.8%	33.3%
More Than One MCO	33.3%	54.5%	25.0%	33.3%	14.3%^	0.0%^

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-13 shows that 38.0 percent of children in foster care and 35.7 percent of controls with two or more antipsychotic prescriptions received blood glucose and cholesterol testing during MY 2021, and the difference was not statistically significant (p=0.67). The rates for children in foster care were notably higher than controls for members 11 to 13 and 14 years of age and older (by 8.3 and 7.5 percentage points, respectively) and female members (by 6.0 percentage points). While there were large rate differences between children in foster care and controls for members 3 to 5 years of age; members in the Other racial group; members in the Central, Northern & Winchester, and Southwest regions; and members enrolled with Aetna, UnitedHealthcare, Molina, and VA Premier, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2021 rates for both children in foster care and controls were above the MY 2021 national Medicaid 50th percentile. The rate for children in foster care declined from MY 2020 to MY 2021 by 0.3 percentage points, while the rate for controls increased by 7.9 percentage points. Children in foster care in the Southwest region were significantly more likely to receive blood glucose and cholesterol testing compared to members in other regions during MY 2021, while members in the Roanoke/Alleghany region were significantly less likely. Additionally, for children in foster care, members enrolled with Molina were significantly less likely to receive blood glucose and cholesterol testing compared to members enrolled with other MCOs.

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

Table 3-14 displays the MY 2019, MY 2020, and MY 2021 *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* indicator measures the percentage of children and adolescents 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as

first-line treatment. Since the children in foster care population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 3-14—Rates of *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	90.7%	67.7%	92.4%+	78.9%	89.2%+	68.4%
Age Category						
≤ 2 Years	—	—	100.0%	—	—	—
3 to 5 Years	60.0%	0.0%	90.9%	66.7%	80.0%	75.0%
6 to 10 Years	95.7%	83.3%	89.3%	72.7%	86.4%	90.0%
11 to 13 Years	100.0%	66.7%	90.5%	80.0%	88.9%	70.0%
≥ 14 Years	86.7%	75.0%	100.0%	85.7%	93.9%	50.0%
Sex						
Male	89.8%	64.7%	86.0%	66.7%	91.2%	75.0%
Female	92.3%	71.4%	100.0%	94.1%	87.8%	57.1%
Race						
Black or African American	86.1%	42.9%	95.7%	75.0%	96.3%	69.2%
White	94.6%	75.0%	90.9%	84.0%	85.7%	69.6%
Other	100.0%	—	100.0%	0.0%	—	50.0%
Region						
Central	90.5%	66.7%	92.9%	88.9%	88.9%	87.5%
Charlottesville/Western	92.9%	66.7%	77.8%	100.0%	91.7%	37.5%
Northern & Winchester	90.0%	100.0%	83.3%	0.0%	80.0%	75.0%
Roanoke/Alleghany	87.5%	90.9%	100.0%	87.5%	90.9%	50.0%
Southwest	100.0%	42.9%	100.0%	—	83.3%	75.0%
Tidewater	90.0%	25.0%	88.9%	64.3%	94.7%	80.0%
MCO						
Aetna	100.0%	33.3%	100.0%	50.0%	100.0%^	0.0%^
HealthKeepers	93.1%	90.0%	86.4%	80.0%	90.5%	81.8%
Molina	100.0%	—	100.0%	100.0%	90.9%	50.0%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Optima	77.8%	0.0%	100.0%	76.9%	81.8%^	100.0%^
VA Premier	90.9%	81.8%	90.3%	80.0%	85.7%	61.5%
UnitedHealthcare	100.0%	50.0%	100.0%	—	66.7%	50.0%
More Than One MCO	100.0%	33.3%	100.0%	100.0%	100.0%^	0.0%^

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-14 shows that 89.2 percent of children in foster care and 68.4 percent of controls had documentation of psychosocial care as first-line treatment during MY 2021, and the difference was statistically significant (p=0.01). While there were large rate differences between children in foster care and controls for most stratified rates, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2021 rates for both children in foster care and controls were above the MY 2021 national Medicaid 50th percentile. The rates for children in foster care and controls declined from MY 2020 to MY 2021 by 3.2 and 10.5 percentage points, respectively. There were no disparities identified for the children in foster care population.

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Table 3-15 displays the MY 2019, MY 2020, and MY 2021 *Follow-Up Care for Children Prescribed ADHD Medication* measure rates among children in foster care and controls by month of follow-up. Table 3-16 displays the MY 2019, MY 2020, and MY 2021 *Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up* indicator rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Follow-Up Care for Children Prescribed ADHD Medication* indicator measures the percentage of children and adolescents 6 to 12 years of age who were newly prescribed ADHD medication who had a follow-up visit within one, two, three, six, or nine months of when the first ADHD medication was dispensed.

Table 3-15—Rates of *Follow-Up Care for Children Prescribed ADHD Medication* Among Children in Foster Care and Controls, by Month of Follow-Up

Month of Follow-Up	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
One-Month	80.8%	78.9%	86.8%	74.8%	78.1%	66.4%
Two-Months	92.5%	88.6%	92.5%	85.4%	88.6%	81.8%
Three-Month	95.0%	91.9%	95.3%	87.8%	93.0%	90.2%
Six-Month	98.3%	98.4%	99.1%	95.9%	96.5%	96.5%
Nine-Month	100.0%	99.2%	99.1%	96.7%	98.2%	97.2%

Table 3-15 shows that 78.1 percent of children in foster care had a follow-up visit within one month of when their first ADHD medication was dispensed, and 98.2 percent of children in foster care had a follow-up visit within nine months. Additionally, the rates for children in foster care were 11.7, 6.8, 2.8, 0.0, and 1.0 percentage points higher than controls for a follow-up visit within one month, two months, three months, six months, and nine months, respectively. These findings indicate that children in foster care are more likely to have a follow-up visit earlier than controls, and this gap between children in foster care and controls closes over time after the ADHD medication is dispensed.

Table 3-16—Rates of *Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	80.8%	78.9%	86.8%+	74.8%	78.1%+	66.4%
Age Category						
6 to 10 Years	85.2%	78.3%	86.7%	79.8%	78.8%	66.7%
11 to 13 Years	68.8%	80.6%	87.1%	61.8%	75.9%	65.9%
Sex						
Male	77.6%	80.0%	83.1%	79.2%	75.6%	67.7%
Female	86.4%	77.1%	94.3%	68.6%	83.3%	64.0%
Race						
Black or African American	78.6%	73.5%	85.4%	67.5%	77.5%	62.3%
White	84.0%	81.7%	87.7%	78.0%	77.8%	68.6%
Other	33.3%	100.0%	100.0%	100.0%	100.0%^	75.0%^

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Region						
Central	83.8%	82.6%	83.9%	75.0%	79.3%	53.6%
Charlottesville/Western	86.7%	75.0%	86.7%	81.8%	63.6%	62.1%
Northern & Winchester	91.7%	71.4%	87.5%	70.0%	80.0%	75.0%
Roanoke/Alleghany	84.2%	84.2%	84.6%	65.2%	90.9%	80.0%
Southwest	57.1%	75.0%	100.0%	78.6%	73.3%	81.3%
Tidewater	73.3%	80.0%	90.5%	76.9%	86.4%	60.6%
MCO						
Aetna	87.5%	85.7%	100.0%	100.0%	72.7%	62.5%
HealthKeepers	80.0%	82.2%	90.3%	66.7%	78.6%	57.4%
Molina	100.0%	100.0%	100.0%	66.7%	66.7%	60.0%
Optima	87.0%	69.6%	84.0%	85.2%	72.0%	72.2%
VA Premier	73.3%	78.4%	79.3%	74.3%	86.4%	73.0%
UnitedHealthcare	100.0%	100.0%	100.0%	83.3%	83.3%	83.3%
More Than One MCO	80.0%	66.7%	87.5%	66.7%	100.0%^	50.0%^

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-16 shows that 78.1 percent of children in foster care and 66.4 percent of controls had a follow-up care visit within 30 days of when the first ADHD medication was dispensed during MY 2021, and the difference was statistically significant (p=0.04). Rates for children in foster care were notably higher than controls for female members (by 19.3 percentage points), Black or African American members (by 15.2 percentage points), and members enrolled with HealthKeepers (by 21.2 percentage points). While rates for children in foster care were higher than controls for members in the Other racial group; members in all regions; and members enrolled with Aetna, Molina, and VA Premier, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2021 rates for both children in foster care and controls were above the MY 2021 national Medicaid 50th percentile. The rates for children in foster care and controls declined from MY 2020 to MY 2021 by 8.7 and 8.4 percentage points, respectively. There were no disparities identified for children in foster care.

Substance Use

Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up (FUA)

The *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* indicator is not presented as a table because the denominators for children in foster care and controls were too small to ensure reliable rates. These denominator sizes indicate that very few children in foster care had ED visits for AOD abuse or dependence.

Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment (IET)

Table 3-17 displays the MY 2019, MY 2020, and MY 2021 *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment* rates among children in foster care and controls 13 years of age and older stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment* indicator measures the percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis. Since the children in foster care population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 3-17—Rates of *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	44.4%	27.3%	29.1%	45.8%	40.8%	48.1%
Age Category						
11 to 13 Years	75.0%	—	0.0%	—	75.0%	—
≥ 14 Years	41.5%	27.3%	31.4%	45.8%	38.8%	48.1%
Sex						
Male	44.0%	20.0%	27.6%	45.5%	45.2%	58.3%
Female	45.0%	38.5%	30.8%	46.2%	34.5%	40.0%
Race						
Black or African American	40.0%	10.0%	31.6%	33.3%	40.0%	80.0%
White	48.3%	28.6%	26.5%	52.9%	38.6%	42.9%
Other	0.0%	100.0%	50.0%	0.0%	100.0%^	0.0%^

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Region						
Central	50.0%	16.7%	40.0%	60.0%	57.1%	60.0%
Charlottesville/Western	66.7%	75.0%	36.4%	—	20.0%	60.0%
Northern & Winchester	0.0%	0.0%	11.1%	20.0%	26.7%	33.3%
Roanoke/Alleghany	50.0%	44.4%	50.0%	60.0%	66.7%	—
Southwest	57.1%	0.0%	33.3%	50.0%	20.0%	42.9%
Tidewater	50.0%	25.0%	0.0%	33.3%	50.0%	50.0%
MCO						
Aetna	33.3%	—	16.7%	50.0%	12.5%	20.0%
HealthKeepers	18.8%	20.0%	8.3%	12.5%	34.8%	40.0%
Molina	100.0%	—	20.0%	—	75.0%^	100.0%^
Optima	50.0%	40.0%	27.3%	75.0%	64.3%	50.0%
VA Premier	66.7%	29.4%	38.9%	50.0%	33.3%	42.9%
UnitedHealthcare	75.0%	—	100.0%	66.7%	42.9%	50.0%
More Than One MCO	100.0%	0.0%	100.0%	100.0%	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-17 shows that 40.8 percent of children in foster care and 48.1 percent of controls with a new episode of AOD abuse or dependence initiated treatment during MY 2021, and the difference was not statistically significant (p=0.51). While there were large rate differences between children in foster care and controls for most stratified rates, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2021 rates for children in foster care were below the MY 2021 national Medicaid 50th percentile, while rates for controls were above the MY 2021 national Medicaid 50th percentile. The rates for children in foster care and controls increased from MY 2020 to MY 2021 by 11.7 and 2.3 percentage points, respectively. There were no disparities identified for children in foster care members.

Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment (IET)

Table 3-18 displays the MY 2019, MY 2020, and MY 2021 *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment* rates among children in foster care and controls 13 years of age and older stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment* indicator measures the percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. Since the children in foster care population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 3-18—Rates of *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	15.6%	9.1%	14.5%	25.0%	25.4%	18.5%
Age Category						
11 to 13 Years	0.0%	—	0.0%	—	0.0%^	—
≥ 14 Years	17.1%	9.1%	15.7%	25.0%	26.9%^	18.5%^
Sex						
Male	12.0%	5.0%	17.2%	27.3%	33.3%	25.0%
Female	20.0%	15.4%	11.5%	23.1%	13.8%	13.3%
Race						
Black or African American	13.3%	0.0%	15.8%	33.3%	28.0%^	0.0%^
White	17.2%	14.3%	11.8%	23.5%	20.5%^	23.8%^
Other	0.0%	0.0%	50.0%	0.0%	100.0%^	0.0%^
Region						
Central	28.6%	16.7%	26.7%	20.0%	28.6%	40.0%
Charlottesville/Western	33.3%	0.0%	9.1%	—	0.0%^	0.0%^
Northern & Winchester	0.0%	0.0%	0.0%	20.0%	13.3%	16.7%
Roanoke/Alleghany	12.5%	22.2%	16.7%	20.0%	50.0%	—
Southwest	14.3%	0.0%	33.3%	33.3%	20.0%	28.6%
Tidewater	0.0%	0.0%	0.0%	33.3%	40.0%^	0.0%^

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
MCO						
Aetna	33.3%	—	16.7%	0.0%	12.5%^	0.0%^
HealthKeepers	0.0%	0.0%	8.3%	12.5%	13.0%	20.0%
Molina	0.0%	—	0.0%	—	50.0%	25.0%
Optima	12.5%	20.0%	0.0%	25.0%	35.7%^	0.0%^
VA Premier	33.3%	11.8%	33.3%	33.3%	33.3%	28.6%
UnitedHealthcare	25.0%	—	0.0%	33.3%	28.6%	50.0%
More Than One MCO	0.0%	0.0%	0.0%	100.0%	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-18 shows that 25.4 percent of children in foster care and 18.5 percent of controls with a new episode of AOD abuse or dependence initiated treatment and engaged in ongoing AOD treatment during MY 2021, and the difference was not statistically significant (p=0.48). While there were large rate differences between children in foster care and controls for most stratified rates, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2021 rates for both children in foster care and controls were above the MY 2021 national Medicaid 50th percentile. The rate for children in foster care increased from MY 2020 to MY 2021 by 10.9 percentage points, while the rate for controls decreased by 6.5 percentage points. For children in foster care only, members in the Roanoke/Alleghany region were significantly more likely to initiate treatment and engage in ongoing AOD treatment compared to members in other regions during MY 2021.

Respiratory Health

Asthma Medication Ratio (AMR)

Table 3-19 displays the MY 2019, MY 2020, and MY 2021 *Asthma Medication Ratio* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Asthma Medication Ratio* indicator measures the percentage of children and adolescents 5 to 18 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Table 3-19—Rates of Appropriate *Asthma Medication Ratio* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	85.7%	75.8%	89.8%+	75.9%	85.7%	80.2%
Age Category						
5 to 11 Years	90.0%	81.3%	94.7%	70.3%	92.9%	76.3%
12 to 18 Years	81.8%	69.8%	86.7%	80.4%	81.0%	83.7%
Sex						
Male	82.6%	71.2%	85.2%	81.1%	83.3%	79.2%
Female	89.5%	82.1%	95.5%	66.7%	88.2%	81.8%
Race						
Black or African American	81.3%	74.4%	78.9%	75.0%	81.3%	74.4%
White	88.5%	76.5%	96.6%	75.6%	94.4%	85.4%
Other	—	100.0%	100.0%	100.0%	0.0%^	100.0%^
Region						
Central	85.7%	70.0%	83.3%	66.7%	83.3%	82.4%
Charlottesville/Western	80.0%	76.9%	100.0%	73.3%	100.0%^	76.9%^
Northern & Winchester	100.0%	87.5%	83.3%	100.0%	0.0%^	75.0%^
Roanoke/Alleghany	100.0%	70.0%	100.0%	100.0%	66.7%	80.0%
Southwest	85.7%	72.7%	85.7%	76.9%	100.0%^	90.0%^
Tidewater	80.0%	79.3%	90.0%	69.2%	88.9%	78.3%
MCO						
Aetna	100.0%	0.0%	100.0%	100.0%	100.0%^	100.0%^
HealthKeepers	90.0%	78.1%	100.0%	70.6%	100.0%^	82.1%^

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Molina	100.0%	—	33.3%	66.7%	0.0%^	—
Optima	90.0%	100.0%	88.9%	71.4%	80.0%	69.6%
VA Premier	73.3%	59.3%	88.9%	91.7%	100.0%^	82.6%^
UnitedHealthcare	100.0%	75.0%	100.0%	40.0%	100.0%^	100.0%^
More Than One MCO	—	66.7%	—	50.0%	—	100.0%^

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-19 shows that 85.7 percent of children in foster care and 80.2 percent of controls who were identified as having persistent asthma had a ratio of controller medications to total asthma medications of 0.50 or greater during MY 2021, and the difference was not statistically significant (p=0.48). While there were large rate differences between children in foster care and controls for many stratified rates such as members 5 to 11 years of age and female members, these rates had small denominators, so the rates may be less reliable.

The rate for children in foster care was above the MY 2021 national Medicaid 50th percentile for members 5 to 11 years of age, while the rate for the controls was below the national Medicaid 50th percentile. For members 12 to 18 years of age, the rates for both children in foster and controls were above the national Medicaid 50th percentile. There were no disparities identified for children in foster care members.

Service Utilization

Ambulatory Care Visits

Table 3-20 displays the MY 2019, MY 2020, and MY 2021 *Ambulatory Care Visits* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Ambulatory Care Visits* indicator measures the percentage of members who had an ambulatory care visit during the measurement year.

Table 3-20—Rates of *Ambulatory Care Visits* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	—	—	—	—	88.9%	89.7%
Age Category						
≤ 2 Years	—	—	—	—	92.2%	93.4%
3 to 5 Years	—	—	—	—	89.4%	90.1%
6 to 10 Years	—	—	—	—	86.5%	89.5%
11 to 13 Years	—	—	—	—	88.2%	89.5%
≥ 14 Years	—	—	—	—	88.7%	86.9%
Sex						
Male	—	—	—	—	88.7%	88.9%
Female	—	—	—	—	89.2%	90.6%
Race						
Black or African American	—	—	—	—	88.4%	88.0%
White	—	—	—	—	89.4%	90.8%
Other	—	—	—	—	84.1%	84.1%
Region						
Central	—	—	—	—	88.2%	87.9%
Charlottesville/Western	—	—	—	—	90.6%	91.7%
Northern & Winchester	—	—	—	—	82.5%	87.6%
Roanoke/Alleghany	—	—	—	—	90.6%	91.3%
Southwest	—	—	—	—	92.1%	91.1%
Tidewater	—	—	—	—	89.8%	88.7%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
MCO						
Aetna	—	—	—	—	87.5%	86.9%
HealthKeepers	—	—	—	—	87.7%	89.8%
Molina	—	—	—	—	86.7%	83.7%
Optima	—	—	—	—	87.8%	90.5%
VA Premier	—	—	—	—	90.9%	91.5%
UnitedHealthcare	—	—	—	—	91.4%	87.7%
More Than One MCO	—	—	—	—	96.4%	92.8%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-20 shows that 88.9 percent of children in foster care and 89.7 percent of controls had an ambulatory care visit during MY 2021, and the difference was not statistically significant (p=0.33). The rate differences between children in foster care and controls were consistent across the stratified rates.

The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For children in foster care only, members in the Southwest region were significantly more likely to have an ambulatory care visit compared to members in other regions in MY 2021, while members in the Northern & Winchester region were significantly less likely. For both children in foster care and controls, members enrolled with VA Premier were significantly more likely to have an ambulatory care visit compared to members enrolled with other MCOs. For children in foster care only, members enrolled with More Than One MCO were significantly more likely to have an ambulatory care visit compared to members enrolled with other MCOs. For both children in foster care and controls, members 2 years of age and younger were significantly more likely to have an ambulatory care visit compared to members in other age groups. For children in foster care only, members 6 to 10 years of age were significantly less likely to have an ambulatory care visit.

ED Visits

Table 3-21 displays the MY 2019, MY 2020, and MY 2021 *ED Visits* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *ED Visits* indicator measures the percentage of members who had an ED visit during the measurement year.

Table 3-21—Rates of *ED Visits* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	—	—	—	—	24.8%-	31.5%
Age Category						
≤ 2 Years	—	—	—	—	26.4%	43.5%
3 to 5 Years	—	—	—	—	20.0%	27.2%
6 to 10 Years	—	—	—	—	16.0%	23.6%
11 to 13 Years	—	—	—	—	18.2%	26.3%
≥ 14 Years	—	—	—	—	37.9%	35.0%
Sex						
Male	—	—	—	—	22.3%	30.5%
Female	—	—	—	—	27.6%	32.6%
Race						
Black or African American	—	—	—	—	24.8%	33.8%
White	—	—	—	—	24.7%	30.5%
Other	—	—	—	—	26.1%	25.0%
Region						
Central	—	—	—	—	25.2%	34.0%
Charlottesville/Western	—	—	—	—	24.6%	27.8%
Northern & Winchester	—	—	—	—	21.3%	29.9%
Roanoke/Alleghany	—	—	—	—	26.9%	35.6%
Southwest	—	—	—	—	29.2%	36.0%
Tidewater	—	—	—	—	22.5%	27.3%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
MCO						
Aetna	—	—	—	—	25.1%	32.7%
HealthKeepers	—	—	—	—	23.7%	32.0%
Molina	—	—	—	—	29.6%	40.9%
Optima	—	—	—	—	26.0%	29.0%
VA Premier	—	—	—	—	24.7%	31.7%
UnitedHealthcare	—	—	—	—	21.8%	28.0%
More Than One MCO	—	—	—	—	22.9%	26.5%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).

+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.

- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.

— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-21 shows that 24.8 percent of children in foster care and 31.5 percent of controls had an ED visit during MY 2021, and the difference was statistically significant ($p<0.001$). The rates for children in foster care were notably lower than controls across all stratified rates, with the largest difference being for members 2 years of age and younger (by 17.1 percentage points) and for members enrolled with Molina (by 11.3 percentage points).

The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both children in foster care and controls, members in the Southwest region were significantly more likely to have an ED visit compared to members in other regions during MY 2021. For children in foster care only, members in the Northern & Winchester region were significantly less likely to have an ED visit compared to members in other regions. For both children in foster care and controls, members 14 years of age and older were significantly more likely to have an ED visit compared to members in other age groups, while members 3 to 5, 6 to 10, and 11 to 13 years of age were significantly less likely. For children in foster care only, females were significantly more likely to have an ED visit compared to male members.

Inpatient Visits

Table 3-22 displays the MY 2019, MY 2020, and MY 2021 *Inpatient Visits* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Inpatient Visits* indicator measures the percentage of members who had an inpatient visit during the measurement year.

Table 3-22—Rates of *Inpatient Visits* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	—	—	—	—	4.5%	4.4%
Age Category						
≤ 2 Years	—	—	—	—	2.1%	6.0%
3 to 5 Years	—	—	—	—	0.8%	0.8%
6 to 10 Years	—	—	—	—	2.9%	2.0%
11 to 13 Years	—	—	—	—	8.3%	5.6%
≥ 14 Years	—	—	—	—	8.2%	7.1%
Sex						
Male	—	—	—	—	3.0%	3.5%
Female	—	—	—	—	6.3%	5.5%
Race						
Black or African American	—	—	—	—	4.7%	4.6%
White	—	—	—	—	4.3%	4.3%
Other	—	—	—	—	6.8%	3.4%
Region						
Central	—	—	—	—	4.8%	5.1%
Charlottesville/Western	—	—	—	—	5.7%	5.1%
Northern & Winchester	—	—	—	—	3.8%	3.2%
Roanoke/Alleghany	—	—	—	—	5.5%	4.0%
Southwest	—	—	—	—	2.6%	4.2%
Tidewater	—	—	—	—	4.0%	4.4%
MCO						
Aetna	—	—	—	—	3.4%	4.0%
HealthKeepers	—	—	—	—	4.5%	4.4%
Molina	—	—	—	—	4.9%	5.9%
Optima	—	—	—	—	5.1%	4.1%
VA Premier	—	—	—	—	4.3%	4.6%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
UnitedHealthcare	—	—	—	—	3.3%	3.3%
More Than One MCO	—	—	—	—	8.4%	6.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-22 shows that 4.5 percent of children in foster care and 4.4 percent of controls had an inpatient visit during MY 2021, and the difference was not statistically significant (p=0.82). The rate differences between children in foster care and controls were similar across the stratified rates.

The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For children in foster care only, members in the Southwest region were significantly less likely to have an inpatient visit compared to members in other regions during MY 2021. For both children in foster care and controls, members 14 years of age and older were significantly more likely to have an inpatient visit compared to members in other age groups, while members 3 to 5 and 6 to 10 years of age were significantly less likely. For children in foster care only, members 11 to 13 years of age were significantly more likely to have an inpatient visit compared to members in other age groups, while members 2 years of age and younger were significantly less likely. For both children in foster care and the controls, females were significantly more likely to have an inpatient visit compared to male members.

Behavioral Health Encounters—Total

Table 3-23 displays the MY 2019, MY 2020, and MY 2021 *Behavioral Health Encounters—Total* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Behavioral Health Encounters—Total* indicator measures the percentage of members who had a behavioral health encounter during the measurement year.

Table 3-23—Rates of *Behavioral Health Encounters—Total* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	—	—	—	—	71.0%+	57.5%
Age Category						
≤ 2 Years	—	—	—	—	45.6%	33.6%
3 to 5 Years	—	—	—	—	62.2%	38.5%
6 to 10 Years	—	—	—	—	76.7%	67.5%
11 to 13 Years	—	—	—	—	84.8%	72.2%
≥ 14 Years	—	—	—	—	83.2%	70.9%
Sex						
Male	—	—	—	—	71.1%	57.7%
Female	—	—	—	—	70.9%	57.2%
Race						
Black or African American	—	—	—	—	70.6%	55.5%
White	—	—	—	—	71.4%	58.6%
Other	—	—	—	—	64.8%	54.5%
Region						
Central	—	—	—	—	71.1%	56.5%
Charlottesville/Western	—	—	—	—	71.3%	59.8%
Northern & Winchester	—	—	—	—	62.3%	46.1%
Roanoke/Alleghany	—	—	—	—	72.9%	62.1%
Southwest	—	—	—	—	76.2%	61.0%
Tidewater	—	—	—	—	72.7%	59.1%
MCO						
Aetna	—	—	—	—	69.1%	53.8%
HealthKeepers	—	—	—	—	70.6%	57.1%
Molina	—	—	—	—	68.5%	50.7%
Optima	—	—	—	—	69.6%	58.5%
VA Premier	—	—	—	—	73.1%	61.9%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
UnitedHealthcare	—	—	—	—	68.3%	50.6%
More Than One MCO	—	—	—	—	86.7%	55.4%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-23 shows that 71.0 percent of children in foster care and 57.5 percent of controls had a behavioral health encounter during MY 2021, and the difference was statistically significant ($p<0.001$). Rates for children in foster care were similarly higher than controls for all stratified categories.

The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both children in foster care and controls, members 6 to 10, 11 to 13, and 14 years of age and older were significantly more likely to have a behavioral health encounter compared to members in other age categories in MY 2021, which may reflect that behavioral health conditions are more likely to be diagnosed later in life. Additionally, for both children in foster care and controls, members in the Northern & Winchester region were less likely to have a behavioral health encounter, while for children in foster care only, members in the Southwest region were more likely to have a behavioral health encounter. Lastly, for children in foster care, members enrolled with More Than One MCO were significantly more likely to have a behavioral health encounter compared to members enrolled with other MCOs.

Behavioral Health Encounters—ARTS

Table 3-24 displays the MY 2019, MY 2020, and MY 2021 *Behavioral Health Encounters—ARTS* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Behavioral Health Encounters—ARTS* indicator measures the percentage of members with a behavioral health encounter with ARTS.

Table 3-24—Rates of *Behavioral Health Encounters—ARTS* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	—	—	—	—	1.9%+	0.7%
Age Category						
≤ 2 Years	—	—	—	—	0.0%^	0.0%^
3 to 5 Years	—	—	—	—	0.0%^	0.2%^
6 to 10 Years	—	—	—	—	0.9%	0.6%
11 to 13 Years	—	—	—	—	1.1%	0.6%
≥ 14 Years	—	—	—	—	6.0%	1.8%
Sex						
Male	—	—	—	—	2.4%	0.5%
Female	—	—	—	—	1.3%	1.0%
Race						
Black or African American	—	—	—	—	2.6%	0.5%
White	—	—	—	—	1.5%	0.8%
Other	—	—	—	—	3.4%	1.1%
Region						
Central	—	—	—	—	1.7%	1.1%
Charlottesville/Western	—	—	—	—	1.0%	0.1%
Northern & Winchester	—	—	—	—	4.0%	1.9%
Roanoke/Alleghany	—	—	—	—	1.3%^	0.0%^
Southwest	—	—	—	—	1.9%	0.9%
Tidewater	—	—	—	—	1.9%	0.5%
MCO						
Aetna	—	—	—	—	1.5%	0.9%
HealthKeepers	—	—	—	—	2.9%	1.1%
Molina	—	—	—	—	1.5%	0.5%
Optima	—	—	—	—	1.5%	0.3%
VA Premier	—	—	—	—	1.5%	0.3%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
UnitedHealthcare	—	—	—	—	2.5%	1.6%
More Than One MCO	—	—	—	—	0.0%^	1.2%^

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-24 shows that 1.9 percent of children in foster care and 0.7 percent of controls had a behavioral health encounter with ARTS during MY 2021, and the difference was statistically significant (p<0.001). Rates for children in foster care were notably higher than controls for members 14 years of age and older (by 4.2 percentage points).

MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. For both children in foster care and controls, members 14 years of age and older and members in the Northern & Winchester region were significantly more likely to have a behavioral health encounter with ARTS compared to members in other age categories and members in other regions, respectively, in MY 2021. For children in foster care only, members 6 to 10 years of age were less likely to have a behavioral health encounter with ARTS than members in other age categories; however, this may be primarily driven by the relatively high proportion of numerator-positive members 4 years of age and older. Additionally, for children in foster care only, male members were more likely to have a behavioral health encounter with ARTS compared to female members. For children in foster care only, Black or African American members were more likely to have an ARTS behavioral health encounter compared to members of other racial groups, while White members were less likely. For children in foster care only, members enrolled with HealthKeepers were more likely to have an ARTS behavioral health encounter compared to members enrolled with other MCOs.

Behavioral Health Encounters—CMH Services

Table 3-25 displays the MY 2019, MY 2020, and MY 2021 *Behavioral Health Encounters—CMH Services* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Behavioral Health Encounters—CMH Services* indicator measures the percentage of members who had a behavioral health encounter with CMH services.

Table 3-25—Rates of *Behavioral Health Encounters—CMH Services* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	—	—	—	—	38.8%+	21.7%
Age Category						
≤ 2 Years	—	—	—	—	7.1%	3.2%
3 to 5 Years	—	—	—	—	33.3%	15.5%
6 to 10 Years	—	—	—	—	46.5%	28.8%
11 to 13 Years	—	—	—	—	53.0%	30.6%
≥ 14 Years	—	—	—	—	51.6%	28.5%
Sex						
Male	—	—	—	—	39.0%	23.8%
Female	—	—	—	—	38.6%	19.1%
Race						
Black or African American	—	—	—	—	40.1%	23.8%
White	—	—	—	—	38.3%	21.0%
Other	—	—	—	—	33.0%	10.2%
Region						
Central	—	—	—	—	41.4%	19.8%
Charlottesville/Western	—	—	—	—	39.1%	21.4%
Northern & Winchester	—	—	—	—	29.7%	10.1%
Roanoke/Alleghany	—	—	—	—	43.3%	26.7%
Southwest	—	—	—	—	39.7%	31.3%
Tidewater	—	—	—	—	38.8%	22.8%
MCO						
Aetna	—	—	—	—	37.3%	20.2%
HealthKeepers	—	—	—	—	37.3%	18.6%
Molina	—	—	—	—	34.0%	20.7%
Optima	—	—	—	—	40.1%	23.5%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
VA Premier	—	—	—	—	40.6%	26.4%
UnitedHealthcare	—	—	—	—	36.2%	15.2%
More Than One MCO	—	—	—	—	50.6%	18.1%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-25 shows that 38.8 percent of children in foster care and 21.7 percent of controls had a behavioral health encounter with CMH services during MY 2021, and the difference was statistically significant ($p<0.001$). Children in foster care rates were notably higher than controls across all stratified rates, with the largest differences being for members 14 years of age and older (by 23.1 percentage points) and for members enrolled with More Than One MCO (by 32.5 percentage points).

The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both children in foster care and controls, members in the Roanoke/Alleghany region were significantly more likely to have a behavioral health encounter with CMH services compared to members in other regions during MY 2021, while members in the Northern & Winchester region were significantly less likely compared to members in other regions. For children in foster care only, members enrolled with More Than One MCO were significantly more likely to have a behavioral health encounter with CMH services compared to members enrolled with other MCOs. For both children in foster care and controls, members 6 to 10, 11 to 13, and 14 years of age and older were significantly more likely to have a behavioral health encounter with CMH services compared to members in other age groups, while members 2 years of age and younger and 3 to 5 years of age were significantly less likely.

Behavioral Health Encounters—RTC Services

Table 3-26 displays the MY 2019, MY 2020, and MY 2021 *Behavioral Health Encounters—RTC Services* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Behavioral Health Encounters—RTC Services* indicator measures the percentage of members who had a behavioral health encounter with RTC services.

Table 3-26—Rates of *Behavioral Health Encounters—RTC Services* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	—	—	—	—	4.4%+	2.6%
Age Category						
≤ 2 Years	—	—	—	—	0.8%	0.8%
3 to 5 Years	—	—	—	—	1.5%	1.5%
6 to 10 Years	—	—	—	—	3.0%	1.1%
11 to 13 Years	—	—	—	—	8.8%	4.1%
≥ 14 Years	—	—	—	—	7.8%	5.1%
Sex						
Male	—	—	—	—	3.2%	1.8%
Female	—	—	—	—	5.7%	3.5%
Race						
Black or African American	—	—	—	—	4.6%	2.7%
White	—	—	—	—	4.2%	2.5%
Other	—	—	—	—	5.7%	2.3%
Region						
Central	—	—	—	—	5.1%	2.7%
Charlottesville/Western	—	—	—	—	5.5%	2.7%
Northern & Winchester	—	—	—	—	3.8%	1.7%
Roanoke/Alleghany	—	—	—	—	5.6%	2.3%
Southwest	—	—	—	—	1.4%	2.3%
Tidewater	—	—	—	—	3.7%	3.4%
MCO						
Aetna	—	—	—	—	2.4%	2.1%
HealthKeepers	—	—	—	—	4.7%	3.3%
Molina	—	—	—	—	3.9%	4.4%
Optima	—	—	—	—	5.0%	2.3%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
VA Premier	—	—	—	—	4.2%	2.4%
UnitedHealthcare	—	—	—	—	3.7%	0.8%
More Than One MCO	—	—	—	—	7.2%	0.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-26 shows that 4.4 percent of children in foster care and 2.6 percent of controls had a behavioral health encounter with RTC services, stratified by residential treatment center services during MY 2021, and the difference was statistically significant (p=<0.001). The rate differences between children in foster care and controls were similar across the stratified rates, except that the rate for children in foster care in the Southwest region was lower than controls (by 0.9 percentage points), and the rate for children in foster care enrolled with Molina was lower than controls (by 0.5 percentage points). Additionally, the gap between rates for children in foster care and controls increased with age from 0.0 to 2.7 percentage points.

The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For children in foster care, members in the Southwest region were significantly less likely to have a behavioral health encounter with RTC services compared to members in other regions during MY 2021. For both children in foster care and controls, members 11 to 13 and 14 years of age and older were significantly more likely to have a behavioral health encounter with RTC services, while members 2 years of age and younger and 6 to 10 years of age were significantly less likely. For children in foster care only, members 3 to 5 years of age were significantly less likely to have a behavioral health encounter with RTC services compared to members in other age groups. For both children in foster care and the controls, female members were significantly more likely to have a behavioral health encounter with RTC services compared to male members.

Behavioral Health Encounters—Therapeutic Services

Table 3-27 displays the MY 2019, MY 2020, and MY 2021 *Behavioral Health Encounters—Therapeutic Services* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The

Behavioral Health Encounters—Therapeutic Services indicator measures the percentage of members who had a behavioral health encounter with therapeutic services.

Table 3-27—Rates of *Behavioral Health Encounters—Therapeutic Services* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	—	—	—	—	10.4%+	5.9%
Age Category						
≤ 2 Years	—	—	—	—	2.0%	1.8%
3 to 5 Years	—	—	—	—	9.2%	6.4%
6 to 10 Years	—	—	—	—	11.1%	8.5%
11 to 13 Years	—	—	—	—	12.6%	7.9%
≥ 14 Years	—	—	—	—	15.8%	5.4%
Sex						
Male	—	—	—	—	12.1%	7.1%
Female	—	—	—	—	8.5%	4.5%
Race						
Black or African American	—	—	—	—	10.5%	6.4%
White	—	—	—	—	10.7%	5.7%
Other	—	—	—	—	3.4%	5.7%
Region						
Central	—	—	—	—	13.4%	6.2%
Charlottesville/Western	—	—	—	—	9.7%	6.0%
Northern & Winchester	—	—	—	—	5.3%	2.7%
Roanoke/Alleghany	—	—	—	—	13.7%	5.1%
Southwest	—	—	—	—	14.7%	10.3%
Tidewater	—	—	—	—	6.6%	6.1%
MCO						
Aetna	—	—	—	—	9.8%	5.2%
HealthKeepers	—	—	—	—	8.6%	6.4%
Molina	—	—	—	—	10.8%	5.4%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Optima	—	—	—	—	10.0%	5.4%
VA Premier	—	—	—	—	12.1%	6.9%
UnitedHealthcare	—	—	—	—	12.8%	4.1%
More Than One MCO	—	—	—	—	13.3%	4.8%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-27 shows that 10.4 percent of children in foster care and 5.9 percent of controls had a behavioral health visit with therapeutic services during MY 2021, and the difference was statistically significant (p=<0.001). Rates for children in foster care were higher than controls for members in all regions and members enrolled with all MCOs, with the largest difference being for the Roanoke/Alleghany region (by 8.6 percentage points) and for members enrolled with More Than One MCO (by 8.5 percentage points). Additionally, the rate difference between children in foster care and controls increases with age from 0.2 percentage points to 10.4 percentage points.

The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator for this analysis. MY 2021 is the first year this measure was calculated; therefore, comparisons to prior year rates are not available. For both children in foster care and controls, members in the Southwest region were significantly more likely to have a behavioral health encounter with therapeutic services compared to members in other regions during MY 2021, while members in the Northern & Winchester region were less likely to have a behavioral health encounter with therapeutic services. For children in foster care only, members were significantly more likely to have a behavioral health encounter with therapeutic services in the Central and Roanoke/Alleghany regions compared to members in other regions, while members in the Tidewater region were significantly less likely. Also, for children in foster care, members enrolled with HealthKeepers were significantly less likely to have a behavioral health encounter with therapeutic services compared to members enrolled with other MCOs. For both children in foster care and controls, members 2 years of age and younger were significantly less likely to have a behavioral health encounter with therapeutic services compared to members in other age groups. For children in foster care, members 14 years of age and older were significantly more likely to have a behavioral health encounter with therapeutic services compared to members in other age groups. For children in foster care only, members in the Other racial group were significantly less likely to have a behavioral health encounter with therapeutic services compared to members in other racial groups. For both children in foster care and the controls, male members were significantly

more likely to have a behavioral health encounter with therapeutic services compared to female members.

Behavioral Health Encounters—Traditional Services

Table 3-28 displays the MY 2019, MY 2020, and MY 2021 *Behavioral Health Encounters—Traditional Services* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Behavioral Health Encounters—Traditional Services* indicator measures the percentage of members who had a behavioral health encounter with traditional services.

Table 3-28—Statewide Rates of *Behavioral Health Encounters—Traditional Services* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	—	—	—	—	67.8%+	53.8%
Age Category						
≤ 2 Years	—	—	—	—	42.9%	33.0%
3 to 5 Years	—	—	—	—	56.5%	35.3%
6 to 10 Years	—	—	—	—	73.7%	63.7%
11 to 13 Years	—	—	—	—	82.3%	68.2%
≥ 14 Years	—	—	—	—	80.8%	65.0%
Sex						
Male	—	—	—	—	67.7%	53.3%
Female	—	—	—	—	67.9%	54.4%
Race						
Black or African American	—	—	—	—	67.1%	50.8%
White	—	—	—	—	68.4%	55.5%
Other	—	—	—	—	60.2%	51.1%
Region						
Central	—	—	—	—	67.1%	52.9%
Charlottesville/Western	—	—	—	—	67.0%	57.3%
Northern & Winchester	—	—	—	—	59.2%	44.6%
Roanoke/Alleghany	—	—	—	—	69.5%	54.6%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Southwest	—	—	—	—	73.8%	56.8%
Tidewater	—	—	—	—	71.0%	56.0%
MCO						
Aetna	—	—	—	—	61.8%	48.0%
HealthKeepers	—	—	—	—	68.4%	54.6%
Molina	—	—	—	—	65.0%	46.8%
Optima	—	—	—	—	67.1%	54.8%
VA Premier	—	—	—	—	70.2%	58.3%
UnitedHealthcare	—	—	—	—	63.0%	45.3%
More Than One MCO	—	—	—	—	85.5%	51.8%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-28 shows that 67.8 percent of children in foster care and 53.8 percent of controls had a behavioral health visit with traditional services during MY 2021, and the difference was statistically significant (p=<0.001). Children in foster care rates were higher than controls across all stratified rates, with the largest difference being for members 3 to 5 years of age (by 21.2 percentage points) and for members enrolled with More Than One MCO (by 33.7 percentage points).

The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For children in foster care and controls, members in the Northern & Winchester region were significantly less likely to have a behavioral health visit with traditional services during MY 2021. For children in foster care only, members in the Southwest region were significantly more likely to have a behavioral health encounter with traditional services compared to members in other regions. For both children in foster care and controls, members enrolled with Aetna were significantly less likely to have a behavioral health encounter with traditional services compared to members enrolled with other MCOs. For children in foster care only, members enrolled with More Than One MCO were significantly more likely to have a behavioral health encounter with traditional services compared to members enrolled with other MCOs. For both children in foster care and controls, members 6 to 10, 11 to 13, and 14 years of age and older were significantly more likely to have a behavioral health encounter with traditional services compared

to members in other age categories, while members 2 years of age and younger and 3 to 5 years of age were significantly less likely.

Overall Service Utilization

Table 3-29 displays the MY 2019, MY 2020, and MY 2021 *Overall Service Utilization* rates among children in foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Overall Service Utilization* indicator measures the percentage of members who had an ambulatory care visit, ED visit, inpatient visit, or behavioral health encounter during the measurement year.

Table 3-29—Rates of *Overall Service Utilization* Among Children in Foster Care and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	—	—	—	—	92.1%	93.0%
Age Category						
≤ 2 Years	—	—	—	—	93.4%	95.6%
3 to 5 Years	—	—	—	—	90.9%	91.4%
6 to 10 Years	—	—	—	—	90.4%	92.9%
11 to 13 Years	—	—	—	—	92.3%	93.6%
≥ 14 Years	—	—	—	—	93.4%	91.7%
Sex						
Male	—	—	—	—	91.6%	92.4%
Female	—	—	—	—	92.8%	93.7%
Race						
Black or African American	—	—	—	—	91.5%	92.4%
White	—	—	—	—	92.6%	93.4%
Other	—	—	—	—	87.5%	88.6%
Region						
Central	—	—	—	—	92.1%	92.1%
Charlottesville/Western	—	—	—	—	92.9%	94.6%
Northern & Winchester	—	—	—	—	86.3%	90.9%
Roanoke/Alleghany	—	—	—	—	94.4%	94.7%
Southwest	—	—	—	—	95.1%	94.4%
Tidewater	—	—	—	—	92.2%	91.3%

Category	MY 2019		MY 2020		MY 2021	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
MCO						
Aetna	—	—	—	—	90.8%	89.9%
HealthKeepers	—	—	—	—	90.6%	93.4%
Molina	—	—	—	—	92.1%^	89.2%^
Optima	—	—	—	—	91.6%	93.1%
VA Premier	—	—	—	—	93.8%	94.6%
UnitedHealthcare	—	—	—	—	93.4%	90.9%
More Than One MCO	—	—	—	—	97.6%	96.4%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for children in foster care was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for children in foster care was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 3-29 shows that 92.1 percent of children in foster care and 93.0 percent of controls had an ambulatory care visit, ED visit, inpatient visit, or behavioral health encounter (i.e., any service) during MY 2021, and the difference was not statistically significant (p=0.18). The rate differences between children in foster care and controls were similar across the stratified rates.

The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated; therefore, comparisons to prior year rates are not available For both children in foster care and controls, members in the Northern & Winchester region were significantly less likely to utilize any service compared to members in other regions during MY 2021. For children in foster care only, members in the Roanoke/Alleghany and Southwest regions were significantly more likely to utilize any service compared to members in other regions. For both children in foster care and controls, members enrolled with VA Premier were significantly more likely to utilize any service compared to members enrolled with other MCOs. For children in foster care only, members enrolled with HealthKeepers were significantly less likely to utilize any service compared to members enrolled with other MCOs. For children in foster care only, members 6 to 10 years of age were significantly less likely to utilize any service compared to members in other age groups.

4. Healthcare Utilization: Children Receiving Adoption Assistance Findings

Characteristics of the Children Receiving Adoption Assistance Eligible Population and Study Population

This section provides findings describing the demographic characteristics of the 8,563 members in the children receiving adoption assistance eligible population and the 7,290 members in the children receiving adoption assistance study population. The eligible population consisted of children in the adoption assistance program younger than 18 years of age as of January 1, 2021, and receiving healthcare coverage from DMAS at any time during MY 2021. Table 4-1 displays the distribution of the children receiving adoption assistance eligible population by age category, sex, race, region, MCO, and Medicaid program.

Table 4-1—Distribution of Children Receiving Adoption Assistance (n=8,519)

Category	Number	Percent
Age Category		
≤ 2 years	325	3.8%
3 to 5 years	1,013	11.8%
6 to 10 years	2,420	28.3%
11 to 13 years	1,944	22.7%
≥ 14 years	2,861	33.4%
Sex		
Male	4,611	53.8%
Female	3,952	46.2%
Race		
Black or African American	2,601	30.4%
White	5,758	67.2%
Other	204	2.4%
Region		
Central	1,848	21.6%
Charlottesville/Western	1,318	15.4%
Northern & Winchester	1,322	15.4%
Roanoke/Alleghany	1,411	16.5%
Southwest	1,035	12.1%
Tidewater	1,616	18.9%
Unknown	13	0.2%

Category	Number	Percent
Latest MCO in the Measurement Year		
Aetna	722	8.4%
HealthKeepers	2,539	29.7%
Molina	370	4.3%
Optima	1,766	20.6%
VA Premier	2,431	28.4%
UnitedHealthcare	611	7.1%
Other*	124	1.4%
Latest Medicaid Program in the Measurement Year		
CCC Plus	254	3.0%
Medallion 4.0	8,185	95.6%
Other*	124	1.4%

**Includes members only enrolled in FFS.*

Children receiving adoption assistance were disproportionately male (53.8 percent) and Black or African American (30.4 percent) compared to the general population in Virginia, which was 49.5 percent male and 20.0 percent Black or African American in 2021.[4-1] Children receiving adoption assistance were mostly from the Central (21.6 percent), Roanoke & Allegany (16.5 percent), and Tidewater (18.9 percent) regions. The region for a small proportion of adoption assistance children (0.2 percent) was unknown; these children tended to be missing some address information or had an out-of-state address. Children receiving adoption assistance were most likely to be enrolled with HealthKeepers (29.7 percent), VA Premier (28.4 percent), or Optima (20.6 percent). Children receiving adoption assistance were most likely to be enrolled through the Medallion 4.0 program (95.6 percent). MCO attribution and Medicaid program attribution was Other for 1.4 percent of children receiving adoption assistance who were only enrolled in FFS during the measurement year.[4-2]

The study population consisted of members in the children receiving adoption assistance eligible population who were continuously enrolled in either the Medallion 4.0 or CCC Plus Medicaid managed care program with any MCO or a combination of MCOs during the study period for whom a match not in a child welfare program could be found. Continuous enrollment was defined as enrollment gaps totaling no more than 45 days. Among the adoption assistance eligible population, 85.1 percent (n=7,290) of children met the requirements for the study population, compared to 50.9 percent of children in foster care. Children receiving adoption assistance may be more likely to meet the continuous enrollment criteria than children in foster care since one of the qualifications for adoption assistance is having been in foster care for 18 months or longer.[4-3] The demographic characteristics of the children receiving

4-1 United States Census Bureau. Virginia QuickFacts. Available at: https://www.census.gov/quickfacts/VA. Accessed on: Jan 11, 2023.

4-2 Adoption assistance children may temporarily move to FFS and may not be enrolled with an MCO or managed care program during the measurement year.

4-3 Virginia Department of Social Services. Adoptive Assistance Screening Tool. Available at: https://dss.virginia.gov/files/division/dfs/ap/intro_page/forms/032-04-0091-06-eng.pdf. Accessed on: Jan 11, 2023.

adoption assistance study population mirrored the demographic characteristics of the eligible population, except that there were 1.6 percent fewer children two years of age or younger. The disproportionate exclusion of infants can be attributed to the inability of children born more than 45 days into the measurement year to meet the continuous enrollment criteria, since these children would have an enrollment gap greater than 45 days.

Table B-2 and Table B-5 present the demographic and health characteristics of continuously enrolled children receiving adoption assistance and the continuously enrolled controls prior to matching (n=7,321). Continuously enrolled children receiving adoption assistance tended to be older, male, White, less likely to be enrolled with HealthKeepers, and less likely to be enrolled through CCC Plus compared to the continuously enrolled controls. Furthermore, continuously enrolled children receiving adoption assistance were less likely to live in the Central, Northern & Winchester, or Tidewater regions and were more likely to live in the Charlottesville/Western, Roanoke/Alleghany, or Southwest regions. In terms of health characteristics, continuously enrolled children receiving adoption assistance were more likely to have diagnoses for health conditions, notably ADHD, anxiety, developmental disorders, and mood disorders. Additionally, children receiving adoption assistance were more likely to have ED and acute inpatient visits for mental health than the controls, which may indicate greater severity of mental illness among adoption assistance children. The higher rate of ED visits and acute inpatient visits may also indicate that children receiving adoption assistance were more likely to seek care for mental illness through these means, especially if prior access to psychiatric care had been limited prior to entering foster care.

HSAG was able to match 99.6 percent (n=7,290) of continuously enrolled children receiving adoption assistance to controls with similar demographic and health characteristics. Table B-8 and Table B-11 present the demographic and health characteristics of the final study population and their matched controls. Matching successfully balanced all demographic and health characteristics between the study population and the controls.

Appendix B presents detailed descriptions of the demographic and health characteristics of children receiving adoption assistance and controls prior to and after matching, as well as covariate balance findings.

Healthcare Utilization Among Children Receiving Adoption Assistance and Controls

This section provides findings from the study indicators used to assess healthcare utilization for children receiving adoption assistance in the study population, as well as findings for the matched controls not enrolled through a child welfare program. The tables displayed in this section also include stratified rates and shading to indicate the results of the health disparities analysis.

Although the controls have been matched to the children receiving adoption assistance on a variety of demographic and health characteristics, HSAG advises caution in comparing the study indicator results between children receiving adoption assistance and controls. Due to the different criteria for denominators across measures, one child in a matched pair may be included in a measure calculation while the other child is not. When matched pairs are separated, the distribution of characteristics in the denominator-eligible study population and the denominator-eligible controls may differ from the overall distribution, and balanced covariates are no longer guaranteed. Furthermore, HSAG advises caution in

interpreting the *p*-values, as denominator sizes vary by measure, and sample size influences the precision of the *p*-value calculation. Healthcare utilization in MY 2020 and MY 2021 may also be impacted by the COVID-19 pandemic; however, rate comparisons within MY 2020 and MY 2021 (i.e., to controls) are still reliable.

Primary Care

Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+)

Table 4-2 displays the MY 2019, MY 2020, and MY 2021 *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicator measures the percentage of children who turned 15 months old during the measurement year who received six or more well-child visits with a PCP.

Table 4-2—Rates of *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	50.0%	52.3%	50.0%	65.3%
Sex						
Male	—	—	50.0%	62.1%	100.0%^	76.9%^
Female	—	—	—	33.3%	0.0%^	52.2%^
Race						
Black or African American	—	—	100.0%	50.0%	—	20.0%
White	—	—	0.0%	53.1%	50.0%	76.9%
Other	—	—	—	—	—	—
Region						
Central	—	—	—	63.6%	—	44.4%
Charlottesville/Western	—	—	—	25.0%	100.0%^	71.4%^
Northern & Winchester	—	—	—	0.0%	—	80.0%
Roanoke/Alleghany	—	—	50.0%	62.5%	100.0%^	50.0%^
Southwest	—	—	—	75.0%	—	100.0%^

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Tidewater	—	—	—	44.4%	0.0%^	70.0%^
MCO						
Aetna	—	—	100.0%	100.0%	—	66.7%
HealthKeepers	—	—	—	33.3%	0.0%^	64.3%^
Molina	—	—	—	100.0%	—	40.0%
Optima	—	—	—	70.0%	100.0%^	71.4%^
VA Premier	—	—	0.0%	50.0%	0.0%^	68.8%^
UnitedHealthcare	—	—	—	25.0%	100.0%^	75.0%^
More Than One MCO	—	—	—	—	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-2 shows that 50.0 percent of children receiving adoption assistance and 65.3 percent of controls who turned 15 months old during MY 2021 received six or more well-child visits with a PCP, and the difference was not statistically significant (p=0.61). While there were large rate differences between children receiving adoption assistance and controls for most stratified rates, these rates had small denominators and may be less reliable.

For all eligible members, the MY 2021 rates for children receiving adoption assistance were below the MY 2021 national Medicaid 50th percentile, while controls were above the MY 2021 national Medicaid 50th percentile. The rate for children receiving adoption assistance did not change from MY 2020 to MY 2021, while the rate for controls increased (by 13 percentage points). There were no disparities identified for children receiving adoption assistance.

Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+)

Table 4-3 displays the MY 2019, MY 2020, and MY 2021 *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Well-Child*

Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits indicator measures the percentage of children who turned 30 months old during the measurement year who received two or more well-child visits with a PCP.

Table 4-3—Rates of *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	79.4%	64.3%	71.0%	72.9%
Sex						
Male	—	—	88.2%	71.4%	65.8%	73.1%
Female	—	—	70.6%	57.1%	77.4%	72.7%
Race						
Black or African American	—	—	94.1%	71.4%	66.7%	84.6%
White	—	—	72.9%	62.9%	72.2%	67.6%
Other	—	—	100.0%	—	—	100.0%^
Region						
Central	—	—	80.0%	42.9%	57.1%	75.0%
Charlottesville/Western	—	—	70.0%	87.5%	81.8%^	100.0%^
Northern & Winchester	—	—	100.0%	100.0%	75.0%^	100.0%^
Roanoke/Alleghany	—	—	92.3%	57.1%	61.5%	54.5%
Southwest	—	—	44.4%	75.0%	81.8%	44.4%
Tidewater	—	—	84.6%	50.0%	75.0%	85.7%
MCO						
Aetna	—	—	33.3%	66.7%	57.1%	66.7%
HealthKeepers	—	—	76.2%	77.8%	83.3%	84.6%
Molina	—	—	—	—	55.6%	71.4%
Optima	—	—	100.0%	44.4%	76.9%	66.7%
VA Premier	—	—	76.9%	61.5%	75.0%	72.7%
UnitedHealthcare	—	—	85.7%	80.0%	62.5%	60.0%
More Than One MCO	—	—	—	—	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-3 shows that 71.0 percent of children receiving adoption assistance and 72.9 percent of controls who turned 30 months old during MY 2021 received two or more well-child visits with a PCP, and the difference was not statistically significant (p=0.82). While there were large rate differences between children receiving adoption assistance and controls for most stratified rates, these rates had small denominators and may be less reliable.

For all eligible members, the MY 2021 rates for children receiving adoption assistance and controls were above the MY 2021 national Medicaid 50th percentile. The rate of well-child visits for children receiving adoption assistance decreased from MY 2020 to MY 2021 by 8.4 percentage points, while the rate for controls increased by 8.6 percentage points. There were no disparities identified for children receiving adoption assistance.

Child and Adolescent Well-Care Visits (WCV)

Table 4-4 displays the MY 2019, MY 2020, and MY 2021 *Child and Adolescent Well-Care Visits* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Child and Adolescent Well-Care Visits* indicator measures the percentage of members 3 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Table 4-4—Rates of *Child and Adolescent Well-Care Visits* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	42.8%+	40.8%	47.1%	48.2%
Age Category						
3 to 11 Years	—	—	47.1%	46.6%	50.0%	51.5%
12 to 17 Years	—	—	41.5%	38.2%	47.0%	48.1%
18 to 21 Years	—	—	27.6%	27.1%	33.6%	30.6%
Sex						
Male	—	—	42.6%	40.1%	47.9%	48.2%
Female	—	—	43.0%	41.6%	46.1%	48.3%
Race						
Black or African American	—	—	47.3%	41.2%	53.5%	50.2%
White	—	—	40.7%	40.4%	44.4%	47.3%
Other	—	—	40.1%	47.8%	40.3%	47.2%
Region						
Central	—	—	40.1%	38.7%	48.5%	48.5%
Charlottesville/Western	—	—	48.3%	39.9%	50.4%	47.9%
Northern & Winchester	—	—	32.5%	47.7%	31.7%	52.2%
Roanoke/Alleghany	—	—	45.6%	39.8%	49.5%	46.4%
Southwest	—	—	39.6%	33.1%	44.4%	40.2%
Tidewater	—	—	49.0%	44.0%	54.2%	51.8%
MCO						
Aetna	—	—	34.5%	36.0%	36.8%	42.4%
HealthKeepers	—	—	44.9%	43.9%	49.8%	53.1%
Molina	—	—	32.7%	26.4%	33.3%	40.6%
Optima	—	—	46.7%	43.5%	50.5%	51.0%
VA Premier	—	—	44.3%	38.8%	48.9%	44.6%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
UnitedHealthcare	—	—	31.6%	39.0%	38.4%	43.5%
More Than One MCO	—	—	39.6%	50.5%	39.4%	60.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-4 shows that 47.1 percent of children receiving adoption assistance and 48.2 percent of controls had a well-care visit with a PCP or an OB/GYN during MY 2021, and the difference was not statistically significant (p=0.17). For children receiving adoption assistance, rates for members in the Northern & Winchester region were notably lower than the controls (by 20.5 percentage points), and for members enrolled with Aetna, Molina, UnitedHealthcare, and More than One MCO, rates were notably lower than controls (by 5.6, 7.3, 5.1, and 20.6 percentage points, respectively).

Rates for children receiving adoption assistance and controls were above the MY 2021 national Medicaid 50th percentile for members 18 to 21 years of age but below the national Medicaid 50th percentile for members 3 1o 11 and 12 to 17 years of age. The rates of well-care visits for both children receiving adoption assistance and the controls increased from MY 2020 to MY 2021 by 4.3 and 7.4 percentage points, respectively. For children receiving adoption assistance and controls, members in the Tidewater region were significantly more likely to have a well-care visit compared to members in other regions during MY 2021, while members in the Northern & Winchester region were significantly less likely. For children receiving adoption assistance only, members in the Charlottesville/Western region were significantly more likely to have a well-care visit. For both children receiving adoption assistance and controls, members enrolled with HealthKeepers and Optima were significantly more likely to have a well-care visit compared to members enrolled with other MCOs, while members enrolled with Aetna, Molina, and UnitedHealthcare were significantly less likely. For both children receiving adoption assistance and controls, Black or African American members were significantly more likely to have a well-care visit, while White members were significantly less likely. For both children receiving adoption assistance and controls, members 3 to 11 years of age were significantly more likely have a well-care visit compared to members in other age groups, while members 18 to 21 years of age were significantly less likely.

Oral Health

Annual Dental Visit (ADV)

Table 4-5 displays the MY 2019, MY 2020, and MY 2021 *Annual Dental Visit* rates among children receiving adoption assistance controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Annual Dental Visit* indicator measures the percentage of members 2 to 20 years of age who had at least one dental visit during the measurement year. Since the children receiving adoption assistance population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 4-5—Rates of *Annual Dental Visits* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	54.1%+	49.9%	53.2%+	50.8%
Age Category						
≤ 2 Years	—	—	46.3%	34.7%	40.5%	40.2%
3 to 5 Years	—	—	50.8%	49.1%	52.2%	50.4%
6 to 10 Years	—	—	59.0%	53.2%	57.5%	55.6%
11 to 13 Years	—	—	56.7%	51.3%	57.2%	52.0%
≥ 14 Years	—	—	49.6%	47.0%	48.1%	46.6%
Sex						
Male	—	—	53.1%	48.0%	52.1%	49.5%
Female	—	—	55.1%	52.1%	54.6%	52.3%
Race						
Black or African American	—	—	53.4%	46.2%	53.9%	49.1%
White	—	—	54.3%	51.6%	53.0%	51.5%
Other	—	—	56.2%	51.4%	50.6%	54.7%
Region						
Central	—	—	55.2%	47.8%	53.7%	51.2%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Charlottesville/Western	—	—	57.1%	50.9%	50.8%	49.3%
Northern & Winchester	—	—	45.3%	57.9%	47.3%	60.0%
Roanoke/Alleghany	—	—	54.2%	48.4%	53.4%	46.8%
Southwest	—	—	62.0%	49.9%	62.9%	51.4%
Tidewater	—	—	52.0%	46.4%	52.8%	47.4%
MCO						
Aetna	—	—	47.1%	47.9%	45.8%	47.1%
HealthKeepers	—	—	55.2%	49.2%	55.2%	53.0%
Molina	—	—	38.3%	36.5%	43.1%	45.5%
Optima	—	—	56.5%	49.9%	54.7%	50.5%
VA Premier	—	—	57.3%	52.3%	53.9%	50.3%
UnitedHealthcare	—	—	45.0%	50.1%	51.0%	49.7%
More Than One MCO	—	—	54.5%	63.4%	62.1%	63.1%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-5 shows that 53.2 percent of children receiving adoption assistance and 50.8 percent of controls had a dental visit during MY 2021, and the difference was statistically significant (p=0.003). The rates for children receiving adoption assistance were higher than controls for members in the Roanoke/Alleghany, Southwest, and Tidewater regions (by 6.6, 11.5, and 5.4 percentage points, respectively). Conversely, the rate for children receiving adoption assistance was notably lower than controls for members in the Northern & Winchester region (by 12.7 percentage points).

Rates for children receiving adoption assistance were above the MY 2021 national Medicaid 50th percentile for members 2 years of age and younger and 11 to 13 years of age, while the rates for other

age categories were below the national Medicaid 50th percentile.[4-4] For controls, only the rate for the members 2 years of age and younger was above the national Medicaid 50th percentile. The rate for children receiving adoption assistance decreased from MY 2020 to MY 2021 by 0.9 percentage points, while rate for the controls increased by 0.9 percentage points. For children receiving adoption assistance only, members in the Southwest region were significantly more likely to have a dental visit compared to members in other regions during MY 2021, while members in the Northern & Winchester region were significantly less likely. Additionally, children receiving adoption assistance and controls enrolled with HealthKeepers were significantly more likely to have a dental visit compared to members enrolled with other MCOs. For children receiving adoption assistance only, members enrolled with Aetna and Molina were significantly less likely to have a dental visit. For both children receiving adoption assistance and controls, female members were significantly more likely to have a dental visit than male members.

Preventive Dental Services (PDENT-CH)

Table 4-6 displays the MY 2019, MY 2020, and MY 2021 *Preventive Dental Services* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Preventive Dental Services* indicator measures the percentage of members 1 to 20 years of age eligible for EPSDT services who received at least one preventive dental service during the measurement year. Since the children receiving adoption assistance population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 4-6—Rates of *Preventive Dental Services* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	49.2%+	43.5%	48.3%+	45.0%
Age Category						
≤ 2 Years	—	—	43.5%	24.8%	37.1%	30.8%
3 to 5 Years	—	—	47.9%	46.4%	49.8%	47.3%
6 to 10 Years	—	—	55.7%	49.2%	54.7%	52.0%
11 to 13 Years	—	—	50.7%	44.2%	51.5%	46.4%

[4-4] Since the national benchmarks display different age stratifications than the age categories in this report, comparisons were made between the age stratifications that were the most similar.

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
≥ 14 Years	—	—	43.3%	38.3%	41.0%	38.6%
Sex						
Male	—	—	49.1%	42.1%	47.4%	44.0%
Female	—	—	49.2%	45.1%	49.3%	46.2%
Race						
Black or African American	—	—	49.3%	40.1%	49.8%	43.6%
White	—	—	49.1%	45.0%	47.6%	45.6%
Other	—	—	49.0%	46.4%	45.6%	48.8%
Region						
Central	—	—	50.5%	41.6%	48.3%	45.0%
Charlottesville/Western	—	—	51.1%	42.6%	45.0%	41.6%
Northern & Winchester	—	—	40.4%	53.2%	42.1%	56.2%
Roanoke/Alleghany	—	—	49.3%	40.4%	48.3%^	41.5%^
Southwest	—	—	57.8%	44.1%	60.1%	45.4%
Tidewater	—	—	47.5%	40.9%	48.0%	42.0%
MCO						
Aetna	—	—	42.0%	39.8%	40.2%	42.7%
HealthKeepers	—	—	49.7%	43.1%	50.3%	47.2%
Molina	—	—	33.3%	29.2%	37.4%	40.5%
Optima	—	—	51.8%	43.1%	49.1%	44.7%
VA Premier	—	—	52.9%	46.3%	49.4%	43.9%
UnitedHealthcare	—	—	39.8%	44.5%	46.5%	45.8%
More Than One MCO	—	—	51.5%	56.4%	57.6%	53.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).

+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.

- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.

— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-6 shows that 48.3 percent of children receiving adoption assistance and 45.0 percent of controls had at least one preventive dental service during MY 2021, and the difference was statistically significant (p=0.001). The rates for children receiving adoption assistance were higher than controls for Black or African American members (by 6.2 percentage points), members in the Southwest region (by 14.7 percentage points), and for members enrolled with VA Premier (5.5 percentage points). Conversely, the rate for children receiving adoption assistance was notably lower than controls for members in the Northern & Winchester region (by 14.1 percentage points).

MY 2021 national Medicaid benchmarks were not available for this indicator. The rate for children receiving adoption assistance decreased from MY 2020 to MY 2021 by 0.9 percentage points, while the rate for controls increased by 1.5 percentage points. For children receiving adoption assistance only, members in the Southwest region were significantly more likely to have a preventive dental service compared to members in other regions during MY 2021. Additionally, children receiving adoption assistance enrolled with HealthKeepers were significantly more likely to have a preventive dental service compared to members enrolled with other MCOs. For children receiving adoption assistance and controls, members 6 to 10 of age were significantly more likely to have a preventive dental service compared to members in other age groups, while members 2 years of age and younger and 14 years of age and older were significantly less likely. Additionally, for children receiving adoption assistance only, members 11 to 13 years of age were significantly more likely to have a preventive dental service.

Oral Evaluation, Dental Services (OEV-CH)

Table 4-7 displays the MY 2019, MY 2020, and MY 2021 *Oral Evaluation, Dental Services* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Oral Evaluation, Dental Services* indicator measures the percentage of enrolled children under 21 years of age who received a comprehensive or periodic oral evaluation within the measurement year. Since the children receiving adoption assistance population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 4-7—Rates of *Oral Evaluation, Dental Services* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	—	—	47.2%+	44.0%
Age Category						
≤ 2 Years	—	—	—	—	36.3%	30.0%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
3 to 5 Years	—	—	—	—	49.1%	45.9%
6 to 10 Years	—	—	—	—	53.5%	50.5%
11 to 13 Years	—	—	—	—	49.6%	45.5%
≥ 14 Years	—	—	—	—	40.5%	38.0%
Sex						
Male	—	—	—	—	46.5%	43.1%
Female	—	—	—	—	48.0%	45.2%
Race						
Black or African American	—	—	—	—	49.2%	42.7%
White	—	—	—	—	46.3%	44.6%
Other	—	—	—	—	45.0%	47.5%
Region						
Central	—	—	—	—	47.5%	44.2%
Charlottesville/Western	—	—	—	—	44.1%	40.4%
Northern & Winchester	—	—	—	—	41.3%	55.3%
Roanoke/Alleghany	—	—	—	—	45.8%	39.9%
Southwest	—	—	—	—	58.8%	44.2%
Tidewater	—	—	—	—	47.8%	41.6%
MCO						
Aetna	—	—	—	—	38.4%	41.9%
HealthKeepers	—	—	—	—	49.1%	46.5%
Molina	—	—	—	—	36.4%	38.8%
Optima	—	—	—	—	48.1%^	44.0%^
VA Premier	—	—	—	—	48.7%	42.4%
UnitedHealthcare	—	—	—	—	45.3%	44.3%
More Than One MCO	—	—	—	—	56.1%	53.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-7 shows that 47.2 percent of children receiving adoption assistance and 44.0 percent of controls received a comprehensive or periodic oral evaluation during MY 2021, and the difference was statistically significant (p=0.001). The rates for children receiving adoption assistance were notably higher than controls for Black or African American members (by 6.5 percentage points); members in the Roanoke/Alleghany, Southwest, and Tidewater regions (by 5.9, 14.6, and 6.2 percentage points, respectively); and for members enrolled with VA Premier (by 6.3 percentage points).

MY 2021 national Medicaid benchmarks were not available for this indicator. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both children receiving adoption assistance and controls, members in the Charlottesville/Western region were significantly less likely to have a comprehensive or periodic oral evaluation compared to members in other regions during MY 2021. For children receiving adoption assistance only, members in the Southwest region were significantly more likely to have a comprehensive or periodic oral evaluation compared to members in other regions, while members in the Northern & Winchester region were significantly less likely. For both children receiving adoption assistance and controls, members enrolled with HealthKeepers were significantly more likely to have a comprehensive or periodic oral evaluation compared to members enrolled with other MCOs. For children receiving adoption assistance only, members were significantly less likely to have a comprehensive or periodic oral evaluation that were enrolled with Aetna and Molina compared to members enrolled with other MCOs. For children receiving adoption assistance only, Black or African American members were significantly more likely to have a comprehensive or periodic oral evaluation compared to members of other racial groups, while White members were significantly less likely. For both children receiving adoption assistance and controls, members 6 to 10 of age were significantly more likely to have a comprehensive or periodic oral evaluation compared to members in other age groups, while members 2 years of age and younger and 14 years of age and older were significantly less likely. Additionally, for children receiving adoption assistance only, members 11 to 13 years of age were significantly more likely to have a comprehensive or periodic oral evaluation.

Topical Fluoride for Children—Dental or Oral Health Services (TFL-CH)

Table 4-8 displays the MY 2019, MY 2020, and MY 2021 *Topical Fluoride for Children—Dental or Oral Health Services* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Topical Fluoride for Children—Dental or Oral Health Services* indicator measures the percentage of enrolled children 1 through 20 years of age who received at least two topical fluoride applications as dental or oral health services within the measurement year. Since the children receiving adoption assistance population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 4-8—Rates of *Topical Fluoride for Children—Dental or Oral Health Services* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	—	—	23.7%+	19.6%
Age Category						
≤ 2 Years	—	—	—	—	19.0%	19.2%
3 to 5 Years	—	—	—	—	24.6%	20.2%
6 to 10 Years	—	—	—	—	29.1%	24.1%
11 to 13 Years	—	—	—	—	25.9%	21.0%
≥ 14 Years	—	—	—	—	17.8%	14.7%
Sex						
Male	—	—	—	—	23.1%	19.8%
Female	—	—	—	—	24.4%	19.3%
Race						
Black or African American	—	—	—	—	25.2%	17.7%
White	—	—	—	—	23.0%	20.2%
Other	—	—	—	—	22.5%	26.3%
Region						
Central	—	—	—	—	26.9%	21.2%
Charlottesville/Western	—	—	—	—	23.3%	19.2%
Northern & Winchester	—	—	—	—	21.3%	29.8%
Roanoke/Alleghany	—	—	—	—	21.0%	15.8%
Southwest	—	—	—	—	28.2%	16.4%
Tidewater	—	—	—	—	21.6%	15.3%
MCO						
Aetna	—	—	—	—	16.2%	17.8%
HealthKeepers	—	—	—	—	25.5%	21.8%
Molina	—	—	—	—	15.2%	16.0%
Optima	—	—	—	—	25.0%	18.0%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
VA Premier	—	—	—	—	24.6%	19.0%
UnitedHealthcare	—	—	—	—	21.7%	20.0%
More Than One MCO	—	—	—	—	24.2%	25.8%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-8 shows that 23.7 percent of children receiving adoption assistance and 19.6 percent of controls received at least two topical fluoride applications as dental or oral health services during MY 2021, and the difference was statistically significant (p=0.001). Low rates may be due to some topical fluoride treatments not being captured in the administrative data, and the ADA only recommends fluoride treatment for people at elevated risk for caries.[4-5] Additionally, the ADA has less strict clinical recommendations for people 6 years of age and older (e.g., people 6 years of age or older can use home-use fluoride treatments instead of receiving fluoride varnish, and two out of three procedure codes in the *Topical Fluoride for Children* specifications are for fluoride varnish).[4-6] The rates for children receiving adoption assistance were notably higher than controls for female members (by 5.1 percentage points); Black or African American members (7.5 percentage points); members in the Central, Roanoke/Alleghany, Southwest and Tidewater regions (by 5.7, 5.2, 11.8, and 6.3 percentage points, respectively); and members enrolled with Optima and Virginia Premier (by 7.0 and 5.6 percentage points, respectively).

MY 2021 national Medicaid benchmarks were not available for this indicator. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both children receiving adoption assistance and controls, members in the Roanoke/Alleghany and Tidewater regions were significantly less likely to have at least two topical fluoride applications compared to members in other regions during MY 2021. For children receiving adoption assistance only, members in the Central and Southwest regions were significantly more likely to have at least two topical fluoride applications compared to members in other regions, while members

4-5 American Dental Association. Fluoride: Topical and Systematic Supplements. Available at: https://www.ada.org/resources/research/science-and-research-institute/oral-health-topics/fluoride-topical-and-systemic-supplements. Accessed on: Jan 11, 2023.
4-6 Ibid.

in the Northern & Winchester region were significantly less likely. For both children receiving adoption assistance and controls, members enrolled with HealthKeepers were significantly more likely to have at least two topical fluoride applications compared to members enrolled with other MCOs. For children receiving adoption assistance only, members in the Black or African American racial group were significantly more likely to have at least two topical fluoride applications compared to other racial groups. For both children receiving adoption assistance and controls, members 6 to 10 years of age were significantly more likely to have at least two topical fluoride applications compared to members in other age categories, while members 14 years of age and older were significantly less likely. Additionally, for children receiving adoption assistance only, members 11 to 13 years of age were significantly more likely to have at least two topical fluoride applications.

Topical Fluoride for Children—Dental Services (TFL-CH)

Table 4-9 displays the MY 2019, MY 2020, and MY 2021 *Topical Fluoride for Children—Dental Services* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Topical Fluoride for Children—Dental Services* indicator measures the percentage of enrolled children 1 through 20 years of age who received at least two topical fluoride applications as dental services within the measurement year. Since the children receiving adoption assistance population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 4-9—Rates of *Topical Fluoride for Children—Dental Services* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	—	—	19.4%+	16.2%
Age Category						
≤ 2 Years	—	—	—	—	14.6%	9.0%
3 to 5 Years	—	—	—	—	19.7%	16.8%
6 to 10 Years	—	—	—	—	24.1%	19.8%
11 to 13 Years	—	—	—	—	20.2%	17.8%
≥ 14 Years	—	—	—	—	15.1%	12.3%
Sex						
Male	—	—	—	—	18.5%	16.5%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Female	—	—	—	—	20.3%	15.8%
Race						
Black or African American	—	—	—	—	19.9%	14.7%
White	—	—	—	—	19.1%	16.7%
Other	—	—	—	—	20.6%	20.0%
Region						
Central	—	—	—	—	19.8%	16.3%
Charlottesville/Western	—	—	—	—	16.1%	14.7%
Northern & Winchester	—	—	—	—	18.1%	25.5%
Roanoke/Alleghany	—	—	—	—	18.2%	13.8%
Southwest	—	—	—	—	26.7%	15.3%
Tidewater	—	—	—	—	18.8%	12.5%
MCO						
Aetna	—	—	—	—	13.5%	15.2%
HealthKeepers	—	—	—	—	20.9%	17.7%
Molina	—	—	—	—	12.8%	14.3%
Optima	—	—	—	—	19.9%	14.3%
VA Premier	—	—	—	—	20.4%	15.8%
UnitedHealthcare	—	—	—	—	16.9%	18.2%
More Than One MCO	—	—	—	—	21.2%	19.7%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-9 shows that 19.4 percent of children receiving adoption assistance and 16.2 percent of controls received at least two topical fluoride applications as dental services during MY 2021, and the

difference was statistically significant (p=0.001). The rates for children receiving adoption assistance were notably higher than controls for members in the Southwest and Tidewater regions (by 11.4, and 6.3 percentage points, respectively), and members enrolled with Optima (by 5.6 percentage points).

MY 2021 national Medicaid benchmarks were not available for this indicator. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For children receiving adoption assistance only, members in the Southwest region were significantly more likely to have at least two topical fluoride applications compared to members in other regions during MY 2021, while members in the Charlottesville/Western region were significantly less likely. For both children receiving adoption assistance and controls, members enrolled with HealthKeepers were significantly more likely to have at least two topical fluoride applications compared to members enrolled with other MCOs. For children receiving adoption assistance only, members enrolled with Aetna and Molina were significantly less likely to have at least two topical fluoride applications compared to members enrolled with other MCOs. For both children receiving adoption assistance and controls, members 6 to 10 years of age were significantly more likely to have at least two topical fluoride applications compared to members in other age groups, while members 14 years of age and older were significantly less likely.

Topical Fluoride for Children—Oral Health Services (TFL-CH)

Table 4-10 displays the MY 2019, MY 2020, and MY 2021 *Topical Fluoride for Children—Oral Health Services* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Topical Fluoride for Children—Oral Health Services* indicator measures the percentage of enrolled children 1 through 20 years of age who received at least two topical fluoride applications as oral health services within the measurement year. Since the children receiving adoption assistance population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 4-10—Rates of *Topical Fluoride for Children—Oral Health Services* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	—	—	1.4%	1.2%
Age Category						
≤ 2 Years	—	—	—	—	1.9%	9.6%
3 to 5 Years	—	—	—	—	2.0%	0.8%
6 to 10 Years	—	—	—	—	1.2%	1.3%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
11 to 13 Years	—	—	—	—	1.7%	1.0%
≥ 14 Years	—	—	—	—	1.1%	0.9%
Sex						
Male	—	—	—	—	1.4%	1.2%
Female	—	—	—	—	1.3%	1.3%
Race						
Black or African American	—	—	—	—	1.8%	1.2%
White	—	—	—	—	1.2%	1.3%
Other	—	—	—	—	0.0%	0.6%
Region						
Central	—	—	—	—	2.0%	1.5%
Charlottesville/Western	—	—	—	—	3.1%	2.0%
Northern & Winchester	—	—	—	—	1.0%	1.4%
Roanoke/Alleghany	—	—	—	—	0.5%	0.5%
Southwest	—	—	—	—	1.0%	0.7%
Tidewater	—	—	—	—	0.4%	1.1%
MCO						
Aetna	—	—	—	—	1.0%	1.3%
HealthKeepers	—	—	—	—	1.4%	1.3%
Molina	—	—	—	—	1.0%	1.4%
Optima	—	—	—	—	1.7%	1.4%
VA Premier	—	—	—	—	1.5%	1.0%
UnitedHealthcare	—	—	—	—	0.2%	1.0%
More Than One MCO	—	—	—	—	0.0%	0.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).

+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.

- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-10 shows that 1.4 percent of children receiving adoption assistance and 1.2 percent of controls received at least two topical fluoride applications as oral health services during MY 2021, and the difference was statistically significant (p=0.001). The differences between rates for both children receiving adoption assistance and controls were similar across the stratified rates, except for rates stratified by age category. While the rates for children receiving adoption assistance were higher than controls for members 3 to 5, 11 to 13, and 14 years of age and older (by 1.2, 0.7, and 0.2 percentage points, respectively), the rate for children receiving adoption assistance was 7.7 percentage points lower than controls for members 2 years of age and younger.

MY 2021 national Medicaid benchmarks were not available for this indicator. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both children receiving adoption assistance and controls, members in the Charlottesville/Western region were significantly more likely to have at least two topical fluoride applications compared to members in other regions during MY 2021, while members in the Roanoke/Alleghany region were significantly less likely. For children receiving adoption assistance only, members in the Central region were significantly more likely to have at least two topical fluoride applications compared to members in other regions, while members in the Tidewater region were significantly less likely. For children receiving adoption assistance only, members enrolled with UnitedHealthcare were significantly less likely to have at least two topical fluoride applications compared to members in other MCOs. For children receiving adoption assistance only, Black or African American members were significantly more likely to have at least two topical fluoride applications as compared to members in other racial groups.

Behavioral Health

Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up (FUH)

Table 4-11 displays the MY 2019, MY 2020, and MY 2021 *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* indicator measures the percentage of discharges for children 6 to 17 years of age who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses for which the member had a follow-up visit within seven days after discharge with a mental health provider. Since the children receiving adoption assistance population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 4-11—Rates of *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	60.2%	58.7%	59.7%	52.0%
Age Category						
6 to 10 Years	—	—	80.0%	76.5%	50.0%	66.7%
11 to 13 Years	—	—	67.7%	69.6%	62.9%	60.0%
≥ 14 Years	—	—	52.2%	48.1%	60.0%	45.9%
Sex						
Male	—	—	63.3%	54.5%	49.2%	57.9%
Female	—	—	57.8%	61.0%	69.8%	48.4%
Race						
Black or African American	—	—	61.1%	50.0%	64.0%	47.5%
White	—	—	59.7%	61.3%	57.7%	54.4%
Other	—	—	—	100.0%	33.3%	66.7%
Region						
Central	—	—	62.5%	55.6%	55.9%^	72.2%^
Charlottesville/Western	—	—	25.0%	68.4%	54.5%^	60.0%^
Northern & Winchester	—	—	50.0%	75.0%	50.0%^	30.0%^
Roanoke/Alleghany	—	—	71.9%	71.4%	70.0%^	60.0%^
Southwest	—	—	66.7%	60.0%	83.3%^	57.1%^
Tidewater	—	—	65.2%	31.3%	60.7%^	40.0%^
MCO						
Aetna	—	—	100.0%	22.2%	75.0%	55.6%
HealthKeepers	—	—	60.0%	60.0%	67.4%	55.9%
Molina	—	—	55.6%	0.0%	37.5%^	100.0%^
Optima	—	—	53.3%	42.1%	65.6%	51.7%
VA Premier	—	—	66.7%	81.6%	50.0%	47.4%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
UnitedHealthcare	—	—	0.0%	0.0%	37.5%	33.3%
More Than One MCO	—	—	100.0%	100.0%	—	50.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-11 shows that 59.7 percent of children receiving adoption assistance and 52.0 percent of controls had a follow-up visit within seven days after discharge with a mental health provider during MY 2021, and the difference was not statistically significant (p=0.25). The rate for children receiving adoption assistance was notably higher than controls for female members (by 21.4 percentage points), Black or African American members (by 16.5 percentage points), and members enrolled with HealthKeepers (by 11.5 percentage points). Additionally, the rate for male children receiving adoption assistance was 8.7 percentage points lower than the rates for male controls. While there were also large rate differences for other rates stratified by region and MCO as well as for members in the Other racial group, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2021 rates for both children receiving adoption assistance and controls were above the MY 2021 national Medicaid 50th percentile. The rate for children receiving adoption assistance decreased from MY 2020 to MY 2021 by 0.5 percentage points, while the rate for the controls decreased by 6.7 percentage points. For children receiving adoption assistance only, female members were significantly more likely to have a follow-up visit within seven days after discharge with a mental health provider than male members during MY 2021.

Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up (FUM)

Table 4-12 displays the MY 2019, MY 2020, and MY 2021 *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* indicator measures the percentage of ED visits for children 6 to 17 years of age with a principal diagnosis of mental illness or intentional self-harm for which the member had a follow-up visit for mental illness within 30 days of the ED visit. Since the children receiving adoption assistance population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 4-12—Rates of *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	77.8%	86.8%	80.0%	67.4%
Age Category						
6 to 10 Years	—	—	75.0%	100.0%	100.0%^	85.7%^
11 to 13 Years	—	—	85.7%	88.2%	80.0%	53.8%
≥ 14 Years	—	—	76.0%	82.1%	77.5%	69.2%
Sex						
Male	—	—	81.1%	84.0%	65.4%	91.7%
Female	—	—	74.3%	89.3%	89.7%	58.8%
Race						
Black or African American	—	—	84.4%	81.8%	84.0%	73.3%
White	—	—	72.5%	90.0%	77.5%	65.5%
Other	—	—	—	100.0%	—	50.0%
Region						
Central	—	—	83.3%	85.7%	75.0%^	73.3%^
Charlottesville/Western	—	—	70.0%	83.3%	70.0%^	50.0%^
Northern & Winchester	—	—	72.2%	66.7%	90.0%^	50.0%^
Roanoke/Alleghany	—	—	91.7%	100.0%	70.0%^	72.7%^
Southwest	—	—	71.4%	100.0%	80.0%^	100.0%^
Tidewater	—	—	76.9%	84.6%	92.9%	62.5%
MCO						
Aetna	—	—	66.7%	100.0%	66.7%	75.0%
HealthKeepers	—	—	85.7%	93.3%	80.8%	50.0%
Molina	—	—	66.7%	100.0%	75.0%^	100.0%^
Optima	—	—	82.4%	87.5%	83.3%	83.3%
VA Premier	—	—	73.1%	76.9%	73.3%	70.0%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
UnitedHealthcare	—	—	0.0%	100.0%	100.0%^	50.0%^
More Than One MCO	—	—	100.0%	0.0%	100.0%^	100.0%^

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-12 shows that 80.0 percent of children receiving adoption assistance and 67.4 percent of controls had a follow-up visit for mental illness within 30 days of an ED visit during MY 2021, and the difference was not statistically significant (p=0.13). The rate for children receiving adoption assistance was higher than controls for female members (by 30.9 percentage points). While there were large rate differences for most other stratified rates, all other stratified rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2021 rates for children receiving adoption assistance were above the MY 2021 national Medicaid 50th percentile, while rates for the control were below the national Medicaid 50th percentile. The rate for children receiving adoption assistance increased from MY 2020 to MY 2021 by 2.2 percentage points, while rates for the controls decreased by 19.4 percentage points. For children receiving adoption assistance only, female members were significantly more likely have a follow-up visit for mental illness within 30 days of an ED visit than male members during MY 2021.

Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing (APM)

Table 4-13 displays the MY 2019, MY 2020, and MY 2021 *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing* indicator measures the percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and who received blood glucose and cholesterol testing. Since the children receiving adoption assistance population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 4-13—Rates of *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	27.7%	25.1%	34.1%	34.6%
Age Category						
≤ 2 Years	—	—	0.0%	—	—	—
3 to 5 Years	—	—	20.0%	28.6%	36.4%	16.7%
6 to 10 Years	—	—	26.9%	19.6%	29.1%	37.7%
11 to 13 Years	—	—	27.3%	41.7%	32.6%	31.8%
≥ 14 Years	—	—	29.0%	20.8%	38.2%	35.8%
Sex						
Male	—	—	26.5%	20.8%	34.0%	32.1%
Female	—	—	30.0%	32.3%	34.3%	39.0%
Race						
Black or African American	—	—	24.9%	29.8%	28.6%	30.9%
White	—	—	29.9%	22.7%	37.3%	36.5%
Other	—	—	10.0%	40.0%	0.0%^	0.0%^
Region						
Central	—	—	27.6%	17.1%	29.8%	29.5%
Charlottesville/Western	—	—	30.3%	23.8%	40.7%	15.4%
Northern & Winchester	—	—	19.1%	41.2%	13.1%	50.0%
Roanoke/Alleghany	—	—	33.1%	32.4%	34.8%	36.8%
Southwest	—	—	38.3%	26.3%	60.0%	43.8%
Tidewater	—	—	22.0%	19.4%	35.5%	34.6%
MCO						
Aetna	—	—	25.9%	40.0%	25.0%	40.0%
HealthKeepers	—	—	25.3%	10.2%	26.2%	34.3%
Molina	—	—	19.0%	100.0%	23.8%	14.3%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Optima	—	—	32.7%	25.7%	35.2%	32.7%
VA Premier	—	—	30.4%	35.6%	42.0%	41.5%
UnitedHealthcare	—	—	19.4%	33.3%	42.9%	15.4%
More Than One MCO	—	—	22.2%	0.0%	66.7%	33.3%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-13 shows that 34.1 percent of children receiving adoption assistance and 34.6 percent of controls with two or more antipsychotic prescriptions received blood glucose and cholesterol testing during MY 2021, and the difference was not statistically significant (p=0.90). The rate for children receiving adoption assistance was notably higher than controls for members in the Southwest region (by 16.2 percentage points). While there were large rate differences between children receiving adoption assistance and controls for members in the Charlottesville/Western and Northern & Winchester regions, as well as for members enrolled with Aetna, Molina, UnitedHealthcare, and More Than One MCO, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2021 rates for children receiving adoption assistance were below the MY 2021 national Medicaid 50th percentile, while rates for the control were above the national Medicaid 50th percentile. Rates for children receiving adoption assistance and controls increased from MY 2020 to MY 2021 by 6.4 and 9.5 percentage points, respectively. For children receiving adoption assistance only, members in the Southwest region were significantly more likely to receive blood glucose and cholesterol testing compared to members in other regions during MY 2021, while members in the Northern & Winchester region were significantly less likely. For children receiving adoption assistance only, members enrolled with VA Premier were significantly more likely to receive blood glucose and cholesterol testing, while members enrolled with HealthKeepers were significantly less likely. For children receiving adoption assistance only, White members were significantly more likely to receive blood glucose and cholesterol testing compared to other racial groups.

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

Table 4-14 displays the MY 2019, MY 2020, and MY 2021 *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* indicator measures the percentage of children and adolescents 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment. Since the children receiving adoption assistance population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 4-14—Rates of *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	59.3%	61.5%	59.3%	65.3%
Age Category						
3 to 5 Years	—	—	33.3%	100.0%	50.0%	33.3%
6 to 10 Years	—	—	63.9%	66.7%	70.7%	72.7%
11 to 13 Years	—	—	63.2%	69.2%	48.5%	66.7%
≥ 14 Years	—	—	53.7%	40.0%	57.8%	62.1%
Sex						
Male	—	—	57.9%	50.0%	57.1%	59.1%
Female	—	—	61.9%	73.7%	63.0%	75.0%
Race						
Black or African American	—	—	70.8%	54.5%	63.8%	61.9%
White	—	—	53.7%	64.3%	56.6%	67.3%
Other	—	—	0.0%	—	—	50.0%
Region						
Central	—	—	44.8%	58.3%	62.5%	73.3%
Charlottesville/Western	—	—	40.0%	60.0%	38.5%	28.6%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Northern & Winchester	—	—	57.1%	66.7%	50.0%	40.0%
Roanoke/Alleghany	—	—	80.0%	60.0%	82.1%	76.9%
Southwest	—	—	88.9%	75.0%	60.0%	85.7%
Tidewater	—	—	54.2%	60.0%	51.6%	55.6%
MCO						
Aetna	—	—	80.0%	0.0%	33.3%	50.0%
HealthKeepers	—	—	45.7%	63.2%	68.1%	63.2%
Molina	—	—	37.5%	—	75.0%^	100.0%^
Optima	—	—	70.6%	60.0%	53.1%	61.1%
VA Premier	—	—	68.8%	81.8%	48.0%	71.4%
UnitedHealthcare	—	—	77.8%	0.0%	50.0%	50.0%
More Than One MCO	—	—	100.0%	—	100.0%^	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-14 shows that 59.3 percent of children receiving adoption assistance and 65.3 percent of controls with a new prescription for an antipsychotic medication had documentation of psychosocial care as first-line treatment during MY 2021, and the difference was not statistically significant (p=0.41). The rates for children receiving adoption assistance were notably lower than the rates for controls among female members (by 8.0 percentage points) and White members (by 10.7 percentage points). While there were large rate differences for members 3 to 5 and 11 to 13 years of age; the Central, Charlottesville/Western, Northern & Winchester, Roanoke/Alleghany, and Southwest regions; as well as the Aetna, Optima, and VA Premier MCOs, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2021 rates for children receiving adoption assistance were below the MY 2021 national Medicaid 50th percentile, while rates for the control were above the national Medicaid 50th percentile. The rate for children receiving adoption assistance did not change from MY 2020 to MY 2021, while the rate for controls increased by 3.8 percentage points. For children receiving adoption

assistance only, members were significantly more likely to have documentation of psychosocial care as first-line treatment in the Roanoke/Alleghany region compared to all other regions during MY 2021.

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Table 4-15 displays the MY 2019, MY 2020, and MY 2021 *Follow-Up Care for Children Prescribed ADHD Medication* rates among children receiving adoption assistance and controls stratified by month of follow-up. Table 4-16 displays the MY 2019, MY 2020, and MY 2021 *Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Follow-Up Care for Children Prescribed ADHD Medication* indicator measures the percentage of children and adolescents 6 to 12 years of age who were newly prescribed ADHD medication and who had at least three follow-up visits within a 10-month period, one of which was within one, two, three, six, or nine months of when the first ADHD medication was dispensed. This indicator has been modified to include children 6 to 13 years of age.

Table 4-15—Rates of *Follow-Up Care for Children Prescribed ADHD Medication* Among Children Receiving Adoption Assistance and Controls, by Month of Follow-Up

Month of Follow-Up	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
One-Month	—	—	57.6%	54.0%	51.4%	58.1%
Two-Month	—	—	71.8%	76.1%	62.9%	74.3%
Three-Month	—	—	79.2%	85.1%	73.1%	81.0%
Six-Month	—	—	89.0%	94.2%	86.1%	91.5%
Nine-Month	—	—	91.8%	96.0%	91.0%	94.0%

Table 4-15 shows that 51.4 percent of children receiving adoption assistance had a follow-up visit within one month of when their first ADHD medication was dispensed, and 91.0 percent of children receiving adoption assistance has a follow-up visit within nine months. Additionally, the rates for children receiving adoption assistance were 6.7, 11.4, 7.9, 5.4, and 3.0 percentage points lower than controls for a follow-up visit within one month, two months, three months, six months, and nine months, respectively. These findings indicate that children receiving adoption assistance were less likely to have a follow-up visit earlier than controls, and this gap between children receiving adoption assistance and controls closes over time after the ADHD medication is dispensed.

Table 4-16—Rates of *Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	57.6%	54.0%	51.4%	58.1%
Age Category						
6 to 10 Years	—	—	62.7%	55.7%	48.4%	56.1%
11 to 13 Years	—	—	47.6%	50.5%	56.7%	61.3%
Sex						
Male	—	—	56.8%	51.2%	48.6%	57.3%
Female	—	—	58.6%	58.7%	55.1%	59.6%
Race						
Black or African American	—	—	56.1%	48.5%	45.2%	59.6%
White	—	—	59.5%	57.5%	53.9%	58.4%
Other	—	—	16.7%	33.3%	57.1%	28.6%
Region						
Central	—	—	53.3%	53.8%	44.8%	55.8%
Charlottesville/Western	—	—	67.7%	57.1%	54.1%	65.2%
Northern & Winchester	—	—	48.1%	48.5%	51.5%	57.1%
Roanoke/Alleghany	—	—	55.6%	57.1%	53.5%	56.5%
Southwest	—	—	79.3%	67.9%	67.7%	62.9%
Tidewater	—	—	50.9%	47.0%	44.2%	54.5%
MCO						
Aetna	—	—	35.7%	78.6%	52.4%	47.8%
HealthKeepers	—	—	54.4%	54.0%	51.6%	58.0%
Molina	—	—	50.0%	66.7%	33.3%	54.5%
Optima	—	—	66.0%	46.3%	55.8%	58.6%
VA Premier	—	—	57.1%	58.2%	51.6%	62.1%
UnitedHealthcare	—	—	64.7%	35.3%	53.8%	53.3%
More Than One MCO	—	—	100.0%	66.7%	20.0%	50.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-16 shows that 51.4 percent of children receiving adoption assistance and 58.1 percent of controls had a follow-up visit within one month after the first ADHD medication was dispensed during MY 2021, and the difference was not statistically significant (p=0.12). The controls' rates were notably higher than children receiving adoption assistance for male members (by 8.7 percentage points); Black or African American members (by 14.4 percentage points); members in the Central, Charlottesville/Western, and Tidewater regions (by 11.0, 11.1, and 10.3 percentage points, respectively), as well as members enrolled with HealthKeepers and VA Premier (by 6.4 and 10.5 percentage points, respectively). While there were also large rate differences for members in the Other racial group, members in the Northern & Winchester region, and members enrolled with Molina and More Than One MCO, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2021 rates for both children receiving adoption assistance and controls and were above the MY 2021 national Medicaid 50th percentile. The rate for children receiving adoption assistance decreased from MY 2020 to MY 2021 by 6.2 percentage points, while the rate for controls increased by 4.1 percentage points. There were no disparities identified for children receiving adoption assistance.

Substance Use

Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up (FUA)

The *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* indicator is not presented as a table because the denominators for children receiving adoption assistance and controls were too small to ensure reliable rates. These denominator sizes indicate that very few children receiving adoption assistance had ED visits for AOD abuse or dependence.

Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment (IET)

Table 4-17 displays the MY 2019, MY 2020, and MY 2021 *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment* rates among children receiving adoption assistance and controls 13 years of age and older stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment* indicator measures the percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis. Since the children receiving adoption assistance population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 4-17—Rates of *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	57.1%	36.2%	55.0%+	31.9%
Age Category						
11 to 13 Years	—	—	100.0%	50.0%	50.0%^	0.0%^
≥ 14 Years	—	—	53.8%	35.7%	55.6%^	34.9%^
Sex						
Male	—	—	62.5%	39.4%	50.0%	45.8%
Female	—	—	50.0%	32.0%	61.1%	17.4%
Race						
Black or African American	—	—	33.3%	41.7%	50.0%	22.2%
White	—	—	63.6%	33.3%	56.5%	35.1%
Other	—	—	—	0.0%	100.0%^	0.0%^
Region						
Central	—	—	66.7%	66.7%	53.8%	16.7%
Charlottesville/Western	—	—	66.7%	37.5%	83.3%	28.6%
Northern & Winchester	—	—	16.7%	33.3%	25.0%	25.0%
Roanoke/Alleghany	—	—	66.7%	38.5%	42.9%	57.1%
Southwest	—	—	33.3%	0.0%	66.7%	36.4%
Tidewater	—	—	100.0%	29.4%	100.0%^	25.0%^
MCO						
Aetna	—	—	33.3%	40.0%	50.0%	50.0%
HealthKeepers	—	—	50.0%	16.7%	64.3%	27.8%
Molina	—	—	25.0%	—	20.0%^	0.0%^
Optima	—	—	100.0%	35.3%	71.4%	50.0%
VA Premier	—	—	54.5%	45.0%	54.5%	38.5%
UnitedHealthcare	—	—	—	50.0%	0.0%^	16.7%^
More Than One MCO	—	—	100.0%	50.0%	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-17 shows that 55.0 percent of children receiving adoption assistance and 31.9 percent of controls with a new episode of AOD abuse or dependence initiated treatment within 14 days of the diagnosis during MY 2021, and the difference was statistically significant (p=0.03). While there were large rate differences between children receiving adoption assistance and controls for most stratified rates, these rates had small denominators, so rates may be less reliable.

For all eligible members, the MY 2021 rates for children receiving adoption assistance were above the MY 2021 national Medicaid 50th percentile, while rates for the controls were below the MY 2021 national Medicaid 50th percentile. The rates for both children receiving adoption assistance and controls decreased from MY 2020 to MY 2021 by 2.1 and 4.3 percentage points, respectively. There were no disparities identified for children receiving adoption assistance.

Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment (IET)

Table 4-18 displays the MY 2019, MY 2020, and MY 2021 *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment* rates among children receiving adoption assistance and controls 13 years and older stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment* indicator measures the percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. Since the children receiving adoption assistance population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

Table 4-18—Rates of *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	25.0%+	8.6%	10.0%	10.6%
Age Category						

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
11 to 13 Years	—	—	50.0%	0.0%	25.0%^	0.0%^
≥ 14 Years	—	—	23.1%	8.9%	8.3%^	11.6%^
Sex						
Male	—	—	31.3%	6.1%	9.1%	16.7%
Female	—	—	16.7%	12.0%	11.1%	4.3%
Race						
Black or African American	—	—	33.3%	4.2%	12.5%^	0.0%^
White	—	—	22.7%	12.1%	8.7%^	13.5%^
Other	—	—	—	0.0%	0.0%^	0.0%^
Region						
Central	—	—	66.7%	22.2%	7.7%^	0.0%^
Charlottesville/Western	—	—	0.0%	12.5%	16.7%	14.3%
Northern & Winchester	—	—	0.0%	0.0%	12.5%	16.7%
Roanoke/Alleghany	—	—	0.0%	7.7%	14.3%^	0.0%^
Southwest	—	—	33.3%	0.0%	0.0%^	18.2%^
Tidewater	—	—	50.0%	5.9%	0.0%^	0.0%^
MCO						
Aetna	—	—	33.3%	40.0%	0.0%^	50.0%^
HealthKeepers	—	—	25.0%	0.0%	14.3%	5.6%
Molina	—	—	0.0%	—	20.0%^	0.0%^
Optima	—	—	60.0%	5.9%	0.0%^	0.0%^
VA Premier	—	—	9.1%	10.0%	9.1%	23.1%
UnitedHealthcare	—	—	—	0.0%	0.0%^	0.0%^
More Than One MCO	—	—	100.0%	0.0%	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).

+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-18 shows that 10.0 percent of children receiving adoption assistance and 10.6 percent of controls with a new episode of AOD abuse or dependence initiated treatment and engaged in ongoing AOD treatment during MY 2021, and the difference was not statistically significant (p=1.00). While there were large rate differences between children receiving adoption assistance and controls for many stratified rates, such as members 11 to 13 years of age and the Black or African American racial group, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2021 rates for both children receiving adoption assistance and controls were below the MY 2021 national Medicaid 50th percentile. The rate for children receiving adoption assistance decreased from MY 2020 to MY 2021 by 15.0 percentage points, while the rate for controls increased by 2.0 percentage points. There were no disparities identified for children receiving adoption assistance.

Respiratory Health

Asthma Medication Ratio (AMR)

Table 4-19 displays the MY 2019, MY 2020, and MY 2021 *Asthma Medication Ratio* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Asthma Medication Ratio* indicator measures the percentage of children and adolescents ages 5 to 18 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Table 4-19—Rates of Appropriate *Asthma Medication Ratio* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	83.4%	76.2%	86.1%+	71.4%
Age Category						
5 to 11 Years	—	—	84.9%	85.9%	86.2%	78.9%
12 to 18 Years	—	—	82.4%	70.2%	86.1%	67.0%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Sex						
Male	—	—	81.2%	79.6%	84.3%	73.5%
Female	—	—	86.2%	70.8%	88.7%	69.0%
Race						
Black or African American	—	—	78.1%	77.1%	83.5%	66.0%
White	—	—	87.4%	74.7%	87.6%	75.0%
Other	—	—	100.0%	100.0%	100.0%^	50.0%^
Region						
Central	—	—	81.0%	80.5%	87.5%	60.0%
Charlottesville/Western	—	—	84.8%	77.1%	90.9%	81.0%
Northern & Winchester	—	—	83.3%	77.8%	81.3%	72.2%
Roanoke/Alleghany	—	—	83.3%	75.0%	89.7%	72.0%
Southwest	—	—	86.2%	68.8%	95.5%	75.0%
Tidewater	—	—	83.0%	73.7%	75.6%	72.2%
MCO						
Aetna	—	—	88.2%	77.8%	80.0%	66.7%
HealthKeepers	—	—	81.8%	78.7%	83.7%	62.5%
Molina	—	—	100.0%	100.0%	88.9%^	100.0%^
Optima	—	—	84.8%	69.2%	88.4%	73.8%
VA Premier	—	—	83.3%	79.0%	85.7%	81.6%
UnitedHealthcare	—	—	66.7%	50.0%	100.0%^	44.4%^
More Than One MCO	—	—	71.4%	80.0%	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).

+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.

- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.

— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-19 shows that 86.1 percent of children receiving adoption assistance and 71.4 percent of controls who were identified as having persistent asthma had a ratio of controller medications to total asthma medications of 0.50 or greater during MY 2021, and the difference was statistically significant (p=0.001). The rates for children receiving adoption assistance were notably higher than controls for members in the Central region (by 27.5 percentage points), as well as members enrolled with HealthKeepers and Optima (by 21.2 and 14.6 percentage points, respectively). While there were large rate differences for the Charlottesville/Western, Northern & Winchester, Roanoke/Alleghany, and Southwest regions, as well as the Aetna MCO, these rates had small denominators, so the rates may be less reliable.

The rates for both children receiving adoption assistance and controls were above the MY 2021 national Medicaid 50th percentile for members 5 to 11 years of age. The rate for children receiving adoption assistance increased from MY 2020 to MY 2021 by 2.7 percentage points, while the rate for the controls decreased by 4.8 percentage points. For children receiving adoption assistance only, members in the Tidewater region were significantly less likely to have a ratio of controller medications to total asthma medications of 0.50 or greater compared to members in other regions during MY 2021.

Service Utilization

Ambulatory Care Visits

Table 4-20 displays the MY 2019, MY 2020, and MY 2021 *Ambulatory Care Visits* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Ambulatory Care Visits* indicator measures the percentage of members who had an ambulatory care visit during the measurement year.

Table 4-20—Rates of *Ambulatory Care Visits* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	—	—	81.4%-	83.6%
Age Category						
≤ 2 Years	—	—	—	—	84.4%	93.1%
3 to 5 Years	—	—	—	—	83.0%	86.3%
6 to 10 Years	—	—	—	—	80.5%	82.8%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
11 to 13 Years	—	—	—	—	82.4%	85.2%
≥ 14 Years	—	—	—	—	80.7%	81.6%
Sex						
Male	—	—	—	—	80.9%	83.7%
Female	—	—	—	—	81.8%	83.4%
Race						
Black or African American	—	—	—	—	80.7%	80.6%
White	—	—	—	—	81.8%	85.0%
Other	—	—	—	—	76.3%	80.6%
Region						
Central	—	—	—	—	82.0%	82.7%
Charlottesville/Western	—	—	—	—	84.1%	83.8%
Northern & Winchester	—	—	—	—	68.7%	82.4%
Roanoke/Alleghany	—	—	—	—	85.5%	86.7%
Southwest	—	—	—	—	90.5%	88.0%
Tidewater	—	—	—	—	78.8%	79.5%
MCO						
Aetna	—	—	—	—	75.5%	81.6%
HealthKeepers	—	—	—	—	81.7%	84.1%
Molina	—	—	—	—	72.4%	71.8%
Optima	—	—	—	—	83.1%	83.5%
VA Premier	—	—	—	—	84.4%	85.6%
UnitedHealthcare	—	—	—	—	74.0%	81.7%
More Than One MCO	—	—	—	—	81.8%	87.9%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).

+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.

- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-20 shows that 81.4 percent of children receiving adoption assistance and 83.6 percent of controls had an ambulatory care visit during MY 2021, and the difference was statistically significant (p=0.001). The rate for children receiving adoption assistance was notably lower than controls for members 2 years of age and younger (by 8.7 percentage points); members in the Northern & Winchester region (by 13.7 percentage points); and members enrolled with Aetna, UnitedHealthcare, and More Than One MCO (by 6.1, 7.7, and 6.1 percentage points, respectively).

The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both children receiving adoption assistance and controls, members in the Roanoke/Alleghany and Southwest regions were significantly more likely to have an ambulatory care visit compared to members in other regions in MY 2021, while members in the Tidewater region were significantly less likely. For children receiving adoption assistance only, members in the Charlottesville/Western region were significantly more likely to have an ambulatory care visit compared to members in other regions, while members in the Northern & Winchester region were significantly less likely. For both children receiving adoption assistance and controls, members enrolled with VA Premier were significantly more likely to have an ambulatory care visit compared to members enrolled with other MCOs, while members enrolled with Molina were significantly less likely. For children receiving adoption assistance only, members enrolled with Aetna and UnitedHealthcare were significantly less likely to have an ambulatory care visit compared to members in other regions.

ED Visits

Table 4-21 displays the MY 2019, MY 2020, and MY 2021 *ED Visits* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *ED Visits* indicator measures the percentage of members who had an ED visit during the measurement year.

Table 4-21—Rates of *ED Visits* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	—	—	16.1%-	24.1%
Age Category						
≤ 2 Years	—	—	—	—	20.6%	31.3%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
3 to 5 Years	—	—	—	—	14.4%	23.6%
6 to 10 Years	—	—	—	—	12.0%	20.9%
11 to 13 Years	—	—	—	—	14.1%	20.0%
≥ 14 Years	—	—	—	—	21.0%	29.1%
Sex						
Male	—	—	—	—	16.1%	22.9%
Female	—	—	—	—	16.1%	25.4%
Race						
Black or African American	—	—	—	—	16.3%	26.6%
White	—	—	—	—	16.0%	23.0%
Other	—	—	—	—	14.4%	21.9%
Region						
Central	—	—	—	—	16.1%	25.0%
Charlottesville/Western	—	—	—	—	14.9%	21.9%
Northern & Winchester	—	—	—	—	13.3%	22.5%
Roanoke/Alleghany	—	—	—	—	16.2%	24.5%
Southwest	—	—	—	—	21.5%	28.5%
Tidewater	—	—	—	—	15.7%	22.9%
MCO						
Aetna	—	—	—	—	16.0%	22.9%
HealthKeepers	—	—	—	—	16.0%	23.8%
Molina	—	—	—	—	14.3%	20.4%
Optima	—	—	—	—	15.9%	22.6%
VA Premier	—	—	—	—	16.0%	26.3%
UnitedHealthcare	—	—	—	—	18.3%	22.7%
More Than One MCO	—	—	—	—	16.7%	37.9%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-21 shows that 16.1 percent of children receiving adoption assistance and 24.1 percent of controls had an ED visit during MY 2021, and the difference was statistically significant (p=0.001). The rates for children receiving adoption assistance were lower than controls for all stratified rates, with the largest difference being for members 2 years of age and younger (by 10.7 percentage points) and for members enrolled with More Than One MCO (by 21.2 percentage points).

The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both children receiving adoption assistance and controls, members in the Southwest region were significantly more likely to have an ED visit compared to members in other regions during MY 2021. For children receiving adoption assistance only, members were significantly less likely to have an ED visit in the Northern & Winchester region compared to members in other regions. For both children receiving adoption assistance and controls, members 14 years of age and older were significantly more likely to have an ED visit compared to members in other age groups, while members 6 to 10 and 11 to 13 years of age were significantly less likely.

Inpatient Visits

Table 4-22 displays the MY 2019, MY 2020, and MY 2021 *Inpatient Visits* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Inpatient Visits* indicator measures the percentage of members who had an inpatient visit during the measurement year.

Table 4-22—Rates of *Inpatient Visits* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	—	—	2.8%	2.4%
Age Category						
≤ 2 Years	—	—	—	—	3.1%	1.9%
3 to 5 Years	—	—	—	—	0.5%	0.6%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
6 to 10 Years	—	—	—	—	1.4%	1.1%
11 to 13 Years	—	—	—	—	3.2%	2.5%
≥ 14 Years	—	—	—	—	4.3%	3.9%
Sex						
Male	—	—	—	—	2.5%	1.7%
Female	—	—	—	—	3.1%	3.2%
Race						
Black or African American	—	—	—	—	3.4%	2.7%
White	—	—	—	—	2.5%	2.2%
Other	—	—	—	—	1.9%	2.5%
Region						
Central	—	—	—	—	3.5%	2.1%
Charlottesville/Western	—	—	—	—	3.4%	2.5%
Northern & Winchester	—	—	—	—	1.9%	2.0%
Roanoke/Alleghany	—	—	—	—	2.4%	2.6%
Southwest	—	—	—	—	1.9%	1.8%
Tidewater	—	—	—	—	3.0%	3.0%
MCO						
Aetna	—	—	—	—	1.5%	2.3%
HealthKeepers	—	—	—	—	2.9%	2.2%
Molina	—	—	—	—	2.4%	1.4%
Optima	—	—	—	—	3.6%	2.8%
VA Premier	—	—	—	—	2.5%	2.3%
UnitedHealthcare	—	—	—	—	2.8%	2.4%
More Than One MCO	—	—	—	—	3.0%	4.5%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).

+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-22 shows that 2.8 percent of children receiving adoption assistance and 2.4 percent of controls had an inpatient visit during MY 2021, and the difference was not statistically significant (p=0.12). The rate differences between children receiving adoption assistance and controls were similar across the stratified rates.

The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For children receiving adoption assistance only, members were significantly more likely to have an inpatient visit in the Central region and were significantly less likely in the Northern & Winchester region compared to members in other regions during MY 2021. For children receiving adoption assistance only, members were significantly more likely to have an inpatient visit when enrolled with Optima compared to members enrolled with other MCOs. For children receiving adoption assistance only, Black or African American members were significantly more likely to have an inpatient visit compared to members in other racial groups. For both children receiving adoption assistance and the controls, members 14 years of age and older were significantly more likely to have an inpatient visit compared to members in other age groups, while members 3 to 5 and 6 to 10 years of age were significantly less likely.

Behavioral Health Encounters—Total

Table 4-23 displays the MY 2019, MY 2020, and MY 2021 *Behavioral Health Encounters—Total* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Behavioral Health Encounters—Total* indicator measures the percentage of members who had a behavioral health encounter during the measurement year.

Table 4-23—Rates of *Behavioral Health Encounters—Total* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	—	—	51.6%+	44.9%
Age Category						
≤ 2 Years	—	—	—	—	25.0%	25.0%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
3 to 5 Years	—	—	—	—	31.0%	23.5%
6 to 10 Years	—	—	—	—	49.5%	42.5%
11 to 13 Years	—	—	—	—	59.5%	54.0%
≥ 14 Years	—	—	—	—	56.2%	48.8%
Sex						
Male	—	—	—	—	54.1%	47.3%
Female	—	—	—	—	48.7%	42.1%
Race						
Black or African American	—	—	—	—	54.6%	44.6%
White	—	—	—	—	50.7%	45.4%
Other	—	—	—	—	38.8%	34.4%
Region						
Central	—	—	—	—	51.3%	43.4%
Charlottesville/Western	—	—	—	—	54.1%	44.2%
Northern & Winchester	—	—	—	—	40.3%	37.0%
Roanoke/Alleghany	—	—	—	—	55.4%	48.9%
Southwest	—	—	—	—	49.7%	46.0%
Tidewater	—	—	—	—	56.6%	49.1%
MCO						
Aetna	—	—	—	—	45.9%	39.4%
HealthKeepers	—	—	—	—	53.0%	47.0%
Molina	—	—	—	—	46.6%	34.7%
Optima	—	—	—	—	54.6%	47.2%
VA Premier	—	—	—	—	52.4%	45.8%
UnitedHealthcare	—	—	—	—	42.5%	38.2%
More Than One MCO	—	—	—	—	53.0%	42.4%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-23 shows that 51.6 percent of children receiving adoption assistance and 44.9 percent of controls had a behavioral health visit during MY 2021, and the difference was statistically significant (p=0.001). The rates for children receiving adoption assistance were notably higher than controls for members 3 to 5, 6 to 10, and 14 years of age and older (by 7.5, 7.0, and 7.4 percentage points, respectively); Black or African American members (by 10.0 percentage points); members in the Central, Charlottesville/Western, Roanoke/Alleghany, and Tidewater regions (by 7.9, 9.9, 6.5, and 7.5 percentage points, respectively); and members enrolled with all MCOs, with the largest difference being for members enrolled with Molina (by 11.9 percentage points).

The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both children receiving adoption assistance and controls, members were significantly more likely to have a behavioral health encounter in the Roanoke/Alleghany and Tidewater regions compared to members in other regions, and were significantly less likely in the Northern & Winchester region compared to other regions during MY 2021. For both children receiving adoption assistance and controls, members were significantly more likely to have a behavioral health encounter when enrolled with Optima compared to members enrolled with other MCOs, and significantly less likely when enrolled with Aetna and UnitedHealthcare than all other MCOs. For children receiving adoption assistance only, Black or African American members were significantly more likely have a behavioral health encounter compared to members in other racial groups, while White members were significantly less likely to have a behavioral health encounter compared to members in other racial groups. Additionally, for both children receiving adoption assistance and controls, members in the Other racial group were significantly less likely to have a behavioral health encounter. For both children receiving adoption assistance and the controls, male members were significantly more likely to have a behavioral health encounter, while female members were significantly less likely to have a behavioral health encounter. For both children receiving adoption assistance and controls, members 11 to 13 years of age and 14 years of age and older were significantly more likely to have a behavioral health visit, while members 2 years of age and younger, 3 to 5 years of age, and 6 to 10 years of age were significantly less likely.

Behavioral Health Encounters—ARTS

Table 4-24 displays the MY 2019, MY 2020, and MY 2021 *Behavioral Health Encounters—ARTS* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Behavioral Health Encounters—ARTS* indicator measures the percentage of members who had a behavioral health encounter with ARTS.

Table 4-24—Rates of *Behavioral Health Encounters—ARTS* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	—	—	0.4%	0.5%
Age Category						
≤ 2 Years	—	—	—	—	0.0%^	0.0%^
3 to 5 Years	—	—	—	—	0.0%^	0.0%^
6 to 10 Years	—	—	—	—	0.1%	0.1%
11 to 13 Years	—	—	—	—	0.2%	0.5%
≥ 14 Years	—	—	—	—	0.8%	1.1%
Sex						
Male	—	—	—	—	0.4%	0.5%
Female	—	—	—	—	0.3%	0.6%
Race						
Black or African American	—	—	—	—	0.5%	0.5%
White	—	—	—	—	0.3%	0.6%
Other	—	—	—	—	1.3%	0.0%
Region						
Central	—	—	—	—	0.4%	0.4%
Charlottesville/Western	—	—	—	—	0.4%	0.4%
Northern & Winchester	—	—	—	—	0.6%	1.1%
Roanoke/Alleghany	—	—	—	—	0.2%	0.6%
Southwest	—	—	—	—	0.3%	0.7%
Tidewater	—	—	—	—	0.2%	0.3%
MCO						
Aetna	—	—	—	—	0.2%	0.3%
HealthKeepers	—	—	—	—	0.4%	0.5%
Molina	—	—	—	—	1.0%	1.0%
Optima	—	—	—	—	0.3%	0.2%
VA Premier	—	—	—	—	0.4%	0.7%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
UnitedHealthcare	—	—	—	—	0.4%	1.0%
More Than One MCO	—	—	—	—	0.0%	1.5%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-24 shows that 0.4 percent children receiving adoption assistance and 0.5 percent of controls had a behavioral health encounter with ARTS during MY 2021, and the difference was not statistically significant (p=0.08). The rate differences between children receiving adoption assistance and controls were similar across the stratified rates.

MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both children receiving adoption assistance and controls, members 14 years of age and older were significantly more likely to have a behavioral health encounter with ARTS compared to members in other age categories, while members 6 to 10 years of age were significantly less likely to have behavioral health encounter with ARTS compared to members in other age categories.

Behavioral Health Encounters—CMH Services

Table 4-25 displays the MY 2019, MY 2020, and MY 2021 *Behavioral Health Encounters—CMH Services* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Behavioral Health Encounters—CMH Services* indicator measures the percentage of members who had a behavioral health encounter with CMH services.

Table 4-25—Statewide Rates of *Behavioral Health Encounters—CMH Services* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	—	—	14.0%	14.2%
Age Category						
≤ 2 Years	—	—	—	—	2.5%	2.5%
3 to 5 Years	—	—	—	—	9.4%	8.6%
6 to 10 Years	—	—	—	—	13.8%	16.1%
11 to 13 Years	—	—	—	—	15.6%	15.2%
≥ 14 Years	—	—	—	—	15.3%	14.5%
Sex						
Male	—	—	—	—	16.2%	16.3%
Female	—	—	—	—	11.5%	11.7%
Race						
Black or African American	—	—	—	—	15.3%	15.6%
White	—	—	—	—	13.7%	13.8%
Other	—	—	—	—	6.9%	8.1%
Region						
Central	—	—	—	—	12.1%	12.3%
Charlottesville/Western	—	—	—	—	13.6%	13.3%
Northern & Winchester	—	—	—	—	9.5%	6.8%
Roanoke/Alleghany	—	—	—	—	17.7%	20.5%
Southwest	—	—	—	—	18.7%	21.6%
Tidewater	—	—	—	—	13.9%	12.6%
MCO						
Aetna	—	—	—	—	12.4%	12.9%
HealthKeepers	—	—	—	—	13.2%	11.3%
Molina	—	—	—	—	11.2%	9.5%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Optima	—	—	—	—	15.1%	14.4%
VA Premier	—	—	—	—	15.1%	18.2%
UnitedHealthcare	—	—	—	—	13.5%	13.3%
More Than One MCO	—	—	—	—	13.6%	16.7%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-25 shows that 14.0 percent of children receiving adoption assistance and 14.2 percent of controls had a behavioral health encounter with CMH services during MY 2021, and the difference was not statistically significant (p=0.76). The rate differences between children receiving adoption assistance and controls were similar across stratified rates.

The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both children receiving adoption assistance and the controls, members in the Roanoke/Alleghany and Southwest regions were significantly more likely to have a behavioral health encounter with CMH services, while members in the Central and Northern & Winchester regions were significantly less likely compared to members in other regions during MY 2021. For both children receiving adoption assistance and controls, Black or African American members were significantly more likely to have a behavioral health encounter with CMH services compared to other racial groups, while members in the Other racial group were significantly less likely. For both children receiving adoption assistance and controls, male members were significantly more likely to have a behavioral health encounter with CMH services, while female members were significantly less likely. For children receiving adoption assistance, members 11 to 13 and 14 years of age and older were significantly more likely to have a behavioral health encounter with CMH services compared to members in other age groups, while members 2 years of age and younger and 3 to 5 years of age were significantly less likely.

Behavioral Health Encounters—RTC Services

Table 4-26 displays the MY 2019, MY 2020, and MY 2021 *Behavioral Health Encounters—RTC Services* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Behavioral Health Encounters—RTC Services* indicator measures the percentage of members who had a behavioral health encounter with RTC services.

Table 4-26—Rates of *Behavioral Health Encounters—RTC Services* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	—	—	2.7%+	1.9%
Age Category						
≤ 2 Years	—	—	—	—	0.0%	1.9%
3 to 5 Years	—	—	—	—	1.7%	1.5%
6 to 10 Years	—	—	—	—	2.1%	0.7%
11 to 13 Years	—	—	—	—	2.5%	2.0%
≥ 14 Years	—	—	—	—	3.9%	2.8%
Sex						
Male	—	—	—	—	2.7%	1.6%
Female	—	—	—	—	2.7%	2.1%
Race						
Black or African American	—	—	—	—	3.3%	2.1%
White	—	—	—	—	2.4%	1.7%
Other	—	—	—	—	3.1%	1.9%
Region						
Central	—	—	—	—	4.0%	1.7%
Charlottesville/Western	—	—	—	—	2.8%	1.4%
Northern & Winchester	—	—	—	—	2.2%	1.9%
Roanoke/Alleghany	—	—	—	—	2.8%	2.5%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Southwest	—	—	—	—	1.0%	1.2%
Tidewater	—	—	—	—	2.5%	2.2%
MCO						
Aetna	—	—	—	—	1.7%	2.0%
HealthKeepers	—	—	—	—	3.4%	2.1%
Molina	—	—	—	—	2.0%	0.7%
Optima	—	—	—	—	3.0%	2.1%
VA Premier	—	—	—	—	2.1%	1.7%
UnitedHealthcare	—	—	—	—	2.8%	1.2%
More Than One MCO	—	—	—	—	1.5%	3.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-26 shows that 2.7 percent of children receiving adoption assistance and 1.9 percent of controls had a behavioral health encounter with RTC services during MY 2021, and the difference was statistically significant (p=0.001). The rate differences between children receiving adoption assistance and controls were similar across the stratified rates, except that the rate for children receiving adoption assistance in the Central region was higher than controls (by 2.3 percentage points), and the rate for children receiving adoption assistance enrolled with More Than One MCO was lower than controls (by 1.5 percentage points).

The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For children receiving adoption assistance only, members in the Central region were significantly more likely to have a behavioral health encounter with RTC services compared to members in other regions during MY 2021, while members in the Southwest region were significantly less likely compared to members in other regions. For children receiving adoption assistance only, members enrolled with HealthKeepers were significantly more likely to have a behavioral health encounter with RTC services compared to members enrolled in other MCOs. For children receiving adoption assistance only, Black or African

American members were significantly more likely to have a behavioral health encounter with RTC services compared to members in other racial groups, while White members were significantly less likely. For both children receiving adoption assistance and the controls, members 14 years of age and older were significantly more likely to have a behavioral health encounter with RTC services compared to members in other age groups, while members 6 to 10 years of age were significantly less likely.

Behavioral Health Encounters—Therapeutic Services

Table 4-27 displays the MY 2019, MY 2020, and MY 2021 *Behavioral Health Encounters—Therapeutic Services* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Behavioral Health Encounters—Therapeutic Services* indicator measures the percentage of members who had a behavioral health encounter with therapeutic services.

Table 4-27—Rates of *Behavioral Health Encounters—Therapeutic Services* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	—	—	5.0%+	4.3%
Age Category						
≤ 2 Years	—	—	—	—	2.5%	2.5%
3 to 5 Years	—	—	—	—	6.5%	5.2%
6 to 10 Years	—	—	—	—	5.8%	5.7%
11 to 13 Years	—	—	—	—	4.2%	3.9%
≥ 14 Years	—	—	—	—	4.6%	3.0%
Sex						
Male	—	—	—	—	6.4%	5.6%
Female	—	—	—	—	3.4%	2.7%
Race						
Black or African American	—	—	—	—	4.9%	4.4%
White	—	—	—	—	5.1%	4.2%
Other	—	—	—	—	2.5%	3.8%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Region						
Central	—	—	—	—	5.4%	4.4%
Charlottesville/Western	—	—	—	—	4.8%	4.1%
Northern & Winchester	—	—	—	—	3.5%	1.8%
Roanoke/Alleghany	—	—	—	—	6.3%	5.0%
Southwest	—	—	—	—	6.5%	8.2%
Tidewater	—	—	—	—	4.0%	3.0%
MCO						
Aetna	—	—	—	—	3.8%	3.5%
HealthKeepers	—	—	—	—	5.4%	3.9%
Molina	—	—	—	—	3.7%	2.4%
Optima	—	—	—	—	4.5%	4.0%
VA Premier	—	—	—	—	5.4%	5.0%
UnitedHealthcare	—	—	—	—	5.6%	5.2%
More Than One MCO	—	—	—	—	3.0%	4.5%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-27 shows that 5.0 percent of children receiving adoption assistance and 4.3 percent of controls had a behavioral health visit with therapeutic services during MY 2021, and the difference was statistically significant (p=0.03). The rate differences between children receiving adoption assistance and controls were similar across the stratified rates.

The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both children receiving adoption assistance and controls, members in the Southwest region were significantly more likely to have a behavioral health encounter with therapeutic services compared to members in other regions

during MY 2021, while members in the Northern & Winchester and Tidewater regions were significantly less likely compared to members in other regions. For children receiving adoption assistance only, members in the Roanoke/Alleghany region were significantly more likely to have a behavioral health encounter with therapeutic services compared to members in other regions. For both children receiving adoption assistance and the controls, male members were significantly more likely to have a behavioral health encounter with therapeutic services, while female members were significantly less likely. For both children receiving adoption assistance and controls, members 6 to 10 years of age were significantly more likely to have a behavioral health encounter with therapeutic services compared to members in other age groups. For children receiving adoption assistance only, members 3 to 5 years of age were significantly more likely to have a behavioral health encounter with therapeutic services compared to members in other age groups.

Behavioral Health Encounters—Traditional Services

Table 4-28 displays the MY 2019, MY 2020, and MY 2021 *Behavioral Health Encounters—Traditional Services* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Behavioral Health Encounters—Traditional Services* indicator measures the percentage of members who had a behavioral health encounter with traditional services.

Table 4-28—Statewide Rates of *Behavioral Health Encounters—Traditional Services* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	—	—	50.3%+	42.4%
Age Category						
≤ 2 Years	—	—	—	—	25.0%	25.0%
3 to 5 Years	—	—	—	—	29.7%	21.8%
6 to 10 Years	—	—	—	—	47.8%	39.5%
11 to 13 Years	—	—	—	—	58.4%	51.9%
≥ 14 Years	—	—	—	—	55.0%	46.1%
Sex						
Male	—	—	—	—	52.7%	44.3%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Female	—	—	—	—	47.6%	40.2%
Race						
Black or African American	—	—	—	—	53.6%	41.1%
White	—	—	—	—	49.2%	43.4%
Other	—	—	—	—	38.1%	32.5%
Region						
Central	—	—	—	—	49.9%	41.2%
Charlottesville/Western	—	—	—	—	53.5%	42.6%
Northern & Winchester	—	—	—	—	39.0%	35.9%
Roanoke/Alleghany	—	—	—	—	53.6%	44.1%
Southwest	—	—	—	—	47.4%	44.2%
Tidewater	—	—	—	—	55.9%	46.2%
MCO						
Aetna	—	—	—	—	43.6%	36.9%
HealthKeepers	—	—	—	—	52.3%	45.1%
Molina	—	—	—	—	43.9%	33.3%
Optima	—	—	—	—	53.8%	44.9%
VA Premier	—	—	—	—	51.0%	42.4%
UnitedHealthcare	—	—	—	—	39.8%	36.0%
More Than One MCO	—	—	—	—	53.0%	39.4%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).

+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.

- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.

— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-28 shows that 50.3 percent of children receiving adoption assistance and 42.4 percent of controls had a behavioral health visit with traditional services during MY 2021, and the difference was statistically significant (p=0.001). The rates for children receiving adoption assistance were notably higher than controls for nearly all stratified rates, with the largest difference being for the Black or African American members (by 12.5 percentage points), members in the Charlottesville/Western, region (by 10.9 percentage points), and members enrolled with More Than One MCO (by 13.6 percentage points).

The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both children receiving adoption assistance and controls, members in the Tidewater region were significantly more likely to have a behavioral health encounter with traditional services compared to members in other regions during MY 2021, while members in the Northern & Winchester region were significantly less likely compared to members in other regions. For children receiving adoption assistance only, members in the Charlottesville/Western and Roanoke/Alleghany regions were significantly more likely to have a behavioral health encounter with traditional services compared to members in other regions. For both children receiving adoption assistance and the controls, members enrolled with HealthKeepers and Optima were significantly more likely to have a behavioral health encounter with traditional services compared to members enrolled with other MCOs, while members enrolled with Aetna, Molina, and UnitedHealthcare were significantly less likely compared to members in other regions. For both children receiving adoption assistance and controls, male members were significantly more likely to have a behavioral health encounter with traditional services compared to female members. For children receiving adoption assistance, Black or African American members were significantly more likely to have a behavioral health encounter with traditional services compared to members in other racial groups, while members in the White and Other racial groups were significantly less likely compared to members in other racial groups. For both children receiving adoption assistance and controls, members 11 to 13 and 14 years of age and older were significantly more likely to have a behavioral health encounter with traditional services compared to members in other age groups, while members 2 years of age and younger, 3 to 5, and 6 to 10 years of age were significantly less likely.

Overall Service Utilization

Table 4-29 displays the MY 2019, MY 2020, and MY 2021 *Overall Service Utilization* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Overall Service Utilization* indicator measures the percentage of members who had an ambulatory care visit, ED visit, inpatient visit, or behavioral health encounter during the measurement year.

Table 4-29—Rates of *Overall Service Utilization* Among Children Receiving Adoption Assistance and Controls

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	—	—	—	—	84.1%	86.7%
Age Category						
≤ 2 Years	—	—	—	—	86.3%	93.8%
3 to 5 Years	—	—	—	—	83.9%	87.8%
6 to 10 Years	—	—	—	—	83.3%	85.7%
11 to 13 Years	—	—	—	—	84.6%	87.9%
≥ 14 Years	—	—	—	—	84.2%	86.1%
Sex						
Male	—	—	—	—	83.8%	87.0%
Female	—	—	—	—	84.4%	86.4%
Race						
Black or African American	—	—	—	—	83.9%	85.1%
White	—	—	—	—	84.2%	87.6%
Other	—	—	—	—	82.5%	83.8%
Region						
Central	—	—	—	—	84.8%	86.0%
Charlottesville/Western	—	—	—	—	86.3%	87.0%
Northern & Winchester	—	—	—	—	72.2%	84.6%
Roanoke/Alleghany	—	—	—	—	87.5%	90.0%
Southwest	—	—	—	—	92.4%	91.2%
Tidewater	—	—	—	—	82.2%	83.3%
MCO						
Aetna	—	—	—	—	78.8%	84.8%
HealthKeepers	—	—	—	—	84.4%	87.2%
Molina	—	—	—	—	75.2%	74.8%
Optima	—	—	—	—	85.8%	86.6%

Category	MY 2019		MY 2020		MY 2021	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
VA Premier	—	—	—	—	86.4%	88.9%
UnitedHealthcare	—	—	—	—	78.5%	84.7%
More Than One MCO	—	—	—	—	86.4%	92.4%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the children receiving adoption assistance was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 4-29 shows that 84.1 percent of children receiving adoption assistance and 86.7 percent of controls had an ambulatory care visit, ED visit, inpatient visit, or behavioral health encounter (i.e., any service) during MY 2021, and the difference was statistically significant (p=0.001). The rate for children receiving adoption assistance was notably lower than controls for members in the Northern & Winchester region (by 12.4 percentage points) and members enrolled with Aetna, UnitedHealthcare, and More Than One MCO (by 6.0, 6.2, and 6.0 percentage points, respectively).

The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both children receiving adoption assistance and controls, members in the Roanoke/Alleghany and Southwest regions were significantly more likely to utilize any service compared to members in other regions during MY 2021, while members in the Northern & Winchester and Tidewater regions were significantly less likely. For children receiving adoption assistance only, members in the Charlottesville/Western region were significantly more likely to utilize any service compared to members in other regions. For both children receiving adoption assistance and controls, members enrolled with VA Premier were significantly more likely to utilize any service compared to members enrolled with other MCOs, while members enrolled with Molina were significantly less likely. For children receiving adoption assistance only, members enrolled with Optima were significantly more likely to utilize any service compared to members enrolled with other MCOs, while members enrolled with Aetna and UnitedHealthcare were significantly less likely.

5. Healthcare Utilization: Former Foster Care Members Findings

Characteristics of the Former Foster Care Eligible Population and Study Population

This section provides findings describing the demographic characteristics of the 2,054 members in the former foster care eligible population and the 1,627 members in the former foster care study population. The eligible population consisted of former foster care members from 19 to 26 years of age as of January 1, 2021, and receiving healthcare coverage from DMAS at any time during MY 2021. Table 5-1 displays the distribution of the former foster care members eligible population by age category, sex, race, region, MCO, and Medicaid program.

Table 5-1—Distribution of Former Foster Care Members (n=2,054)†

Category	Number	Percent
Age Category		
19 to 22 Years	1,359	66.2%
23 to 26 Years	695	33.8%
Sex		
Male	983	47.9%
Female	1,071	52.1%
Race		
Black or African American	740	36.0%
White	1,235	60.1%
Other	79	3.8%
Region		
Central	492	24.0%
Charlottesville/Western	352	17.1%
Northern & Winchester	235	11.4%
Roanoke/Alleghany	305	14.8%
Southwest	228	11.1%
Tidewater	437	21.3%
Latest MCO in the Measurement Year		
Aetna	187	9.1%
HealthKeepers	560	27.3%
Molina	141	6.9%
Optima	458	22.3%
VA Premier	532	25.9%
UnitedHealthcare	154	7.5%
Other*	22	1.1%

Category	Number	Percent
Latest Medicaid Program in the Measurement Year		
CCC Plus	97	4.7%
Medallion 4.0	1,935	94.2%
Other*	22	1.1%

† Members with an Unknown Region are included in the total number of former foster care members but are not displayed in this table.
**Includes members only enrolled in FFS.*

Members in the former foster care population were disproportionately female (52.1 percent) and Black or African American (36.0 percent) compared to the general population in Virginia, which was 49.5 percent male and 20.0 percent Black or African American in 2021.[5-1] Former foster care members were mostly from the Central (24.0 percent), Tidewater (21.3 percent), or Charlottesville/Western (17.1 percent) regions. The region for a small proportion of former foster care members was unknown; these members tended to be missing some address information or had an out-of-state address. Former foster care members were most likely to be enrolled with HealthKeepers (27.3 percent), VA Premier (25.9 percent), or Optima (22.3 percent). Former foster care members were most likely to be enrolled through the Medallion 4.0 program (94.2 percent). MCO attribution and Medicaid Program attribution was Other for 2.4 percent of former foster care members who were only enrolled in FFS during the measurement year.[5-2]

The study population were members in the former foster care eligible population who were continuously enrolled in either the Medallion 4.0 or CCC Plus Medicaid managed care program with any MCO or a combination of MCOs during the study period, for whom a match not in a child welfare program could be found. Continuous enrollment was defined as enrollment gaps totaling no more than 45 days. Among the former foster care eligible population, 79.2 percent (n=1,627) of members met the requirements for the study population. The demographic makeup of the study population mirrored the demographic makeup of the former foster care eligible population, except that there were 2.5 percent more male members.

Table B-3 and Table B-6 present the demographic and health characteristics of continuously enrolled former foster care members (n=1,632) and the continuously enrolled comparison group (n=165,312) prior to matching. Continuously enrolled former foster care members tended to be younger, male, White, less likely to be enrolled with Aetna and more likely to be enrolled with VA Premier, and less likely to be enrolled through CCC Plus compared to the continuously enrolled comparison group. Furthermore, continuously enrolled former foster care members were less likely to live in the Tidewater, Central, or Northern & Winchester regions and more likely to live in the Charlottesville/Western, Roanoke/Alleghany, or Southwest regions. In terms of health characteristics, continuously enrolled former foster care members were more likely to have diagnoses for several health conditions, primarily mood disorders and anxiety disorders.

5-1 United States Census Bureau. Virginia QuickFacts. Available at: https://www.census.gov/quickfacts/VA. Accessed on: Jan 11, 2023.

5-2 Former foster care members may temporarily move to FFS and may not be enrolled with an MCO or managed care program during the measurement year.

HSAG was able to match 99.6 percent (n=1,627) of continuously enrolled former foster care members to members in the comparison group with similar demographic and health characteristics. Table B-9 and Table B-12 present the demographic and health characteristics of the final study population and their matched controls. Matching successfully balanced all demographic and health characteristics between the study population and the controls.

Appendix B presents detailed descriptions of the demographic and health characteristics of former foster care members and members in the comparison group prior to matching, as well as covariate balance findings.

Healthcare Utilization Among Former Foster Care Members and Controls

This section provides findings from the study indicators used to assess healthcare utilization for the former foster care members study population, as well as findings for the matched controls not enrolled through a child welfare program. The tables displayed in this section also include stratified rates and shading to indicate the results of the health disparities analysis.

Although the controls have been matched to the former foster care members on a variety of demographic and health characteristics, HSAG advises caution in comparing the study indicator results between the former foster care members and controls. Due to the different criteria for denominators across measures, one member in a matched pair may be included in a measure calculation while the other member is not. When matched pairs are separated, the distribution of characteristics in the denominator-eligible study population and the denominator-eligible controls may differ from the overall distribution, and balanced covariates are no longer guaranteed. Furthermore, HSAG advises caution in interpreting the *p*-values, as denominator sizes vary by measure, and sample size influences the precision of the *p*-value calculation. Healthcare utilization in MY 2020 and MY 2021 may also be impacted by the COVID-19 pandemic; however, rate comparisons within MY 2020 and MY 2021 (i.e., to controls) are still reliable.

Primary Care

Child and Adolescent Well-Care Visits (WCV)

Table 5-2 displays the MY 2019, MY 2020, and MY 2021 *Child and Adolescent Well-Care Visits* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Child and Adolescent Well-Care Visits* indicator measures the percentage of members 3 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. Since the former foster care population includes members 19 to 26 years of age, this indicator has been modified to include the corresponding ages.

Table 5-2—Rates of *Child and Adolescent Well-Care Visits* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	15.3%	14.7%	19.6%	17.4%
Sex						
Male	—	—	9.3%	7.4%	11.0%	9.8%
Female	—	—	21.8%	24.0%	28.3%	26.0%
Race						
Black or African American	—	—	17.4%	15.3%	20.2%	17.0%
White	—	—	14.2%	14.4%	18.4%	17.6%
Other	—	—	10.0%	10.0%	35.7%	19.0%
Region						
Central	—	—	20.5%	14.2%	22.5%	22.3%
Charlottesville/Western	—	—	15.6%	11.0%	20.3%	12.4%
Northern & Winchester	—	—	14.0%	20.0%	22.2%	25.8%
Roanoke/Alleghany	—	—	6.1%	17.5%	17.1%	12.8%
Southwest	—	—	14.0%	5.2%	16.7%	9.1%
Tidewater	—	—	16.0%	19.0%	17.8%	19.4%
MCO						
Aetna	—	—	3.2%	18.8%	18.4%	19.5%
HealthKeepers	—	—	19.3%	15.5%	20.3%	22.0%
Molina	—	—	3.2%	8.8%	0.0%^	18.2%^
Optima	—	—	17.3%	16.4%	22.7%	17.5%
VA Premier	—	—	15.7%	13.2%	21.7%	11.3%
UnitedHealthcare	—	—	10.5%	12.8%	12.9%	21.9%
More Than One MCO	—	—	50.0%	33.3%	0.0%	50.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-2 shows that 19.6 percent of former foster care members and 17.4 percent of controls had a well-care visit with a PCP or an OB/GYN during MY 2021, and the difference was not statistically significant (p=0.37). The rates for former foster care members were notably higher than controls for members in the Charlottesville/Western and Southwest regions (by 7.9 and 7.6 percentage points, respectively) and members enrolled with Optima and VA Premier (by 5.2 and 10.4 percentage points, respectively). Conversely, the rate for former foster care members enrolled with UnitedHealthcare was 9.0 percentage points lower than the rate for the controls. While there were large rate differences for the Other racial group, these rates had small denominators, so rates may be less reliable.

Rates for both the former foster care members and controls were below the MY 2021 national Medicaid 50th percentile for members 18 to 21 years of age. The rate of well-care visits for former foster care members increased by 4.3 percentage points from MY 2020 to MY 2021, while the rate for controls increased by 2.7 percentage points. For both former foster care members and controls, female members were significantly more likely to have a well-care visit compared to male members in MY 2021.

Oral Health

Annual Dental Visit (ADV)

Table 5-3 displays the MY 2019, MY 2020, and MY 2021 *Annual Dental Visit* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Annual Dental Visit* indicator measures the percentage of members 2 to 20 years of age who had at least one dental visit during the measurement year. Since the former foster care population includes members 19 to 26 years of age, this indicator has been modified to include the corresponding ages.

Table 5-3—Rates of *Annual Dental Visits* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	26.5%	24.8%	32.1%	27.2%
Sex						
Male	—	—	23.1%	19.8%	25.0%	20.1%
Female	—	—	29.9%	32.7%	39.8%	35.1%
Race						
Black or African American	—	—	28.0%	17.6%	37.1%	25.6%
White	—	—	26.0%	27.7%	28.9%	29.1%
Other	—	—	20.0%	50.0%	37.5%	16.7%

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Region						
Central	—	—	37.5%	20.9%	45.1%	29.9%
Charlottesville/Western	—	—	33.3%	31.4%	35.7%	25.4%
Northern & Winchester	—	—	21.4%	21.4%	38.9%	22.9%
Roanoke/Alleghany	—	—	15.6%	26.1%	26.3%	28.6%
Southwest	—	—	13.0%	28.6%	40.0%	28.6%
Tidewater	—	—	23.5%	22.2%	17.9%	27.0%
MCO						
Aetna	—	—	26.7%	12.5%	23.5%	36.4%
HealthKeepers	—	—	31.7%	31.5%	37.2%	23.0%
Molina	—	—	22.2%	28.6%	23.1%	50.0%
Optima	—	—	28.0%	20.3%	21.8%	25.9%
VA Premier	—	—	21.7%	26.4%	40.0%	30.8%
UnitedHealthcare	—	—	15.4%	15.0%	23.1%	6.3%
More Than One MCO	—	—	100.0%	—	—	100.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-3 shows that 32.1 percent of former foster care members and 27.2 percent of controls had a dental visit during MY 2021, and the difference was not statistically significant (p=0.21). The rates for former foster care members were notably higher than controls for Black or African American members (by 11.5 percentage points); members in the Central, Charlottesville/Western, and Northern & Winchester regions (by 15.2, 10.3, and 16.0 percentage points, respectively); and members enrolled with HealthKeepers and VA Premier (by 14.2 and 9.2 percentage points, respectively). Conversely, the rates for former foster care members were notably lower than controls in the Tidewater region and members enrolled with Aetna (by 9.1 and 12.9 percentage points, respectively). While there were large rate differences for the Other racial group, Southwest region, and Molina and UnitedHealthcare MCOs, these rates had small denominators, so the rates may be less reliable.

The rate for the former foster care members was above the MY 2021 national Medicaid 50th percentile for members 19 to 20 years of age. The rate of dental visits for former foster care members increased by 5.6 percentage points from MY 2020 to MY 2021, while the rate for controls increased by 2.4 percentage points. For both former foster care members and controls, female members were significantly more likely to have a dental visit compared to male members in MY 2021. For former foster care members only, members in the Central region were significantly more likely to have a dental visit compared to members in other regions, while members in the Tidewater region were significantly less likely.

Preventive Dental Services (PDENT-CH)

Table 5-4 displays the MY 2019, MY 2020, and MY 2021 *Preventive Dental Services* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Preventive Dental Services* indicator measures the percentage of individuals 1 to 20 years of age eligible for EPSDT services who received at least one preventive dental service during the reporting period. Since the former foster care population includes members 19 to 26 years of age, this indicator has been modified to include the corresponding ages.

Table 5-4—Rates of *Preventive Dental Services* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	20.3%	16.1%	22.5%	20.1%
Sex						
Male	—	—	18.3%	12.6%	17.7%	14.0%
Female	—	—	22.2%	21.5%	27.7%	26.7%
Race						
Black or African American	—	—	24.0%	15.4%	28.1%	19.0%
White	—	—	18.9%	15.3%	19.1%	21.5%
Other	—	—	0.0%	50.0%	25.0%	8.3%
Region						
Central	—	—	34.4%	16.4%	34.6%	20.8%
Charlottesville/Western	—	—	26.7%	19.6%	18.6%	23.1%
Northern & Winchester	—	—	14.3%	17.9%	27.8%	22.9%
Roanoke/Alleghany	—	—	3.1%	13.0%	23.1%	17.9%
Southwest	—	—	8.3%	14.3%	23.3%	17.1%
Tidewater	—	—	17.6%	14.8%	13.4%	17.6%

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
MCO						
Aetna	—	—	20.0%	12.5%	16.7%	27.3%
HealthKeepers	—	—	20.6%	23.3%	23.1%	17.0%
Molina	—	—	11.1%	14.3%	23.1%	40.0%
Optima	—	—	24.0%	12.5%	17.9%	20.0%
VA Premier	—	—	18.0%	13.8%	29.6%	21.7%
UnitedHealthcare	—	—	15.4%	15.0%	7.7%	6.3%
More Than One MCO	—	—	100.0%	—	—	0.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-4 shows that 22.5 percent of former foster care members and 20.1 percent of controls had a preventive dental service during MY 2021, and the difference was not statistically significant (p=0.48). The rates for former foster care members were notably higher than controls for Black or African American members (by 9.1 percentage points); members in the Central, Roanoke/Alleghany, and Southwest regions (by 13.8, 5.2, and 6.2 percentage points, respectively); and members enrolled with HealthKeepers and VA Premier (by 6.1 and 7.9 percentage points, respectively). While there were large rate differences for the Other racial group and members enrolled with Aetna and Molina, these rates had small denominators, so the rates may be less reliable.

MY 2021 national Medicaid benchmarks were not available for this indicator. The rate of preventive dental services for former foster care members increased by 2.2 percentage points from MY 2020 to MY 2021, while the rate for controls increased by 4.0 percentage points. For former foster care members only, members in the Central region were significantly more likely to have a preventive dental service compared to members in other regions in MY 2021, while members in the Tidewater region were less likely.

Oral Evaluation, Dental Services (OEV-CH)

Table 5-5 displays the MY 2019, MY 2020, and MY 2021 *Oral Evaluation, Dental Services* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Oral Evaluation, Dental Services* indicator measures the percentage of enrolled children under 21 years of age who received a comprehensive or periodic oral evaluation within the measurement year. Since the former foster care population includes members 19 to 26 years of age, this indicator has been modified to include the corresponding ages.

Table 5-5—Rates of *Oral Evaluation, Dental Services* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	—	—	24.1%	20.7%
Sex						
Male	—	—	—	—	19.2%	15.2%
Female	—	—	—	—	29.4%	26.7%
Race						
Black or African American	—	—	—	—	31.5%	18.2%
White	—	—	—	—	19.7%	23.2%
Other	—	—	—	—	25.0%	8.3%
Region						
Central	—	—	—	—	38.5%	20.8%
Charlottesville/Western	—	—	—	—	27.9%	21.5%
Northern & Winchester	—	—	—	—	22.2%	22.9%
Roanoke/Alleghany	—	—	—	—	20.5%	25.0%
Southwest	—	—	—	—	23.3%	17.1%
Tidewater	—	—	—	—	13.4%	18.9%
MCO						
Aetna	—	—	—	—	22.2%	27.3%
HealthKeepers	—	—	—	—	26.9%	17.0%
Molina	—	—	—	—	15.4%	40.0%
Optima	—	—	—	—	19.6%	20.0%
VA Premier	—	—	—	—	29.6%	22.8%

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
UnitedHealthcare	—	—	—	—	7.7%	6.3%
More Than One MCO	—	—	—	—	—	100.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-5 shows that 24.1 percent of former foster care members and 20.7 percent of controls had a comprehensive or periodic oral evaluation during MY 2021, and the difference was not statistically significant (p=0.34). The rates for former foster care members were notably higher than controls for Black or African American members (by 13.3 percentage points), members in the Central, Charlottesville/Western and Southwest regions (by 17.7, 6.4, and 6.2 percentage points, respectively), and members enrolled with HealthKeepers and VA Premier (by 9.9 and 6.8 percentage points, respectively). Conversely, the rates for former foster care members were notably lower than controls for members in the Tidewater region and members enrolled with Aetna (by 5.5 and 5.1 percentage points, respectively). While there were large rate differences for the Other racial group and members enrolled with Molina, these rates had small denominators, so the rates may be less reliable.

MY 2021 national Medicaid benchmarks were not available for this indicator. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For former foster care members only, Black or African American members were significantly more likely to have a comprehensive or periodic oral evaluation compared to members of other racial groups in MY 2021, while White members were less likely. For former foster care members only, members in the Central region were more likely to have an oral evaluation compared to members in other regions, while members in the Tidewater region were less likely.

Topical Fluoride for Children—Dental or Oral Health Services (TFL-CH)

Table 5-6 displays the MY 2019, MY 2020, and MY 2021 *Topical Fluoride for Children—Dental or Oral Health Services* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Topical Fluoride for Children—Dental or Oral Health Services* indicator measures the percentage of enrolled children 1 through 20 years of age who received at least two topical fluoride applications as dental or oral health services within the measurement year. Since the former foster care population includes members 19 to 26 years of age, this indicator has been modified to include the corresponding ages.

Table 5-6—Rates of T*opical Fluoride for Children—Dental or Oral Health Services* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	—	—	4.5%	4.2%
Sex						
Male	—	—	—	—	4.7%	1.8%
Female	—	—	—	—	4.2%	6.8%
Race						
Black or African American	—	—	—	—	7.9%	0.8%
White	—	—	—	—	1.3%	6.7%
Other	—	—	—	—	25.0%^	0.0%^
Region						
Central	—	—	—	—	7.8%	5.2%
Charlottesville/Western	—	—	—	—	4.8%	4.8%
Northern & Winchester	—	—	—	—	0.0%^	5.7%^
Roanoke/Alleghany	—	—	—	—	7.9%	3.6%
Southwest	—	—	—	—	3.3%	2.9%
Tidewater	—	—	—	—	1.5%	2.7%
MCO						
Aetna	—	—	—	—	5.9%	4.5%
HealthKeepers	—	—	—	—	3.8%	2.3%
Molina	—	—	—	—	15.4%^	0.0%^
Optima	—	—	—	—	0.0%^	4.7%^
VA Premier	—	—	—	—	5.7%	5.5%
UnitedHealthcare	—	—	—	—	7.7%	6.3%
More Than One MCO	—	—	—	—	—	0.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-6 shows that 4.5 percent of former foster care members and 4.2 percent of controls received at least two topical fluoride applications as dental or oral health services during MY 2021, and the difference was not statistically significant (p=0.86). Low rates may be due to some topical fluoride treatments not being captured in the administrative data, and the ADA only recommends fluoride treatment for people at elevated risk for caries.[5-3] Additionally, the ADA has less strict clinical recommendations for people 6 years of age and older (e.g., people 6 years of age or older can use home-use fluoride treatments instead of receiving fluoride varnish, and two out of three procedure codes in the *Topical Fluoride for Children* specifications are for fluoride varnish).[5-4] The rates for former foster care members were notably higher than controls for Black or African members (by 7.1 percentage points). Conversely, the rate for former foster care members in the White racial group was lower than the rate for controls (by 5.4 percentage points). While there were large rate differences for the Other racial group and members enrolled with Molina, these rates had small denominators, so the rates may be less reliable.

MY 2021 national Medicaid benchmarks were not available for this indicator. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For former foster care members only, White members were significantly less likely to have topical fluoride applications compared to members of other racial groups in MY 2021.

Topical Fluoride for Children—Dental Services (TFL-CH)

Table 5-7 displays the MY 2019, MY 2020, and MY 2021 *Topical Fluoride for Children—Dental Services* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Topical Fluoride for Children—Dental Services* indicator measures the percentage of enrolled children 1 through 20 years of age who received at least two topical fluoride applications as dental services within the measurement year. Since the former foster care population includes members 19 to 26 years of age, this indicator has been modified to include the corresponding ages.

Table 5-7—Rates of *Topical Fluoride for Children—Dental Services* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	—	—	4.1%	3.2%
Sex						
Male	—	—	—	—	3.9%	1.8%
Female	—	—	—	—	4.2%	4.7%

[5-3] American Dental Association. Fluoride: Topical and Systematic Supplements. Available at: https://www.ada.org/resources/research/science-and-research-institute/oral-health-topics/fluoride-topical-and-systemic-supplements. Accessed on: Jan 11, 2023.

[5-4] Ibid.

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Race						
Black or African American	—	—	—	—	6.7%	0.8%
White	—	—	—	—	1.3%	5.0%
Other	—	—	—	—	25.0%^	0.0%^
Region						
Central	—	—	—	—	7.8%	1.3%
Charlottesville/Western	—	—	—	—	4.8%	4.8%
Northern & Winchester	—	—	—	—	0.0%^	5.7%^
Roanoke/Alleghany	—	—	—	—	5.3%	3.6%
Southwest	—	—	—	—	3.3%	2.9%
Tidewater	—	—	—	—	1.5%	2.7%
MCO						
Aetna	—	—	—	—	5.9%^	0.0%^
HealthKeepers	—	—	—	—	2.6%	2.3%
Molina	—	—	—	—	15.4%^	0.0%^
Optima	—	—	—	—	0.0%^	2.4%^
VA Premier	—	—	—	—	5.7%	5.5%
UnitedHealthcare	—	—	—	—	7.7%	6.3%
More Than One MCO	—	—	—	—	—	0.0%^

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-7 shows that 4.1 percent of former foster care members and 3.2 percent of controls received at least two topical fluoride applications as dental services during MY 2021, and the difference was not statistically significant (p=0.59). Low rates may be due to some topical fluoride treatments not being captured in the administrative data, and ADA only recommends fluoride treatment for people at

elevated risk for caries.[5-5] Additionally, ADA has less strict clinical recommendations for people 6 years of age and older (e.g., people 6 years of age or older can use home-use fluoride treatments instead of receiving fluoride varnish, and two out of three procedure codes in the TFL-CH specifications are for fluoride varnish).[5-6] The rates for former foster care members were notably higher than controls for Black or African members (by 5.9 percentage points). While there were large rate differences for the Other racial group and members enrolled with Aetna and Molina, these rates had small denominators, so the rates may be less reliable.

MY 2021 national Medicaid benchmarks were not available for this indicator. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For former foster care members only, White members were significantly less likely to have topical fluoride applications as dental services compared to members of other racial groups in MY 2021.

Topical Fluoride for Children—Oral Health Services (TFL-CH)

The *Topical Fluoride for Children—Oral Health Services* measure is not presented as a table because all rates were zero. These rates indicate that very few former foster care members had topical fluoride treatments as oral health services.

Behavioral Health

Antidepressant Medication Management—Effective Acute Phase Treatment (AMM)

Table 5-8 displays the MY 2019, MY 2020, and MY 2021 *Antidepressant Medication Management—Effective Acute Phase Treatment* rates among former foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Antidepressant Medication Management—Effective Acute Phase Treatment* indicator measures the percentage of members18 years of age and older with a diagnosis of major depression who were treated with antidepressant medication and who remained on an antidepressant medication treatment for at least 12 weeks. Since the former foster care population includes members 19 to 26 years of age, this indicator has been modified to include the corresponding ages.

5-5 American Dental Association. Fluoride: Topical and Systematic Supplements. Available at: https://www.ada.org/resources/research/science-and-research-institute/oral-health-topics/fluoride-topical-and-systemic-supplements. Accessed on: Jan 11, 2023.

5-6 Ibid.

Table 5-8—Rates of *Antidepressant Medication Management—Effective Acute Phase Treatment* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	—	—	33.3%	42.1%
Age Category						
19 to 22 Years	—	—	—	—	33.3%	35.9%
23 to 26 Years	—	—	—	—	33.3%	54.8%
Sex						
Male	—	—	—	—	25.0%	42.9%
Female	—	—	—	—	36.7%	41.8%
Race						
Black or African American	—	—	—	—	19.6%	36.7%
White	—	—	—	—	42.9%	45.3%
Other	—	—	—	—	50.0%^	0.0%^
Region						
Central	—	—	—	—	30.0%	50.0%
Charlottesville/Western	—	—	—	—	47.4%	50.0%
Northern & Winchester	—	—	—	—	38.5%	25.0%
Roanoke/Alleghany	—	—	—	—	22.2%	33.3%
Southwest	—	—	—	—	42.9%	36.4%
Tidewater	—	—	—	—	23.5%	38.5%
MCO						
Aetna	—	—	—	—	40.0%	45.5%
HealthKeepers	—	—	—	—	25.0%	39.1%
Molina	—	—	—	—	30.0%	33.3%
Optima	—	—	—	—	26.1%	28.6%
VA Premier	—	—	—	—	39.4%	51.6%
UnitedHealthcare	—	—	—	—	62.5%	66.7%
More Than One MCO	—	—	—	—	0.0%^	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).

+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-8 shows that 33.3 percent of former foster care members and 42.1 percent of controls who had a diagnosis of major depression and who were treated with an antidepressant medication remained an on antidepressant medication for at least 12 weeks during MY 2021, and the difference was not statistically significant (p=0.19). The rates for former foster care members were notably lower than controls for members 23 to 26 years of age (by 21.5 percentage points), male and female members (by 17.9 and 5.1 percentage points, respectively), members in the Black or African American racial group (by 17.1 percentage points), members in the Central region (by 20.0 percentage points), and members enrolled with VA Premier (by 12.2 percentage points). While there were large rate differences for the Other racial group; members in the Northern & Winchester, Roanoke/Alleghany, Southwest, or Tidewater regions; and members enrolled with Aetna or HealthKeepers, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2021 rates for both former foster care members and controls were below the MY 2021 national Medicaid 50th percentile. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For former foster care members only, Black or African American members were significantly less likely to continue antidepressant medication compared to members of other racial groups in MY 2021, while White members were more likely.

Antidepressant Medication Management—Effective Continuation Phase Treatment (AMM)

Table 5-9 displays the MY 2019, MY 2020, and MY 2021 *Antidepressant Medication Management—Effective Continuation Phase Treatment* rates among former foster care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Antidepressant Medication Management—Effective Continuation Phase Treatment* indicator measures the percentage of members 18 years of age and older with a diagnosis of major depression who were treated with antidepressant medication and who remained on an antidepressant medication treatment for at least six months. Since the former foster care population includes members 19 to 26 years of age, this indicator has been modified to include the corresponding ages.

Table 5-9—Rates of *Antidepressant Medication Management—Effective Continuation Phase* Treatment Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	—	—	13.5%	20.0%
Age Category						
19 to 22 Years	—	—	—	—	13.6%	18.8%
23 to 26 Years	—	—	—	—	13.3%	22.6%
Sex						
Male	—	—	—	—	6.3%	17.9%
Female	—	—	—	—	16.5%	20.9%
Race						
Black or African American	—	—	—	—	10.9%	16.7%
White	—	—	—	—	15.9%	21.9%
Other	—	—	—	—	0.0%^	0.0%^
Region						
Central	—	—	—	—	16.7%	23.3%
Charlottesville/Western	—	—	—	—	5.3%	22.2%
Northern & Winchester	—	—	—	—	15.4%	12.5%
Roanoke/Alleghany	—	—	—	—	11.1%^	0.0%^
Southwest	—	—	—	—	21.4%	36.4%
Tidewater	—	—	—	—	11.8%	23.1%
MCO						
Aetna	—	—	—	—	20.0%	18.2%
HealthKeepers	—	—	—	—	8.3%	21.7%
Molina	—	—	—	—	10.0%^	0.0%^
Optima	—	—	—	—	8.7%	14.3%
VA Premier	—	—	—	—	18.2%	22.6%
UnitedHealthcare	—	—	—	—	25.0%	66.7%
More Than One MCO	—	—	—	—	0.0%^	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.

- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-9 shows that 13.5 percent of former foster care members and 20.0 percent of controls who had a diagnosis of major depression and who were treated with an antidepressant medication remained an on antidepressant medication for at least six months during MY 2021, and the difference was not statistically significant (p=0.21). The rates for former foster care members were lower than controls for all stratified categories for which there were sufficiently large denominators to ensure reliable rates.

MY 2021 national Medicaid benchmarks were not available for this indicator. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically.

Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up (FUH)

Table 5-10 displays the MY 2019, MY 2020, and MY 2021 *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* indicator measures the percentage of discharges for members 18 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses for which the member had a follow-up visit within seven days after discharge with a mental health provider. Since the former foster care population includes members 19 to 26 years of age, this indicator has been modified to include the corresponding ages.

Table 5-10—Rates of *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	22.6%	12.9%	26.9%	33.3%
Age Category						
19- to 22 years	—	—	24.5%	9.1%	22.9%	35.0%
23 to 26 Years	—	—	15.4%	22.2%	36.8%	30.8%
Sex						
Male	—	—	14.3%	7.1%	18.8%	36.8%
Female	—	—	29.4%	17.6%	34.3%	28.6%

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Race						
Black or African American	—	—	27.3%	0.0%	22.2%	31.3%
White	—	—	21.1%	18.2%	27.3%	37.5%
Other	—	—	0.0%	—	40.0%^	0.0%^
Region						
Central	—	—	21.1%	0.0%	21.1%	45.5%
Charlottesville/Western	—	—	26.7%	11.1%	22.2%	50.0%
Northern & Winchester	—	—	20.0%	100.0%	37.5%^	0.0%^
Roanoke/Alleghany	—	—	0.0%	33.3%	14.3%^	100.0%^
Southwest	—	—	33.3%	25.0%	36.4%	20.0%
Tidewater	—	—	16.7%	0.0%	30.8%	12.5%
MCO						
Aetna	—	—	0.0%	0.0%	44.4%	66.7%
HealthKeepers	—	—	26.3%	0.0%	27.8%	25.0%
Molina	—	—	50.0%	—	0.0%^	100.0%^
Optima	—	—	25.0%	0.0%	33.3%	36.4%
VA Premier	—	—	23.1%	25.0%	15.0%	23.1%
UnitedHealthcare	—	—	0.0%	25.0%	50.0%^	0.0%^
More Than One MCO	—	—	—	0.0%	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-10 shows that 26.9 percent of former foster care members and 33.3 percent of controls had a follow-up visit within seven days after discharge during MY 2021, and the difference was not statistically significant (p=0.50). While there were large rate differences between former foster care members and controls among the stratified categories, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2021 rate for the former foster care members was below the MY 2021 national Medicaid 50th percentile for members 18 to 64 years of age, while the rate for the controls was above the benchmark. The rate for former foster care members increased from MY 2020 to MY 2021 (by 4.3 percentage points), while the rate for controls increased by 20.4 percentage points.

Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up (FUM)

Table 5-11 displays the MY 2019, MY 2020, and MY 2021 *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* indicator measures the percentage of ED visits for children 6 to 17 years of age with a principal diagnosis of mental illness or intentional self-harm for which the member had a follow-up visit for mental illness within 30 days of the ED visit. Since the former foster care population includes members 19 to 26 years of age, this indicator has been modified to include the corresponding ages.

Table 5-11—Rates of *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	36.1%	52.6%	48.6%	26.7%
Age Category						
19 to 22 Years	—	—	32.1%	54.5%	38.1%	20.0%
23 to 26 Years	—	—	50.0%	50.0%	64.3%	40.0%
Sex						
Male	—	—	33.3%	28.6%	47.1%^	0.0%^
Female	—	—	38.9%	66.7%	50.0%^	50.0%^
Race						
Black or African American	—	—	40.0%	57.1%	55.6%	66.7%
White	—	—	35.0%	50.0%	45.8%	16.7%
Other	—	—	0.0%	—	50.0%	—
Region						
Central	—	—	55.6%	0.0%	40.0%	50.0%
Charlottesville/Western	—	—	50.0%	83.3%	85.7%^	100.0%^
Northern & Winchester	—	—	0.0%	100.0%	0.0%^	0.0%^

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Roanoke/Alleghany	—	—	28.6%	40.0%	50.0%	14.3%
Southwest	—	—	25.0%	50.0%	20.0%^	0.0%^
Tidewater	—	—	33.3%	25.0%	57.1%^	0.0%^
MCO						
Aetna	—	—	50.0%	50.0%	80.0%	33.3%
HealthKeepers	—	—	30.0%	25.0%	33.3%^	100.0%^
Molina	—	—	0.0%	0.0%	66.7%^	0.0%^
Optima	—	—	50.0%	50.0%	50.0%	50.0%
VA Premier	—	—	44.4%	85.7%	37.5%	14.3%
UnitedHealthcare	—	—	0.0%	0.0%	66.7%^	0.0%^
More Than One MCO	—	—	—	—	0.0%^	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-11 shows that 48.6 percent of former foster care members and 26.7 percent of controls had a follow-up visit within 30 days after an ED visit during MY 2021, and the difference was not statistically significant (p=0.21). While there were large rate differences between former foster care members and controls, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2021 rate for the former foster care members was similar to the MY 2021 national Medicaid 50th percentile for members 18 to 64 years of age, while the rate for controls was below the national Medicaid 50th percentile. The rate of follow-up visits within 30 days of an ED visit for mental illness for former foster care members increased by 12.5 percentage points from MY 2020 to MY 2021, while the rate for controls decreased by 25.9 percentage points.

Substance Use

Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up (FUA)

Table 5-12 displays the MY 2019, MY 2020, and MY 2021 *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* indicator measures the percentage of ED visits for members 18 years of age and older with a principal diagnosis of AOD abuse or dependence for which the member had a follow-up visit for AOD abuse or dependence. Since the former foster care population includes members 19 to 26 years of age, this indicator has been modified to include the corresponding ages.

Table 5-12—Rates of *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	5.9%-	44.4%	5.0%	14.3%
Age Category						
19 to 22 Years	—	—	0.0%	40.0%	6.7%^	18.2%^
23 to 26 Years	—	—	14.3%	50.0%	0.0%^	0.0%^
Sex						
Male	—	—	11.1%	75.0%	0.0%^	22.2%^
Female	—	—	0.0%	20.0%	9.1%^	0.0%^
Race						
Black or African American	—	—	0.0%	50.0%	0.0%^	33.3%^
White	—	—	9.1%	42.9%	9.1%^	9.1%^
Other	—	—	0.0%	—	—	—
Region						
Central	—	—	0.0%	100.0%	0.0%^	0.0%^
Charlottesville/Western	—	—	0.0%	50.0%	0.0%^	0.0%^
Northern & Winchester	—	—	20.0%	50.0%	0.0%^	100.0%^
Roanoke/Alleghany	—	—	0.0%	33.3%	0.0%^	20.0%^
Southwest	—	—	0.0%	—	25.0%^	—

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Tidewater	—	—	0.0%	0.0%	0.0%^	0.0%^
MCO						
Aetna	—	—	0.0%	0.0%	0.0%^	33.3%^
HealthKeepers	—	—	0.0%	50.0%	0.0%^	100.0%^
Molina	—	—	0.0%	50.0%	0.0%^	—
Optima	—	—	0.0%	50.0%	33.3%^	0.0%^
VA Premier	—	—	0.0%	50.0%	0.0%^	0.0%^
UnitedHealthcare	—	—	50.0%	—	—	—
More Than One MCO	—	—	—	—	0.0%^	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-12 shows that 5.0 percent former foster care members and 14.3 percent of controls had a follow-up visit within 30 days after an ED visit for AOD abuse or dependence in MY 2021, and the difference was not statistically significant (p=0.56). The rates for both former foster care members and controls have small denominators, so the rates may be less reliable.

For all eligible members, the MY 2021 rates for both former foster care members and controls were below the MY 2021 national Medicaid 50th percentile for members 18 years of age and older. The rate of follow-up visits within 30 days of an ED visit for AOD abuse or dependence for former foster care members increased by 0.9 percentage points from MY 2020 to MY 2021, while the rate for controls decreased by 30.1 percentage points.

Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment (IET)

Table 5-13 displays the MY 2019, MY 2020, and MY 2021 *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Initiation and Engagement of AOD Abuse or*

Dependence Treatment—Initiation of AOD Treatment indicator measures the percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis. Since the former foster care population includes members 19 to 26 years of age, this indicator has been modified to include the corresponding ages.

Table 5-13—Rates of *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	43.0%	47.3%	49.3%	54.5%
Age Category						
19 to 22 Years	—	—	45.1%	50.0%	48.9%	51.7%
23 to 26 Years	—	—	37.9%	43.3%	50.0%	59.0%
Sex						
Male	—	—	49.0%	50.0%	47.2%	56.9%
Female	—	—	36.7%	43.8%	51.4%	51.2%
Race						
Black or African American	—	—	48.0%	55.6%	34.1%	40.0%
White	—	—	40.3%	44.4%	54.1%	60.9%
Other	—	—	66.7%	50.0%	100.0%^	—
Region						
Central	—	—	41.2%	83.3%	44.0%	36.4%
Charlottesville/Western	—	—	42.9%	27.3%	54.5%	63.2%
Northern & Winchester	—	—	40.0%	40.0%	39.1%	50.0%
Roanoke/Alleghany	—	—	40.9%	35.7%	55.6%	57.1%
Southwest	—	—	38.9%	41.7%	48.1%	77.8%
Tidewater	—	—	58.3%	53.3%	54.5%	43.8%
MCO						
Aetna	—	—	54.5%	44.4%	41.2%	40.0%
HealthKeepers	—	—	31.8%	69.2%	43.2%	61.5%
Molina	—	—	50.0%	40.0%	66.7%	75.0%
Optima	—	—	45.0%	25.0%	57.7%	50.0%

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
VA Premier	—	—	41.9%	57.9%	46.5%	51.9%
UnitedHealthcare	—	—	42.9%	36.4%	64.3%	60.0%
More Than One MCO	—	—	100.0%	—	33.3%	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-13 shows that 49.3 percent of former foster care members and 54.5 percent of controls with a new episode of AOD abuse or dependence initiated treatment during MY 2021, and the difference was not statistically significant (p=0.42). The rates for former foster care members were notably lower than controls for members 23 to 26 years of age (by 9.0 percentage points) and male members (by 9.7 percentage points). Rates differences between former foster care members and controls were consistent across the Black or African American and White racial groups. While there were large rate differences for all regions and all MCOs, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2021 rates for both former foster care members and controls were above the MY 2021 national Medicaid 50th percentile for the 18 years of age and older age category. The rate of treatment initiation for former foster care members increased by 6.3 percentage points from MY 2020 to MY 2021, while the rate for controls increased by 7.2 percentage points. For the former foster care members only, Black or African American members were significantly less likely to initiate AOD abuse or dependence treatment compared to members of other racial groups in MY 2021.

Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment (IET)

Table 5-14 displays the MY 2019, MY 2020, and MY 2021 *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment* indicator measures the percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. Since

the former foster care population includes members 19 to 26 years of age, this indicator has been modified to include the corresponding ages.

Table 5-14—Rates of *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	13.0%	23.0%	16.4%-	28.3%
Age Category						
19 to 22 Years	—	—	14.1%	18.2%	12.8%	31.7%
23 to 26 Years	—	—	10.3%	30.0%	23.1%	23.1%
Sex						
Male	—	—	17.6%	21.4%	16.7%	32.8%
Female	—	—	8.2%	25.0%	16.2%	22.0%
Race						
Black or African American	—	—	12.0%	27.8%	13.6%	10.0%
White	—	—	13.9%	20.4%	16.3%	36.2%
Other	—	—	0.0%	50.0%	50.0%	—
Region						
Central	—	—	23.5%	33.3%	4.0%	9.1%
Charlottesville/Western	—	—	9.5%	18.2%	22.7%	26.3%
Northern & Winchester	—	—	10.0%	30.0%	13.0%	20.0%
Roanoke/Alleghany	—	—	13.6%	21.4%	14.8%	35.7%
Southwest	—	—	16.7%	25.0%	22.2%	55.6%
Tidewater	—	—	0.0%	13.3%	22.7%	25.0%
MCO						
Aetna	—	—	27.3%	22.2%	11.8%	20.0%
HealthKeepers	—	—	0.0%	38.5%	16.2%	38.5%
Molina	—	—	0.0%	20.0%	16.7%	25.0%
Optima	—	—	5.0%	8.3%	23.1%	22.7%
VA Premier	—	—	25.8%	31.6%	14.0%	29.6%

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
UnitedHealthcare	—	—	14.3%	9.1%	21.4%	20.0%
More Than One MCO	—	—	0.0%	—	0.0%^	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-14 shows that 16.4 percent of former foster care members and 28.3 percent of controls with a new episode of AOD abuse or dependence initiated treatment and engaged in treatment during MY 2021, and the difference was statistically significant (p=0.03). The rates for former foster care members were notably lower than controls for members19 to 22 years of age (by 18.9 percentage points), male members (by 16.1 percentage points), and White members (by 19.9 percentage points). While there were large rate differences for all regions and all MCOs, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2021 rates for both former foster care members and controls were above the MY 2021 national Medicaid 50th percentile for members 18 years of age and older. The rate of initiating and engaging in treatment for former foster care members increased by 3.4 percentage points from MY 2020 to MY 2021, while the rate for controls increased by 5.3 percentage points.

Respiratory Health

Asthma Medication Ratio (AMR)

Table 5-15 displays the MY 2019, MY 2020, and MY 2021 *Asthma Medication Ratio* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Asthma Medication Ratio* indicator measures the percentage of members ages 19 to 64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. Since the former foster care population includes members 19 to 26 years of age, this indicator has been modified to include the corresponding ages.

Table 5-15—Rates of Appropriate *Asthma Medication Ratio* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	55.6%	33.3%	69.2%	66.7%
Sex						
Male	—	—	50.0%	66.7%	50.0%^	100.0%^
Female	—	—	57.1%	25.0%	72.7%^	44.4%^
Race						
Black or African American	—	—	50.0%	33.3%	40.0%	83.3%
White	—	—	57.1%	33.3%	87.5%	55.6%
Other	—	—	—	—	—	—
Region						
Central	—	—	—	0.0%	0.0%^	66.7%^
Charlottesville/Western	—	—	100.0%	33.3%	100.0%^	33.3%^
Northern & Winchester	—	—	0.0%	50.0%	100.0%^	100.0%^
Roanoke/Alleghany	—	—	100.0%	0.0%	100.0%^	50.0%^
Southwest	—	—	0.0%	0.0%	100.0%^	100.0%^
Tidewater	—	—	50.0%	75.0%	60.0%	75.0%
MCO						
Aetna	—	—	0.0%	0.0%	—	100.0%^
HealthKeepers	—	—	0.0%	40.0%	66.7%	33.3%
Molina	—	—	—	0.0%	—	—
Optima	—	—	75.0%	0.0%	62.5%^	100.0%^

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
VA Premier	—	—	100.0%	50.0%	100.0%^	75.0%^
UnitedHealthcare	—	—	—	—	—	—
More Than One MCO	—	—	—	—	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-15 shows that 69.2 percent of former foster care members and 66.7 percent of controls who were identified as having persistent asthma had a ratio of controller medications to total asthma medications of 0.50 or greater during MY 2021, and the difference was not statistically significant (p=1.00). While there were large rate differences for nearly all stratified rates, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2021 rates for both former foster care members and controls were above the MY 2021 national Medicaid 50th percentile for the 18 to 50 years of age category. The rate for former foster care members and controls increased by 13.6 percentage points and 33.4 percentage points, respectively, from MY 2020 to MY 2021. There were no disparities identified for former foster care members.

Service Utilization

Ambulatory Care Visits

Table 5-16 displays the MY 2019, MY 2020, and MY 2021 *Ambulatory Care Visits* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Ambulatory Care Visits* indicator measures the percentage of members who had an ambulatory care visit during the measurement year.

Table 5-16—Rates of *Ambulatory Care Visits* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	—	—	62.3%	66.9%
Age Category						
19 to 22 Years	—	—	—	—	63.3%	68.8%
23 to 26 Years	—	—	—	—	60.4%	63.3%
Sex						
Male	—	—	—	—	48.4%	54.9%
Female	—	—	—	—	76.5%	79.4%
Race						
Black or African American	—	—	—	—	59.0%	63.9%
White	—	—	—	—	64.2%	68.9%
Other	—	—	—	—	65.0%	63.3%
Region						
Central	—	—	—	—	62.2%	66.9%
Charlottesville/Western	—	—	—	—	63.7%	70.9%
Northern & Winchester	—	—	—	—	61.7%	62.8%
Roanoke/Alleghany	—	—	—	—	60.0%	70.6%
Southwest	—	—	—	—	66.1%	68.9%
Tidewater	—	—	—	—	61.4%	61.9%
MCO						
Aetna	—	—	—	—	61.0%	75.9%
HealthKeepers	—	—	—	—	63.6%	65.0%
Molina	—	—	—	—	45.0%	49.5%
Optima	—	—	—	—	62.4%	71.7%
VA Premier	—	—	—	—	66.2%	69.2%
UnitedHealthcare	—	—	—	—	58.0%	52.1%
More Than One MCO	—	—	—	—	82.4%	94.1%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-16 shows that 62.3 percent of former foster care members and 66.9 percent of controls had an ambulatory care visit during MY 2021, and the difference was statistically significant (p=0.01). The rates for former foster care members were notably lower than controls for members 19 to 22 years of age (by 5.5 percentage points); male members (by 6.5 percentage points); members in the Charlottesville/Western and Roanoke/Alleghany regions (by 7.2 and 10.6 percentage points, respectively); and members enrolled with Aetna, Optima, and More Than One MCO (by 14.9, 9.3, and 11.7 percentage points, respectively). Conversely, the rate for former foster care members enrolled with UnitedHealthcare was higher than the rate for the controls (by 5.9 percentage points).

MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both former foster care members and controls, female members were significantly more likely to have an ambulatory care visit compared to male members, while members enrolled with Molina were significantly less likely than members enrolled with other MCOs in MY 2021. Additionally, for former foster care members only, Black or African American members were significantly less likely than members in other racial groups to have an ambulatory care visit.

ED Visits

Table 5-17 displays the MY 2019, MY 2020, and MY 2021 *ED Visits* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *ED Visits* indicator measures the percentage of members who had an ED visit during the measurement year.

Table 5-17—Rates of *ED Visits* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	—	—	44.3%+	38.5%
Age Category						
19 to 22 Years	—	—	—	—	45.9%	38.3%

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
23 to 26 Years	—	—	—	—	41.2%	38.9%
Sex						
Male	—	—	—	—	39.5%	31.0%
Female	—	—	—	—	49.1%	46.2%
Race						
Black or African American	—	—	—	—	45.4%	47.1%
White	—	—	—	—	44.9%	34.9%
Other	—	—	—	—	21.7%	11.7%
Region						
Central	—	—	—	—	43.8%	47.9%
Charlottesville/Western	—	—	—	—	40.8%	31.5%
Northern & Winchester	—	—	—	—	43.3%	26.7%
Roanoke/Alleghany	—	—	—	—	51.0%	35.9%
Southwest	—	—	—	—	44.6%	44.1%
Tidewater	—	—	—	—	43.2%	38.9%
MCO						
Aetna	—	—	—	—	49.6%	42.6%
HealthKeepers	—	—	—	—	45.0%	36.4%
Molina	—	—	—	—	38.7%	38.7%
Optima	—	—	—	—	42.0%	41.2%
VA Premier	—	—	—	—	45.3%	38.4%
UnitedHealthcare	—	—	—	—	43.7%	35.3%
More Than One MCO	—	—	—	—	41.2%	23.5%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.

— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-17 shows that 44.3 percent of former foster care members and 38.5 percent of controls had an ED visit during MY 2021, and the difference was statistically significant ($p<0.001$). The rates for former foster care members were notably higher than controls for members 19 to 22 years of age (by 7.6 percentage points); male members (by 8.5 percentage points); members in the White and Other racial groups (by 10.0 and 10.0 percentage points, respectively); members in the Charlottesville/Western, Northern & Winchester, and Roanoke/Alleghany regions (by 9.3, 16.6, and 15.1 percentage points, respectively); and members enrolled with Aetna, HealthKeepers, VA Premier, UnitedHealthcare, and More Than One MCO (by 7.0, 8.6, 6.9, 8.4, and 17.7 percentage points, respectively).

MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both former foster care members and controls, female members were significantly more likely to have an ED visit compared to male members in MY 2021. For both former foster care members and controls, members in the Other racial group were significantly less likely than Black or African American or White members to have an ED visit. For former foster care members only, members in the Roanoke/Alleghany region were significantly more likely to have an ED visit than members in other regions.

Inpatient Visits

Table 5-18 displays the MY 2019, MY 2020, and MY 2021 *Inpatient Visits* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Inpatient Visits* indicator measures the percentage of members with an inpatient visit during the measurement year.

Table 5-18—Rates of *Inpatient Visits* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	—	—	10.4%	9.6%
Age Category						
19 to 22 Years	—	—	—	—	11.0%	8.8%
23 to 26 Years	—	—	—	—	9.2%	11.3%
Sex						
Male	—	—	—	—	6.7%	4.6%
Female	—	—	—	—	14.1%	14.9%

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Race						
Black or African American	—	—	—	—	10.3%	11.7%
White	—	—	—	—	10.5%	8.8%
Other	—	—	—	—	10.0%	3.3%
Region						
Central	—	—	—	—	9.9%	10.2%
Charlottesville/Western	—	—	—	—	9.0%	11.8%
Northern & Winchester	—	—	—	—	10.0%	5.6%
Roanoke/Alleghany	—	—	—	—	10.2%	8.6%
Southwest	—	—	—	—	12.4%	13.6%
Tidewater	—	—	—	—	11.4%	8.2%
MCO						
Aetna	—	—	—	—	12.8%	12.1%
HealthKeepers	—	—	—	—	10.2%	6.8%
Molina	—	—	—	—	7.2%	9.0%
Optima	—	—	—	—	9.9%	10.4%
VA Premier	—	—	—	—	11.3%	11.0%
UnitedHealthcare	—	—	—	—	9.2%	9.2%
More Than One MCO	—	—	—	—	11.8%	17.6%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-18 shows that 10.4 percent of former foster care members and 9.6 percent of controls had an inpatient visit during MY 2021, and the difference was not statistically significant (p=0.48). The rates for former foster care members were notably higher than controls for members in the Other racial group (by 6.7 percentage points), while the rates for former foster care members were notably lower than controls for members enrolled with More Than One MCO (by 5.8 percentage points).

MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both former foster care members and controls, female members were significantly more likely to have an inpatient visit compared to male members in MY 2021.

Behavioral Health Encounters—Total

Table 5-19 displays the MY 2019, MY 2020, and MY 2021 *Behavioral Health Encounters—Total* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Behavioral Health Encounters—Total* indicator measures the percentage of members with a behavioral health encounter during the measurement year.

Table 5-19—Rates of *Behavioral Health Encounters—Total* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	—	—	35.6%+	31.9%
Age Category						
19 to 22 Years	—	—	—	—	36.4%	32.3%
23 to 26 Years	—	—	—	—	34.3%	31.1%
Sex						
Male	—	—	—	—	28.4%	26.0%
Female	—	—	—	—	43.0%	38.1%
Race						
Black or African American	—	—	—	—	34.0%	28.7%
White	—	—	—	—	36.9%	34.6%
Other	—	—	—	—	31.7%	20.0%
Region						
Central	—	—	—	—	38.5%	33.6%
Charlottesville/Western	—	—	—	—	37.0%	36.3%
Northern & Winchester	—	—	—	—	32.8%	27.2%
Roanoke/Alleghany	—	—	—	—	38.4%	34.7%
Southwest	—	—	—	—	33.3%	35.6%
Tidewater	—	—	—	—	32.1%	25.0%

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
MCO						
Aetna	—	—	—	—	37.6%	38.3%
HealthKeepers	—	—	—	—	35.5%	32.7%
Molina	—	—	—	—	27.9%	19.8%
Optima	—	—	—	—	35.4%	30.8%
VA Premier	—	—	—	—	37.0%	33.8%
UnitedHealthcare	—	—	—	—	34.5%	29.4%
More Than One MCO	—	—	—	—	52.9%	29.4%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-19 shows that 35.6 percent of former foster care members and 31.9 percent of controls had a behavioral health encounter during MY 2021, and the difference was statistically significant (p=0.02). The rates for former foster care members were notably higher than controls for members in the Black or African American and Other racial groups (by 5.3 and 11.7 percentage points, respectively); members in the Tidewater region (by 7.1 percentage points); and members enrolled with Molina, UnitedHealthcare, and More Than One MCO (by 8.1, 5.1, and 23.5 percentage points, respectively).

MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both former foster care members and controls, female members were significantly more likely to have a behavioral health encounter compared to male members in MY 2021.

Behavioral Health Encounters—ARTS

Table 5-20 displays the MY 2019, MY 2020, and MY 2021 *Behavioral Health Encounters—ARTS* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Behavioral Health Encounters—ARTS* indicator measures the percentage of members with a behavioral health encounter with ARTS.

Table 5-20—Rates of *Behavioral Health Encounters—ARTS* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	—	—	5.8%	4.5%
Age Category						
19 to 22 Years	—	—	—	—	5.4%	4.0%
23 to 26 Years	—	—	—	—	6.7%	5.5%
Sex						
Male	—	—	—	—	5.5%	5.5%
Female	—	—	—	—	6.2%	3.4%
Race						
Black or African American	—	—	—	—	4.6%	2.7%
White	—	—	—	—	6.7%	5.8%
Other	—	—	—	—	5.0%^	0.0%^
Region						
Central	—	—	—	—	5.2%	3.9%
Charlottesville/Western	—	—	—	—	3.8%	5.5%
Northern & Winchester	—	—	—	—	5.6%	3.9%
Roanoke/Alleghany	—	—	—	—	6.5%	3.3%
Southwest	—	—	—	—	10.7%	10.7%
Tidewater	—	—	—	—	5.4%	2.3%
MCO						
Aetna	—	—	—	—	7.1%	5.7%
HealthKeepers	—	—	—	—	7.3%	4.8%
Molina	—	—	—	—	2.7%	2.7%
Optima	—	—	—	—	4.1%	3.6%
VA Premier	—	—	—	—	5.3%	4.4%
UnitedHealthcare	—	—	—	—	7.6%	7.6%
More Than One MCO	—	—	—	—	17.6%	0.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-20 shows that 5.8 percent of former foster care members and 4.5 percent of controls had a behavioral health encounter with ARTS during MY 2021, and the difference was not statistically significant (p=0.08). The rates for former foster care members were notably higher than controls for the Other racial group (by 5.0 percentage points) and members enrolled with More Than One MCO (by 17.6 percentage points).

MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both former foster care members and controls, members in the Southwest region were more likely to have a behavioral health visit with ARTS than members in other regions.

Behavioral Health Encounters—CMH Services

Table 5-21 displays the MY 2019, MY 2020, and MY 2021 *Behavioral Health Encounters—CMH Services* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Behavioral Health Encounters—CMH Services* indicator measures the percentage of members with a behavioral health encounter with CMH services.

Table 5-21—Rates of *Behavioral Health Encounters—CMH Services* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	—	—	10.1%+	6.3%
Age Category						
19 to 22 Years	—	—	—	—	10.1%	6.1%
23 to 26 Years	—	—	—	—	10.1%	6.5%
Sex						
Male	—	—	—	—	8.9%	5.3%
Female	—	—	—	—	11.3%	7.3%

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Race						
Black or African American	—	—	—	—	12.2%	7.9%
White	—	—	—	—	8.7%	5.5%
Other	—	—	—	—	11.7%	1.7%
Region						
Central	—	—	—	—	15.6%	9.6%
Charlottesville/Western	—	—	—	—	9.7%	6.6%
Northern & Winchester	—	—	—	—	5.6%	3.9%
Roanoke/Alleghany	—	—	—	—	10.2%	8.2%
Southwest	—	—	—	—	9.6%	6.2%
Tidewater	—	—	—	—	6.8%	2.3%
MCO						
Aetna	—	—	—	—	14.2%	7.1%
HealthKeepers	—	—	—	—	9.8%	6.1%
Molina	—	—	—	—	8.1%	3.6%
Optima	—	—	—	—	9.6%	4.9%
VA Premier	—	—	—	—	9.4%	8.0%
UnitedHealthcare	—	—	—	—	7.6%	5.9%
More Than One MCO	—	—	—	—	41.2%	5.9%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-21 shows that 10.1 percent of former foster care members and 6.3 percent of controls had a behavioral health encounter with CMH services during MY 2021, and the difference was statistically significant ($p<0.001$). The rates for former foster care members were notably higher than controls for members in the Other racial group (by 10.0 percentage points), members in the Central region (by 6.0

percentage points), and members enrolled with Aetna and More Than One MCO (by 7.1 and 35.3 percentage points).

MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both former foster care members and controls, Black or African members were significantly more likely to have a behavioral health encounter with CMH services compared to members in other racial groups in MY 2021, and members in the Central region were significantly more likely to have a behavioral health encounter with CMH compared to members in other regions, while members in the Tidewater region were less likely. For former foster care members only, White members were significantly less likely to have a behavioral health encounter with CMH services compared to members in other racial groups, while members in the Northern & Winchester region were less likely. Lastly, members enrolled with More Than One MCO were more likely to have a behavioral health encounter with CMH services compared to members enrolled with other MCOs.

Behavioral Health Encounters—RTC Services

Table 5-22 displays the MY 2019, MY 2020, and MY 2021 *Behavioral Health Encounters—RTC Services* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Behavioral Health Encounters—RTC Services* indicator measures the percentage of members with a behavioral health encounter with RTC services.

Table 5-22—Rates of *Behavioral Health Encounters—RTC Services* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	—	—	5.0%+	2.5%
Age Category						
19 to 22 Years	—	—	—	—	5.4%	2.2%
23 to 26 Years	—	—	—	—	4.4%	3.0%
Sex						
Male	—	—	—	—	4.9%	3.0%
Female	—	—	—	—	5.2%	1.9%
Race						
Black or African American	—	—	—	—	4.9%	2.5%

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
White	—	—	—	—	5.1%	2.5%
Other	—	—	—	—	5.0%	1.7%
Region						
Central	—	—	—	—	5.2%	2.6%
Charlottesville/Western	—	—	—	—	3.8%	4.2%
Northern & Winchester	—	—	—	—	5.0%	1.1%
Roanoke/Alleghany	—	—	—	—	4.1%	1.2%
Southwest	—	—	—	—	7.3%	3.4%
Tidewater	—	—	—	—	5.4%	2.0%
MCO						
Aetna	—	—	—	—	4.3%	2.1%
HealthKeepers	—	—	—	—	5.7%	1.8%
Molina	—	—	—	—	3.6%	1.8%
Optima	—	—	—	—	4.9%	3.3%
VA Premier	—	—	—	—	5.7%	3.0%
UnitedHealthcare	—	—	—	—	3.4%	1.7%
More Than One MCO	—	—	—	—	0.0%	0.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-22 shows that 5.0 percent of former foster care members and 2.5 percent of controls had a behavioral health encounter with RTC services during MY 2021, and the difference was statistically significant (p<0.001). The rate differences between former foster care members and controls were similar across the stratified rates.

MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically.

Behavioral Health Encounters—Therapeutic Services

Table 5-23 displays the MY 2019, MY 2020, and MY 2021 *Behavioral Health Encounters—Therapeutic Services* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Behavioral Health Encounters—Therapeutic Services* indicator measures the percentage of members with a behavioral health encounter with therapeutic services.

Table 5-23—Rates of *Behavioral Health Encounters—Therapeutic Services* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	—	—	4.1%	2.9%
Age Category						
19 to 22 Years	—	—	—	—	4.0%	2.9%
23 to 26 Years	—	—	—	—	4.4%	2.8%
Sex						
Male	—	—	—	—	3.3%	2.6%
Female	—	—	—	—	5.0%	3.1%
Race						
Black or African American	—	—	—	—	5.6%	4.6%
White	—	—	—	—	3.1%	2.1%
Other	—	—	—	—	6.7%^	0.0%^
Region						
Central	—	—	—	—	10.2%	6.8%
Charlottesville/Western	—	—	—	—	2.4%	1.4%
Northern & Winchester	—	—	—	—	0.0%^	0.6%^
Roanoke/Alleghany	—	—	—	—	2.9%	3.7%
Southwest	—	—	—	—	1.1%	2.3%
Tidewater	—	—	—	—	3.4%	0.9%
MCO						
Aetna	—	—	—	—	5.0%	1.4%
HealthKeepers	—	—	—	—	4.3%	3.2%
Molina	—	—	—	—	1.8%	0.9%
Optima	—	—	—	—	4.1%	2.7%
VA Premier	—	—	—	—	3.4%	3.7%
UnitedHealthcare	—	—	—	—	3.4%	2.5%
More Than One MCO	—	—	—	—	29.4%	5.9%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-23 shows that 4.1 percent of former foster care members and 2.9 percent of controls had a behavioral health encounter with therapeutic services during MY 2021, and the difference was not statistically significant (p=0.06). The rates for former foster care members were notably higher than controls for members in the Other racial group (by 6.7 percentage points) and members enrolled with More Than One MCO (by 23.5 percentage points).

MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both former foster care members and controls, Black or African American members were significantly more likely to have a behavioral health encounter with therapeutic services, and White members were significantly less likely. For both former foster care members and controls, members in the Central region were significantly more likely to have a behavioral health encounter with therapeutic services compared to members in other regions. For former foster care members only, members enrolled with More Than One MCO were significantly more likely to have a behavioral health encounter with therapeutic services compared to members enrolled with other MCOs.

Behavioral Health Encounters—Traditional Services

Table 5-24 displays the MY 2019, MY 2020, and MY 2021 *Behavioral Health Encounters—Traditional Services* rates among former foster care members and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Behavioral Health Encounters—Traditional Services* indicator measures the percentage of members with a behavioral health encounter with traditional services.

Table 5-24—Rates of *Behavioral Health Encounters—Traditional Services* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	—	—	34.2%+	30.9%
Age Category						
19 to 22 Years	—	—	—	—	34.8%	31.3%
23 to 26 Years	—	—	—	—	33.0%	30.0%
Sex						
Male	—	—	—	—	26.7%	24.9%
Female	—	—	—	—	41.8%	37.1%
Race						
Black or African American	—	—	—	—	32.1%	26.5%
White	—	—	—	—	35.6%	34.2%
Other	—	—	—	—	31.7%	20.0%
Region						
Central	—	—	—	—	35.7%	30.7%
Charlottesville/Western	—	—	—	—	36.0%	35.6%
Northern & Winchester	—	—	—	—	32.8%	26.7%
Roanoke/Alleghany	—	—	—	—	35.1%	33.9%
Southwest	—	—	—	—	32.8%	35.6%
Tidewater	—	—	—	—	31.8%	24.7%
MCO						
Aetna	—	—	—	—	36.9%	36.9%
HealthKeepers	—	—	—	—	34.5%	31.4%
Molina	—	—	—	—	25.2%	19.8%
Optima	—	—	—	—	34.1%	29.9%
VA Premier	—	—	—	—	34.9%	32.4%
UnitedHealthcare	—	—	—	—	33.6%	29.4%
More Than One MCO	—	—	—	—	47.1%	29.4%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-24 shows that 34.2 percent of former foster care members and 30.9 percent of controls had a behavioral health encounter with traditional services during MY 2021, and the difference was statistically significant (p=0.04). The rates for former foster care members were notably higher than controls for members in the Black or African American and Other racial groups (by 5.6 and 11.7 percentage points, respectively); members in the Central, Northern & Winchester, and Tidewater regions (by 5.0, 6.1, and 7.1 percentage points, respectively); and members enrolled with Molina and More Than One MCO (by 5.4 and 17.7 percentage points, respectively).

MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For both former foster care members and controls, female members were significantly more likely to have a behavioral health encounter with traditional services compared to male members in MY 2021. For both former foster care members and controls, members enrolled with Molina were significantly less likely to have a behavioral health encounter with traditional services compared to members enrolled with other MCOs.

Overall Service Utilization

Table 5-25 displays the MY 2019, MY 2020, and MY 2021 *Overall Service Utilization* rates among former foster care members care and controls stratified by member characteristics. For MY 2021, member characteristics with identified health disparities are indicated with shading. The *Overall Service Utilization* indicator measures the percentage of members with an ambulatory care visit, ED visit, inpatient visit, or behavioral health encounter during the measurement year.

Table 5-25—Rates of *Overall Service Utilization* Among Former Foster Care Members and Controls

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	—	—	74.7%	75.4%
Age Category						
19 to 22 Years	—	—	—	—	76.3%	75.7%

Category	MY 2019		MY 2020		MY 2021	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
23 to 26 Years	—	—	—	—	71.6%	74.7%
Sex						
Male	—	—	—	—	65.7%	64.5%
Female	—	—	—	—	83.8%	86.7%
Race						
Black or African American	—	—	—	—	73.8%	75.3%
White	—	—	—	—	75.8%	75.9%
Other	—	—	—	—	65.0%	66.7%
Region						
Central	—	—	—	—	75.0%	78.1%
Charlottesville/Western	—	—	—	—	75.1%	75.8%
Northern & Winchester	—	—	—	—	72.8%	70.6%
Roanoke/Alleghany	—	—	—	—	77.1%	76.7%
Southwest	—	—	—	—	75.1%	78.0%
Tidewater	—	—	—	—	73.0%	72.2%
MCO						
Aetna	—	—	—	—	74.5%	84.4%
HealthKeepers	—	—	—	—	74.8%	74.1%
Molina	—	—	—	—	60.4%	64.9%
Optima	—	—	—	—	74.5%	76.9%
VA Premier	—	—	—	—	77.9%	77.7%
UnitedHealthcare	—	—	—	—	73.9%	63.0%
More Than One MCO	—	—	—	—	94.1%	94.1%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.
^ Indicates that disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).
+ Indicates that the rate for the former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for the former foster care members was significantly lower than the rate for the control group of all eligible members.
— Indicates that a rate was not presented either because it was not calculated for the measurement year or the denominator was zero.

Table 5-25 shows that 74.7 percent of former foster care members and 75.4 percent of controls had an ambulatory care visit, ED visit, inpatient visit, or behavioral health encounter (i.e., any service) during

MY 2021, and the difference was not statistically significant (p=0.66). The rates for former foster care members were notably higher than controls for members enrolled with UnitedHealthcare (by 10.9 percentage points), and former foster care members' rates were notably lower than controls for members enrolled with Aetna (by 9.9 percentage points).

MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. MY 2021 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. For former foster care members only, members 19 to 22 years of age were significantly more likely to utilize any service compared to members 23 to 26 years of age in MY 2021. Additionally, for both former foster care members and controls, female members were significantly more likely to utilize any service compared to male members, and members enrolled with Molina were significantly less likely to utilize any service compared to members enrolled with other MCOs.

6. Timely Access to Care Findings

Timely Access to Care for New Foster Care Members

This section provides findings from the study indicators used to assess timely access to care for new foster care members for MY 2021. The tables displayed in this section also include stratified rates and shading to indicate the results of the health disparities analysis.

Timely Access to Primary Care

Table 6-1 displays the MY 2021 rates for the *Timely Access to Primary Care for New Foster Members* indicator for the statewide population and stratified by member characteristics. Member characteristics with identified health disparities are indicated with shading. The *Timely Access to Primary Care for New Foster Members* indicator measures the percentage of members newly enrolled in the foster care program who had at least one visit with a PCP within 30 days after the first foster care enrollment date or within 90 days prior to the first foster care enrollment date.

Table 6-1—Rates of *Timely Access to Primary Care* Among New Foster Care Members

Category	Denominator	Numerator	Rate
All Eligible Members*	1,699	1,464	86.2%
Age Category			
≤ 2 Years	580	534	92.1%
3 to 5 Years	207	183	88.4%
6 to 10 Years	301	246	81.7%
11 to 13 Years	228	193	84.6%
≥ 14 Years	383	308	80.4%
Sex			
Male	877	751	85.6%
Female	822	713	86.7%
Race			
Black or African American	515	435	84.5%
White	1,150	1,000	87.0%
Other	34	29	85.3%
Region			
Central	287	244	85.0%
Charlottesville/Western	285	253	88.8%

Category	Denominator	Numerator	Rate
Northern & Winchester	243	193	79.4%
Roanoke/Alleghany	358	317	88.5%
Southwest	231	209	90.5%
Tidewater	288	243	84.4%
MCO			
Aetna	225	187	83.1%
HealthKeepers	409	347	84.8%
Molina	129	114	88.4%
Optima	333	289	86.8%
VA Premier	419	363	86.6%
UnitedHealthcare	174	154	88.5%

**Members with Unknown Region and/or More than One MCO are included in the All Eligible Members rate but are not displayed in this table.*

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

Table 6-1 shows that 86.2 percent of newly enrolled members in the foster care program had at least one visit with a PCP within 30 days after the first foster care enrollment date or within 90 days prior to the first foster care enrollment date. MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator for this analysis. Members 2 years of age and younger were significantly more likely to have a PCP visit compared to members in other age categories, while members 6 to 10 years and 14 years of age and older were less likely to have a PCP visit compared to members in other age categories. Additionally, members in the Southwest region were more likely to have a PCP visit, while members in the Northern & Winchester region were less likely to have a PCP visit compared to members in other regions.

Timely Access to Dental Care

Table 6-2 displays the MY 2021 rates for the *Timely Access to Dental Care for New Foster Members* indicator for the statewide population and stratified by member characteristics. Member characteristics with identified health disparities are indicated with shading. The *Timely Access to Dental Care for New Foster Members* indicator measures the percentage of members newly enrolled in the foster care program who had at least one visit with a dental provider within 30 days after the first foster care enrollment date or within 90 days prior to the first foster care enrollment date.

Table 6-2—Rates of *Timely Access to Dental Care* Among New Foster Care Members

Category	Denominator	Numerator	Rate
All Eligible Members*	1,699	747	44.0%
Age Category			
≤ 2 Years	580	114	19.7%
3 to 5 Years	207	120	58.0%
6 to 10 Years	301	178	59.1%
11 to 13 Years	228	141	61.8%
≥ 14 Years	383	194	50.7%
Sex			
Male	877	347	39.6%
Female	822	400	48.7%
Race			
Black or African American	515	210	40.8%
White	1150	518	45.0%
Other	34	19	55.9%
Region			
Central	287	121	42.2%
Charlottesville/Western	285	124	43.5%
Northern & Winchester	243	107	44.0%
Roanoke/Alleghany	358	148	41.3%
Southwest	231	125	54.1%
Tidewater	288	119	41.3%
MCO			
Aetna	225	101	44.9%
HealthKeepers	409	193	47.2%
Molina	129	51	39.5%
Optima	333	119	35.7%
VA Premier	419	196	46.8%
UnitedHealthcare	174	84	48.3%

**Members with Unknown Region and More than One MCO are included in the All Eligible Members rate but are not displayed in this table.*

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

Table 6-2 shows that 44.0 percent of newly enrolled members in the foster care program had at least one visit with a dental provider within 30 days after the first foster care enrollment date or within 90 days prior to the first foster care enrollment date. MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator for this analysis. Members 2 years of age and younger were significantly less likely to have a dental provider visit compared to members in other age categories, while members in other age categories were more likely to have visit with a dental provider. Female members were significantly more likely to have a visit with a dental provider than male members. Additionally, members in the Southwest region were significantly more likely to have a visit with a dental provider compared to members in other regions, and members enrolled with Optima were less likely to have a visit with a dental provider compared to members enrolled with other MCOs.

Timely Access to Primary Care or Dental Care

Table 6-3 displays the MY 2021 rates for the *Timely Access to Primary Care or Dental Care for New Foster Members* indicator for the statewide population and stratified by member characteristics. Member characteristics with identified health disparities are indicated with shading. The *Timely Access to Primary Care or Dental Care for New Foster Members* indicator measures the percentage of members newly enrolled in the foster care program who had at least one visit with a PCP or dental provider within 30 days after the first foster care enrollment date or within 90 days prior to the first foster care enrollment date.

Table 6-3—Rates of *Timely Access to Primary Care or Dental Care* Among New Foster Care Members

Category	Denominator	Numerator	Rate
All Eligible Members*	1,699	1,534	90.3%
Age Category			
≤ 2 Years	580	535	92.2%
3 to 5 Years	207	192	92.8%
6 to 10 Years	301	262	87.0%
11 to 13 Years	228	209	91.7%
≥ 14 Years	383	336	87.7%
Sex			
Male	877	790	90.1%
Female	822	744	90.5%
Race			
Black or African American	515	456	88.5%

Category	Denominator	Numerator	Rate
White	1150	1046	91.0%
Other	34	32	94.1%
Region			
Central	287	262	91.3%
Charlottesville/Western	285	266	93.3%
Northern & Winchester	243	205	84.4%
Roanoke/Alleghany	358	326	91.1%
Southwest	231	217	93.9%
Tidewater	288	253	87.8%
MCO			
Aetna	225	202	89.8%
HealthKeepers	409	364	89.0%
Molina	129	116	89.9%
Optima	333	303	91.0%
VA Premier	419	380	90.7%
UnitedHealthcare	174	159	91.4%

**Members with Unknown Region and More than One MCO are included in the All Eligible Members rate but are not displayed in this table.*

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.

Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

Table 6-3 shows that 90.3 percent of newly enrolled members in the foster care program had at least one visit with a PCP or dental provider within 30 days after the first foster care enrollment date or within 90 days prior to the first foster care enrollment date. MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator for this analysis. Members 6 to 10 years of age were less likely to have a PCP or dental provider visit compared to members in other age categories. Additionally, members in the Southwest region were more likely to have a PCP or dental provider visit, while members in the Northern & Winchester region were less likely to have a PCP or dental provider visit compared to members in other regions.

Timely Access to Primary Care and Dental Care

Table 6-4 displays the MY 2021 rates for the *Timely Access to Primary Care and Dental Care for New Foster Members* indicator for the statewide population and stratified by member characteristics. Member characteristics with identified health disparities are indicated with shading. The *Timely Access to Primary Care and Dental Care for New Foster Members* indicator measures the percentage of members newly enrolled in the foster care program who had at least one visit with a PCP and one visit with a dental provider within 30 days after the first foster care enrollment date or within 90 days prior to the first foster care enrollment date.

Table 6-4—Rates of *Timely Access to Primary Care and Dental Care* Among New Foster Care Members

Category	Denominator	Numerator	Rate
All Eligible Members*	1,699	677	39.8%
Age Category			
≤ 2 Years	580	113	19.5%
3 to 5 Years	207	111	53.6%
6 to 10 Years	301	162	53.8%
11 to 13 Years	228	125	54.8%
≥ 14 Years	383	166	43.3%
Sex			
Male	877	308	35.1%
Female	822	369	44.9%
Race			
Black or African American	515	189	36.7%
White	1150	472	41.0%
Other	34	16	47.1%
Region			
Central	287	103	35.9%
Charlottesville/Western	285	111	38.9%
Northern & Winchester	243	95	39.1%
Roanoke/Alleghany	358	139	38.8%
Southwest	231	117	50.6%
Tidewater	288	109	37.8%
MCO			
Aetna	225	86	38.2%
HealthKeepers	409	176	43.0%
Molina	129	49	38.0%
Optima	333	105	31.5%
VA Premier	419	179	42.7%
UnitedHealthcare	174	79	45.4%

**Members with Unknown Region and More than One MCO are included in the All Eligible Members rate but are not displayed in this table.*

Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

Table 6-4 shows that 39.8 percent of newly enrolled members in the foster care program had at least one visit with a PCP and one visit with a dental provider within 30 days after the first foster care enrollment date or within 90 days prior to the first foster care enrollment date. MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator for this analysis. Members 2 years of age and younger were significantly less likely to have a PCP visit and dental provider visit compared to members in other age categories, while members 3 to 5, 6 to 10, and 11 to 13 years of age were more likely to have a PCP visit and a dental provider visit compared to members in other age categories. Female members were significantly more likely to have a PCP visit and a dental provider visit compared to male members. Additionally, members in the Southwest region were more likely to have a PCP visit and a dental provider visit compared to members in other regions, while members enrolled with Optima were less likely to have a PCP visit and a dental provider visit compared to members enrolled with other MCOs.

Timely Access to Care for Members Who Aged Out of Foster Care

Timely Access to Primary Care

Table 6-5 displays the MY 2021 rates for the *Timely Access to Primary Care for Members Who Aged Out of Foster Care* indicator for the statewide population and stratified by member characteristics. Member characteristics with identified health disparities are indicated with shading. The *Timely Access to Primary Care for Members Who Aged Out of Foster Care* indicator measures the percent of 19-year-old members who had aged out of foster care who had at least one visit with a PCP during the measurement year.

Table 6-5—Rates of *Timely Access to Primary Care* for Members Who Aged Out of Foster Care

Category	Denominator	Numerator	Rate
All Eligible Members*	179	125	69.8%
Sex			
Male	97	59	60.8%
Female	82	66	80.5%
Race			
Black or African American	65	45	69.2%
White	109	78	71.6%
Region			
Central	43	30	69.8%
Charlottesville/Western	34	25	73.5%

Category	Denominator	Numerator	Rate
Northern & Winchester	S	S	S
Roanoke/Alleghany	28	20	71.4%
Southwest	S	S	S
Tidewater	34	20	58.8%
MCO			
Aetna	S	S	S
HealthKeepers	58	42	72.4%
Molina	S	S	S
Optima	38	25	65.8%
VA Premier	51	41	80.4%
UnitedHealthcare	S	S	S

**Members of Other Race are included in the All Eligible Members rate but are not displayed in this table.*
S indicates that the rate has been suppressed due to a small numerator or denominator (i.e., less than or equal to 10).
Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

Table 6-5 shows that 69.8 percent of members who aged out of foster care had at least one visit with a PCP during MY 2021. The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator for this analysis. Female members who aged out of foster care were significantly more likely to have a PCP visit compared to male members.

Timely Access to Dental Care

Table 6-6 displays the MY 2021 rates for the *Timely Access to Dental Care for Members Who Aged Out of Foster Care* indicator for the statewide population and stratified by member characteristics. Member characteristics with identified health disparities are indicated with shading. The *Timely Access to Dental Care for Members Who Aged Out of Foster Care* indicator measures the percent of 19-year-old members who had aged out of foster care who had at least one visit with a dental provider during the measurement year.

Table 6-6—Rates of *Timely Access to Dental Care* for Members Who Aged Out of Foster Care

Category	Denominator	Numerator	Rate
All Eligible Members*	179	62	34.6%
Sex			
Male	97	27	27.8%
Female	82	35	42.7%
Race			

Category	Denominator	Numerator	Rate
Black or African American	65	26	40.0%
White	109	34	31.2%
Region			
Central	43	21	48.8%
Charlottesville/Western	S	S	S
Northern & Winchester	S	S	S
Roanoke/Alleghany	S	S	S
Southwest	25	11	44.0%
Tidewater	S	S	S
MCO			
Aetna	S	S	S
HealthKeepers	58	21	36.2%
Molina	S	S	S
Optima	S	S	S
VA Premier	51	25	49.0%
UnitedHealthcare	S	S	S

**Members of Other Race are included in the All Eligible Members rate but are not displayed in this table.*
S indicates that the rate has been suppressed due to a small numerator or denominator (i.e., less than or equal to 10).
Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

Table 6-6 shows that 34.6 percent of members who aged out of foster care had at least one visit with a dental provider during MY 2021. The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator for this analysis. Female members who aged out of foster care were significantly more likely to have a dental provider visit compared to male members. Additionally, members in the Central region were significantly more likely to have a dental provider visit compared to members in other regions, and members enrolled with VA Premier were more likely to have a dental provider visit compared to members enrolled with other MCOs.

Timely Access to Primary Care or Dental Care

Table 6-7 displays the MY 2021 rates for the *Timely Access to Primary Care or Dental Care for Members Who Aged Out of Foster Care* indicator for the statewide population and stratified by member characteristics. Member characteristics with identified health disparities are indicated with shading. The *Timely Access to Primary Care or Dental Care for Members Who Aged Out of Foster Care* indicator measures the percent of 19-year-old members who had aged out of foster care who had at least one visit with a PCP or dental provider during the measurement year.

Table 6-7—Rates of *Timely Access to Primary Care or Dental Care* for Members Who Aged Out of Foster Care

Category	Denominator	Numerator	Rate
All Eligible Members*	179	133	74.3%
Sex			
Male	97	63	64.9%
Female	82	70	85.4%
Race			
Black or African American	65	48	73.8%
White	109	83	76.1%
Region			
Central	43	32	74.4%
Charlottesville/Western	34	25	73.5%
Northern & Winchester	15	12	80.0%
Roanoke/Alleghany	28	22	78.6%
Southwest	25	22	88.0%
Tidewater	34	20	58.8%
MCO			
Aetna	S	S	S
HealthKeepers	58	43	74.1%
Molina	S	S	S
Optima	38	25	65.8%
VA Premier	51	45	88.2%
UnitedHealthcare	S	S	S

**Members of Other Race are included in the All Eligible Members rate but are not displayed in this table.*
S indicates that the rate has been suppressed due to a small numerator or denominator (i.e., less than or equal to 10).
Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

Table 6-7 shows that 74.3 percent of members who aged out of foster care had at least one visit with a PCP or dental care provider during MY 2021. The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator for this analysis. Female members who aged out of foster care were significantly more likely to have a PCP or dental visit compared to male members. Additionally, members in the Tidewater region were significantly less likely to have a PCP or dental provider visit compared to members in other regions, and members enrolled with VA Premier were more likely to have a PCP or dental visit compared to members enrolled with other MCOs.

Timely Access to Primary Care and Dental Care

Table 6-8 displays the MY 2021 rates for the *Timely Access to Primary Care and Dental Care for Members Who Aged Out of Foster Care* indicator for the statewide population and stratified by member characteristics. Member characteristics with identified health disparities are indicated with shading. The *Timely Access to Primary Care and Dental Care for Members Who Aged Out of Foster Care* indicator measures the percent of 19-year-old members who had aged out of foster care who had at least one visit with a PCP and at least one visit with a dental provider during the measurement year.

Table 6-8—Rates of *Timely Access to Primary Care and Dental Care* for Members Who Aged Out of Foster Care

Category	Denominator	Numerator	Rate
All Eligible Members*	179	54	30.2%
Sex			
Male	97	23	23.7%
Female	82	31	37.8%
Race			
Black or African American	65	23	35.4%
White	109	29	26.6%
Region			
Central	43	19	44.2%
Charlottesville/Western	S	S	S
Northern & Winchester	S	S	S
Roanoke/Alleghany	S	S	S
Southwest	S	S	S
Tidewater	S	S	S
MCO			
Aetna	S	S	S
HealthKeepers	58	20	34.5%
Molina	S	S	S
Optima	S	S	S
VA Premier	51	21	41.2%
UnitedHealthcare	S	S	S

**Members of Other Race are included in the All Eligible Members rate but are not displayed in this table.*
S indicates that the rate has been suppressed due to a small numerator or denominator (i.e., less than or equal to 10).
Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

Table 6-8 shows that 30.2 percent of members who aged out of foster care had at least one PCP visit and at least one visit with a dental care provider during MY 2021. Given that the statewide rates for the *Timely Access to Primary Care for Members Who Aged Out of Foster Care* indicator were 35.2 percentage points lower than the rates for the *Timely Access to Dental Care for Members Who Aged Out of Foster Care* indicator, the *Timely Access to Primary Care and Dental Care Members Who Aged Out of Foster Care* statewide rate was mostly limited by the low rates of dental provider visits. The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator for this analysis. Female members who aged out of foster care were significantly more likely to have a PCP visit and a dental provider visit compared to male members. Additionally, members in the Central region were significantly more likely to have a PCP visit and a dental provider visit compared to members in other regions, and members enrolled with VA Premier were more likely to have a PCP visit and a dental provider visit compared to members enrolled with other MCOs.

Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care

Timely Access to Behavioral Health Care

Table 6-9 displays the MY 2021 rates for the *Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care* indicator for the statewide population and stratified by member characteristics. Member characteristics with identified health disparities are indicated with shading. The *Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care* indicator measures the percent of 19-year-old members who had aged out of foster care who had at least one visit with an MHP during the measurement year.

Table 6-9—Rates of *Timely Access to Behavioral Health Care* for Members Who Aged Out of Foster Care

Category	Denominator	Numerator	Rate
All Eligible Members*	179	58	32.4%
Sex			
Male	97	27	27.8%
Female	82	31	37.8%
Race			
Black or African American	65	22	33.8%
White	109	34	31.2%
Region			
Central	43	15	34.9%
Charlottesville/Western	34	12	35.3%
Northern & Winchester	S	S	S
Roanoke/Alleghany	S	S	S
Southwest	S	S	S

Category	Denominator	Numerator	Rate
Tidewater	S	S	S
MCO			
Aetna	S	S	S
HealthKeepers	58	17	29.3%
Molina	S	S	S
Optima	S	S	S
VA Premier	51	23	45.1%
UnitedHealthcare	S	S	S

**Members of Other Race are included in the All Eligible Members rate but are not displayed in this table.*
S indicates that the rate has been suppressed due to a small numerator or denominator (i.e., less than or equal to 10).
Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

Table 6-9 shows that 32.4 percent of members who aged out of the foster care program had at least one visit with an MHP during MY 2021. The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator for this analysis. Members who aged out of foster care and were enrolled with VA Premier were more likely to have an MHP visit compared to members enrolled with other MCOs.

Timely Access to Behavioral Health Care For Members Who Aged Out of Foster Care with a Behavioral Health Diagnosis

Table 6-10 displays the MY 2021 rates for the *Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care with a Behavioral Health Diagnosis* indicator for the statewide population and stratified by member characteristics. Member characteristics with identified health disparities are indicated with shading. The *Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care with a Behavioral Health Diagnosis* indicator measures the percent of 19-year-old members who had aged out of foster care and who have a diagnosis of mental illness who had at least one visit with an MHP during the measurement year.

Table 6-10—Rates of *Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care with a Behavioral Health Diagnosis*

Category	Denominator	Numerator	Rate
All Eligible Members*	142	56	39.4%
Sex			
Male	76	27	35.5%
Female	66	29	43.9%
Race			
Black or African American	55	22	40.0%

Category	Denominator	Numerator	Rate
White	84	33	39.3%
Region			
Central	33	14	42.4%
Charlottesville/Western	30	11	36.7%
Northern & Winchester	S	S	S
Roanoke/Alleghany	S	S	S
Southwest	S	S	S
Tidewater	S	S	S
MCO			
Aetna	S	S	S
HealthKeepers	43	16	37.2%
Molina	S	S	S
Optima	S	S	S
VA Premier	44	23	52.3%
UnitedHealthcare	S	S	S

**Members of Other Race are included in the All Eligible Members rate but are not displayed in this table.*
S indicates that the rate has been suppressed due to a small numerator or denominator (i.e., less than or equal to 10).
Blue shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was higher than the reference group rate.
Orange shading indicates that a disparity was identified (i.e., had a p-value less than or equal to 0.05) and the stratified rate was lower than the reference group rate.

Table 6-10 shows that 39.4 percent of members who had aged out of foster care and who have a diagnosis of mental illness had at least one visit with an MHP during MY 2021. Therefore, this rate is 7.0 percentage points higher than the rate for all members who aged out of foster care. Of note, 79.3 percent of members who aged out of foster care had a diagnosis of mental illness and were included in this rate's denominator. The MY 2021 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator for this analysis. Members enrolled with VA Premier were more likely to have an MHP visit compared to members enrolled with other MCOs.

7. Conclusions and Recommendations

SFY 2021–2022 is the seventh year of the Child Welfare Focus Study and the fourth year to conduct a comparative analysis to similar members also enrolled in Medicaid (i.e., controls). HSAG collaborated with DMAS to ensure that this study may inform current and future quality improvement actions affecting children in foster care, children receiving adoption assistance, and former foster care members. Comparing children in foster care, children receiving adoption assistance, and former foster care members to similar members offers a comprehensive investigation of the unique successes and challenges in these members' healthcare. The present healthcare utilization rates for the study populations can be understood in the context of the indicator results for controls, after accounting for Medicaid managed care enrollment, age, race, sex, region, MCO, Medicaid program, and pertinent health characteristics. Furthermore, tracking rates over time provides insight into the impact on healthcare utilization of quality improvement efforts, the COVID-19 pandemic, and other variables correlated with time. The SFY 2021–2022 study also introduced an analysis of timely access to care for members transitioning into and out of the foster care program and an assessment of disparities in healthcare utilization and timely access to care across key member characteristics. The following section discusses limitations of the study and then provides conclusions and recommendations specific to each study population and analysis.

Study Limitations

Study findings and conclusions may be affected by limitations related to the study design and source data. As such, caveats include, but are not limited to, the following:

- Study indicator rates must be interpreted with caution given the denominator limitations. The covariate balance between the denominator-limited study populations and the denominator-limited controls group may be disrupted when one member in a matched pair qualifies for a study indicator denominator and the other member does not. The smaller the denominators, the greater the risk of imbalance between the study populations and their controls. Covariate balance between the stratification-limited study populations and the stratification-limited controls group may be similarly disrupted when only one member in a matched pair qualifies for a stratification that was matched by propensity score. However, for the SFY 2021–2022 study, all characteristics for which rates were stratified were exact-matched except for member sex, and HSAG found that most covariates were balanced within statewide male and female groups.
- Study indicator results and the accuracy of demographic characteristics (e.g., region, MCO) may be influenced by the accuracy and timeliness of the administrative claims and encounter data used for calculations and must be interpreted within the broader context of the population. Many study indicators are also based on CMS Core Set technical specifications, which may not comprehensively mirror the complete range of clinical practices recommended by AAP for members in the study population (e.g., an enhanced periodicity schedule customized to align with the needs of children in foster care). Furthermore, selected study indicators were originally developed by CMS to assess access to care or the degree to which care adhered to clinical guidelines. These measures were not necessarily developed to assess healthcare utilization. For example, most study indicators do not assess the frequency of service utilization; they only assess whether or not a visit

occurred. Findings should be interpreted with respect to the intent of the CMS Core Set technical specifications.

- Methodology changes in MY 2020 may impact trending results for children in foster care. The current study trended study indicator rates for children in foster care across MY 2019, MY 2020, and MY 2021. Since adoption assistance children were included as a study population in MY 2020, they were removed from the pool of members from which controls for children in foster care could be selected. Therefore, while the control pool for MY 2019 included adoption assistance children, the control pool for MY 2020 and MY 2021 did not. Of note, only 1.4 percent of members in the control pool for MY 2019 would have been removed by the methodology change. Additionally, while MY 2019 only assessed members enrolled through Medallion 4.0, the MY 2020 and MY 2021 analyses also included members enrolled through CCC Plus. However, only 22 children in foster care in the study population were enrolled in CCC Plus in MY 2021. Therefore, given that the methodology changes only affect a small proportion of members, HSAG expects impacts on trending to be limited.
- The study populations and controls were limited by several factors, including continuous enrollment and having a comparable match; therefore, study findings are not generalizable to other children in foster care, children receiving adoption assistance, or former foster care members; to other members not in these programs; or to other CMS Core Set measure calculations. However, despite the limitations of the denominators, study indicator results are generalizable to the full study population and controls.
- MY 2020 and MY 2021 findings may be impacted by the onset of the COVID-19 pandemic. Therefore, HSAG recommends exercising caution when interpreting MY 2020 and MY 2021 findings or making comparisons to MY 2019 results, where applicable.

Conclusions and Recommendations

Healthcare Utilization: Children in Foster Care

Children in foster care are children who have been removed from their birth family homes for reasons of neglect, abuse, abandonment, or other issues endangering their health and/or safety.[7-1] While these children are in foster care, the State has custody and therefore primary responsibility for ensuring children receive the appropriate healthcare services. For example, a foster child's service worker must ensure the child meets a schedule of well-child visits and dental examinations based on nationally recognized guidelines.[7-2] This study demonstrated that children in foster care have higher rates of appropriate healthcare utilization than comparable controls for most study indicators in MY 2019, MY 2020, and MY 2021. Study findings show that MY 2021 rate differences between children in foster care and controls were greatest among the dental study indicators (*Annual Dental Visit; Preventive Dental Services; Oral Evaluation, Dental Services;* and *Topical Fluoride for Children—Dental or Oral Health Services* by 18.2, 19.0, 19.0, and 14.2 percentage points, respectively), the *Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics* measure (by 20.4 percentage

7-1 Virginia Department of Social Services. Foster Care (FC). Available at: https://www.dss.virginia.gov/family/fc/index.cgi#manuals. Accessed on: Jan 11, 2023.

7-2 Virginia Department of Social Services. Child and Family Services Manual: Identifying Services to Be Provided. Available at: Child and Family Services Manual.pdf. Accessed on: Jan 11, 2023.

points), and the *Behavioral Health Encounters—CMH Services* indicator (by 17.1 percentage points). Rate differences between children in foster care and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2021, children in foster care had lower rates compared to controls for only four study indicators: *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment, Ambulatory Care Visits, ED Visits*, and *Overall Service Utilization.* For *Initiation of AOD Treatment*, children in foster care had a higher rate than controls during MY 2019 but a lower rate than controls in MY 2020. However, the rate for children in foster care increased from 29.1 percent to 40.8 percent from MY 2020 to MY 2021, and the gap between children in foster care and controls reduced from 16.7 to 7.3 percentage points. Additionally, the rate for children in foster care for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment* study indicator was lower than controls during MY 2020 but higher than controls during MY 2021, indicating improvement in AOD treatment engagement as well. For the *ED Visits* study indicator, the rate for children in foster care was 6.7 percentage points lower than the rate for controls, which could reflect better management of health conditions for children in foster care. For the *Ambulatory Care Visits* and *Overall Service Utilization* indicators, the rate difference between children in foster care and controls was less than 1 percentage point, and the rates for children in foster care were very high for both indicators.

Among children in foster care, four study indicator rates increased, while 13 study indicator rates decreased from MY 2020 to MY 2021, and seven study indicator rates increased, while eight study indicator rates decreased from MY 2019 to MY 2021. The largest declines from MY 2020 to MY 2021 were for the *Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up* indicator (by 8.7 percentage points), the *Annual Dental Visit* indicator (by 8.5 percentage points), and the *Preventive Dental Services* indicator (by 7.4 percentage points). Among controls for children in foster care, 13 study indicator rates increased, while four study indicator rates decreased from MY 2020 to MY 2021, and eight study indicator rates increased, while nine study indicator rates decreased from MY 2019 to MY 2022. Some declines in rates may be attributable to the COVID-19 pandemic during MY 2020 and MY 2021. For instance, from March 2020 to May 2020, most elective procedures and outpatient visits were cancelled or postponed nationwide.[7-3] Additionally, utilization of ambulatory care services remained below expected rates into early 2021, and rates for Medicaid enrollees were slower to rebound after COVID-19 outbreaks than commercial, Medicare Advantage, and Medicare FFS enrollees.[7-4] Despite the nationwide decline in healthcare utilization, six of the MY 2020 to MY 2021 rate declines were by less than 3 percent.

Among children in foster care, 17 study indicators demonstrated disparities across age categories. These disparities were typically seen among the controls as well, and sometimes reflect the relevance of certain services to specific age categories. For example, behavioral health conditions are more likely to be diagnosed later in life, so rates for the *Behavioral Health Encounters* indicators are expected to be higher among older children. However, for other measures, such as *Child and Adolescent Well-Care Visits*, older children were less likely to have a well-care visit despite Virginia state guidelines that

[7-3] Choi SE, Simon L, Basu S, Barrow JR. *Changes in dental care use patterns due to COVID-19 among insured patients in the United States*. Journal of the American Dental Association. 2021. Available at: https://jada.ada.org/article/S0002-8177(21)00417-7/pdf. Accessed on: Jan 11, 2023.

[7-4] Mafi JN, Craff M, Vangala S. *Trends in US Ambulatory Care Patterns During the COVID-19 Pandemic, 2019-2021.* Journal of the American Medical Association. 2022. Available at: https://jamanetwork.com/journals/jama/fullarticle/2788140. Accessed on: Jan 11, 2023.

children in foster care should have an annual well-child visit up to age 18.[7-5] Additionally, for the *Follow-Up for Hospitalization After Mental Illness—7-Day Follow-Up* indicator, the rate for children in foster care 14 years of age or older was lower than the rate for controls as well as all other age categories. Six study indicators demonstrated disparities between males and females. Female members were more likely to have an annual dental visit, ED visit, inpatient visit, and behavioral health encounter with RTC services, while male members were more likely to have a behavioral health encounter with ARTS or therapeutic services. Only two study indicators demonstrated disparities between racial groups. Black or African American members were more likely to have a behavioral health encounter with ARTS compared to other racial groups, while White members were less likely, and members in the Other racial group were less likely to have a behavioral health encounter with therapeutic services. These disparities were not seen among controls. There were also some disparities identified across regions and MCOs; however, no region or MCO performed consistently better or worse across study indicators.

Based on the findings detailed in this report, HSAG offers the following recommendations related to children in foster care:

- The SFY 2020–2021 study recommended monitoring the *Initiation and Engagement of AOD Abuse or Dependence Treatment* study indicators, since rates for children in foster care were notably lower than the rates for controls during MY 2020. The SFY 2021–2022 study found that rates improved for both measures, such that MY 2021 rates for children in foster care were higher than controls for engagement in AOD treatment, and the gap between children in foster care and controls halved for initiation of AOD treatment. However, rates for both study indicators are still below the MY 2021 national Medicaid 50th percentiles, so DMAS may consider focusing quality improvement efforts toward improving initiation and engagement in AOD abuse or dependence treatment for children in foster care.
- Among children in foster care, 13 study indicator rates decreased from MY 2020 to MY 2021, and eight study indicator rates decreased from MY 2019 to MY 2021. These rates may be impacted by the COVID-19 pandemic. DMAS may consider continuing to monitor these study indicators to ensure that these rates return to pre-pandemic levels.
- SFY 2021–2022 is the first year to introduce a health disparities analysis. The analysis identified few disparities of concern among children in foster care. However, DMAS may consider focusing quality improvement efforts to reduce health disparities toward improving the rate of well-care visits and follow-up visits after hospitalization for mental illness among older children in foster care and improving the rate of annual dental visits among male children in foster care.
- While the current study design provides insight into utilization of healthcare services, it does not assess the quality of care received. DMAS may consider having future studies focus on high-utilization medical conditions that especially impact children in foster care and whether these members are receiving appropriate care for these conditions. For example, a future focus study may assess whether members in this population with asthma are receiving and adhering to appropriate medications.

[7-5] Virginia Department of Social Services. Child and Family Services Manual: Identifying Services To Be Provided. 2021. Available at: https://www.dss.virginia.gov/files/division/dfs/fc/intro_page/guidance_manuals/fc/07_2021/section_12_identifying_services_to_be_provided.pdf. Accessed on: Jan 11, 2023.

Healthcare Utilization: Children Receiving Adoption Assistance

Children in the adoption assistance program are children who have been adopted from foster care but who faced additional barriers to adoption compared to other children in foster care, such as special medical conditions and extended time spent in foster care.[7-6] Whereas the State is primarily responsible for ensuring children in foster care receive appropriate healthcare services, the adoptive parents are primarily responsible for children in the adoption assistance program. Furthermore, adoptive parents are not required to ensure the adoption assistance child meets the same medical service requirements as children in foster care, such as a specific schedule of well-child visits.[7-7] The SFY 2021–2022 study was the second study to assess healthcare utilization for children receiving adoption assistance. This study demonstrated that children receiving adoption assistance have higher rates of appropriate healthcare utilization than comparable controls for 47 percent of study indicators in MY 2021 compared to 60 percent of study indicators in MY 2020. Study findings show that children receiving adoption assistance had higher rates than controls for all six Oral Health domain study indicators, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up, Follow-Up After ED Visit for Mental Illness—30-Day Follow*-Up, *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment*, *Asthma Medication Ratio, Inpatient Visits*, and four out of six *Behavioral Health Encounters* study indicators. Rate differences between children receiving adoption assistance and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2021, children receiving adoption assistance had lower rates compared to controls for the three Primary Care domain study indicators, most Behavioral Health domain study indicators, *Ambulatory Care Visits*, *ED Visits*, and *Overall Service Utilization*. The largest differences were for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* study indicator (by 15.3 percentage points) and the *Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up* study indicator (by 11.4 percentage points). However, for eight study indicators, the rates for children receiving adoption assistance were less than 3 percentage points lower than the controls. Additionally, the *ED Visits* rate for children receiving adoption assistance was 8.0 percentage points lower than controls, which may indicate that health conditions for children receiving adoption assistance are being better managed.

Among children receiving adoption assistance, four study indicator rates increased, while 12 study indicator rates decreased from MY 2020 to MY 2021. The largest declines from MY 2020 to MY 2021 were for the *Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment* study indicator (by 15.0 percentage points) and the *Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up* study indicator (by 8.9 percentage points). The *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* study indicator also declined by 33.0 percentage points; however, the denominator is very small, so rate changes across time are expected to be larger. Among controls for children receiving adoption assistance, nine study indicator rates increased, while nine study indicator rates decreased from MY 2020 to MY 2021. Some declines in rates may be attributable to the COVID-19 pandemic during MY 2020 and MY 2021. Despite

[7-6] Virginia Department of Social Services. Adoptive Assistance Screening Tool. Available at: https://dss.virginia.gov/files/division/dfs/ap/intro_page/forms/032-04-0091-06-eng.pdf. Accessed on: Jan 11, 2023.

[7-7] Virginia Department of Social Services. Child and Family Services Manual: Adoption Assistance. Available at: https://www.dss.virginia.gov/files/division/dfs/ap/intro_page/manuals/07-01-2019/section_2_adoption_assistance_-July_2019.pdf. Accessed on: Jan 11, 2023.

the nationwide decline in healthcare utilization, four of the rate declines among children in adoption assistance were by less than 3 percent.

Since children receiving adoption assistance is the largest group among the child welfare populations, and *p*-value calculations are influenced by sample size, statistical tests to identify health disparities were most sensitive for this population. Among children receiving adoption assistance, 14 study indicators demonstrated disparities across age categories. Like the findings for children in foster care, these disparities were typically seen among the controls as well, and sometimes reflect the relevance of certain services to specific age categories. However, for other measures, such as *Child and Adolescent Well-Care Visits* and *Annual Dental Visit*, older children receiving adoption assistance were less likely to have a well-care visit and annual dental visit compared to younger children. Seven study indicators demonstrated disparities between males and females. Female members were more likely to have an annual dental visit and follow-up visits after hospitalizations or ED visits for mental illness, while male members were more likely to have any behavioral health encounter and behavioral health encounters with CMH, therapeutic, or traditional services.

Nine study indicators demonstrated disparities between racial groups. Black or African American members were more likely to have a well-care visit, oral evaluation, topical fluoride treatment, inpatient visit, and any behavioral health encounter except ARTS compared to other racial groups, while White members were less likely to have a well-care visit, oral evaluation, and any behavioral health encounter except ARTS and CMH services. However, White members on antipsychotics were more likely to have metabolic monitoring. Additionally, children receiving adoption assistance in the Other racial group were less likely to have a behavioral health encounter with CMH or traditional services. Some of these disparities were seen among controls. There were also some disparities identified across regions and MCOs. For example, members in the Northern & Winchester region were less likely to have a well-care visit, any of the services in the Oral Health domain (e.g., annual dental visit, preventive dental services), ambulatory care visit, and behavioral health encounter compared to members in other regions, and members enrolled with Aetna and Molina were less likely to have a well-care visit, any of the services in the Oral Health domain, and an ambulatory care visit compared to members enrolled with other MCOs. Additionally, members enrolled with Aetna were less likely to have a behavioral health encounter.

Based on the findings detailed in this report, HSAG offers the following recommendations related to children receiving adoption assistance:

- The SFY 2021–2022 study found that children receiving adoption assistance had lower rates than controls for the three Primary Care domain study indicators and most Behavioral Health domain study indicators. DMAS may consider focusing quality improvement efforts toward improving utilization of primary care services and behavioral health services, where appropriate, for children receiving adoption assistance.
- SFY 2021–2022 is the second year to include analyses for children receiving adoption assistance. However, considering the impact of the COVID-19 pandemic on healthcare utilization during MY 2020 and MY 2021, the rates for children receiving adoption assistance in MY 2020 and MY 2021 may not be representative of their historical rates. Therefore, DMAS should consider monitoring this population's rates over time to verify appropriate baseline rates, identify areas for improvement, and monitor impacts of program changes.
- SFY 2021–2022 is the first year to introduce a health disparities analysis. The analysis identified disparities in healthcare utilization across age, sex, race, region, and MCO for children receiving adoption assistance. Rates tended to be lower for older, male, and White members, as well as

members in the Northern & Winchester region and members enrolled with Aetna and Molina. DMAS may consider focusing quality improvement efforts to reduce health disparities among children receiving adoption assistance toward these subpopulations.

- While the current study design provides insight into utilization of healthcare services, it does not assess the quality of care received. DMAS may consider having future studies focus on high-utilization medical conditions that especially impact children receiving adoption assistance and whether these members are receiving appropriate care for these conditions. For example, a future focus study may assess whether members in this population with asthma are receiving and adhering to appropriate medications.

Healthcare Utilization: Former Foster Care Members

For this study, former foster care members were defined as young adults 19 to 26 years of age who were in foster care and enrolled in Medicaid at the time of their 18th birthday. These members aged out of the foster care program without a permanent home and are eligible to continue receiving Medicaid benefits through age 26. While the State has primary responsibility for the healthcare of children in foster care, and adoptive parents have primary responsibility for the healthcare of children receiving adoption assistance, former foster care members are responsible for their own healthcare. Unlike children in foster care, former foster care members are not required by the State to meet a certain schedule of medical services. Furthermore, this population is more likely to experience barriers to healthcare, such as poverty and homelessness.[7-8] The SFY 2021–2022 study was the second study to assess healthcare utilization for former foster care members. This study demonstrated that former foster care members have higher rates of appropriate healthcare utilization than comparable controls for 64 percent of study indicators in MY 2021 compared to 45 percent of study indicators in MY 2020. Study findings show that former foster care members had higher rates than controls for *Child and Adolescent Well-Care Visits*, all Oral Health domain study indicators, *Follow-Up After ED Visit for Mental Illness—30-Day Follow*-Up, *Asthma Medication Ratio, ED Visits, Inpatient Visits*, and all *Behavioral Health Encounters* study indicators. Rate differences between former foster care members and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2021, former foster care members had lower rates compared to controls for the *Antidepressant Medication Management* study indicators, the *Initiation and Engagement of AOD Abuse or Dependence Treatment* study indicators, *Ambulatory Care Visits*, and *Overall Service Utilization*. The largest differences were for the *Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment* study indicator (by 11.9 percentage points), the *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* study indicator (by 9.3 percentage points), and the *Antidepressant Medication Management—Effective Acute Phase Treatment* study indicator (by 8.8 percentage points).

Among former foster care members, all study indicator rates except *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* increased from MY 2020 to MY 2021. However, the *Follow-*

[7-8] Virginia Department of Social Services. Child and Family Services Manual: Achieving Permanency for Older Youth: Working with Youth 14-17. Available at: https://www.dss.virginia.gov/files/division/dfs/fc/intro_page/guidance_manuals/fc/07_2021/Section_13_achieving_permanency_for_older_youth.pdf. Accessed on: Jan 11, 2023.

Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up study indicator only declined by 0.9 percentage points. Among controls for former foster care members, all study indicator rates except two (i.e., *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up*) also increased from MY 2020 to MY 2021.

Among former foster care members, only the *Overall Service Utilization* study indicator demonstrated disparities across age categories, whereby members 23 to 26 years of age were less likely to have an ambulatory care visit, ED visit, inpatient visit, or behavioral health encounter compared to members 19 to 22 years of age. This disparity was not seen among controls. Seven study indicators demonstrated disparities between males and females. Female members were more likely to have a well-care visit, annual dental visit, ambulatory care visit, ED visit, inpatient visit, any behavioral health encounter, and behavioral health encounters with traditional services.

Seven study indicators demonstrated disparities between racial groups. Black or African American former foster care members were more likely to have an oral evaluation or behavioral health encounter with therapeutic services and less likely to initiate AOD treatment or have an ambulatory care visit compared to members in other racial groups, while White former foster care members were less likely to receive an oral evaluation, topical fluoride treatment, or behavioral health encounter with therapeutic services. Additionally, among members with a diagnosis of major depression who were treated with antidepressant medication, Black or African American members were less likely to remain on an antidepressant medication treatment for at least 12 weeks, while White members were more likely. This finding was not seen among controls. For region and MCO, the only notable finding was that former foster care members in the Tidewater region were less likely to have an annual dental visit, preventive dental services, and oral evaluation compared to members in other regions.

Based on the findings detailed in this report, HSAG offers the following recommendations related to former foster care members:

- The SFY 2021–2022 study found that former foster care members had lower rates than controls for the *Antidepressant Medication Management* study indicators and the *Initiation and Engagement of AOD Abuse or Dependence Treatment* study indicators. DMAS may consider focusing quality improvement efforts toward improving utilization of these services, where appropriate, for former foster care members.
- SFY 2021–2022 is the second year to include analyses for former foster care members. However, considering the impact of the COVID-19 pandemic on healthcare utilization during MY 2020 and MY 2021, former foster care members' rates during MY 2020 and MY 2021 may not be representative of their historical rates. Therefore, DMAS should consider monitoring former foster care members' rates over time to verify appropriate baseline rates, identify areas for improvement, and monitor impacts of program changes.
- SFY 2021–2022 is the first year to introduce a health disparities analysis. The analysis identified disparities in healthcare utilization across age, sex, race, and region among former foster care members. Rates tended to be lower for older, male members, as well as members in the Tidewater region. Racial groups with lower rates differed by study indicator. DMAS may consider focusing quality improvement efforts to reduce health disparities among former foster care members toward these subpopulations.

Timely Access to Care

SFY 2021–2022 is the first year to introduce analyses for timely access to care. Virginia state guidelines require that children in foster care receive a medical examination no later than 30 days after initial placement in foster care.[7-9] Additionally, DMAS' Medallion 4.0 Managed Care Contract encourages MCOs to assist in ensuring that children in foster care receive both a PCP and a dental visit within 30 days of plan enrollment, unless the child's social worker attests that the child has seen a provider within 90 days prior to enrollment.[7-10] DMAS is also working with the Virginia Department of Social Services and the MCOs to meet a goal of statewide improvement in timely initial medical exams. The SFY 2021–2022 study found that 86.2 percent of new foster care members had a visit with a PCP within 30 days after or 90 days prior to entering foster care. Therefore, most children in foster care are receiving timely access to primary care; however, there may be some room for improvement in meeting state guidelines. Additionally, 44.0 percent of new foster care members had a visit with a dental provider within 30 days after or 90 days prior to entering foster care, and most of these children also had a visit with a PCP. Study indicators also assessed timely access to care for members who aged out of foster care. Findings demonstrate that 69.8 percent of members who aged out of foster care in the year prior to the measurement year had a visit with a PCP during the measurement year. Similar to new foster care members, 34.6 percent of members who aged out of foster care had a visit with a dental practitioner during the measurement year, and most of these members also had a visit with a PCP. Additionally, most members who aged out of foster care had a behavioral health diagnosis, and 39.4 percent of these members with a behavioral health diagnosis had a visit with an MHP during the measurement year.

Like the healthcare utilization analysis, HSAG conducted a health disparities analysis for the timely access to care study indicators. Among new foster care members, older children were less likely to have a visit with a PCP and more likely to have a visit with a dental practitioner. Female members who aged out of foster care were more likely to have a visit with a PCP than male members, and for both new foster care members and members who aged out of foster care, female members were more likely to have a visit with a dental practitioner. There were no disparities identified between racial groups, and there were few disparities identified by region and MCO. Of note, members enrolled with VA Premier who aged out of foster care were more likely to have a visit with a dental practitioner and an MHP compared to members enrolled with other MCOs.

Based on the findings detailed in this report, HSAG offers the following recommendations related to timely access to care:

- The study indicator findings identified some opportunities for improvement in timely access to healthcare services for both new foster care members and members who aged out of foster care. For new foster care members, DMAS should continue to monitor the MCOs' monthly reporting on foster care members which includes foster care eligibility dates, date of the member's health risk assessment, whether a care coordinator is assigned, whether a care coordination plan is in place, and the member's service utilization. DMAS should then continue to share the trends, performance, and service utilization identified from the monthly reporting with each MCO in order for MCOs to

[7-9] Virginia Department of Social Services. Child and Family Services Manual: Identifying Services to Be Provided. Available at: Child and Family Services Manual.pdf. Accessed on: Jan 11, 2023.

[7-10] Commonwealth of Virginia DMAS. Medallion 4.0 Managed Care Services Agreement: Member Eligibility, Enrollment, and General Responsibilities. Available at: https://www.dmas.virginia.gov/media/3583/medallion-4-contract-sfy22-v1.pdf. Accessed on: Jan 11, 2023.

explain trends or inconsistencies in the data either on a case-by-case basis or by the Compliance Review Committee at the monthly compliance meeting with MCO leadership. DMAS may also consider monitoring who is involved in the development of the care coordination plan (e.g., foster parents) and include that information in the trends shared with the MCOs. For members who age out of foster care, DMAS may consider working with VDSS to incorporate education about navigating the healthcare system and a recommended schedule for healthcare services (i.e., PCP visits, dental practitioner visits, and MHP visits, as applicable) into the transition plan for youth 14 years of age and older.[7-11]

- While most new foster care members and members who aged out of foster care had a timely visit with a PCP, most members did not have a timely visit with a dental practitioner. DMAS may consider leveraging the strategies that have improved the timeliness of PCP visit rates to improve the timeliness of dental practitioner visit rates.
- The health disparities analysis identified disparities in timely access to care across age, sex, region, and MCO. For example, rates tended to be lower for male members, and among new foster care members, older children were less likely to have a visit with a PCP and more likely to have a visit with a dental practitioner. DMAS may consider focusing quality improvement efforts to reduce health disparities in timely access to care toward these subpopulations.
- SFY 2021–2022 is the first year to introduce analyses for timely access to care, and MY 2021 results may be impacted by the COVID-19 pandemic. DMAS may consider continuing to monitor timely access to care to verify appropriate baseline rates and monitor impacts of quality improvement efforts.

DMAS' Input on Prior Focus Study Recommendations

In addition to the recommendations noted above, DMAS provided the following detailed feedback regarding quality improvement actions or initiatives related to the 2020–2021 Foster Care Focus Study.

Data Recommendations

For the first time during the 2020–21 Foster Care Focus Study, two additional populations (former foster care members and children receiving adoption assistance) were included in addition to children in foster care. These data have availed DMAS the opportunity to compare various outcomes for each individual child welfare population (i.e., foster care, adoption assistance, and former foster care) separately, including those related to behavioral health services, a focus of this study and key program area for DMAS. DMAS has requested that the 2021–2022 study, as well as all future studies, continue to include data from these additional member populations to establish an accurate baseline rate.

DMAS will continue to analyze data and utilize recommendations posed by HSAG to improve access to healthcare services for these newly included groups in order to determine areas of focus and improvement.

[7-11] Virginia Department of Social Services. Child and Family Services Manual: Fostering Futures. Available at: Child and Family Services Manual.pdf. Accessed on: Jan 11, 2023.

Safe and Sound Task Force

Under the leadership of Virginia's Governor Glenn Youngkin and Secretary of Health and Human Resources John Littel, the Safe and Sound Task Force was created. The objective of the task force is to define the problems related to children sleeping in VDSS offices, hotels, or emergency rooms so that DMAS can develop solutions and begin the process of safely and immediately ending this practice.

The Safe and Sound Task Force objectives also include finding safe placements for youth in foster care who are currently displaced or at risk of placement disruption and in Local Department of Social Services (LDSS) custody. This consists of identifying a reservoir of placements for youth who may need them in the future and eventually moving upstream, as well as making and acting on recommendations to address underlying reasons why youth are displaced—addressing the foundational aspects of youth entering foster care.

As part of the broader goals of the Safe and Sound Task Force, the core team implemented a Rapid Response process at the State level to temporarily provide urgent support to youth in foster care who do not have an identified place to safely reside. The Rapid Response is designed to bring together the LDSS, health plans, care team members, providers, and others to identify the placement and care needs of the youth, family support, and youth's ideas/input for placement and to identify a placement for that youth. The local Rapid Response PST will develop and/or align with an existing process/team so that Rapid Response meetings can occur in local communities where the youth is known best.

When the task force began its work, the 2021 baseline was 324 children (an average of 27 per month). The current number is an average of three per month, a 90 percent decrease in 90 days. As of July 1, 2022, this in no longer a widespread challenge in Virginia. The task force will continue under this administration to focus on increasing the provision of services to children, families, and those in the community who provide for their well-being.

Community Partnerships

In August 2022, DMAS completed its first full year of hosting the Foster Care Partnership meetings with stakeholders from across the State. These stakeholders included those from the VDSS, the Virginia Commission on Youth, LDSS, LCPAs, DMAS MCOs, and the Virginia Office of Children's Services, among others.

Two sub-groups from the partnership also met throughout the year to focus on actionable goals related to improving services for youth in foster care. These action groups are focused on transition planning and increasing utilization of services for the foster care member population. Both action groups were created based on cross-sector and collaborative discussions around current needs of youth in foster care. Additionally, the focus areas of the action groups were chosen based on the results and recommendations of the 2020–2021 Foster Care Focus Study. For the first year of the partnership, the goals established were to share services, roles, and resources available among participating agencies working with youth in foster care. Between the large group, Foster Care Partnership meetings, and each action group, eight peer education sessions were provided. Information shared with the group included:

- MCO case management by United Healthcare
- Virginia's Fostering Futures and Independent Living services by VDSS

- Other independent living programs and transition services by Fostering Acadia (Independent Living/Licensed Child Placing Agency)
- TFC services by Embrace (Licensed Child Placing Agency)
- Children's Services Act and FAPT functions by the Office of Children's Services
- LDSS intake processes by Roanoke and Bedford DSS
- Medicaid behavioral health services/FFS administration by Magellan of Virginia
- Successful transition of older youth in foster care by non-profit agency ProjectLIFE

Another joint goal of both action groups this year was to develop a universal MCO resource document to distribute to local DSS staff and foster families. The purpose of the document was to be an engaging way to provide information about Medicaid managed care for youth in foster care in Virginia. This document has been collaboratively developed and will be finalized and distributed by the end of 2022.

It is the goal of DMAS and the Foster Care Partnership to improve service utilization and outcomes for children in foster care, children receiving adoption assistance, and former foster care members through these groups and the larger Partnership.

DMAS plans to continue facilitating the Foster Care Partnership and related sub-groups through 2023, with a continued focus on interagency collaboration for improved outcomes and service utilization for youth in foster care, adoption assistance, and former foster care individuals in Virginia. DMAS and the MCOs will specifically be collaborating with LDSS agencies and local CSA Coordinators in the upcoming year. DMAS will be providing statewide trainings and presentations around Medicaid and managed care case management services for these member populations, and will be working with these agencies to enhance intersecting processes and improve service coordination.

Foster Care Affinity Group

During CY 2022, Virginia continued to host the CMS and Children's Bureau's Improving Timely Health Care for Children and Youth in Foster Care Affinity Group to support states in implementing quality improvement (QI) activities to improve timely healthcare services to meet the needs of children in foster care. The Virginia Affinity Group's aim statement is to increase the rate of children entering foster care who receive an initial medical examination within 30 days, according to Virginia State guidelines. The Affinity Group is co-led by DMAS and VDSS, and members also include representation from three MCOs, as well as support and testing teams from LDSS. The Affinity Group meets several times monthly to develop and implement small tests of change, track initial medical examination data for new foster care members, and analyze the success of each test for improving the timeliness of medical utilization upon entering foster care. The project is expected to conclude in December 2023, with the goal of a statewide improvement in timely initial medical exams.

The Virginia team has spent the last year gathering and analyzing data to establish a baseline rate for a sample population; creating a detailed, cross-agency process flow document; and determining the initial areas of focus and test(s) of change to explore. The initial area of focus identified by the team after reviewing the process flow was timely transfer of information about new foster care members from the LDSS agency to the MCOs. The hypothesis for the first improvement test was that notifying the health plans of new foster care members earlier would allow them to begin care coordination efforts sooner, thus improving the timeliness of initial medical care. One MCO began utilizing weekly enrollment reports from DMAS to identify new foster care members earlier than the end-of-month enrollment

reports that are currently used by all MCOs. Testing the use of the weekly enrollment report did lead to the identification of new foster care members sooner, and initial data also demonstrated an improvement in the timeliness of initial outreach by the MCO to the new members. However, thus far, the data from this initial test has not yet demonstrated an improvement in the rate of medical examinations within 30 days for those members. The Affinity Group will continue to meet several times per month for the remainder of 2022 and into 2023. The current area of focus is on the intake process at the LDSS level, and the Virginia team is working with several local offices that have volunteered to assist in the process flow development as well as some tests of change. The next tests will be related to timely outreach and scheduling of appointments on the DSS end. The Virginia team will continue to carry out and measure small tests of change in order to identify successful interventions to implement on a wider scale by the end of the project.

Member Outreach

As mentioned previously, in 2022, a flyer was created as an output of the Service Utilization and Transition Planning Action Groups of the Foster Care Partnership that outlined Medicaid and managed care services for youth in foster care and transitioning out. The flyer was created to be distributed, both electronically and physically, to LDSS offices and community partners who work with youth in foster care, foster parents, and former foster care members. The flyer includes information regarding Medicaid coverage for youth, managed care case management services, and information regarding transition to independent living services, including the VDSS Fostering Futures Program. It also includes contact information and information about accessing services.

DMAS' Maternal and Child Health team has participated in several panels and/or provided educational information and training regarding the DMAS Foster Care and Adoption Assistance program, services and benefits available, and managed care case management. These outreach and education opportunities have included a presentation to the Virginia Commission on Youth, a Health Training Day for foster care youth and young adults transitioning into independent living settings, and the Central Region Independent Living Advocates for Youth, among other things. DMAS will continue making education, awareness, and training an area of focus for this member population and stakeholders who work with them around the State. Continued collaboration and understanding of DMAS' role will improve services and utilization for youth in foster care, adoption assistance members, and former foster care members.

DMAS continues to maintain managed care contract requirements that all MCOs have foster care liaisons with competencies in child welfare to support members in foster care and address foster care-specific inquiries from stakeholders such as LDSS and LCPAs. DMAS also has a dedicated foster care email box to streamline and address inquiries related to foster care and adoption assistance services.

Foster Care and Adoption Assistance Annual Report

In CY 2022, DMAS compiled a 2020–2021 Foster Care and Adoption Assistance Annual Report. This report reviewed program initiatives and updates regarding the DMAS foster care and adoption assistance programs. Included in the report are demographic data provided by HSAG, along with a brief presentation of outcome data provided by HSAG during SFY 2020–2021. The report provided other highlights, accomplishments, and overall DMAS outcomes related to the foster care and adoption assistance member populations, as well as ongoing initiatives such as the Foster Care Partnership, Foster Care Affinity Group, and continued stakeholder engagement.

Medallion 4.0 Program Oversight Efforts

DMAS will soon operate under one unified health program called Cardinal Care. Cardinal Care is a single brand encompassing all health coverage programs for Virginia's 2 million Medicaid members, expected to go live in early 2023. Cardinal Care will include Medallion 4.0, CCC Plus, FAMIS, and FFS members, and will offer the following:

- Improved overall member experience with Medicaid
- A single system of care for all members
- Reduced transitions between programs or gaps in care as member needs change
- A streamlined enrollment process
- An enhanced model of care to determine intensity and frequency of care coordination for members based on their needs, with youth in foster care and transitioning out of foster care included in high-priority populations. Children in foster care or receiving adoption assistance and former foster care members will be assigned to high intensity care management for the first three months following enrollment into Medicaid or entry into the child welfare system. Children aging out of foster care will also be assigned to high intensity case management for three months prior to when they age out, and three months after aging out. Outside of these mandatory high-intensity periods, children in foster care, children receiving adoption assistance, or former foster care members will remain a "priority population," thereby receiving low, moderate, or high intensity care management at the MCO's discretion.

Providers will also experience the benefits of a consolidated program, such as an easier contracting and credentialing process during provider enrollment and renewal.

Partnership for Petersburg (P4P)

On August 26, 2022, Governor Glenn Youngkin announced the new Partnership for Petersburg initiative, which includes six focus areas: Prepare Petersburg Students for Life, Improve Access to Health Care, Keep Our Community Safe, Keep Petersburg Moving, Foster Business & Economic Growth, and Build Relationships with Community and Faith Leaders. The Commonwealth of Virginia and community partners will work together to improve the health of Petersburg residents by expanding access to screenings, promoting awareness of primary care and prenatal care, and addressing health disparities by connecting Petersburg residents with medical and social services.

Appendix A: Study Indicators

For reference, Appendix A provides the technical specifications set, description, denominator, and numerator(s) for each of the 44 study indicators calculated for this report. For further detail on how numerators and denominators were calculated, please refer to the technical specifications referenced.

Primary Care

Well-Child Visits in the First 30 Months of Life (W30)

- *Specifications Set*: FFY 2022 Child Core Set technical specifications, with study-specific continuous enrollment modifications
- *Description:* The percentage of children who turned 15 months of age who had six or more well-child visits with a PCP and the percentage of children who turned 30 months of age who had two or more well-child visits with a PCP
- *Denominator:* Members in the study population split into two groups—children who turn 15 months of age during the measurement year and children who turn 30 months of age during the measurement year
- *Numerator:*
  - *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits:* For children who turn 15 months of age during the measurement year, six or more well-child visits (Well-Care Value Set) with a PCP on different dates of service on or before the child's 15-month birthday
  - *Well-Child Visits in the First 30 Months—Two or More Well-Child Visits:* For children who turn age 30 months during the measurement year, two or more well-child visits (Well-Care Value Set) with a PCP on different dates of service between the day after the child's 15-month birthday and their 30-month birthday

Child and Adolescent Well-Care Visits (WCV)

- *Specifications Set*: FFY 2022 Child Core Set technical specifications, with study-specific continuous enrollment modifications
- *Description:* The percentage of members who had at least one comprehensive well-care visit with a PCP or OB/GYN
- *Denominator:* Members in the study population split into three groups: members 3–11 years, members 12–17 years, and members 18–21 years as of the end of the measurement year
- *Numerator:* One or more well-care visits (Well-Care Value Set) during the measurement year with a PCP or an OB/GYN

Oral Health

Annual Dental Visit (ADV)

- *Specifications Set:* National Quality Forum (NQF) #1388 technical specifications, with study-specific continuous enrollment modifications
- *Description:* The percentage of members who had at least one dental visit during the measurement year
- *Denominator:* Members in the study population who are at least 2 years old as of the end of the measurement year
- *Numerator:* One or more visits with a dental practitioner during the measurement year

Preventive Dental Services (PDENT-CH)

- *Specifications Set:* FFY 2021 Child Core Set technical specifications, with study-specific continuous enrollment modifications
- *Description:* Percentage of members who received at least one preventive dental service during the measurement year
- *Denominator:* Members in the study population who are 1–20 years old as of the end of the measurement year and who are eligible for EPSDT services
- *Numerator:* One or more instances of preventive dental service by or under the supervision of a dentist

Oral Evaluation, Dental Services (OEV-CH)

- *Specifications Set:* FFY 2022 Child Core Set technical specifications, with study-specific continuous enrollment modifications
- *Description*: Percentage of members who received a comprehensive or periodic oral evaluation within the measurement year
- *Denominator*: Members in the study population who are under the age of 21 as of the end of the measurement year
- *Numerator*: One or more oral evaluations received as a dental service during the measurement year

Topical Fluoride for Children—Dental or Oral Health Services (TFL-CH)

- *Specifications Set:* FFY 2022 Child Core Set technical specifications, with study-specific continuous enrollment modifications, with study-specific modifications to use provider type and specialty codes to identify visits to dental practitioners

- *Description*: Percentage of members who received at least two topical fluoride applications as dental or oral services
- *Denominator*: Members in the study population who are under the age of 21 as of the end of the measurement year
- *Numerator*:
  - *Dental or Oral Health Services*: Two or more topical fluoride applications as dental or oral services during the measurement year
  - *Dental Services*: Two or more topical fluoride applications as dental services during the measurement year
  - *Oral Health Services*: Two or more topical fluoride applications as oral services during the measurement year

Behavioral Health

Antidepressant Medication Management (AMM)

- *Specifications Set:* FFY 2022 Adult Core Set technical specifications, with study-specific continuous enrollment modifications
- *Description*: Percentage of members who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported:
  - *Effective Acute Phase Treatment*: Percentage of members who remained on an antidepressant medication for at least 84 days
  - *Effective Continuation Phase Treatment*: Percentage of members who remained on an antidepressant medication for at least 180 days
- *Denominator*: Members in the study population who are 18 years or older as of the end of the measurement year, received a prescription for an antidepressant, and had a diagnosis of major depression
- *Numerator*: Two numerators are calculated:
  - *Effective Acute Phase Treatment*: At least 84 days of treatment with antidepressant medication starting on the index prescription start date
  - *Effective Continuation Phase Treatment*: At least 180 days of treatment with antidepressant medication starting on the index prescription start date

Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up (FUH)

- *Specifications Set:* FFY 2022 Adult and Child Core Set technical specifications, with study-specific continuous enrollment modifications
- *Description:* Percentage of discharges for members who were hospitalized for treatment of selected mental illness or intentional self-harm diagnosis and who had a follow-up visit with a mental health provider

- *Denominator:* Discharges of the members in the study population who are at least 6 years old as of the date of the discharge with a hospitalization for treatment of selected mental illness or intentional self-harm diagnosis (Mental Illness Value Set, Intentional Self-Harm Dataset)
- *Numerator:* A follow-up visit with a mental health provider within seven days after discharge

Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up (FUM)

- *Specifications Set:* FFY 2022 Adult and Child Core Set technical specifications, with study-specific continuous enrollment modifications
- *Description:* Percentage of ED visits for members with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness within 30 days
- *Denominator:* ED visits (ED Value Set) of the members in the study population who are at least 6 years old as of the date of the ED visit with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set, Intentional Self Harm Dataset)
- *Numerator:* A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm (Mental Illness Value Set, Intentional Self Harm Dataset) and any diagnosis of a mental health disorder within 30 days of the ED visit

Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing (APM)

- *Specifications Set:* FFY 2022 Child Core Set technical specifications, with study-specific continuous enrollment modifications
- *Description:* Percentage of members who had two or more antipsychotic prescriptions and had metabolic testing
- *Denominator:* Members in the study population who are 1–17 years old by the end of the measurement year and who have two or more antipsychotic prescriptions (Antipsychotic Medications List, Antipsychotic Combination Medications List, Prochlorperazine Medications List) on different dates of service during the measurement year
- *Numerator:* At least one test for blood glucose (Glucose Lab Test Value Set, Glucose Test Result or Finding Value Set) or hemoglobin A1c (HbA1c) (HbA1c Lab Test Value Set, HbA1c Test Result or Finding Value Set) during the measurement year AND at least one test for low-density lipoprotein cholesterol (LDL-C) (LDL-C Lab Test Value Set, LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set, Cholesterol Test Result or Finding Value Set)

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

- *Specifications Set:* FFY 2022 Child Core Set technical specifications, with study-specific continuous enrollment modifications and a four-month look-back period from the earliest prescription dispensing data for eligible children

- *Description:* Percentage of members who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment
- *Denominator:* Members in the study population who were 1–17 years old by the end of the measurement year and who have a new prescription for an antipsychotic medication (Antipsychotic Medications List, Antipsychotic Combination Medications List) during the intake period
- *Numerator:* Documentation of psychosocial care (Psychosocial Care Value Set) during the look-back period

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

- *Specifications Set:* FFY 2022 Child Core Set technical specifications, with study-specific continuous enrollment modifications and modifications to the follow-up windows
- *Description:* Percentage of members newly prescribed ADHD medication who had at least three follow-up visits within a 10-month period, one of which was within one, two, three, six, or nine months of when the first ADHD medication was dispensed
- *Denominator:* Members in the study population who have a prescription for ADHD medication (ADHD Medications List) and who are ages 6 to 12 years old as of the earliest prescription dispensing date
- Numerator:
  - *One-Month Follow-Up*: A follow-up visit with a practitioner with prescribing authority, within one month after the earliest prescription dispensing date
  - *Two-Month Follow-Up*: A follow-up visit with a practitioner with prescribing authority, within two months after the earliest prescription dispensing date
  - *Three-Month Follow-Up*: A follow-up visit with a practitioner with prescribing authority, within three months after the earliest prescription dispensing date
  - *Six-Month Follow-Up*: A follow-up visit with a practitioner with prescribing authority, within six months after the earliest prescription dispensing date
  - *Nine-Month Follow-Up*: A follow-up visit with a practitioner with prescribing authority, within nine months after the earliest prescription dispensing date

Substance Use

Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up (FUA)

- *Specifications Set:* FFY 2022 Adult and Child Core Set technical specifications, with study-specific continuous enrollment modifications
- *Description:* Percentage of ED visits for members with a principal diagnosis of AOD use or dependence who had a follow-up visit for AOD use or dependence within 30 days of the ED visit

- *Denominator:* ED visits of the members in the study population who are at least 13 years of age or older as of the date of the ED visit with an ED visit (ED Value Set) with a principal diagnosis of AOD use or dependence (AOD Abuse and Dependence Value Set)
- *Numerator:* A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit, including visits that occur on the date of the ED visit

Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)

- *Specifications Set:* FFY 2022 Adult Core Set technical specifications, with study-specific continuous enrollment modifications and a two-month look-back period from the earliest eligible encounter with a diagnosis of AOD use or dependence for all eligible children
- *Description:* Percentage of members with a new episode of AOD use or dependence who initiated AOD treatment and who were engaged in AOD treatment
- *Denominator:* Members in the study population who are at least 13 years old as of the end of the measurement year with a new episode of AOD use or dependence during the measurement year (AOD Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set)
- *Numerator:*
  - *Initiation of AOD Treatment:* An initiation visit, defined as an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of diagnosis
  - *Engagement of AOD Treatment:* An initiation visit AND two or more additional AOD services or medication treatment within 34 days of the initiation visit

Respiratory Health

Asthma Medication Ratio (AMR)

- *Specifications Set:* FFY 2022 Adult and Child Core Set technical specifications, with study-specific continuous enrollment modifications and a one-year look-back period for all eligible children
- *Description:* Percentage of members who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year
- *Denominator:* Members in the study population who are at least 5 years old as of the end of the measurement year and are identified as having persistent asthma
- *Numerator:* Medication ratio of controller medications (Asthma Controller Medications List) to total asthma medications (Asthma Controller Medications List and Asthma Reliever Medications List) of 0.50 or greater during the measurement year

Service Utilization

Ambulatory Care Visits

- *Specifications Set:* None. Defined by DMAS.
- *Description:* Defined by DMAS as the percentage of members who had an ambulatory care visit among the total number of members
- *Denominator:* All members in the population of interest
- *Numerator:* Members in the denominator with an ambulatory care visit during the measurement year. Ambulatory care visits are defined as claims/encounters with a code in the FFY 2022 Adult and Child Core Set Ambulatory Outpatient Visits Value Set, Telephone Visits Value Set, or Online Assessments Value Set.

ED Visits

- *Specifications Set:* None. Defined by DMAS.
- *Description:* Defined by DMAS as the percentage of members who had an ED visit among the total number of members
- *Denominator:* All members in the population of interest
- *Numerator:* Members in the denominator with an ED visit during the measurement year. ED visits are defined as claims/encounters with a code in the FFY 2022 Adult and Child Core Set ED Value Set or with codes in both the ED Procedure Code Value Set and the ED POS Value Set. Do not include ED visits which result in an inpatient stay (Inpatient Stay Value Set). An ED visit results in an IP stay if the IP stay begins during or the day after the ED visit.

Inpatient Visits

- *Specifications Set:* None. Defined by DMAS
- *Description:* Defined by DMAS as the percentage of members who had an inpatient visit among the total number of members
- *Denominator:* All members in the population of interest
- *Numerator:* Members in the denominator with an acute or nonacute inpatient visit during the measurement year. An inpatient visit is defined using the FFY 2022 Adult and Child Core Set Inpatient Stay Value Set.

Behavioral Health Encounters

- *Specifications Set:* None. Defined by DMAS
- *Description:* Defined by DMAS as the percentage of members who had a behavioral health encounter among the total number of members, stratified by CMH, RTC, therapeutic, ARTS, and traditional services
- *Denominator:* All members in the population of interest
- *Numerator:*
  - *ARTS:* Members in the denominator with an ARTS visit during the measurement year. An ARTS visit is defined using the ARTS code set developed by DMAS and HSAG. Additionally, some visits require a primary behavioral health diagnosis and/or primary substance use disorder diagnosis on the claim/encounter, as indicated in the code sets.
  - *CMH Services:* Members in the denominator with a CMH services visit during the measurement year. A CMH services visit is defined using the CMH code set developed by DMAS and HSAG. Additionally, some visits require a primary behavioral health diagnosis on the claim/encounter, as indicated in the code sets.
  - *RTC Services*: Members in the denominator with an RTC services visit during the measurement year. An RTC services visit is defined using the RTC code set[A-1] developed by DMAS and HSAG. Additionally, some visits require a primary behavioral health diagnosis on the claim/encounter, as indicated in the code sets.
  - *Therapeutic Services:* Members in the denominator with a therapeutic services visit during the measurement year. A therapeutic services visit is defined using the therapeutic services code set developed by DMAS and HSAG. Additionally, some visits require a primary behavioral health diagnosis on the claim/encounter, as indicated in the code sets.
  - *Traditional Services:* Members in the denominator with a behavioral health services visit that is not CMH, RTC, or therapeutic during the measurement year. A traditional services visit is defined using the traditional services code sets developed by DMAS and HSAG. Additionally, some visits require a primary behavioral health diagnosis on the claim/encounter, as indicated in the code sets.
  - *Total*: Members in the denominator with any behavioral health encounter during the measurement year. A behavioral health encounter is defined using the behavioral health code sets (i.e., CMH, RTC, therapeutic, ARTS, and traditional) developed by DMAS and HSAG. Additionally, some visits require a primary behavioral health diagnosis on the claim/encounter, as indicated in the code sets.

[A-1] Please note, acute inpatient psychiatric hospital stays, identified by revenue code 0204, are included as RTC services.

Overall Service Utilization

- *Specifications Set:* None. Defined by DMAS
- *Description:* Defined by DMAS as the percentage of members who had an ambulatory care visit, ED visit, inpatient visit, or behavioral health encounter during the measurement year
- *Denominator:* All members in the population of interest
- *Numerator:* Members in the denominator with an ambulatory care visit, ED visit, inpatient visit, or behavioral health encounter during the measurement year. The four visit types are defined in the *Ambulatory Care Visits, ED Visits, Inpatient Visits,* and *Behavioral Health Encounters* study indicator descriptions above.

Timely Access to Care

Timely Access to Care for New Foster Care Members

- *Specifications Set:* None. Defined by HSAG and DMAS. Full specifications are available in the *2021–22 Task I2 Child Welfare Focus Study Methodology* document.
- *Description:* Percentage of members who were newly enrolled in the foster care program who received timely access to care.
- *Denominator:* Members in the study population who were under 18 years of age as of January 1 of the measurement year and who were newly enrolled in the foster care program between January 1 of the measurement year and December 1 of the measurement year. Members must be continuously enrolled in a single Medicaid managed care program (i.e., Medallion 4.0 or CCC Plus) with aid category "76" with any MCO or combination of MCOs for the 31-day period that includes the first foster care program enrollment date through 30 days after the first foster care program enrollment date.
- *Numerator:*
  - *Timely Access to Primary Care for New Foster Care Members*: Members in the denominator who had at least one visit with a PCP during the 121-day period that includes the 90 days prior to the first foster care program enrollment date through 30 days after the first foster care program enrollment date.
  - *Timely Access to Dental Care for New Foster Care Members*: Members in the denominator who had at least one visit with a dental provider during the 121-day period that includes the 90 days prior to the first foster care program enrollment date through 30 days after the first foster care program enrollment date.
  - *Timely Access to Primary Care or Dental Care for New Foster Care Members*: Members in the denominator who had at least one visit with a PCP or dental provider during the 121-day period that includes the 90 days prior to the first foster care program enrollment date through 30 days after the first foster care program enrollment date.
  - *Timely Access to Primary Care and Dental Care for New Foster Care Members*: Members in the denominator who had at least one visit with a PCP and at least one visit with a dental provider during the 121-day period that includes the 90 days prior to first foster care program enrollment date through 30 days after the first foster care program enrollment date.

Timely Access to Care for Members Who Aged Out of Foster Care

- *Specifications Set:* None. Defined by HSAG and DMAS. Full specifications are available in the *2021–22 Task I2 Child Welfare Focus Study Methodology* document.
- *Description:* Percentage of members who aged out foster care who received timely access to care.
- *Denominator:* Members in the study population who were 19 years old as of January 1 of the measurement year and who were enrolled in Medicaid under aid category "76" (i.e., foster care) on their 18th birthday. Members must be continuously enrolled in a single Medicaid managed care program (i.e., Medallion 4.0 or CCC Plus) under aid category "70" (i.e., former foster care) with any MCO or combination of MCOs for the measurement year.
- *Numerator:*
  - *Timely Access to Primary Care for Members Who Aged Out of Foster Care*: Members in the denominator who had at least one visit with a PCP during the measurement year.
  - *Timely Access to Dental Care for Members Who Aged Out of Foster Care*: Members in the denominator who had at least one visit with a dental provider during the measurement year.
  - *Timely Access to Primary Care or Dental Care Who Aged Out of Foster Care*: Members in the denominator who had at least one visit with a PCP or dental provider during the measurement year.
  - *Timely Access to Primary Care and Dental Care Who Aged Out of Foster Care*: Members in the denominator who had at least one visit with a PCP and at least one visit with a dental provider during the measurement year.

Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care

- *Specifications Set:* None. Defined by HSAG and DMAS. Full specifications are available in the *2021-22 Task I2 Child Welfare Focus Study Methodology* document.
- *Description:* Percentage of members who aged out foster care who received timely access to behavioral healthcare.
- *Denominator:*
  - *Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care:* Members who were 19 years old as of January 1 of the measurement year and who were enrolled in Medicaid under aid category "76" (i.e., foster care) on their 18th birthday. Members must be continuously enrolled in a single Medicaid managed care program (i.e., Medallion 4.0 or CCC Plus) under aid category "70" (i.e., former foster care) with any MCO or combination of MCOs for the measurement year.
  - *Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care with a Behavioral Health Diagnosis*: Among the members identified in the denominator for the *Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care* measure, members with at least two visits on separate dates of service with a primary diagnosis of mental illness during the 24 months prior to the measurement year.
- *Numerator*: Members in the denominator who had at least one visit with an MHP during the measurement year.

Appendix B: Characteristics of the Controls

Appendix B lists the following reference information related to HSAG's approach to identifying matched controls for children in foster care, children receiving adoption assistance, and former foster care members for the healthcare utilization analysis:

- Demographic and health characteristics prior to matching
  - Continuously enrolled children in foster care compared to their continuously enrolled controls (Table B-1 and Table B-4)
  - Continuously enrolled children receiving adoption assistance compared to their continuously enrolled controls (Table B-2 and Table B-5)
  - Continuously enrolled former foster care members compared to their continuously enrolled controls (Table B-3 and Table B-6)
- Detailed information on the health characteristic methodology
- Demographic and health characteristics after matching
  - Children in foster care study population compared to their final matched controls (Table B-7 and Table B-10)
  - Children receiving adoption assistance study population compared to their final matched controls (Table B-8 and Table B-11)
  - Former foster care members study population compared to their final matched controls (Table B-9 and Table B-12)
- Detailed findings and discussion of the covariate balance checks

Characteristics Before Matching

Table B-1 presents the findings of the demographic characteristic assessment of continuously enrolled children in foster care compared to their continuously enrolled controls, prior to matching.

Table B-1—Demographic Distribution of Children in Foster Care (n=3,635) and Controls (n=626,070) Continuously Enrolled in Managed Care, Before Matching

Category	Number of Children in Foster Care	Percent of Children in Foster Care	Number of Controls	Percent of Controls
Age Category				
≤ 2 years	691	19.0%	115,060	18.4%
3 to 5 years	654	18.0%	109,805	17.5%
6 to 10 years	856	23.5%	174,161	27.8%

Category	Number of Children in Foster Care	Percent of Children in Foster Care	Number of Controls	Percent of Controls
11 to 13 years	496	13.6%	105,515	16.9%
≥ 14 years	938	25.8%	121,529	19.4%
Sex				
Male	1,977	54.4%	319,812	51.1%
Female	1,658	45.6%	306,258	48.9%
Race				
Black or African American	1,254	34.5%	232,775	37.2%
White	2,289	63.0%	338,894	54.1%
Other	92	2.5%	54,401	8.7%
Region				
Central	708	19.5%	158,320	25.3%
Charlottesville/Western	715	19.7%	71,564	11.4%
Northern & Winchester	543	14.9%	159,532	25.5%
Roanoke/Alleghany	563	15.5%	58,576	9.4%
Southwest	450	12.4%	S	S
Tidewater	644	17.7%	143,373	22.9%
Unknown	12	0.3%	S	S
Continuously Enrolled MCO				
Aetna	349	9.6%	62,591	10.0%
HealthKeepers	997	27.4%	210,896	33.7%
Molina	224	6.2%	28,271	4.5%
Optima	788	21.7%	128,834	20.6%
VA Premier	921	25.3%	132,345	21.1%
UnitedHealthcare	256	7.0%	57,607	9.2%
More Than One MCO	100	2.8%	5,526	0.9%
Medicaid Program				
CCC Plus	22	0.6%	24,016	3.8%
Medallion 4.0	3,613	99.4%	602,054	96.2%

S indicates that the rate has been suppressed due to a small numerator (i.e., less than or equal to 10). In instances where only one stratification was suppressed, the values for the second smallest population were also suppressed, even if the values were 11 or more.

Table B-2 presents the findings of the demographic characteristic assessment of continuously enrolled children receiving adoption assistance compared to their continuously enrolled controls, prior to matching.

Table B-2—Demographic Distribution of Children Receiving Adoption Assistance (n=7,321) and Controls (n=626,070) Continuously Enrolled in Managed Care, Before Matching

Category	Number of Children Receiving Adoption Assistance	Percent of Children Receiving Adoption Assistance	Number of Controls	Percent of Controls
Age Category				
≤ 2 years	161	2.2%	115,060	18.4%
3 to 5 years	803	11.0%	109,805	17.5%
6 to 10 years	2,102	28.7%	174,161	27.8%
11 to 13 years	1,708	23.3%	105,515	16.9%
≥ 14 years	2,547	34.8%	121,529	19.4%
Sex				
Male	3,922	53.6%	319,812	51.1%
Female	3,399	46.4%	306,258	48.9%
Race				
Black or African American	2,264	30.9%	232,775	37.2%
White	4,894	66.8%	338,894	54.1%
Other	163	2.2%	54,401	8.7%
Region				
Central	1,585	21.7%	158,320	25.3%
Charlottesville/Western	1,143	15.6%	71,564	11.4%
Northern & Winchester	1,082	14.8%	159,532	25.5%
Roanoke/Alleghany	1,217	16.6%	58,576	9.4%
Southwest	S	S	S	S
Tidewater	1,388	19.0%	143,373	22.9%
Unknown	S	S	S	S
Continuously Enrolled MCO				
Aetna	607	8.3%	62,591	10.0%
HealthKeepers	2,200	30.1%	210,896	33.7%
Molina	296	4.0%	28,271	4.5%
Optima	1,519	20.7%	128,834	20.6%

Category	Number of Children Receiving Adoption Assistance	Percent of Children Receiving Adoption Assistance	Number of Controls	Percent of Controls
VA Premier	2,126	29.0%	132,345	21.1%
UnitedHealthcare	504	6.9%	57,607	9.2%
More Than One MCO	69	0.9%	5,526	0.9%
Medicaid Program				
CCC Plus	222	3.0%	24,016	3.8%
Medallion 4.0	7,099	97.0%	602,054	96.2%

S indicates that the rate has been suppressed due to a small numerator (i.e., less than or equal to 10). In instances where only one stratification was suppressed, the values for the second smallest population were also suppressed, even if the values were 11 or more.

Table B-3 presents the findings of the demographic characteristic assessment of continuously enrolled former foster care members compared to their continuously enrolled controls, prior to matching.

Table B-3—Demographic Distribution of Former Foster Care Members (n=1,632) and Controls (n=165,312) Continuously Enrolled in Managed Care, Before Matching

Category	Number of Former Foster Care Members	Percent of Former Foster Care Members	Number of Controls	Percent of Controls
Age Category				
19 to 22 Years	1,066	65.3%	90,438	54.7%
23 to 26 Years	566	34.7%	74,874	45.3%
Sex				
Male	825	50.6%	63,566	38.5%
Female	807	49.4%	101,746	61.5%
Race				
Black or African American	595	36.5%	63,874	38.6%
White	977	59.9%	82,059	49.6%
Other	60	3.7%	19,379	11.7%
Region				
Central	386	23.7%	43,770	26.5%
Charlottesville/Western	291	17.8%	19,967	12.1%

Category	Number of Former Foster Care Members	Percent of Former Foster Care Members	Number of Controls	Percent of Controls
Northern & Winchester	180	11.0%	33,058	20.0%
Roanoke/Alleghany	245	15.0%	17,036	10.3%
Southwest	177	10.8%	11,063	6.7%
Tidewater	353	21.6%	40,418	24.4%
Continuously Enrolled MCO				
Aetna	141	8.6%	25,251	15.3%
HealthKeepers	441	27.0%	44,387	26.9%
Molina	113	6.9%	14,161	8.6%
Optima	364	22.3%	32,520	19.7%
VA Premier	437	26.8%	30,822	18.6%
UnitedHealthcare	119	7.3%	16,890	10.2%
More Than One MCO	17	1.0%	1,281	0.8%
Medicaid Program				
CCC Plus	61	3.7%	18,179	11.0%
Medallion 4.0	1,571	96.3%	147,133	89.0%

Health Characteristic Methodology

In order to identify controls with similar health characteristics to the continuously enrolled children in foster care, children receiving adoption assistance, and former foster care members (i.e., cases), HSAG identified primary diagnoses which occurred at different rates within the claims for continuously enrolled cases and the claims for continuously enrolled controls. For members older than two years of age as of January 1, 2021, the claims assessment period was January 1, 2020, through December 31, 2020. For children two years of age or younger as of January 1, 2021, the claims assessment period was January 1, 2021, through December 31, 2021, since many of the diagnoses of interest (e.g., mental health diagnoses) are not typically diagnosed until later in life. In addition to evaluating the prevalence of diagnoses, HSAG also evaluated the frequency of ED and inpatient visits for mental health during the year prior to the measurement year (i.e., January 1, 2020, through December 31, 2020) for all members. HSAG used the year prior to the measurement year to ensure that the members would not be matched on any of the outcomes of interest (e.g., the *ED Visits* study indicator) during the measurement year.[B-1]

[B-1] Historically, HSAG assessed the frequency of ED and inpatient visits for mental health during the measurement year for children two years of age or younger, since mental health conditions are more likely to

These diagnoses were grouped into 13 categories using CCS:[B-2,B-3] For the health characteristics used in the MY 2019 and MY 2020 Foster Care Focus Studies (e.g., adjustment disorder), HSAG verified that there were no new pertinent diagnosis codes and continued to use the version 2019 CCS. For the health characteristics that are new to the Child Welfare Focus Study (e.g., maltreatment/abuse), HSAG used the version 2021 CCS.

- **Adjustment Disorder**: At least one primary diagnosis during the claims assessment period meeting any of the following second-level CCS Categories:
  - Adjustment disorders [5.1]
- **ADHD**: At least one primary diagnosis during the claims assessment period meeting any of the following second-level CCS Categories:
  - Attention deficit, conduct, and disruptive behavior disorders [5.3]
  - Impulse control disorders not elsewhere classified [5.7]
- **Anxiety Disorder**: At least one primary diagnosis during the claims assessment period meeting any of the following second-level CCS Categories:
  - Anxiety disorders [5.2]
- **Congenital Anomaly**: At least one primary diagnosis during the claims assessment period meeting any of the following second-level CCS Categories: [B-4]
  - Cardiac and circulatory congenital anomalies [14.1]
  - Digestive congenital anomalies [14.2]
  - Genitourinary congenital anomalies [14.3]
  - Nervous system congenital anomalies [14.4]
  - Other congenital anomalies [14.5]
- **Developmental Disorder**: At least one primary diagnosis during the claims assessment period meeting any of the following second-level CCS Categories:
  - Developmental disorders [5.5]
  - Disorders usually diagnosed in infancy, childhood, or adolescence [5.6]
- **Intentional Self-Harm**: At least one primary diagnosis during the claims assessment period meeting any of the following second-level CCS Categories:

present in older children. However, this year's focus study introduced the *ED Visits*, *Inpatient Visits*, and *Behavioral Health Encounters* study indicators. Therefore, matching on ED and inpatient visits for mental health during the measurement year would result in matching on outcomes of interest. HSAG evaluated the frequency of ED and inpatient visits for mental health for children two years of age or younger during the measurement year (e.g., January 1, 2021 through December 31, 2021) and determined that very few visits occurred, resulting in minimal impact to the matching. As a result, the claims assessment period for these health characteristics was changed to the year prior to the measurement year for all members.

B-2 Agency for Healthcare Research and Quality. Clinical Classifications Software (CCS) for ICD-10-CM (beta version). Available at: www.hcup-us.ahrq.gov/toolssoftware/ccs10/ccs10.jsp. Accessed on: Jan 11, 2023.

B-3 Agency for Healthcare Research and Quality. Clinical Classifications Software (CCS) for ICD-10-CM (beta version). Available at: https://www.hcup-us.ahrq.gov/toolssoftware/ccsr/ccsr_archive.jsp#ccsr. Accessed on: Jan 11, 2023.

B-4 The percent of members with a congenital anomaly differed between cases and controls for children in foster care and children receiving adoption assistance but did not differ for former foster care members. Therefore, congenital anomaly is not used in the matching for former foster care members.

  - Suicide and intentional self-inflicted injury [5.13]
- **Maltreatment/Abuse**: At least one primary diagnosis during the claims assessment period meeting any of the following first-level, second-level, third-level, outpatient, or inpatient CCS Categories:[B-5]
  - Maltreatment/abuse [INJ032]
  - Maltreatment/abuse, subsequent encounter [INJ068]
- **Mood Disorder**: At least one primary diagnosis during the claims assessment period meeting any of the following second-level CCS Categories:
  - Mood disorders [5.8]
- **Neurological Disorder**: At least one primary diagnosis during the claims assessment period meeting any of the following first-level CCS Categories:[B-6]
  - Cerebral palsy [NVS007]
  - Epilepsy; convulsions [NVS009]
- **Obesity and Metabolic Syndrome**: At least one primary diagnosis during the claims assessment period meeting any of the following second-level CCS Categories:
  - Diabetes mellitus without complication [3.2]
  - Diabetes mellitus with complications [3.3]
  - Other endocrine disorders [3.4]
  - Nutritional deficiencies [3.5]
  - Disorders of lipid metabolism [3.6]
  - Other nutritional, endocrine, and metabolic disorders [3.11]
- **Other Mental Health Disorder**: At least one primary diagnosis during the claims assessment period meeting any of the following second-level CCS Categories:
  - Miscellaneous mental disorders [5.15]
- **Psychotic Disorder**: At least one primary diagnosis during the claims assessment period meeting any of the following second-level CCS Categories:
  - Schizophrenia and other psychotic disorders [5.10]
- **Substance Use Disorder**: At least one primary diagnosis during the claims assessment period meeting any of the following second-level CCS Categories:
  - Alcohol-related disorders [5.11]
  - Substance-related disorders [5.12]
- **Rheumatologic Condition**: At least one primary diagnosis during the claims assessment period meeting any of the following second-level CCS Categories:
  - Other connective tissue disease [13.8]

B-5 The percent of members with a maltreatment/abuse diagnosis differed between cases and controls for children in foster care but did not differ for children receiving adoption assistance or former foster care members. Therefore, congenital anomaly is not used in the matching for children receiving adoption assistance or former foster care members.

B-6 The percent of members with a neurological disorder differed between cases and controls for children receiving adoption assistance but did not differ for children in foster care or former foster care members. Therefore, neurological disorders are not used in the matching for children in foster care or former foster care members.

Additionally, since mental health diagnoses featured prominently among claims for the cases, HSAG also sought to ensure comparability in the severity of mental health conditions between the cases and controls. Therefore, HSAG also identified ED visits and acute inpatient visits with a primary diagnosis relating to mental health. These visits were defined as:

- **ED Visit for Mental Health**: At least one claim during the claims assessment period meeting both of the following conditions:
  - The claim's revenue code starts with: [045]
  - The claim's primary diagnosis is included in the FFY 2022 CMS Core Set Mental Health Diagnosis Value Set
- **Acute Inpatient Visit for Mental Health**: At least one claim during the claims assessment period meeting all the following conditions:
  - The claim's revenue code is included in the FFY 2022 CMS Core Set Inpatient Stay Value Set
  - The claim's revenue code and type of bill code is not included in the FFY2022 CMS Core Set Nonacute Inpatient Stay Value Set
  - The claim's primary diagnosis is included in the FFY 2022 CMS Core Set Mental Health Diagnosis Value Set

HSAG calculated the initial propensity models using all health characteristics listed above and then removed health characteristics that were insignificant in the initial model, based on the Wald Chi-square test for logistic regression model coefficients. The subsequent health characteristics tables include only the significant health characteristics included in the final propensity score models for each population.

Table B-4 presents the health characteristic assessment findings for continuously enrolled children in foster care and controls, prior to matching.

Table B-4—Distribution of Health Characteristics Among Children in Foster Care (n=3,635) and Controls (n=626,070) Continuously Enrolled in Managed Care, Before Matching

Category	Number of Children in Foster Care	Percent of Children in Foster Care	Number of Controls	Percent of Controls
Adjustment Disorder	1,250	34.4%	16,708	2.7%
Attention Deficit Hyperactivity Disorder	1,247	34.3%	45,487	7.3%
Anxiety Disorder	852	23.4%	15,840	2.5%
Congenital Anomaly	172	4.7%	17,255	2.8%
Developmental Disorder	915	25.2%	47,918	7.7%
Intentional Self-Harm	118	3.2%	2,342	0.4%
Maltreatment/Abuse	75	2.1%	1,387	0.2%
Mood Disorder	780	21.5%	17,411	2.8%
Obesity and Metabolic Syndrome	691	19.0%	39,055	6.2%
Other Mental Health Disorder	305	8.4%	2,444	0.4%
Rheumatologic Condition	254	7.0%	19,993	3.2%
Substance Use Disorder	120	3.3%	1,127	0.2%

Category	Number of Children in Foster Care	Percent of Children in Foster Care	Number of Controls	Percent of Controls
ED Visit for Mental Health	58	1.6%	1,122	0.2%
Acute Inpatient Visit for Mental Health	131	3.6%	2,046	0.3%

Table B-5 presents the health characteristic assessment findings for continuously enrolled children receiving adoption assistance and controls, prior to matching.

Table B-5—Distribution of Health Characteristics Among Children Receiving Adoption Assistance (n=7,321) and Controls (n=626,070) Continuously Enrolled in Managed Care, Before Matching

Category	Number of Children Receiving Adoption Assistance	Percent of Children Receiving Adoption Assistance	Number of Controls	Percent of Controls
Adjustment Disorder	699	9.5%	16,708	2.7%
Attention Deficit Hyperactivity Disorder	2,245	30.7%	45,487	7.3%
Anxiety Disorder	794	10.8%	15,840	2.5%
Congenital Anomaly	283	3.9%	17,255	2.8%
Developmental Disorder	1,292	17.6%	47,918	7.7%
Mood Disorder	768	10.5%	17,411	2.8%
Neurological Disorder	200	2.7%	7,312	1.2%
Other Mental Health Disorder	98	1.3%	2,444	0.4%
Substance Use Disorder	54	0.7%	1,127	0.2%
ED Visit for Mental Health	43	0.6%	1,122	0.2%
Acute Inpatient Visit for Mental Health	104	1.4%	2,046	0.3%

Table B-6 presents the health characteristic assessment findings for continuously enrolled former foster care members and controls, prior to matching.

Table B-6—Distribution of Health Characteristics Among Former Foster Care Members (n=1,632) and Controls (n=165,312) Continuously Enrolled in Managed Care, Before Matching

Category	Number of Former Foster Care Members	Percent of Former Foster Care Members	Number of Controls	Percent of Controls
Adjustment Disorder	79	4.8%	3,178	1.9%
Attention Deficit Hyperactivity Disorder	115	7.0%	4,545	2.7%
Anxiety Disorder	251	15.4%	13,105	7.9%
Developmental Disorder	58	3.6%	5,683	3.4%

Category	Number of Former Foster Care Members	Percent of Former Foster Care Members	Number of Controls	Percent of Controls
Mood Disorder	368	22.5%	16,378	9.9%
Rheumatologic Condition	148	9.1%	10,542	6.4%
Substance Use Disorder	128	7.8%	5,587	3.4%

Characteristics After Matching

Table B-7 presents the demographic characteristic assessment findings for the final children in foster care study population and controls, after matching the populations of continuously enrolled children in foster care and controls.

Table B-7—Demographic Distribution of Children in Foster Care (n=3,436) and Controls (n=3,436) Continuously Enrolled in Managed Care After Matching

Category	Number of Children in Foster Care	Percent of Children in Foster Care	Number of Controls	Percent of Controls	Chi-square Balance Test *p*	Standardized Differences Assessment *d*
Age Category						
≤ 2 years	666	19.4%	666	19.4%	1.00	0.000
3 to 5 years	595	17.3%	595	17.3%		0.000
6 to 10 years	802	23.3%	802	23.3%		0.000
11 to 13 years	468	13.6%	468	13.6%		0.000
≥ 14 years	905	26.3%	905	26.3%		0.000
Sex						
Male	1,862	54.2%	1,885	54.9%	0.58	-0.013
Female	1,574	45.8%	1,551	45.1%		0.013
Race						
Black or African American	1,159	33.7%	1,159	33.7%	1.00	0.000
White	2,189	63.7%	2,189	63.7%		0.000
Other	88	2.6%	88	2.6%		0.000
Region						
Central	662	19.3%	662	19.3%	1.00	0.000
Charlottesville/Western	672	19.6%	672	19.6%		0.000
Northern & Winchester	525	15.3%	525	15.3%		0.000

Category	Number of Children in Foster Care	Percent of Children in Foster Care	Number of Controls	Percent of Controls	Chi-square Balance Test *p*	Standardized Differences Assessment *d*
Roanoke/Alleghany	531	15.5%	531	15.5%		0.000
Southwest	428	12.5%	428	12.5%		0.000
Tidewater	618	18.0%	618	18.0%		0.000
Continuously Enrolled MCO						
Aetna	327	9.5%	327	9.5%	1.00	0.000
HealthKeepers	959	27.9%	959	27.9%		0.000
Molina	203	5.9%	203	5.9%		0.000
Optima	739	21.5%	739	21.5%		0.000
VA Premier	882	25.7%	882	25.7%		0.000
UnitedHealthcare	243	7.1%	243	7.1%		0.000
More Than One MCO	83	2.4%	83	2.4%		0.000
Medicaid Program						
CCC Plus	22	0.6%	55	1.6%	<0.001*	-0.091
Medallion 4.0	3,414	99.4%	3,381	98.4%		0.091

** Indicates that the covariate balance test found imbalance between the children in foster care and controls.*

The age category, race, region, and MCO distributions were identical in the children in foster care study population and the controls due to exact matching on these characteristics. Neither the covariate-level Chi-square tests nor the standardized differences test identified any significant differences in sex. While the Chi-square test identified imbalance in Medicaid Program, the standardized differences assessment did not. Due to the large sample size, and since larger sample sizes increase the sensitivity of the Chi-square test, HSAG only considered a characteristic to be imbalanced if both the Chi-square test and standardized differences assessment indicated imbalance.

Table B-8 presents the demographic characteristic assessment findings for the final children receiving adoption assistance study population and controls, after matching the populations of continuously enrolled children receiving adoption assistance and controls.

Table B-8—Demographic Distribution of Children Receiving Adoption Assistance (n=7,290) and Controls (n=7,290) Continuously Enrolled in Managed Care, After Matching

Category	Number of Children Receiving Adoption Assistance	Percent of Children Receiving Adoption Assistance	Number of Controls	Percent of Controls	Chi-square Balance Test *p*	Standardized Differences Assessment *d*
Age Category						
≤ 2 years	160	2.2%	160	2.2%	1.00	0.000

Category	Number of Children Receiving Adoption Assistance	Percent of Children Receiving Adoption Assistance	Number of Controls	Percent of Controls	Chi-square Balance Test *p*	Standardized Differences Assessment *d*
3 to 5 years	801	11.0%	801	11.0%		0.000
6 to 10 years	2,092	28.7%	2,092	28.7%		0.000
11 to 13 years	1,698	23.3%	1,698	23.3%		0.000
≥ 14 years	2,539	34.8%	2,539	34.8%		0.000
Sex						
Male	3,903	53.5%	3,941	54.1%	0.53	-0.010
Female	3,387	46.5%	3,349	45.9%		0.010
Race						
Black or African American	2,252	30.9%	2,252	30.9%	1.00	0.000
White	4,878	66.9%	4,878	66.9%		0.000
Other	160	2.2%	160	2.2%		0.000
Region						
Central	1,582	21.7%	1,582	21.7%	1.00	0.000
Charlottesville/Western	1,135	15.6%	1,135	15.6%		0.000
Northern & Winchester	1,081	14.8%	1,081	14.8%		0.000
Roanoke/Alleghany	1,212	16.6%	1,212	16.6%		0.000
Southwest	895	12.3%	895	12.3%		0.000
Tidewater	1,385	19.0%	1,385	19.0%		0.000
Continuously Enrolled MCO						
Aetna	599	8.2%	599	8.2%	1.00	0.000
HealthKeepers	2,198	30.2%	2,198	30.2%		0.000
Molina	294	4.0%	294	4.0%		0.000
Optima	1,512	20.7%	1,512	20.7%		0.000
VA Premier	2,118	29.1%	2,118	29.1%		0.000
UnitedHealthcare	503	6.9%	503	6.9%		0.000
More Than One MCO	66	0.9%	66	0.9%		0.000
Medicaid Program						
CCC Plus	222	3.0%	244	3.3%	0.30	-0.017
Medallion 4.0	7,068	97.0%	7,046	96.7%		0.017

The age category, race, region, and MCO distributions were identical in the children receiving adoption assistance study population and the controls due to exact matching on these characteristics. Neither the covariate-level Chi-square tests nor the standardized differences test identified any significant

differences in the demographic characteristics of the matched children receiving adoption assistance and controls.

Table B-9 presents the demographic characteristic assessment findings for the final former foster care members study population and controls, after matching the populations of continuously enrolled former foster care members and controls.

Table B-9—Demographic Distribution of Former Foster Care Members (n=1,627) and Controls (n=1,627) Continuously Enrolled in Managed Care, After Matching

Category	Number of Former Foster Care Members	Percent of Former Foster Care Members	Number of Controls	Percent of Controls	Chi-square Balance Test *p*	Standardized Differences Assessment *d*
Age Category						
19 to 22 Years	1,061	65.2%	1,061	65.2%	1.00	0.000
23 to 26 Years	566	34.8%	566	34.8%		0.000
Sex						
Male	820	50.4%	831	51.1%	0.70	-0.014
Female	807	49.6%	796	48.9%		0.014
Race						
Black or African American	592	36.4%	592	36.4%	1.00	0.000
White	975	59.9%	975	59.9%		0.000
Other	60	3.7%	60	3.7%		0.000
Region						
Central	384	23.6%	384	23.6%	1.00	0.000
Charlottesville/Western	289	17.8%	289	17.8%		0.000
Northern & Winchester	180	11.1%	180	11.1%		0.000
Roanoke/Alleghany	245	15.1%	245	15.1%		0.000
Southwest	177	10.9%	177	10.9%		0.000
Tidewater	352	21.6%	352	21.6%		0.000
Continuously Enrolled MCO						
Aetna	141	8.7%	141	8.7%	1.00	0.000
HealthKeepers	440	27.0%	440	27.0%		0.000
Molina	111	6.8%	111	6.8%		0.000
Optima	364	22.4%	364	22.4%		0.000
VA Premier	435	26.7%	435	26.7%		0.000
UnitedHealthcare	119	7.3%	119	7.3%		0.000
More Than One MCO	17	1.0%	17	1.0%		0.000

Category	Number of Former Foster Care Members	Percent of Former Foster Care Members	Number of Controls	Percent of Controls	Chi-square Balance Test *p*	Standardized Differences Assessment *d*
Medicaid Program						
CCC Plus	61	3.7%	57	3.5%	0.71	0.013
Medallion 4.0	1,566	96.3%	1,570	96.5%		-0.013

The age category, race, region, and MCO distributions were identical in the former foster care members study population and the controls due to exact matching on these characteristics. Neither the covariate-level Chi-square tests nor the standardized differences test identified any significant differences in the demographic characteristics of the matched former foster care members and controls.

Table B-10 presents the health characteristic assessment findings for the final children in foster care study population and the controls, after matching continuously enrolled children in foster care and controls.

Table B-10—Distribution of Health Characteristics Among Children in Foster Care (n=3,436) and Controls (n=3,436) Continuously Enrolled in Managed Care, After Matching

Category	Number of Children in Foster Care	Percent of Children in Foster Care	Number of Controls	Percent of Controls	Chi-square Balance Test *p*	Standardized Differences Assessment *d*
Adjustment Disorder	1,098	32.0%	1,089	31.7%	0.82	0.006
Attention Deficit Hyperactivity Disorder	1,122	32.7%	1,147	33.4%	0.32	0.024
Anxiety Disorder	748	21.8%	714	20.8%	0.52	-0.015
Congenital Anomaly	152	4.4%	162	4.7%	0.56	-0.014
Developmental Disorder	792	23.1%	813	23.7%	0.55	-0.014
Intentional Self-Harm	107	3.1%	73	2.1%	0.01*	0.062
Maltreatment/Abuse	59	1.7%	50	1.5%	0.004*	0.070
Mood Disorder	710	20.7%	615	17.9%	0.38	0.021
Obesity and Metabolic Syndrome	611	17.8%	688	20.0%	0.02*	-0.057
Other Mental Health Disorder	216	6.3%	152	4.4%	<0.001*	0.083

Category	Number of Children in Foster Care	Percent of Children in Foster Care	Number of Controls	Percent of Controls	Chi-square Balance Test *p*	Standardized Differences Assessment *d*
Rheumatologic Condition	227	6.6%	212	6.2%	0.46	0.018
Substance Use Disorder	96	2.8%	59	1.7%	0.003*	0.073
ED Visit for Mental Health	50	1.5%	30	0.9%	0.02*	0.054
Acute Inpatient Visit for Mental Health	121	3.5%	78	2.3%	0.002*	0.075

** Indicates that the covariate balance test found imbalance between the children in foster care and controls.*

The health characteristics distributions for the children in foster care study population and the controls were balanced by matching. While the Chi-square tests found imbalance for several health characteristics (e.g., intentional self-harm, substance use disorder disorder) and the omnibus test (p<0.001) identified imbalance in at least one covariate, the standardized differences assessment found no imbalances in the health characteristics. Due to the large sample size, and since larger sample sizes increase the sensitivity of the Chi-square test, HSAG only considered a characteristic to be meaningfully imbalanced if both the Chi-square test and standardized differences assessment indicated imbalance. The largest imbalance was 2.2 percent for Obesity and Metabolic Syndrome; however, this was a substantial improvement from the 12.8 percent difference between cases and controls prior to matching.

Table B-11 presents the health characteristic assessment findings for the final children receiving adoption assistance study population and controls, after matching continuously enrolled children receiving adoption assistance and controls.

Table B-11—Distribution of Health Characteristics Among Children Receiving Adoption Assistance (n=7,290) and Controls (n=7,290) Continuously Enrolled in Managed Care, After Matching

Category	Number of Children Receiving Adoption Assistance	Percent of Children Receiving Adoption Assistance	Number of Controls	Percent of Controls	Chi-square Balance Test *p*	Standardized Differences Assessment *d*
Adjustment Disorder	686	9.4%	689	9.5%	0.93	-0.001
Attention Deficit Hyperactivity Disorder	2,221	30.5%	2,254	30.9%	0.53	0.010
Anxiety Disorder	772	10.6%	749	10.3%	0.55	-0.010
Congenital Anomaly	280	3.8%	270	3.7%	0.66	0.007

Category	Number of Children Receiving Adoption Assistance	Percent of Children Receiving Adoption Assistance	Number of Controls	Percent of Controls	Chi-square Balance Test *p*	Standardized Differences Assessment *d*
Developmental Disorder	1,271	17.4%	1,193	16.4%	0.08	0.029
Mood Disorder	748	10.3%	760	10.4%	0.74	-0.005
Neurological Disorder	195	2.7%	177	2.4%	0.34	0.016
Other Mental Health Disorder	91	1.2%	63	0.9%	0.02*	0.038
Substance Use Disorder	51	0.7%	42	0.6%	0.35	0.016
ED Visit for Mental Health	43	0.6%	29	0.4%	0.10	0.027
Acute Inpatient Visit for Mental Health	100	1.4%	98	1.3%	0.89	0.002

** Indicates that the covariate balance test found imbalance between the children receiving adoption assistance and controls.*

The health characteristics distributions for the children receiving adoption assistance study population and the controls were balanced by matching. While the Chi-square tests found imbalance for one health characteristic (i.e., Other Mental Health Disorder), the omnibus test (p=0.36) indicated overall balance, and the standardized differences assessment found no imbalances in the health characteristics. Due to the large sample size, and since larger sample sizes increase the sensitivity of the Chi-square test, HSAG only considered a characteristic to be meaningfully imbalanced if both the Chi-square test and standardized differences assessment indicated imbalance. The percent difference for Other Mental Health Disorder was only 0.3 percent.

Table B-12 presents the health characteristic assessment findings for the final former foster care members study population and controls, after matching continuously enrolled former foster care members and controls.

Table B-12—Distribution of Health Characteristics Among Former Foster Care Members (n=1,627) and Controls (n=1,627) Continuously Enrolled in Managed Care, After Matching

Category	Number of Former Foster Care Members	Percent of Former Foster Care Members	Number of Controls	Percent of Controls	Chi-square Balance Test *p*	Standardized Differences Assessment *d*
Adjustment Disorder	77	4.7%	60	3.7%	0.14	0.052
Attention Deficit Hyperactivity Disorder	111	6.8%	106	6.5%	0.52	0.022
Anxiety Disorder	248	15.2%	235	14.4%	0.73	0.012

Category	Number of Former Foster Care Members	Percent of Former Foster Care Members	Number of Controls	Percent of Controls	Chi-square Balance Test *p*	Standardized Differences Assessment *d*
Developmental Disorder	56	3.4%	55	3.4%	0.92	0.003
Mood Disorder	363	22.3%	346	21.3%	0.47	0.025
Rheumatologic Condition	147	9.0%	150	9.2%	0.86	-0.006
Substance Use Disorder	125	7.7%	109	6.7%	0.28	0.038

** Indicates that the covariate balance test found imbalance between the former foster care members and controls.*

The health characteristics distributions for the former foster care members study population and the controls were balanced by matching. Neither the Chi-square tests nor the standard differences assessment identified any imbalances in the health characteristics. The omnibus test also did not identify any imbalance (p=0.92).