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Commonwealth of Virginia
Department of Medical Assistance Services

2022–23 Child Welfare Focus Study Report

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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) 2022–23 (Contract Year 2). 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.

The 2022–23 Child Welfare Focus Study assesses healthcare utilization during measurement year (MY) 2022 (i.e., January 1–December 31, 2022) 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 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, 2022, 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, 2022, 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, 2022, 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 (Acute) or Commonwealth Coordinated Care Plus (CCC Plus) (Managed Long–Term Services and Supports [MLTSS]) 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; timely access to primary and dental care for members who aged out of the foster care program; and timely access to behavioral healthcare for members who were newly enrolled in foster care, members who were newly enrolled in adoption assistance, and members who age out of the foster care program. These members were continuously enrolled in the Medallion 4.0 (Acute) or CCC Plus (MLTSS) 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 2022.

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 32 study indicators, across six domains, as displayed in Table 1-1.

Table 1-1—Healthcare Utilization Measure Indicators

Measure and Indicators
Primary Care
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 (TFL-CH)
Behavioral Health
Antidepressant Medication Management—Effective Acute Phase Treatment (AMM–A) and Effective Continuation Phase Treatment (AMM–C)*
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)
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)^

Measure and Indicators
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 Substance Use—30-Day Follow-Up (FUA)†
Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment (IET–I) and Engagement of SUD Treatment (IET–E)
Respiratory Health
Asthma Medication Ratio (AMR)
Service Utilization
Ambulatory Care Visits
ED Visits
Inpatient Visits
Behavioral Health Encounters—Total, Addiction and Recovery Treatment Services (ARTS), Community Mental Health (CMH) Services, Residential Treatment Center (RTC) Services, Therapeutic Services, and Traditional Services
Overall Service Utilization

^ Indicates these study 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 study indicators were only calculated for the former foster care members as the measure indicates are only applicable to members 18 years of age and older.*
† Indicates these study indicators were only calculated for the former foster care members, as the denominators for the children in foster care and the children receiving adoption assistance members are historically very small.

Timely Access to Care Analysis

To determine the extent to which children newly enrolled in foster care, members receiving adoption assistance, 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 five measures, representing 16 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 Care for New Foster Care Members
Timely Access to Behavioral Health Care for New Foster Care Members—Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members, Timely Access to Behavioral Health Care Within

Measure and Indicators
60 Days for New Foster Care Members with a Behavioral Health Diagnosis, Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members, and Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members With a Behavioral Health Diagnosis
Timely Access to Behavioral Health Care for Members Receiving Adoption Assistance—Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members and Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members With a Behavioral Health Diagnosis
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: Study Indicators 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) 2023 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 were 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	61.5%	52.9%	<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	65.1%	57.7%	0.16
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	77.9%	65.0%	0.002*
Oral Health			
Annual Dental Visit	68.6%	53.7%	<0.001*
Preventive Dental Services	63.3%	47.7%	<0.001*
Oral Evaluation, Dental Services	61.8%	46.2%	<0.001*
Topical Fluoride for Children—Dental or Oral Health Services	29.1%	19.3%	<0.001*
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	35.6%	57.6%	0.01*
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up	87.7%	74.4%	0.08
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing	38.3%	31.3%	0.18
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	77.9%	60.8%	0.04*
Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up	77.3%	75.0%	0.67
Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up	90.0%	90.1%	0.97
Follow-Up Care for Children Prescribed ADHD Medication—Three-Month Follow-Up	93.6%	93.4%	0.94
Follow-Up Care for Children Prescribed ADHD Medication—Six-Month Follow-Up	97.3%	97.4%	1.00
Follow-Up Care for Children Prescribed ADHD Medication—Nine-Month Follow-Up	97.3%	98.7%	0.65
Substance Use			
Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment	40.4%	50.0%	0.33

Measure	Children in Foster Care Rate	Controls Rate	*p*
Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment	10.5%	13.6%	0.63
Respiratory Health			
Asthma Medication Ratio	82.5%	76.1%	0.43
Service Utilization			
Ambulatory Care Visits	86.8%	88.1%	0.08
Emergency Department Visits	26.9%	35.5%	<0.001*
Inpatient Visits	5.1%	4.2%	0.09
Behavioral Health Encounters—Total	65.4%	51.9%	<0.001*
Behavioral Health Encounters—ARTS	2.8%	1.5%	<0.001*
Behavioral Health Encounters—CMH Services	35.3%	20.0%	<0.001*
Behavioral Health Encounters—RTC Services	5.5%	4.1%	0.005*
Behavioral Health Encounters—Therapeutic Services	10.9%	6.0%	<0.001*
Behavioral Health Encounters—Traditional Services	61.2%	47.9%	<0.001*
Overall Service Utilization	89.7%	91.6%	0.005*

** Indicates that the rates were statistically different between the children in foster care and controls.*
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: Study Indicators for indicator-specific technical specifications.

Among the 29 study indicators, children in foster care demonstrated rates of healthcare utilization higher than or equal to controls for 20 study indicators, 13 of which were statistically significant. Of note, the rates for children in foster care for three study indicators were significantly lower than the rate for controls. The children in foster care eligible population included 7,008 children enrolled in Medicaid during MY 2022. Among the eligible population, 3,873 children (55.3 percent) were continuously enrolled with any MCO or combination of MCOs during the measurement year. Finally, 3,695 of the continuously enrolled children in foster care (95.4 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 3.5 percent fewer children 2 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 were 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	45.9%	47.3%	0.08
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	0.0%	55.3%	0.11
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	79.2%	65.7%	0.17
Oral Health			
Annual Dental Visit	57.3%	54.3%	<0.001*
Preventive Dental Services	53.2%	49.5%	<0.001*
Oral Evaluation, Dental Services	52.1%	48.1%	<0.001*
Topical Fluoride for Children—Dental or Oral Health Services	23.3%	19.5%	<0.001*
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	53.7%	59.7%	0.39
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up	84.4%	79.3%	0.47
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing	37.6%	33.2%	0.27
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	58.9%	53.3%	0.46
Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up	52.9%	62.9%	0.02*
Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up	68.9%	80.6%	0.001*
Follow-Up Care for Children Prescribed ADHD Medication—Three-Month Follow-Up	80.9%	87.0%	0.05*
Follow-Up Care for Children Prescribed ADHD Medication—Six-Month Follow-Up	91.4%	94.6%	0.14
Follow-Up Care for Children Prescribed ADHD Medication—Nine-Month Follow-Up	94.6%	96.5%	0.26
Substance Use			
Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment	42.3%	37.5%	0.60
Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment	7.7%	6.3%	1.00
Respiratory Health			
Asthma Medication Ratio	86.0%	71.0%	0.003*
Service Utilization			
Ambulatory Care Visits	81.4%	82.9%	0.02*

Measure	Children Receiving Adoption Assistance Rate	Controls Rate	*p*
Emergency Department Visits	17.7%	29.3%	<0.001*
Inpatient Visits	3.3%	2.3%	<0.001*
Behavioral Health Encounters—Total	45.7%	40.2%	<0.001*
Behavioral Health Encounters—ARTS	1.0%	0.9%	0.45
Behavioral Health Encounters—CMH Services	13.1%	13.4%	0.61
Behavioral Health Encounters—RTC Services	4.3%	2.6%	<0.001*
Behavioral Health Encounters—Therapeutic Services	5.3%	4.2%	0.001*
Behavioral Health Encounters—Traditional Services	43.2%	37.2%	<0.001*
Overall Service Utilization	84.0%	86.9%	<0.001*

** Indicates that the rates were 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: Study Indicators for indicator-specific technical specifications.

Among the 29 study indicators, children receiving adoption assistance demonstrated higher rates of healthcare utilization than controls for 17 study indicators, 10 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 8,508 children enrolled in Medicaid during MY 2022. Among the eligible population, 7,299 children (85.8 percent) were continuously enrolled with any MCO or combination of MCOs during the measurement year. Finally, 7,270 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 were 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	17.8%	16.6%	0.60
Oral Health			
Annual Dental Visit	29.1%	28.0%	0.80
Preventive Dental Services	21.7%	21.7%	1.00

Measure	Former Foster Care Members Rate	Controls Rate	*p*
Oral Evaluation, Dental Services	22.2%	22.0%	0.96
Topical Fluoride for Children—Dental or Oral Health Services	4.9%	3.5%	0.42
Behavioral Health			
Antidepressant Medication Management—Effective Acute Phase Treatment	27.8%	36.2%	0.20
Antidepressant Medication Management—Effective Continuation Phase Treatment	12.4%	16.2%	0.44
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	14.9%	32.1%	0.06
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up	36.4%	43.8%	0.60
Substance Use			
Follow-Up After ED Visit for Substance Use—30-Day Follow-Up	18.4%	13.3%	1.00
Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment	44.0%	43.3%	0.91
Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment	13.7%	12.2%	0.74
Respiratory Health			
Asthma Medication Ratio	22.2%	60.0%	0.06
Service Utilization			
Ambulatory Care Visits	60.5%	66.6%	<0.001*
Emergency Department Visits	45.4%	39.1%	<0.001*
Inpatient Visits	9.9%	9.9%	1.00
Behavioral Health Encounters—Total	33.6%	28.3%	<0.001*
Behavioral Health Encounters—ARTS	7.3%	5.5%	0.02*
Behavioral Health Encounters—CMH Services	9.8%	5.1%	<0.001*
Behavioral Health Encounters—RTC Services	5.1%	2.7%	<0.001*
Behavioral Health Encounters—Therapeutic Services	2.0%	0.6%	<0.001*
Behavioral Health Encounters—Traditional Services	32.2%	27.0%	<0.001*
Overall Service Utilization	73.7%	75.0%	0.38

** Indicates that the rates were statistically different between the former foster care members and controls.*
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: Study Indicators for indicator-specific technical specifications.

Among the 23 study indicators, former foster care members demonstrated higher rates of healthcare utilization than controls for 14 study indicators, seven of which were significantly different. Of note, the former foster care rate for one study indicator was significantly lower than the rate for controls. The former foster care members eligible population included 2,145 members enrolled in Medicaid during MY 2022. Among the eligible population, 1,780 members (83.0 percent) were continuously enrolled with any MCO or combination of MCOs during the measurement year. Finally, 1,779 of the continuously enrolled former foster care members (99.9 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 2.1 percent more members enrolled in Medallion 4.0 (Acute).

Timely Access to Care Findings

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

Table 1-6—Timely Access to Care Study Indicator Results

Measure	Denominator	Numerator	Rate
Timely Access to Care for New Foster Care Members—Timely Access to Primary Care for New Foster Care Members	1,778	1,544	86.8%
Timely Access to Care for New Foster Care Members—Timely Access to Dental Care for New Foster Care Members	1,778	840	47.2%
Timely Access to Care for New Foster Care Members—Timely Access to Primary Care or Dental Care for New Foster Care Members	1,778	1,621	91.2%
Timely Access to Care for New Foster Care Members—Timely Access to Primary Care and Dental Care for New Foster Care Members	1,778	763	42.9%
Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members—Timely Access to Behavioral Health Care for New Foster Care Members	1,601	809	50.5%
Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members—Timely Access to Behavioral Health Care for New Foster Members With a Behavioral Health Diagnosis	643	508	79.0%
Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members—Timely Access to Behavioral Health Care for New Foster Care Members	1,368	918	67.1%
Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members—Timely Access to Behavioral Health Care for New Foster Members With a Behavioral Health Diagnosis	520	484	93.1%
Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members—Timely Access to Behavioral Health Care for New Adoption Assistance Members	812	360	44.3%
Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members—Timely Access to Behavioral Health Care for New Adoption Assistance Members With a Behavioral Health Diagnosis	356	243	68.3%
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	152	103	67.8%
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	152	45	29.6%
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	152	109	71.7%

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	152	39	25.7%
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	152	59	38.8%
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	120	55	45.8%

Please refer to Appendix A: Study Indicators 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) (86.8 percent and 67.8 percent, respectively), while the majority of these members did not have a timely visit with a dental provider (47.2 percent and 29.6 percent, respectively). Most members who had a dental provider visit also had a PCP visit. Among members newly enrolled in foster care, members newly enrolled in adoption assistance, and members who aged out of foster care, members with a behavioral health diagnosis were more likely to have a visit with a mental health provider (MHP) (by 26.0 percentage points, 24.0 percentage points, and 7 percentage points, respectively, for a visit within one year). Among those with a behavioral health diagnosis, 93.1 percent of new foster care members and 68.3 percent of new adoption assistance members had an MHP visit within one year of enrollment. Furthermore, 79.0 percent of children newly enrolled in foster care had an MHP visit within 60 days of enrollment. However, only 45.8 percent of members who aged out of foster care had an MHP visit within the measurement year.

Health Disparities Findings

Table 1-7 contains the count and percentage of 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	15	57.7%
Healthcare Utilization: Children Receiving Adoption Assistance	15	57.7%
Healthcare Utilization: Former Foster Care Members	5	21.7%
Timely Access to Care	9	56.3%
Sex		
Healthcare Utilization: Children in Foster Care	5	19.2%
Healthcare Utilization: Children Receiving Adoption Assistance	4	15.4%

Disparity Type and Analysis	Count of Study Indicators	Percent of Study Indicators
Healthcare Utilization: Former Foster Care Members	12	52.2%
Timely Access to Care	10	62.5%
Race		
Healthcare Utilization: Children in Foster Care	7	26.9%
Healthcare Utilization: Children Receiving Adoption Assistance	7	26.9%
Healthcare Utilization: Former Foster Care Members	4	17.4%
Timely Access to Care	2	12.5%
Region		
Healthcare Utilization: Children in Foster Care	15	57.7%
Healthcare Utilization: Children Receiving Adoption Assistance	15	57.7%
Healthcare Utilization: Former Foster Care Members	11	47.8%
Timely Access to Care	10	62.5%
MCO		
Healthcare Utilization: Children in Foster Care	15	57.7%
Healthcare Utilization: Children Receiving Adoption Assistance	15	57.7%
Healthcare Utilization: Former Foster Care Members	6	26.1%
Timely Access to Care	5	31.3%

For the healthcare utilization study indicators, the health disparities analysis identified few disparities by race for all study populations and by sex for children in foster care and children receiving adoption assistance; however, 52.2 percent of former foster care members demonstrated a disparity by sex. There were consistent trends among these disparities for the former foster care members (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 both children in foster care and children receiving adoption assistance, 57.7 percent of study indicators demonstrated a disparity by age category. 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 analysis, a majority of study indicators demonstrated disparities by age, sex, and region.

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 2022–23 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.
- The administrative claims and encounter data do not include denied pharmacy encounters. Therefore, study indicators for which the specifications include denied claims may underestimate pharmaceutical events (e.g., identification of members on antipsychotics for the denominator of the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* indicator). However, this limitation applies to all reported measurement years and populations, so trending and comparisons between populations are not affected.
- 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, MY 2021, and MY 2022 findings may be impacted by the onset of the coronavirus disease 2019 (COVID-19) public health emergency (PHE). Therefore, HSAG recommends exercising caution when interpreting these findings, where applicable.

Conclusions and Recommendations

The 2022–23 Child Welfare Focus Study highlights identified priorities for the Virginia Medicaid program related to improving and monitoring healthcare utilization and timely access to care for members in child welfare programs and identifying health disparities. DMAS continues to work with HSAG and the MCOs to address areas of opportunity to provide high quality care to Virginians. This section includes the conclusions from this year's study, recommendations for DMAS' consideration, and DMAS' follow-up on prior year focus study recommendations. As context for the conclusions and recommendations, DMAS has implemented policy changes and supported initiatives during the study period to improve utilization of and timely access to care among members in child welfare programs, including the following:

- As part of the SFY 2022–23 Medallion 4.0 Managed Care Services Agreement, effective July 1, 2022:
  - DMAS added language to improve continuity of and timely access to care for former foster care members, including ensuring MCOs provide members who are aging out of foster care with a "health summary" consolidating key medical information, ensuring MCOs coordinate with the local departments of social services (LDSS) during the transition period, ensuring case management continues during the transition period, and ensuring MCOs document transition needs for children in foster care who will age out of foster care in their individualized care plan, if applicable.
  - DMAS added language requiring MCOs to participate in child welfare stakeholder collaboration work groups, when requested.
- On April 1, 2022, Governor Glenn Youngkin launched the Safe and Sound Task Force, which aims to work collaboratively across state and local agencies to address barriers related to safe and appropriate placements for children in foster care. DMAS participates in the Task Force and supports efforts to improve timely access to and utilization of medical and behavioral healthcare services for children in foster care.
- DMAS and the Department of Behavioral Health and Developmental Services collaborated to launch Project BRAVO (Behavioral Health Redesign for Access, Value and Outcomes), a multi-phase initiative to enhance behavioral health services in Virginia. Under this initiative, Virginia Medicaid began covering additional behavioral health services such as mental health intensive outpatient services, effective July 1, 2021, and multisystemic therapy, effective December 1, 2021.

Please see the DMAS' Input on Prior Year Focus Study Recommendations section for more details regarding additional DMAS initiatives related to members in child welfare programs.

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.[1-1] 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.[1-2] This study demonstrated that children in foster care had higher rates of appropriate healthcare utilization than comparable controls for the majority of study indicators in MY 2022, MY 2021, and MY 2020. Among study indicators where children in foster care had higher rates, MY 2022 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 14.9, 15.6, 15.6, and 9.8 percentage points, respectively), the *Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics* indicator (by 17.1 percentage points), and the *Behavioral Health Encounters—CMH Services*, *Behavioral Health Encounters—Traditional Services,* and *Follow-Up After ED Visit for Mental*

[1-1] Virginia Department of Social Services. Foster Care (FC). Available at: https://www.dss.virginia.gov/family/fc/index.cgi#manuals. Accessed on: Mar 20, 2024.

[1-2] 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: Mar 20, 2024.

Illness—30-Day Follow-Up indicators (by 15.3, 13.3, and 13.3 percentage points, respectively). Rate differences between children in foster care and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2022, children in foster care had lower rates compared to controls for nine study indicators, of which three were statistically significant: *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*, *ED Visits*, and *Overall Service Utilization.* For *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*, the rate for children in foster care was 22.0 percentage points lower than the rate for controls in MY 2022, although children in foster care had a higher rate than controls during MY 2020 and MY 2021. For the *ED Visits* study indicator, the rate for children in foster care was 8.6 percentage points lower than the rate for controls, which could reflect better management of health conditions for children in foster care. For the *Overall Service Utilization* indicators, the rate difference between children in foster care and controls was less than 2 percentage points, and the rates for children in foster care were very high. Additionally, while the rate difference was not statistically significant due to small denominators, the rate for children in foster for the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* was 9.6 percentage points lower than rate for controls, and there were similar findings in MY 2020 and MY 2021.

Among children in foster care, eight study indicator rates increased, while 18 study indicator rates decreased from MY 2021 to MY 2022, and from MY 2020 to MY 2022, two study indicator rates increased, while 13 study indicator rates decreased. The largest declines from MY 2021 to MY 2022 were for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* indicator (by 28.6 percentage points), the *Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics* indicator (by 11.0 percentage points), and the *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* indicator (by 10.2 percentage points). However, eight of the MY 2021 to MY 2022 rate declines for children in foster care were by less than 3 percentage points. Among controls for children in foster care, 12 study indicator rates increased, while 16 study indicator rates decreased from MY 2021 to MY 2022, and from MY 2020 to MY 2022, 12 study indicator rates increased, while five study indicator rates decreased.

Among children in foster care, 15 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, children in foster care who were 14 years of age and older also had significantly lower rates for the *Preventive Dental Services; Oral Evaluation, Dental Services;* and *Topical Fluoride for Children—Dental or Oral Health Services* indicators despite Virginia State guidelines that children in foster care should have dental examinations every six months while in foster care.[1-3] Additionally, for the *ED Visits* and *Inpatient Visits* indicators, the rates for children in foster care 14 years of age and older were higher than the rates for controls as well as all other age categories. Five study indicators demonstrated disparities between males and females—female members had significantly higher rates for the *Inpatient Visits* indicator, while male members had significantly higher rates for 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* and *Behavioral Health Encounters—Therapeutic Services*

[1-3] 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: Mar 20, 2024.

indicators. Seven study indicators demonstrated disparities between racial groups—Black or African American members had significantly lower rates for the *Ambulatory Care Visits, Behavioral Health Encounters—ARTS*, and *Overall Service Utilization* indicators compared to other racial groups, while White members had significantly higher rates for the *Ambulatory Care Visits*, *Behavioral Health Encounters—ARTS, Behavioral Health Encounters—Traditional Services*, and *Overall Service Utilization* indicators. Finally, members in the Other racial group had significantly lower rates for the *ED Visits*, *Behavioral Health Encounters—CMH Services*, and *Behavioral Health Encounters—Total* indicators. These disparities typically existed among controls as well.

Among children in foster care, 15 study indicators had disparities across regions. Of note, members in the Roanoke/Alleghany region consistently had significantly lower rates for Oral Health domain study indicators, while members in the Southwest region had significantly better rates for several of the Oral Health domain and *Behavioral Health Encounters* indicators compared to members in other regions. Findings also showed 15 study indicators with disparities between MCOs. Of note, members enrolled with Molina had lower rates for three of the four Oral Health domain study indicators as well as the *Ambulatory Care Visits* indicator compared to members enrolled with other MCOs.

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

- Findings show that the rates for children in foster care for the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* indicator were lower than controls for MY 2020, MY 2021, and MY 2022. Additionally, the rates for the *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* indicator were lower than controls for MY 2020 and MY 2022. For both indicators, MY 2022 rates were below the national Medicaid 50th percentiles. Additionally, children in foster care had a significantly lower rate than controls for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* indicator. However, children in foster care had a similar rate as controls when looking at follow-up visits within 30 days, suggesting that timeliness of care is a key factor. Therefore, HSAG recommends that DMAS consider focusing quality improvement efforts toward improving utilization of these services for children in foster care. For example, the MCOs could work with case managers, service workers, and foster parents to identify barriers to SUD treatment and mental health treatment (e.g., the foster child's consent for SUD treatment, timeliness of review for ARTS coverage, and timely access to mental health providers) and test strategies to address those specific barriers.
- The COVID-19 PHE impacted healthcare utilization nationally and ended in May 2023. All study indicator findings in this report may be affected by the COVID-19 PHE. DMAS may consider continuing to monitor these study indicators to ensure that these rates stabilize over MY 2023 and MY 2024 and establish a new baseline post-pandemic.
- SFY 2022–23 is the second year to include a health disparities analysis in this study. While a greater percentage of indicators demonstrated racial disparities during MY 2022 compared to MY 2021, a lower percentage of indicators had disparities by age, sex, region, and MCO in MY 2022. The analysis identified few disparities of concern among children in foster care. DMAS may consider focusing quality improvement efforts to reduce health disparities toward improving the rate of dental services, preventing ED visits, where appropriate, and understanding the main drivers of inpatient visits among older children in foster care and improving the rates of dental services among children in foster care in the Roanoke/Alleghany region. DMAS and the MCOs may consider conducting focus groups with key parties (i.e., case managers, service workers, and foster parents) for these subpopulations (i.e., older children and members in the Roanoke/Alleghany region) to

understand challenges associated with utilization of these services and implement targeted interventions for the greatest impact.

- While the current study design provides insight into utilization of healthcare services, it does not assess the comprehensiveness 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 psychotic disorders are receiving and adhering to appropriate medications and managing their condition in the appropriate settings.

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.[1-4] 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.[1-5] This study demonstrated that children receiving adoption assistance have higher rates of appropriate healthcare utilization than comparable controls for approximately half of study indicators in MY 2022, MY 2021, and MY 2020. Study findings show that children receiving adoption assistance had higher rates than controls for all four Oral Health domain study indicators, *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, Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up*, *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing*, *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*, both *Initiation and Engagement of SUD Treatment* indicators, *Asthma Medication Ratio, Inpatient Visits*, and five 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 2022, children receiving adoption assistance had lower rates compared to controls 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*, *Child and Adolescent Well-Care Visits, Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up,* all *Follow-Up Care for Children Prescribed ADHD Medication* study indicators, *Ambulatory Care Visits*, *ED Visits*, *Behavioral Health Encounters—CMH Services,* and *Overall Service Utilization*, of which six differences were statistically significant. 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 55.3 percentage points) and the *Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up* study indicator (by 11.7 percentage points). However, the denominator for the *Well-Child Visits in the First 30 Months*

[1-4] 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: Mar 20, 2024

[1-5] 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: Mar 20, 2024.

of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits study indicator was very small, so the rate is expected to fluctuate more. For five 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 11.6 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, 16 study indicator rates increased, while 12 study indicator rates decreased from MY 2021 to MY 2022, and from MY 2020 to MY 2022, nine study indicator rates increased, while six study indicator rates decreased. The largest declines from MY 2021 to MY 2022 were for the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* study indicator (by 11.8 percentage points) and *the Behavioral Health Encounters—Traditional* study indicator (by 7.1 percentage points). 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 also decreased (by 50.0 percentage points); however, the denominator is very small for this study indicator, so rate changes across time are expected to be larger. Additionally, six of the rate declines among children in adoption assistance from MY 2021 to MY 2022 were by less than 3 percentage points. Among controls for children receiving adoption assistance, 15 study indicator rates increased, while 14 study indicator rates decreased from MY 2021 to MY 2022, and from MY 2020 to MY 2022, 13 study indicator rates increased, while four study indicator rates decreased.

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, 15 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 all indicators in the Oral Health domain, older children receiving adoption assistance had significantly lower rates compared to younger children. Four study indicators demonstrated disparities between males and females—female members had significantly higher rates for the *Inpatient Visits* indicator, while male members had significantly higher rates for the *Behavioral Health Encounters—Total, Behavioral Health Encounters—CMH Services,* and *Behavioral Health Encounters—Therapeutic Services* indicators. Seven study indicators demonstrated disparities between racial groups—Black or African American members had significantly higher rates for the *Child and Adolescent Well-Care Visits*, *Oral Evaluation, Dental Services*, *Behavioral Health Encounters—CMH Services, Behavioral Health Encounters—RTC Services,* and *Behavioral Health Encounters—Traditional Services* indicators and a significantly lower rate for the *Ambulatory Care Visits* indicator compared to other racial groups, while White members had a significantly higher rate for the *Ambulatory Care Visits* indicator and significantly lower rates for the *Child and Adolescent Well-Care Visits, Oral Evaluation, Dental Services, and Behavioral Health Encounters—Traditional Services* indicators. Additionally, children receiving adoption assistance in the Other racial group had a significantly lower rate for the *Behavioral Health Encounters—Traditional Services* indicator. Some of these disparities were also seen among controls.

There were also some disparities identified across regions and MCOs. For example, members in the Northern & Winchester region had significantly lower rates for well-child visits, three of the four indicators in the Oral Health domain, and three types of behavioral health encounters compared to members in other regions. Additionally, members enrolled with Aetna and Molina had significantly lower rates for well-child visits, all indicators in the Oral Health domain, and two types of behavioral health encounters compared to members enrolled with other MCOs.

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

- The SFY 2022–23 study found that children receiving adoption assistance had lower rates than controls 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*, *Child and Adolescent Well-Care Visits*, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up,* and all *Follow-Up Care for Children Prescribed ADHD Medication* study indicators. However, many children receiving adoption assistance have special medical conditions that may preclude doctor visits from being billed as a well-child visit. Therefore, HSAG recommends that DMAS consider focusing quality improvement efforts toward improving utilization of behavioral health services, where appropriate, for children receiving adoption assistance. For example, MCOs could work with care coordinators and adoptive parents to identify barriers to behavioral health follow-up visits (e.g., availability of behavioral health providers and transportation challenges for adoption parents) and test strategies to address those specific barriers.
- The COVID-19 PHE impacted healthcare utilization nationally and ended in May 2023. All study indicator findings in this report may be affected by the COVID-19 PHE. DMAS may consider continuing to monitor these study indicators to ensure that these rates stabilize over MY 2023 and MY 2024 and establish a new baseline post-pandemic.
- SFY 2022–23 is the second year to include a health disparities analysis in this study. While a greater percentage of indicators demonstrated disparities by age during MY 2022 compared to MY 2021, a lower percentage of indicators had disparities by sex, race, region, and MCO in MY 2022. Rates tended to be lower for older members, as well as for members in the Northern & Winchester region and members enrolled with Aetna and Molina. DMAS and the MCOs may consider conducting focus groups with key parties (i.e., care coordinators and adoptive parents) for these subpopulations to understand challenges associated with utilization of these services and implement targeted interventions for the greatest impact.
- While the current study design provides insight into utilization of healthcare services, it does not assess the comprehensiveness 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.[1-6] This study demonstrated that former foster care members have higher rates of appropriate healthcare utilization than comparable controls for approximately half of the study indicators in MY 2022, MY 2021, and MY 2020. Study findings show that former foster care members had higher rates than controls for *Child and Adolescent Well-Care Visits*, *Annual Dental Visit*, *Oral Evaluations, Dental Services, Topical Fluoride for Children—Dental or Oral Health Services, Follow-Up After ED Visit for Substance Use—30-Day Follow-Up*, both *Initiation and Engagement of SUD Treatment* indicators*, ED 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 2022, former foster care members had lower rates compared to controls for all Behavioral Health domain study indicators*, Asthma Medication Ratio, Ambulatory Care Visits*, and *Overall Service Utilization*. The largest differences were for the *Asthma Medication Ratio* study indicator (by 37.8 percentage points), the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* study indicator (by 17.2 percentage points), the *Antidepressant Medication Management—Effective Acute Phase Treatment* study indicator (by 8.4 percentage points), and the *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* study indicator (by 7.4 percentage points).

Among former foster care members, all study indicator rates except the *Topical Fluoride for Children—Dental or Oral Health Services, Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment, ED Visits, Behavioral Health Encounters—ARTS,* and the *Behavioral Health Encounters—RTC Services* study indicators decreased from MY 2021 to MY 2022. The largest declines from MY 2021 to MY 2022 were for the *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* indicator (by 12.2 percentage points) and the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* indicator (by 12.0 percentage points). The *Asthma Medication Ratio* indicator also decreased substantially (by 47.0 percentage points); however, the denominator is small, so rate changes across time are expected to be larger. Among controls for former foster care members, all study indicator rates decreased from MY 2021 to MY 2022 except for the *Annual Dental Visit, Preventive Dental Services, Topical Fluoride for Children—Dental or Oral Health Services, Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up, Inpatient Visits, ED Visits, Behavioral Health Encounters—ARTS,* and *Behavioral Health Encounters—RTC Services* study indicators.

Among former foster care members, five study indicators demonstrated disparities across age categories. Members 23 to 26 years of age were less likely to have an ED visit, behavioral health encounter with CMH services or any service, a follow-up visit after an ED visit for mental illness, or any service utilization type compared to members 19 to 22 years of age. Twelve indicators demonstrated disparities by sex, where male members consistently had lower rates of healthcare utilization compared to female members. Male members had significantly lower rates for the *Child and Adolescent Well-Care Visits, Annual Dental Visit, Preventive Dental Services, Oral Evaluation, Dental Services, Ambulatory Care Visits, ED Visits, Inpatient Visits, Behavioral Health Encounters—Total, Behavioral Health Encounters—ARTS, Behavioral Health Encounters—Traditional Services,* and *Overall Service Utilization* indicators*.* Four study indicators demonstrated disparities by race/ethnicity. Of note, White members had significantly higher rates for the *Ambulatory Care Visits* indicator, while Black or African American members had significantly lower rates; however, Black or African American members had

[1-6] 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_2022/Section_13_achieving_permanency_for_older_youth.pdf. Accessed on: Mar 20, 2024.

significantly higher rates for the *Behavioral Health Encounters—CMH Services* and *Behavioral Health Encounters—Therapeutic Services* indicators, while White members had significantly lower rates. Eleven study indicators demonstrated disparities by region. Of note, members in the Tidewater region had significantly lower rates for the *Ambulatory Care Visits, Annual Dental Visit, Preventive Dental Services, Oral Evaluation, Dental Services, Behavioral Health Encounters—ARTS, Behavioral Health Encounters—CMH Services, Behavioral Health Encounters—Traditional Services, Behavioral Health Encounters—Total,* and *Overall Service Utilization* indicators. Six study indicators demonstrated disparities by MCO; however, there were no overarching trends.

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

- The SFY 2022–23 study found that former foster care members had lower rates than controls for all Behavioral Health domain study indicators. HSAG recommends that DMAS consider focusing quality improvement efforts toward improving utilization of these services, where appropriate, for former foster care members. MCOs could work with case managers and service workers who maintain contact with former foster care members to identify challenges with utilizing these behavioral health services to inform quality improvement efforts.
  - In July 2022, DMAS began requiring MCOs to provide members aging out of foster care with a "health summary" consolidating key medical information (e.g., providers, appointments, prescriptions). It will be important to monitor whether these additional resources impact utilization of behavioral health services for members who aged out of foster care in CY 2023.
- The COVID-19 PHE impacted healthcare utilization nationally and ended in May 2023. All study indicator findings in this report may be affected by the COVID-19 PHE. DMAS may consider continuing to monitor these study indicators to ensure that these rates stabilize over MY 2023 and MY 2024 and establish a new baseline post-pandemic.
- SFY 2022–23 is the second year to include a health disparities analysis in this study. The analysis identified disparities in healthcare utilization across age, sex, race, and region among former foster care members. Disparities were particularly consistent for male members, who had significantly lower utilization of services for 11 study indicators, and for members in the Tidewater region, who had significantly lower utilization of services for nine study indicators. DMAS may consider focusing quality improvement efforts among former foster care members toward these subpopulations. DMAS and the MCOs may consider conducting focus groups with members from these subpopulations (i.e., male members and members in the Tidewater region) to understand challenges associated with utilization of these services and implement targeted interventions for the greatest impacts.

Timely Access to Care

SFY 2022–23 is the second year to include analyses for timely access to care in this study. Virginia State guidelines require that children in foster care receive a medical examination no later than 30 days after initial placement in foster care.[1-7] Virginia State guidelines also require that the child have a visit

[1-7] Virginia Department of Social Services. Child and Family Services Manual: Identifying Services to be Provided. Available at: https://www.dss.virginia.gov/files/division/dfs/fc/intro_page/guidance_manuals/fc/07_2022/section_12_identifying_services_to_be_provided.pdf. Accessed on: Mar 20, 2024.

with a mental health professional within 60 days of initial placement in foster care if a trauma, mental health, or substance use condition is identified during the medical examination.[1-8] 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.[1-9] DMAS is 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 2022–23 study found that 86.8 percent of new foster care members had a visit with a PCP within 30 days after or 90 days prior to entering foster care during MY 2022, an increase of 0.6 percentage points from the year prior. Therefore, most children in foster care are receiving timely access to primary care; however, there may still be some room for improvement in meeting State guidelines. Additionally, 47.2 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 during MY 2022. This rate improved by 3.2 percentage points from MY 2021. Study indicators also assessed timely access to primary and dental care for members who aged out of foster care. Findings demonstrate that 67.8 percent of members who aged out of foster care in the year prior to the MY had a visit with a PCP during MY 2022, and this rate decreased by 2.0 percentage points from MY 2021. Similar to new foster care members, only 29.6 percent of members who aged out of foster care had a visit with a dental practitioner during MY 2022, and most of these members also had a visit with a PCP. This rate decreased by 5.0 percentage points from MY 2021.

Several study indicators assessed timely access to behavioral healthcare, including several new study indicators introduced in the SFY 2022–23 study assessing timely access to behavioral healthcare for new foster care members and new adoption assistance members. The SFY 2022–23 study found that 50.5 percent of new foster care members and 79.0 percent of new foster care members with a diagnosed behavioral health condition had at least one visit with an MHP within 60 days of enrollment in the foster care program. Additionally, 67.1 percent of new foster care members and 93.1 percent of new foster care members with a behavioral health diagnosis had a visit with an MHP within a year after enrollment in the foster care program. For newly enrolled members in the adoption assistance program, 44.3 percent of all members and 68.3 percent of members with a behavioral health diagnosis had a visit with an MHP. Lastly, 78.9 percent of members who aged out of foster care had a behavioral health diagnosis, and 45.8 percent of these members with a behavioral health diagnosis had a visit with an MHP during MY 2022; this rate improved by 6.4 percentage points from MY 2021.

Similar to the healthcare utilization analysis, HSAG conducted a health disparities analysis for the timely access to care study indicators. Among new foster care members, older members were less likely to have a visit with a PCP and more likely to have a visit with a dental practitioner. Additionally, for new foster care members, older members were more likely to have an MHP visit among all members but less likely among members with a behavioral health diagnosis for both the 60-day and one-year time frames. Female members who aged out of foster care were more likely to have a visit with a dental practitioner 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 PCP. The rate difference was particularly large for members who aged out of foster care and had PCP visits, where the rate for male members was 41.6 percentage points lower than the rate for female members. Members newly enrolled in foster care in the Northern & Winchester region were significantly less likely to have a PCP or MHP visit compared to members in other regions, and members newly enrolled in the adoption assistance

[1-8] Ibid.

[1-9] Commonwealth of Virginia DMAS. Medallion 4.0 Managed Care Services Agreement. Available at: https://www.dmas.virginia.gov/media/4981/medallion-40-sfy23.pdf. Accessed on: Mar 20, 2024.

program in Northern & Winchester were significantly less likely to have an MHP visit. There were no notable trends across indicators by race/ethnicity or MCO.

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, particularly in dental care for new foster care members and both primary care and dental care for members who aged out of foster care. The MCOs may consider working with case managers for both new foster care members and members who age out of foster care, service workers and foster parents for new foster care members, and service workers who maintain contact with members who aged out of foster care to identify challenges (e.g., healthcare navigation, dental provider availability, and transiency) to inform quality improvement efforts.
  - In July 2022, DMAS began requiring MCOs to provide members aging out of foster care with a "health summary" consolidating key medical information (e.g., providers, appointments, prescriptions). It will be important to monitor whether these additional resources impact timely access to care for members who aged out of foster care in CY 2023.
  - During SFY 2022–23, the Foster Care Affinity Group, which is co-led by DMAS and VDSS, piloted strategies to improve timely access to initial comprehensive medical examinations for new foster care members and will continue to adapt and scale up strategies to improve timely access to care.
- The health disparities analysis identified disparities in timely access to care across age, sex, and region. The greatest disparity was between female and male members who aged out of foster care, where male members were much less likely to have a PCP visit. This disparity persisted over both MY 2021 and MY 2022. DMAS may consider focusing quality improvement efforts for timely access to care toward male members who aged out of foster care.
- SFY 2022–23 is the second year to include analyses for timely access to care, and both MY 2021 and MY 2022 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 the impact 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 2021–22 Child Welfare Focus Study.

Data Recommendations

SFY 2021–22 was the first year to introduce new analyses related to health disparities and timely access to care for children in foster care, children receiving adoption assistance, and former foster care members. 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 such as age, sex, race, region, and MCO. DMAS has requested that the 2022–23 study, as well as all future studies, continue to include these additional analyses to verify appropriate baseline rates, identify areas for improvement, and monitor impacts of program changes.

SFY 2021–22 is the second year to include analyses for children receiving adoption assistance and former foster care members. However, considering the impact of the COVID-19 pandemic on healthcare utilization during MY 2020 and MY 2021, children receiving adoption assistance and former foster care members' rates during MY 2020 and MY 2021 may not be representative of their historical rates. Therefore, DMAS has requested that the 2022–23 study 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 and reduce health disparities among members involved in the child welfare system, to determine areas of focus and improvement.

Safe and Sound Task Force

Under the leadership of Virginia's Governor, the Safe and Sound Task Force has continued through SFY 2022–23. The objective of the task force is to work collaboratively across state and local agencies to address the barriers related to safe and appropriate placements (including access to medical and behavioral health services) for children in foster care.

Two core priorities identified by the Task Force during SFY 2022–23 include addressing gaps in children's community-based behavioral health services and increasing access to evidence-based services, as well as improving residential treatment services for children. DMAS will continue to analyze data and utilize recommendations posed by HSAG around behavioral health encounters measures (including timely access to care) to determine areas of focus and improvement for all three child welfare member populations included in this study.

The Task Force will continue under the current administration to focus on increasing the provision of services to children, families, and those in the community who provide for their well-being. Representatives from DMAS' Health Care Services and Behavioral Health divisions will continue to participate in the Core Team of the Task Force to work toward the goal of improving medical and behavioral healthcare services as well as timely access to and utilization of services for child welfare members.

Community Partnerships

During SFY 2022–23, DMAS continued hosting virtual statewide Foster Care Partnership meetings with child welfare stakeholders from across the state. These stakeholders included those from the VDSS, the Virginia Commission on Youth, LDSS, Licensed Child Placing Agencies (LCPAs), MCOs, and the Virginia Office of Children's Services, among others.

The purpose of the Foster Care Partnership is to improve collaboration among all individuals involved in the treatment and care of youth in foster care in Virginia, as well as to focus on actionable goals related to improving services for youth in foster care. The areas of focus, or "action groups" for this year were created based on cross-sector discussions around current needs of youth in foster care, factoring in results and recommendations of the 2021–22 Child Welfare Focus Study.

One action group planned and implemented four webinar trainings for local and state DSS workers and foster parents related to various topics of interest and importance, including:

- Medicaid services and benefits available, care coordination, and MCOs' role in assisting DSS in meeting the spectrum of healthcare needs of youth in foster care
- Residential treatment services for youth
- Dental benefit for youth in foster care
- Trauma-informed MCO care coordination

The second action group of the Foster Care Partnership this year focused on continuing the Foster Care Affinity Group project, with a specific focus on timely access to initial well-child visits upon entering foster care, which will be discussed in the Foster Care Affinity Group section below.

DMAS plans to continue facilitating the Foster Care Partnership and related sub-groups, with a continued focus on interagency collaboration for improved outcomes and service utilization for children in foster care, children receiving adoption assistance, and former foster care members in Virginia. DMAS will continue to use HSAG study recommendations for these member populations to inform the quality improvement focus areas for the group.

Right Help Right Now

The Governor's Right Help Right Now plan aims to achieve the goal that all Virginians will, 1) be able to access behavioral healthcare when they need it; 2) have prevention and management services personalized to their needs, particularly for children, youth, and families; 3) know who to call, who will help, and where to go when in crisis; and 4) have paths to re-entry and stabilization when transitioning from a crisis. DMAS is an integral partner and stakeholder within this plan. This year, in support of the Governor's Right Help Right Now Behavioral Health Transformation Plan, DMAS in collaboration with other state agencies and stakeholders has been working on the following initiatives:

- Identifying service innovations and best practices in behavioral health services, which include a specific focus on developing a new school-based behavioral health service for youth and researching best practice models for youth mental health residential treatment services
- Identifying and researching evidence-based programs specific to youth
- Assessment of health plan behavioral health network adequacy.

DMAS' goal, in partnership with this plan, is to increase efficacy, access, and utilization of effective and appropriate behavioral health services for Medicaid members in Virginia. Considering the importance of behavioral health services to the child welfare member population, DMAS will continue to work collaboratively with its partners to move Right Help Right Now forward, enhance current services, identify innovations in service delivery, and close capacity gaps in these services.

Foster Care Affinity Group

During CY 2023, 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 work together toward the goals of the project. 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 SFY 2022–23 continuing to gather and analyze data related to the process and outcome measures identified in the project, which include: the timely transfer of information about new foster care members from the LDSS agencies to the MCOs, timely initial MCO outreach to foster care members to begin care coordination and service initiation efforts, and timely initial comprehensive medical examinations. According to the data collected for this project, most children entering foster care in Virginia are already enrolled in a Medicaid MCO. However, upon entering DSS custody there is still a statewide delay of 63 days on average for the data system to update the enrollment information for the MCO to be notified that their member has entered foster care. This means that Medicaid and MCOs are not often able to intervene or assist with care coordination for members in foster care in the first 30 days of their placement into custody.

The most successful pilot to date has been a warm handoff with Bedford County DSS, where the Foster Care Supervisor sends a secure email to DMAS on the date of custody for all new foster care admissions in Bedford. DMAS is then able to inform the child's assigned MCO that their member has entered foster care and needs outreach and assistance in setting up initial services, which includes a comprehensive medical exam within the first 30 days of placement. Through this warm handoff, the MCO notification time in Bedford during SFY 2022–23 improved from an average of 39 days to one (1) day from the date of custody. Additionally, successful outreach by the MCO to the member or legal guardian improved in Bedford County from an average of 52 days to an average of four days. Finally, the rate of initial medical exams occurring within 30 days of custody has improved in Bedford from an average of 69 percent to 73 percent since starting the warm handoff pilot.

The Affinity Group will continue to meet as a quality improvement-focused action group of the Foster Care Partnership. This group will continue working to adapt and scale up the current Affinity Group project aim and will also develop collaborative quality improvement projects in different areas of service utilization for youth in foster care taking into account the recommendations of the HSAG Child Welfare Focus Study.

Member Outreach

During SFY 2022–23, DMAS launched a quarterly Foster Care Newsletter to keep partners and stakeholders up to date about resources, events and trainings, and any changes or news related to Medicaid that may impact youth in the child welfare system. These newsletters have included information from all recent Foster Care Partnership trainings, as well as upcoming events and trainings, and member "success stories" related to MCOs addressing barriers to necessary services and improving access to care.

Additionally, during SFY 2022–23, a flyer created by the Foster Care Partnership continued to be distributed electronically on a regular basis to LDSS foster care staff and other stakeholders. 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 for all MCOs and DMAS, 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 at the annual Children's Services Act Conference, DMAS' BabySteps Bimonthly meeting, Safe & Sound Task Force, and the Central Region Independent Living Advocates for Youth, among others. 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 children in foster care, children receiving adoption assistance, 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 2023, DMAS compiled a 2021–22 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 2021–22. 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 (Acute) Program Oversight Efforts

On October 1, 2023, DMAS began rolling out a unified health program called Cardinal Care. Cardinal Care is a single brand encompassing all health coverage programs for Virginia's 2 million Medicaid members. Cardinal Care includes Medallion 4.0 (Acute), CCC Plus (MLTSS), 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 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, including DMAS, has continued to work together on this initiative 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.

Psychiatric Residential Treatment Facility (PRTF) Workgroup

At the direction of the Secretary of Health and Human Resources, DMAS convened a workgroup consisting of program experts, representatives of stakeholder organizations, and other local and state agencies to assess the impacts of including coverage for Residential Treatment Services for youth with a primary mental health diagnosis provided by a PRTF in the Medicaid Managed Care contract. (Members are currently excluded from managed care for all services for the duration of their time in a PRTF.) This workgroup met three times for two-hour sessions each to discuss the impact, structure, and costs of including this service in managed care. The work group recommended that DMAS be directed to implement a managed care carve-out for PRTF, such that members would remain with their MCO for coverage of all non-PRTF services, and that the benefits and services that make up PRTF are carved out and managed via FFS.

Current Procurement for Cardinal Care Managed Care Contracts and a Single Foster Care Specialty Plan

The current procurement underway reflects DMAS' goals to improve MCO accountability in service delivery and member access with particular focus on behavioral health, and maternal and child health. Cardinal Care will emphasize enhanced expectations for performance and quality improvement, member engagement, use of new technology, and new payment models.

The current procurement includes a provision for one MCO to administer a single specialty plan for the child welfare member populations. Through the Foster Care Specialty Plan, DMAS will select one MCO that will operate statewide and work collaboratively with DMAS, the Department of Social Services (DSS), and the Office of Childrens' Services.

DMAS plans to enroll all children and youth in foster care in the Foster Care Specialty Plan. It is anticipated that youth in adoption assistance and former foster care members will be auto-assigned to the Foster Care Specialty Plan but may elect to enroll in another health plan.

2. Overview and Methodology

Overview

Beginning in contract year 2015–16, 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 2022–23, 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 2022 (i.e., January 1, 2022–December 31, 2022). While historically the Child Welfare Focus Study evaluated healthcare utilization among members in the study populations, for the 2021–22 and 2022–23 focus studies, 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]

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

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2-1 Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 9. Conducting Focus Studies of Health Care Quality*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Mar 20, 2024.

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: Mar 20, 2024.

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.

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 health differences that are closely linked with social, economic, and/or environmental disadvantages.[2-6] The 2022–23 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 2022 findings to MY 2020 and MY 2021 findings, where applicable. Since the COVID-19 PHE began during MY 2020, results should be interpreted with caution as they may be impacted by policies enacted to address the PHE.

Methodology

Data Sources

This study examines services received by children in foster care, children receiving adoption assistance, and former foster care members during MY 2022 (i.e., January 1, 2022–December 31, 2022). Additionally, selected study indicators include services occurring up to one year before this measurement year. Appendix A: Study Indicators provides detailed information on the measurement period for each study indicator. HSAG received administrative claims and encounters paid through June 30, 2023, as well as demographic, eligibility, and enrollment data, from DMAS in July 2023 for this study. In addition, DMAS supplied HSAG with dental encounter data from the Medicaid dental benefit manager, DentaQuest.

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, 2022, 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, 2022, and identified by DMAS as enrolled in Medicaid under the aid category "072" for children in the adoption assistance program.

2-5 CMS. CMS External Quality Review (EQR) Protocols. Available at: http://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Mar 20, 2024.

2-6 Commonwealth of Virginia DMAS. 2023–2025 Quality Strategy. Available at: https://www.dmas.virginia.gov/media/5569/va2023-dmas-quality-strategy-f1.pdf. Accessed on: Mar 20, 2024.

- Former Foster Care Members—All members enrolled in Medicaid 19 to 26 years of age as of January 1, 2022, 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 [Acute] or CCC Plus [MLTSS]) 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 (Acute) enrollment was identified by the benefit package prefixes of "0103" or "0143," indicating enrollment in Medallion 3.0 or Medallion 4.0 (Acute), respectively. CCC Plus (MLTSS) enrollment was identified by benefit package prefixes of "0112" and "0114," indicating enrollment in the CCC Program for Dual-Eligibility or CCC Plus (MLTSS), 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 (Acute) or CCC Plus (MLTSS) 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: Characteristics of the Controls 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 logistic regression models to predict child welfare program 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.

[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: Mar 20, 2024.

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 (Acute), CCC Plus (MLTSS)

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
- Diagnosis of Developmental Disorder (Children in Foster Care and Adoption Assistance Children only)
- 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 only)
- Diagnosis of Rheumatologic Condition (Former Foster Care Members only)
- Diagnosis of Substance Use Disorder
- Diagnosis of Psychotic Disorder (Former Foster Care Members only)
- 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 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

[2-8] Age categories were calculated using the member's age at the beginning of the measurement year (i.e., January 1, 2022).

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

the Mid-Atlantic, Inc. (UnitedHealthcare); Virginia Premier Health Plan, Inc. (VA Premier); and More Than One MCO[2-10, 2-11]

- Region: Central, Charlottesville/Western, Northern & Winchester, Roanoke/Alleghany, Southwest, Tidewater, and Unknown[2-12, 2-13]
- Race category: White, Black or African American, and Other[2-14]

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. HSAG exact-matched by race since study indicator rates were stratified by race, and HSAG found that other characteristics were not sufficiently balanced within racial groups without exact matching. The study also stratified 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 subsection for more information on how rates were stratified.

Finally, HSAG matched the continuously enrolled groups and controls on their propensity scores within exact-matched sub-groups using the greedy 5→1 algorithm.[2-15] 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: Characteristics of the Controls details the interpretation of the covariate balance tests.

[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] While Optima and VA Premier merged as of July 1, 2023, the 2022–23 Child Welfare Focus Study presents the MCOs separately given the report findings are for MY 2022.

[2-12] Regional attribution was based on the demographic file and the SFY 2021–22 Managed Care Services Agreement provided by DMAS and reflects the managed care regions.

[2-13] Commonwealth of Virginia Department of Medical Assistance Services. Medallion 4.0 (Acute) Managed Care Services Agreement: Jul 1, 2021–Jun 30, 2022. Attachment XII. 405–406. Available at: https://www.dmas.virginia.gov/media/3583/medallion-4-contract-sfy22-v1.pdf. Accessed on: Mar 20, 2024.

[2-14] 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.

[2-15] 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: Mar 20, 2024.

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 2023 Reporting or custom measure specifications. The healthcare utilization analysis assessed 20 measures, representing 32 study indicators, across six domains as displayed in Table 2-1.

Table 2-1—Healthcare Utilization Measure Indicators

Measure and Indicators
Primary Care
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 (TFL-CH)
Behavioral Health
Antidepressant Medication Management—Effective Acute Phase Treatment (AMM–A) and Effective Continuation Phase Treatment (AMM–C)*
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)
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 Substance Use—30-Day Follow-Up (FUA)†
Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment (IET–I) and Engagement of SUD Treatment (IET–E)
Respiratory Health
Asthma Medication Ratio (AMR)
Service Utilization
Ambulatory Care Visits
ED Visits

Measure and Indicators
Inpatient Visits
Behavioral Health Encounters—Total, ARTS, CMH Services, RTC Services, Therapeutic Services, and Traditional Services
Overall Service Utilization

^ Indicates these study 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 study indicators were only calculated for former foster care members as the measure indicators are only applicable to members 18 years of age and older.*
† Indicates these study indicators were only calculated for the former foster care members, as the denominators for the children in foster care and the children receiving adoption assistance members are historically very small.

When available, HSAG compared MY 2022 study indicator rates to NCQA's Quality Compass®[2-16] national Medicaid health maintenance organization (HMO) percentiles or CMS' FFY 2022 Adult and Child Core Set national medians[2-17] (henceforth referred to as national Medicaid percentiles), where applicable, 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.

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 5 measures, representing 16 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

[2-16] Quality Compass® is a registered trademark of NCQA.
[2-17] Centers for Medicare & Medicaid Services. 2022 Child and Adult Health Care Quality Measures Quality. Available at: https://data.medicaid.gov/dataset/dfd13757-d763-4f7a-9641-3f06ce21b4c6. Accessed on: Mar 20, 2024.

Measure and Indicators
Dental Care for New Foster Care Members, and Timely Access to Primary Care and Dental Care 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
Timely Access to Behavioral Health Care for New Foster Care Members—Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members, Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members With a Behavioral Health Diagnosis, Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members, and Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members With a Behavioral Health Diagnosis
Timely Access to Behavioral Health Care for Members Receiving Adoption Assistance—Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members and Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members With a Behavioral Health Diagnosis

Appendix A: Study Indicators 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 and MY 2022. For each demographic characteristic (i.e., age category, sex, race, region, and continuously enrolled MCO, where applicable[2-18]), 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 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

[2-18] 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.

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 7,008 children in the foster care eligible population and the 3,695 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, 2022, receiving healthcare coverage from DMAS at any time during MY 2022. 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=7,008)

Category	Number	Percent
Age Category		
≤ 2 years	1,469	21.0%
3 to 5 years	1,129	16.1%
6 to 10 years	1,546	22.1%
11 to 13 years	967	13.8%
≥ 14 years	1,897	27.1%
Sex		
Male	3,719	53.1%
Female	3,289	46.9%
Race		
Black or African American	2,292	32.7%
White	4,543	64.8%
Other	173	2.5%
Region		
Central	1,367	19.5%
Charlottesville/Western	1,276	18.2%
Northern & Winchester	1,012	14.4%
Roanoke/Alleghany	1,233	17.6%
Southwest	879	12.5%
Tidewater	1,188	17.0%
Unknown	53	0.8%
Latest MCO in the Measurement Year		
Aetna	726	10.4%
HealthKeepers	1,922	27.4%
Molina	431	6.2%
Optima	1,463	20.9%
UnitedHealthcare	572	8.2%

Category	Number	Percent
VA Premier	1,739	24.8%
Other*	155	2.2%
Latest Medicaid Program in the Measurement Year		
CCC Plus (MLTSS)	89	1.3%
Medallion 4.0 (Acute)	6,755	96.4%
Other**	164	2.3%

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

Children in foster care were disproportionately male (53.1 percent) and Black or African American (32.7 percent) compared to the general population in Virginia, which was 49.5 percent male and 20.0 percent Black or African American in 2022.[3-1] Children in foster care were mostly from the Central (19.5 percent), Charlottesville/Western (18.2 percent), and Roanoke/Alleghany (17.6 percent) regions. The region for a small proportion of children in foster care (0.8 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 (27.4 percent), VA Premier (24.8 percent), or Optima (20.9 percent). MCO attribution was Other for 2.2 percent of children in foster care who were only enrolled in FFS during MY 2022.[3-2] Children in foster care were most likely to be enrolled through the Medallion 4.0 (Acute) program (96.4 percent). The Medicaid program for 2.3 percent of children in foster care was Other, meaning they were enrolled through FAMIS or were only enrolled in FFS during MY 2022.[3-3]

The study population consisted of those in the children in foster care eligible population who were continuously enrolled in either Medallion 4.0 (Acute) or CCC Plus (MLTSS) 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, 52.7 percent (n=3,695) of children met the requirements for the study population, compared to 50.9 percent for MY 2021 and 46.5 percent for MY 2020. The demographic makeup of the study population mirrored the demographic makeup of the foster care eligible population, except that there were 3.5 percentage points fewer children 2 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-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=3,873). 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 (MLTSS) compared to the continuously enrolled controls. Furthermore, continuously enrolled children in foster care were less likely to live in the Central, Tidewater, or Northern & Winchester regions and more likely to live in the

3-1 United States Census Bureau. Virginia QuickFacts. Available at: https://www.census.gov/quickfacts/VA. Accessed on: Mar 20, 2024.
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.

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 Child Welfare 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 95.4 percent (n=3,695) 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: Characteristics of the Controls 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. The narrative focuses on differences in rates for children in foster care and controls that were greater than 5.0 percentage points for stratified rates during MY 2022. If the difference for All Eligible Members was greater than 5.0 percentage points, the narrative for stratified rates instead focuses on differences between children in foster care and controls that were greater than the difference for All Eligible Members or that were greater than 5.0 percentage points in the opposite direction. The narrative does not discuss differences for which the children in foster care denominator or the controls denominator was less than 30, since these rates are expected to have greater variability. Additionally, the narrative compares the rates for All Eligible Members to the MY 2022 national Medicaid 50th percentile, discusses the change in the rates for All Eligible Members from MY 2021 to MY 2022, and discusses health disparities identified in MY 2022.

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),

Healthcare utilization in MY 2020, MY 2021, and MY 2022 may also be impacted by the COVID-19 pandemic; however, rate comparisons within MY 2020, MY 2021, and MY 2022 (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 3-2 displays the MY 2020, MY 2021, and MY 2022 *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 and MY 2022, 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 2020		MY 2021		MY 2022	
	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%	65.1%	57.7%
Sex						
Male	58.4%	59.5%	66.0%	59.6%	67.4%	60.4%
Female	74.4%	52.7%	61.4%	60.6%	62.5%	54.4%
Race						
Black or African American	66.3%	47.1%	60.0%	48.2%	65.5%	53.2%
White	64.3%	59.6%	64.8%	66.0%	64.5%	59.3%
Other	66.7%	100.0%	100.0%^	75.0%^	100.0%	80.0%
Region						
Central	51.1%	51.5%	51.5%	57.6%	61.3%	56.0%
Charlottesville/Western	73.1%	54.5%	66.7%	73.1%	70.0%	60.0%
Northern & Winchester	69.7%	57.1%	60.0%	57.7%	64.3%	64.1%
Roanoke/Alleghany	56.7%	65.2%	74.5%	51.7%	73.5%	44.1%
Southwest	66.7%	50.0%	73.3%	71.4%	52.6%	71.4%
Tidewater	76.1%	58.3%	58.1%	56.3%	62.5%	57.9%
MCO						
Aetna	53.3%	37.5%	58.3%	68.4%	64.7%	64.0%
HealthKeepers	73.6%	56.4%	65.9%	60.0%	68.8%	54.2%
Molina	55.6%	44.4%	62.5%	60.0%	44.4%	60.0%
Optima	72.5%	75.7%	76.7%	50.0%	71.8%	55.0%

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
UnitedHealthcare	52.9%	42.9%	55.0%	84.6%	69.2%	61.5%
VA Premier	58.3%	52.8%	58.7%	52.4%	68.0%	60.0%
More Than One MCO	60.0%	20.0%	100.0%^	75.0%^	33.3%	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 3-2 shows that 65.1 percent of children in foster care and 57.7 percent of controls who turned 15 months old during MY 2022 received six or more well-child visits with a PCP, and the difference was not statistically significant (p=0.16). The rates for children in foster care were notably higher than controls for female members (by 8.1 percentage points), Black or African American members (by 12.3 percentage points), members in the Roanoke/Alleghany region (by 29.4 percentage points), and members enrolled with HealthKeepers and Optima (by 14.6 and 16.8 percentage points, respectively). While there was a large rate difference for members in the Other racial group; members in the Central, Charlottesville/Western, Southwest, and Tidewater regions; and members enrolled with Molina, UnitedHealthcare, VA Premier, and More Than One MCO, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2022 rate for children in foster care was above the MY 2022 national Medicaid 50th percentile, while the rate for controls was below the MY 2022 national Medicaid 50th percentile. The rate of well-child visits for children in foster care increased by 1.3 percentage points from MY 2021 to MY 2022, while the rate for controls decreased by 2.3 percentage points. There were no disparities identified for 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 2020, MY 2021, and MY 2022 *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 and MY 2022, 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 2020		MY 2021		MY 2022	
	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%	77.9%+	65.0%
Sex						
Male	72.8%	75.2%	81.8%	77.5%	85.4%	64.9%
Female	83.8%	73.3%	76.8%	73.4%	68.9%	65.1%
Race						
Black or African American	79.5%	68.7%	84.0%	78.1%	75.6%	57.6%
White	75.9%	77.9%	76.4%	75.0%	79.0%	69.7%
Other	100.0%	66.7%	100.0%^	50.0%^	83.3%	66.7%
Region						
Central	73.3%	69.7%	86.0%	56.4%	78.4%	51.4%
Charlottesville/Western	92.3%	76.3%	75.0%	85.0%	71.8%	66.0%
Northern & Winchester	75.0%	78.3%	76.9%	74.5%	75.6%	69.4%
Roanoke/Alleghany	52.2%	71.0%	73.7%	82.9%	80.0%	76.9%
Southwest	74.1%	76.0%	77.3%	76.9%	81.0%	70.6%
Tidewater	85.0%	76.2%	88.1%	80.6%	81.8%	58.8%
MCO						
Aetna	69.2%	60.0%	92.9%	85.7%	66.7%	60.0%
HealthKeepers	77.6%	88.2%	74.2%	75.0%	86.9%	73.1%
Molina	75.0%	66.7%	73.7%	70.0%	72.2%	52.6%
Optima	89.7%	80.9%	89.6%	84.6%	84.1%	61.1%
UnitedHealthcare	42.9%	57.9%	63.2%	83.3%	55.6%	58.8%
VA Premier	74.5%	69.0%	77.1%	63.8%	76.9%	67.4%
More Than One MCO	100.0%	0.0%	100.0%^	66.7%^	100.0%^	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 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 77.9 percent of children in foster care and 65.0 percent of controls who turned 30 months old during MY 2022 received two or more well-child visits with a PCP, and the difference was statistically significant (p=0.002). The rates for children in foster care were notably higher than controls for male members (by 20.5 percentage points); members in the Central, Southwest, and Tidewater

regions (by 27.0, 10.4 and 23.0 percentage points, respectively); and members enrolled with Optima, HealthKeepers, and Molina (by 23.0, 13.8, and 19.6 percentage points, respectively). The rate for children in foster care was also notably higher than the control rate for members in the Black or African American racial group (by 18.0 percentage points). While there were large rate differences for members in the Other racial group 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 2022 rate for children in foster care was above the MY 2022 national Medicaid 50th percentile, while the rate for controls was below the MY 2022 national Medicaid 50th percentile. The rate of well-child visits for children in foster care and controls decreased by 1.8 and 10.8 percentage points, respectively, from MY 2021 to MY 2022. For children in foster care, male members were significantly more likely to have a well-care visit and female members were significantly less likely during MY 2022. Additionally, children in foster care enrolled with UnitedHealthcare were significantly less likely to have a well-care visit during MY 2022.

Child and Adolescent Well-Care Visits (WCV)

Table 3-4 displays the MY 2020, MY 2021, and MY 2022 *Child and Adolescent Well-Care Visits* rates among children in foster care and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 2020		MY 2021		MY 2022	
	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%	61.5%+	52.9%
Age Category						
3 to 11 Years	72.6%	54.7%	68.5%	60.2%	64.7%	59.6%
12 to 17 Years	65.4%	42.4%	63.8%	50.5%	60.8%	47.4%
18 to 21 Years	50.9%	35.6%	45.5%	34.6%	44.8%	32.7%
Sex						
Male	68.0%	48.6%	64.5%	55.4%	60.6%	55.4%
Female	68.1%	48.3%	65.3%	53.8%	62.5%	49.7%
Race						
Black or African American	67.9%	49.8%	66.0%	56.9%	63.1%	55.6%
White	68.4%	47.9%	64.5%	53.5%	60.7%	51.4%
Other	60.0%	46.9%	57.7%	53.1%	60.3%	54.2%
Region						
Central	64.6%	42.5%	61.8%	56.2%	60.1%	51.6%
Charlottesville/Western	67.6%	50.4%	66.2%	50.3%	59.9%	49.7%

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Northern & Winchester	68.0%	56.8%	63.6%	58.3%	64.9%	60.2%
Roanoke/Alleghany	64.5%	43.1%	61.3%	54.8%	62.2%	51.0%
Southwest	65.5%	38.9%	63.5%	45.6%	62.0%	46.0%
Tidewater	77.9%	58.5%	71.4%	61.1%	60.9%	58.5%
MCO						
Aetna	57.5%	42.9%	59.5%	49.6%	62.5%	52.1%
HealthKeepers	69.6%	53.5%	65.8%	61.4%	63.6%	57.0%
Molina	63.6%	30.5%	59.5%	46.6%	60.1%	43.6%
Optima	70.4%	51.2%	65.4%	55.2%	57.4%	52.7%
UnitedHealthcare	64.6%	48.8%	63.4%	48.8%	63.3%	56.8%
VA Premier	68.5%	44.9%	65.9%	51.2%	60.5%	49.8%
More Than One MCO	68.3%	53.8%	72.5%	62.7%	80.3%	53.7%

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 61.5 percent of children in foster care and 52.9 percent of controls had a well-care visit with a PCP or an OB/GYN during MY 2022, 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 for female members (by 12.8 percentage points); members 12 to 17 and 18 to 21 years of age (by 13.4 and 12.1 percentage points, respectively); White members (by 9.3 percentage points); members in the Central, Charlottesville, Roanoke/Alleghany, and Southwest regions (by 8.5, 10.2, 11.2, and 16.0 percentage points, respectively); and members enrolled with Aetna, Molina, VA Premier, and More Than One MCO (by 10.4, 16.5, 10.7, and 26.6 percentage points, respectively).

MY 2022 rates for both children in foster care and controls were above the MY 2022 national Medicaid 50th percentile for members 3 to 11 years of age; however, the rate for children in foster care only exceeded the MY 2022 Medicaid 50th percentile for members 12 to 17 years of age. The rate of well-care visits for both children in foster care and controls decreased from MY 2021 to MY 2022 by 3.3 and 1.8 percentage points, respectively. 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 than all other age groups during MY 2021 and MY 2022, while members 18 to 21 years of age were significantly less likely. Additionally, children in foster care enrolled with Optima were significantly less likely to have a well-care visit during MY 2022, while children in foster care enrolled with More Than One MCO were significantly more likely.

Oral Health

Annual Dental Visit (ADV)

Table 3-5 displays the MY 2020, MY 2021, and MY 2022 *Annual Dental Visit* rates among children in foster care and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 Visit* Among Children in Foster Care and Controls

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	79.1%+	50.0%	70.6%+	52.4%	68.6%+	53.7%
Age Category						
≤ 2 Years	67.4%	38.0%	59.1%	38.9%	56.7%	36.8%
3 to 5 Years	82.1%	51.4%	70.4%	53.1%	69.8%	56.9%
6 to 10 Years	82.4%	56.3%	74.0%	59.1%	71.5%	61.8%
11 to 13 Years	82.0%	54.3%	77.5%	56.5%	76.4%	56.2%
≥ 14 Years	78.9%	47.4%	70.2%	50.8%	67.4%	51.2%
Sex						
Male	77.6%	49.6%	68.8%	51.2%	67.5%	53.1%
Female	81.0%	50.6%	72.7%	53.9%	69.9%	54.4%
Race						
Black or African American	78.0%	44.8%	71.2%	53.5%	68.8%	50.3%
White	80.1%	52.5%	70.2%	51.9%	68.6%	55.3%
Other	70.0%	55.9%	70.2%	52.4%	65.4%	57.7%
Region						
Central	78.3%	46.2%	70.0%	53.2%	69.4%	53.6%
Charlottesville/Western	76.8%	52.9%	68.1%	49.5%	67.6%	53.5%
Northern & Winchester	80.6%	57.5%	71.9%	64.4%	67.9%	64.2%
Roanoke/Alleghany	76.9%	45.4%	64.9%	45.2%	65.1%	51.0%
Southwest	81.4%	47.7%	75.7%	53.3%	74.1%	51.5%
Tidewater	81.9%	51.3%	73.9%	50.3%	68.8%	49.4%
MCO						
Aetna	75.7%	43.1%	67.7%	51.6%	68.0%	50.1%
HealthKeepers	77.6%	52.9%	71.2%	55.0%	70.8%	58.8%
Molina	82.9%	39.5%	64.4%	48.4%	60.7%	41.1%
Optima	77.0%	49.7%	68.7%	48.1%	66.6%	52.7%
UnitedHealthcare	80.2%	51.6%	77.7%	50.9%	68.3%	50.0%

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
VA Premier	81.2%	49.8%	71.1%	54.4%	68.4%	53.7%
More Than One MCO	90.6%	58.3%	79.7%	58.9%	87.3%	56.8%

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 3-5 shows that 68.6 percent of children in foster care and 53.7 percent of controls had a dental visit during MY 2022, 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 for members that were 2 years of age and younger and 11 to 13 years of age (by 19.9 and 20.2 percentage points, respectively); female members (by 15.5 percentage points); Black or African American members (by 18.5 percentage points); members in the Central region and the Tidewater region (by 15.8 and 19.4 percentage points, respectively); and members enrolled with Aetna, Molina, UnitedHealthcare, and More Than One MCO (by 17.9, 19.6, 18.3, and 30.5 percentage points, respectively).

The rate for children in foster care was above the MY 2022 national Medicaid 50th percentile for members 2 years of age and younger, while the rate for controls of this age group was below the MY 2022 Medicaid 50th percentile. Rates for both children in foster care and controls were higher than the national Medicaid 50th percentiles for all other age groups.[3-4] The rate for children in foster care decreased by 2.0 percentage points from MY 2021 to MY 2022, while the rate for controls increased by 1.3 percentage points. 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 groups, 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. The age disparities identified during MY 2022 for children in foster care also existed during MY 2021. For children in foster care, members in the Roanoke/Alleghany region were significantly less likely to have a dental visit compared to members in other regions, while members in the Southwest region were significantly more likely. Both of these regional disparities existed during MY 2021. Additionally, for children in foster care only, members enrolled with More Than One MCO were significantly more likely to have a dental visit compared to members enrolled with other MCOs, while members enrolled in Molina were significantly less likely.

[3-4] 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.

Preventive Dental Services (PDENT-CH)

Table 3-6 displays the MY 2020, MY 2021, and MY 2022 *Preventive Dental Services* rates among children in foster care and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	72.0%+	42.8%	64.6%+	45.6%	63.3%+	47.7%
Age Category						
≤ 2 Years	53.8%	28.3%	50.2%	31.0%	49.0%	28.1%
3 to 5 Years	79.3%	47.5%	68.4%	49.1%	67.0%	54.2%
6 to 10 Years	79.6%	52.6%	70.9%	55.9%	69.2%	58.8%
11 to 13 Years	77.2%	48.7%	71.2%	49.4%	73.0%	51.8%
≥ 14 Years	71.3%	38.6%	63.5%	42.5%	60.7%	44.8%
Sex						
Male	70.9%	42.4%	64.1%	44.9%	63.0%	47.7%
Female	73.2%	43.2%	65.1%	46.4%	63.7%	47.6%
Race						
Black or African American	71.8%	38.6%	66.5%	47.5%	63.5%	44.7%
White	72.3%	44.8%	63.5%	44.5%	63.3%	49.0%
Other	64.5%	48.6%	64.8%	48.3%	59.8%	51.2%
Region						
Central	70.4%	39.4%	64.8%	46.7%	64.9%	48.9%
Charlottesville/Western	71.7%	45.0%	60.4%	42.0%	62.2%	47.4%
Northern & Winchester	74.7%	52.2%	65.6%	57.2%	63.2%	58.6%
Roanoke/Alleghany	66.0%	37.0%	57.2%	38.7%	56.5%	42.1%
Southwest	73.0%	40.4%	70.3%	45.8%	69.0%	46.2%
Tidewater	76.2%	43.5%	70.3%	44.3%	65.2%	43.6%
MCO						
Aetna	64.8%	36.7%	62.7%	46.5%	62.1%	44.0%
HealthKeepers	71.3%	45.9%	65.3%	49.4%	65.0%	52.3%
Molina	73.3%	32.3%	56.2%	38.4%	54.3%	31.8%
Optima	70.8%	42.1%	64.4%	40.5%	61.3%	46.6%
UnitedHealthcare	70.2%	45.7%	70.8%	44.6%	64.1%	47.2%

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
VA Premier	74.8%	42.6%	64.0%	46.6%	64.4%	48.8%
More Than One MCO	79.8%	46.7%	73.8%	54.4%	78.8%	47.5%

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 3-6 shows that 63.3 percent of children in foster care and 47.7 percent of controls had at least one preventive dental service during MY 2022, and the difference was statistically significant ($p<0.001$). The rates for children in foster care were higher than controls across all stratified rates, with the largest differences for members 2 years of age and younger, 11 to 13 years of age, and 14 years of age and older (by 20.9, 21.2, and 15.9 percentage points, respectively); Black or African American members (by 18.8 percentage points); members in the Southwest, Tidewater, and Central regions (by 22.8, 21.6, and 16.0 percentage points, respectively); and members enrolled with Aetna, Molina, UnitedHealthcare, VA Premier, and More Than One MCO (by 18.1, 22.5, 16.9, 15.6, and 31.3 percentage points, respectively).

MY 2022 national Medicaid benchmarks were not available for this indicator. The rate for children in foster care decreased by 1.3 percentage points from MY 2021 to MY 2022, while the rate for controls increased by 2.1 percentage points. For both children in foster care and controls, members 3 to 5, 6 to 10, and 11 to 13 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 and 14 years of age and older were significantly less likely. The disparities identified for members 6 to 10 years of age and 2 years of age and younger also existed during MY 2021. For both children in foster care and controls, members in the Roanoke/Alleghany region were significantly less likely to have a preventive dental service compared to members in other regions during MY 2022. For children in foster care only, members in the Southwest region were significantly more likely to have a preventive dental service compared to members in other regions. The disparities identified for members in the Southwest region and Roanoke/Alleghany region also existed during MY 2021. For both children in foster care and controls, members in the Charlottesville/Western region were significantly less likely to have a preventive dental service during MY 2021; however, this disparity was no longer present during MY 2022, since the rate for the Charlottesville/Western region increased from MY 2021 (by 1.8 percentage points for children in foster care and by 5.4 percentage points for controls). Additionally, for both children in foster care and controls, members enrolled with Molina were significantly less likely to have a preventive dental service during MY 2021 and MY 2022 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 preventive dental service compared to members enrolled with other MCOs. This

disparity was not present during MY 2021; however, the rate increased from MY 2021 to MY 2022 (by 5.0 percentage points).

Oral Evaluation, Dental Services (OEV-CH)

Table 3-7 displays the MY 2020, MY 2021, and MY 2022 *Oral Evaluation, Dental Services* rates among children in foster care and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 2020		MY 2021		MY 2022	
	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%	61.8%+	46.2%
Age Category						
≤ 2 Years	—	—	51.5%	30.2%	50.3%	27.3%
3 to 5 Years	—	—	66.7%	46.9%	65.2%	51.7%
6 to 10 Years	—	—	68.7%	54.5%	67.2%	57.4%
11 to 13 Years	—	—	68.4%	47.0%	69.8%	50.4%
≥ 14 Years	—	—	63.1%	43.3%	58.9%	43.9%
Sex						
Male	—	—	63.0%	44.0%	61.7%	46.1%
Female	—	—	64.1%	45.1%	61.9%	46.3%
Race						
Black or African American	—	—	65.1%	47.0%	62.2%	43.5%
White	—	—	62.5%	43.0%	61.8%	47.6%
Other	—	—	65.9%	47.7%	56.1%	46.3%
Region						
Central	—	—	65.4%	46.2%	63.4%	47.9%
Charlottesville/Western	—	—	56.8%	39.4%	59.4%	45.6%
Northern & Winchester	—	—	65.5%	56.8%	62.6%	56.1%
Roanoke/Alleghany	—	—	55.6%	36.7%	54.5%	41.2%
Southwest	—	—	69.2%	44.9%	67.3%	43.9%
Tidewater	—	—	69.9%	44.2%	64.9%	42.8%
MCO						
Aetna	—	—	60.6%	45.3%	59.8%	42.5%
HealthKeepers	—	—	65.5%	49.1%	64.4%	51.2%

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Molina	—	—	56.2%	36.9%	54.8%	29.7%
Optima	—	—	62.9%	40.1%	58.9%	45.4%
UnitedHealthcare	—	—	71.2%	42.4%	62.8%	44.9%
VA Premier	—	—	61.7%	44.4%	62.8%	47.0%
More Than One MCO	—	—	72.3%	53.0%	72.3%	47.0%

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 61.8 percent of children in foster care and 46.2 percent of controls received a comprehensive or periodic oral evaluation during MY 2022, 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 for members 2 years of age and younger and 11 to 13 years of age (by 23.0 and 19.4 percentage points, respectively); male and female members (each by 15.6 percentage points); Black or African American members (by 18.7 percentage points); members enrolled with Aetna, Molina, UnitedHealthcare, VA Premier, and More Than One MCO (by 17.3, 25.1, 17.9, 15.8, and 25.3 percentage points, respectively); and members in the Southwest region and the Tidewater region (by 23.4 and 22.1 percentage points, respectively).

MY 2022 national Medicaid benchmarks were not available for this indicator. The rate for children in foster care decreased by 1.7 percentage points from MY 2021 to MY 2022, while the rate for controls increased by 1.7 percentage points. For both children in foster care and controls, members 6 to 10 and 11 to 13 years of age were significantly more likely to have an oral evaluation compared to members in other age groups during MY 2022, while members 2 years of age and younger and 14 years of age and older were significantly less likely. The MY 2022 disparities identified for children in foster care for members 2 years of age and younger, 6 to 10, and 11 to 13 years of age also existed during MY 2021. However, the disparity for members 14 years of age and older was new for MY 2022, which was due to the rate increasing from MY 2021 to MY 2022 (by 4.2 percentage points). For both children in foster care and controls, members in the Roanoke/Alleghany region were significantly less likely to have an oral evaluation compared to members in other regions during MY 2022. For children in foster care only, members were significantly more likely to have an oral evaluation in the Southwest region compared to members in other regions. The disparities identified for children in foster care in the Southwest region and the Roanoke/Alleghany region also existed during MY 2021. For both children in foster care and controls, members in the Charlottesville/Western region were significantly less likely to have an oral evaluation during MY 2021 compared to members in other regions; however, this disparity was eliminated during MY 2022 given the rate increase from MY 2021 (by 2.6 percentage points for children in foster care and by 6.2 percentage points for controls). For both children in foster care and controls,

members enrolled with HealthKeepers were significantly more likely to have an oral evaluation than all other MCOs during MY 2022, while members enrolled with Molina were significantly less likely. For children in foster care only, members enrolled with More Than One MCO were significantly more likely to have an oral evaluation compared to members enrolled with other MCOs. The disparities identified for members enrolled with Molina also existed in MY 2021.

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

Table 3-8 displays the MY 2020, MY 2021, and MY 2022 *Topical Fluoride for Children—Dental or Oral Health Services* rates among children in foster care and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 2020		MY 2021		MY 2022	
	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%	29.1%+	19.3%
Age Category						
≤ 2 Years	—	—	29.5%	20.5%	26.1%	16.8%
3 to 5 Years	—	—	36.5%	19.9%	31.8%	21.4%
6 to 10 Years	—	—	41.9%	25.8%	33.7%	24.4%
11 to 13 Years	—	—	43.6%	24.4%	35.5%	19.9%
≥ 14 Years	—	—	27.5%	15.4%	22.4%	15.0%
Sex						
Male	—	—	34.5%	19.7%	30.9%	19.9%
Female	—	—	35.7%	22.2%	27.1%	18.7%
Race						
Black or African American	—	—	35.0%	19.3%	30.9%	17.3%
White	—	—	35.1%	21.3%	28.4%	20.2%
Other	—	—	33.3%	28.7%	24.7%	24.4%
Region						
Central	—	—	38.4%	21.9%	30.6%	21.7%
Charlottesville/Western	—	—	30.8%	18.2%	29.5%	14.6%
Northern & Winchester	—	—	41.9%	30.2%	32.3%	29.8%
Roanoke/Alleghany	—	—	24.5%	16.5%	21.3%	14.5%
Southwest	—	—	33.1%	18.4%	26.6%	15.3%
Tidewater	—	—	40.5%	20.1%	33.4%	20.0%

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
MCO						
Aetna	—	—	30.2%	21.8%	26.7%	16.9%
HealthKeepers	—	—	38.8%	25.1%	32.0%	23.1%
Molina	—	—	30.7%	15.8%	24.4%	14.7%
Optima	—	—	34.6%	18.2%	28.2%	19.2%
UnitedHealthcare	—	—	34.2%	17.6%	27.5%	21.0%
VA Premier	—	—	32.6%	19.7%	27.7%	17.3%
More Than One MCO	—	—	52.5%	24.1%	47.4%	13.9%

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 3-8 shows that 29.1 percent of children in foster care and 19.3 percent of controls received at least two topical fluoride applications as dental or oral health services during MY 2022, 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.[3-5] Additionally, ADA has less strict clinical recommendations for people 6 years of age and older (e.g., people 6 years of age and 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).[3-6] The rates for children in foster care were higher than controls across all stratified rates, with the largest difference being for members 3 to 5 and 11 to 13 years of age (by 10.4 and 15.6 percentage points, respectively); male members (by 11.0 percentage points); Black or African American members (by 13.6 percentage points); members in the Charlottesville/Western, Southwest, and Tidewater regions (by 14.9, 11.3, and 13.4 percentage points, respectively); and members enrolled with Aetna, VA Premier, and More than One MCO (by 9.8, 10.4, and 33.5 percentage points, respectively).

Rates for both children in foster care and controls were at or above the MY 2022 national Medicaid 50th percentile. The rate for children in foster care decreased by 5.9 percentage points from MY 2021 to MY 2022, while the rate for controls decreased by 1.5 percentage points. For both children in foster care and controls, members 6 to 10 years of age were significantly more likely to receive at least two topical fluoride applications during MY 2022 compared to members in other age groups, while members 14

3-5 American Dental Association. Fluoride: Topical and Systematic Supplements. Available at: https://www.ada.org/resources/ada-library/oral-health-topics/fluoride-topical-and-systemic-supplements. Accessed on: Mar 20, 2024.
3-6 Ibid.

years of age and older were significantly less likely. For children in foster care only, members 11 to 13 years of age were significantly more likely to receive at least two topical fluoride applications compared to members in other age groups. The disparities identified for children in foster care members 6 to 10 years of age, 11 to 13 years of age, and 14 years of age and older during MY 2022 also existed during MY 2021. For both children in foster care and controls, members in the Roanoke/Alleghany region were significantly less likely to receive at least two topical fluoride applications compared to members in other regions during MY 2022. For children in foster care only, members in the Tidewater region were significantly more likely to receive at least two topical fluoride applications compared to members in other regions. The disparities identified for children in foster care in the Roanoke/Alleghany region and the Tidewater region also existed during MY 2021. 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 during MY 2022. 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 compared to members enrolled with other MCOs. The disparities identified for children in foster care enrolled with HealthKeepers and More Than One MCO also existed during MY 2021.

Behavioral Health

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

Table 3-9 displays the MY 2020, MY 2021, and MY 2022 *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 and MY 2022, 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 3-9—Rates of *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* Among Children in Foster Care and Controls

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	65.6%	59.2%	64.2%	59.7%	35.6%-	57.6%
Age Category						
3 to 5 Years	100.0%	0.0%	100.0%^	—	—	—
6 to 10 Years	82.4%	87.5%	81.0%	50.0%	58.3%	62.5%
11 to 13 Years	72.7%	50.0%	71.0%	68.8%	31.6%	58.8%
≥ 14 Years	56.6%	57.7%	51.9%	57.5%	32.2%	56.1%
Sex						
Male	63.2%	61.5%	75.9%	58.8%	35.5%	60.0%

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Female	67.3%	58.3%	59.7%	60.0%	35.6%	56.1%
Race						
Black or African American	60.0%	77.8%	60.5%	72.7%	23.5%	50.0%
White	68.4%	55.0%	68.2%	53.8%	42.3%	60.9%
Other	100.0%	—	0.0%^	0.0%^	50.0%	—
Region						
Central	70.6%	70.0%	42.3%	72.7%	36.4%	55.6%
Charlottesville/Western	55.6%	55.6%	55.6%	53.3%	23.1%	53.8%
Northern & Winchester	25.0%	0.0%	93.3%	25.0%	50.0%	80.0%
Roanoke/Alleghany	57.1%	83.3%	73.7%	70.0%	50.0%	62.5%
Southwest	87.5%	62.5%	57.1%	28.6%	33.3%	60.0%
Tidewater	85.7%	50.0%	83.3%	73.3%	30.8%	41.7%
MCO						
Aetna	53.8%	50.0%	50.0%	80.0%	42.9%	50.0%
HealthKeepers	64.3%	63.6%	74.2%	73.9%	33.3%	46.7%
Molina	71.4%	66.7%	71.4%	37.5%	40.0%^	0.0%^
Optima	81.3%	50.0%	59.3%	50.0%	27.3%	81.3%
UnitedHealthcare	50.0%	66.7%	50.0%^	0.0%^	50.0%	33.3%
VA Premier	57.9%	61.5%	54.2%	53.3%	40.6%	66.7%
More Than One MCO	33.3%	100.0%	85.7%	—	0.0%^	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 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 35.6 percent of children in foster care and 57.6 percent of controls had a follow-up visit within seven days after discharge with a mental health provider during MY 2022, and the difference was statistically significant (p= 0.01). However, rates for a follow-up visit within 30 days after discharge were similar between children in foster care and controls, indicating that children in foster care still have follow-up visits, but the visits are less timely compared to controls. Rates for children in foster care were notably higher than controls for members enrolled with UnitedHealthcare (by 16.7 percentage points) and notably lower than controls for members 14 years of age and older (by 23.9 percentage points). While there were large rate differences between foster care members and controls for members 11 to 13 years of age; male members; Black or African American members; members in the Charlottesville,

Northern & Winchester, and Southwest regions; and members enrolled in Optima, VA Premier, and More Than One MCO, these rates had a small denominator, so the rates may be less reliable.

For all eligible members, the MY 2022 rates for controls were above the MY 2022 national Medicaid 50th percentile, while the rates for children in foster care were below the MY 2022 national Medicaid 50th percentile. The rate for both children in foster care and controls decreased from MY 2021 to MY 2022 by 28.6 and 2.1 percentage points, respectively. The large decrease observed during MY 2022 in the rate for children in foster care is due to a relative increase in follow-up visits between eight and 15 days after hospitalization for mental illness and a relative decrease in follow-up visits within seven days. There were no disparities identified for children in foster care during MY 2022.

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

Table 3-10 displays the MY 2020, MY 2021, and MY 2022 *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 and MY 2022, 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 3-10—Rates of *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* Among Children in Foster Care and Controls

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	87.8%	78.9%	92.9%	81.5%	87.7%	74.4%
Age Category						
3 to 5 Years	100.0%	—	—	—	—	100.0%^
6 to 10 Years	100.0%	83.3%	100.0%^	87.5%^	87.5%	60.0%
11 to 13 Years	90.9%	75.0%	80.0%	83.3%	92.3%	70.0%
≥ 14 Years	80.8%	77.8%	92.0%	76.9%	86.1%	83.3%
Sex						
Male	78.9%	88.9%	93.3%	90.9%	82.6%	70.6%
Female	93.3%	70.0%	92.6%	75.0%	90.5%	77.3%
Race						
Black or African American	86.7%	80.0%	93.8%^	100.0%^	88.2%	57.1%
White	87.9%	75.0%	92.0%^	68.8%^	87.5%	78.1%
Other	100.0%	100.0%	100.0%^	100.0%^	—	—
Region						
Central	92.9%	60.0%	100.0%^	100.0%^	93.8%	70.0%
Charlottesville/Western	66.7%	75.0%	88.9%	80.0%	82.4%	66.7%
Northern & Winchester	100.0%	100.0%	100.0%^	66.7%^	100.0%^	83.3%^

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Roanoke/Alleghany	81.8%	100.0%	100.0%^	50.0%^	83.3%	76.9%
Southwest	100.0%	—	100.0%^	—	80.0%^	100.0%^
Tidewater	85.7%	80.0%	83.3%^	100.0%^	90.9%	33.3%
MCO						
Aetna	100.0%	50.0%	100.0%^	50.0%^	50.0%^	100.0%^
HealthKeepers	89.5%	100.0%	90.9%	90.0%	88.2%	45.5%
Molina	—	100.0%	100.0%^	100.0%^	50.0%	—
Optima	81.8%	71.4%	83.3%	83.3%	86.7%	75.0%
UnitedHealthcare	—	—	100.0%^	100.0%^	100.0%^	100.0%^
VA Premier	84.6%	100.0%	90.0%	71.4%	91.3%	90.9%
More Than One MCO	100.0%	100.0%	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 3-10 shows that 87.7 percent of children in foster care and 74.4 percent of controls had a follow-up visit for mental illness within 30 days of the ED visit during MY 2022, and the difference was not statistically significant (p=0.08). While there were large rate differences between children in foster care and controls for members 6 to 10 and 11 to 13 years of age; Black or African American members; members in the Central, Charlottesville/Western, Northern & Winchester, Southwest, and Tidewater regions; and members enrolled with Aetna and HealthKeepers, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2022 rates for both children in foster care and controls were above the MY 2022 national Medicaid 50th percentile. The rates for children in foster care and controls decreased from MY 2021 to MY 2022 by 5.2 and 7.1 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 3-11 displays the MY 2020, MY 2021, and MY 2022 *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 and MY 2022, 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 3-11—Rates of *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing* Among Children in Foster Care and Controls

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	38.3%	27.8%	38.0%	35.7%	38.3%	31.3%
Age Category						
≤ 2 Years	0.0%	—	—	—	—	0.0%^
3 to 5 Years	50.0%	0.0%	25.0%	85.7%	40.0%	33.3%
6 to 10 Years	28.9%	15.8%	36.8%	35.6%	40.0%	19.4%
11 to 13 Years	39.0%	35.5%	36.4%	28.1%	36.8%	32.3%
≥ 14 Years	42.4%	36.1%	40.8%	33.3%	37.7%	37.5%
Sex						
Male	41.1%	25.0%	36.2%	36.7%	37.4%	25.6%
Female	34.8%	32.5%	40.0%	34.0%	39.3%	41.3%
Race						
Black or African American	34.7%	15.6%	41.4%	36.4%	40.2%	36.0%
White	40.5%	32.0%	35.4%	36.3%	38.0%	30.4%
Other	25.0%	100.0%	75.0%^	0.0%^	0.0%^	0.0%^
Region						
Central	39.4%	31.8%	42.3%	34.6%	40.4%	22.2%
Charlottesville/Western	35.3%	25.0%	36.6%	46.4%	36.0%	31.6%
Northern & Winchester	43.8%	30.8%	42.9%	30.0%	44.1%	47.4%
Roanoke/Alleghany	35.3%	21.1%	18.4%	43.8%	37.0%	38.5%
Southwest	41.5%	45.5%	55.9%	46.2%	37.0%	41.2%
Tidewater	36.6%	22.6%	38.2%	21.2%	36.2%	10.0%
MCO						
Aetna	30.8%	60.0%	58.8%	33.3%	43.5%	35.7%
HealthKeepers	28.0%	32.5%	39.8%	26.7%	31.9%	30.6%
Molina	50.0%	33.3%	10.5%	25.0%	62.5%	50.0%
Optima	44.1%	14.8%	36.5%	35.5%	34.4%	29.0%
UnitedHealthcare	45.5%	16.7%	53.8%	33.3%	66.7%	54.5%
VA Premier	45.7%	28.6%	41.3%	57.1%	40.5%	27.6%
More Than One MCO	25.0%	33.3%	14.3%^	0.0%^	22.2%^	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 3-11 shows that 38.3 percent of children in foster care and 31.3 percent of controls with two or more antipsychotic prescriptions received blood glucose and cholesterol testing during MY 2022, and the difference was not statistically significant (p=0.18). The rates for children in foster care were notably higher than controls for members 6 to 10 years of age (by 20.6 percentage points), male members (by 11.8 percentage points), White members (by 7.6 percentage points), and members enrolled with Aetna (by 7.8 percentage points). While there were large rate differences between children in foster care and controls for members in the Central region and the Tidewater region, as well as members enrolled with Molina, UnitedHealthcare, VA Premier, and More Than One MCO, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2022 rates for children in foster were above the MY 2022 national Medicaid 50th percentile, while the rates for the controls were below the MY 2022 national Medicaid 50th percentile. The rate for children in foster care increased from MY 2021 to MY 2022 by 0.3 percentage points, while the rate for controls decreased by 4.4 percentage points. For children in foster care, members in the Roanoke/Alleghany region were significantly less likely to receive blood glucose and cholesterol testing during MY 2021 compared to members in other regions. However, this disparity was eliminated during MY 2022 due to a rate increase for the Roanoke/Alleghany region (by 18.6 percentage points). Children in foster care enrolled with Molina were significantly less likely to receive blood glucose and cholesterol testing during MY 2021 compared to members enrolled with other MCOs; however, since the rate for Molina increased from MY 2021 to MY 2022 (by 52.0 percentage points), members enrolled in Molina are now significantly more likely to receive blood glucose and cholesterol testing.

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

Table 3-12 displays the MY 2020, MY 2021, and MY 2022 *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 and MY 2022, 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 3-12—Rates of *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* Among Children in Foster Care and Controls

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	92.4%+	78.9%	89.2%+	68.4%	77.9%+	60.8%
Age Category						
≤ 2 Years	100.0%	—	—	—	—	0.0%^
3 to 5 Years	90.9%	66.7%	80.0%	75.0%	60.0%	62.5%
6 to 10 Years	89.3%	72.7%	86.4%	90.0%	87.1%	37.5%
11 to 13 Years	90.5%	80.0%	88.9%	70.0%	75.0%	50.0%
≥ 14 Years	100.0%	85.7%	93.9%	50.0%	70.8%	75.0%
Sex						
Male	86.0%	66.7%	91.2%	75.0%	71.8%	53.8%
Female	100.0%	94.1%	87.8%	57.1%	86.2%	68.0%
Race						
Black or African American	95.7%	75.0%	96.3%	69.2%	86.4%	54.5%
White	90.9%	84.0%	85.7%	69.6%	75.6%	62.5%
Other	100.0%	0.0%	—	50.0%	0.0%^	—
Region						
Central	92.9%	88.9%	88.9%	87.5%	80.0%	66.7%
Charlottesville/Western	77.8%	100.0%	91.7%	37.5%	84.2%	88.9%
Northern & Winchester	83.3%	0.0%	80.0%	75.0%	80.0%	71.4%
Roanoke/Alleghany	100.0%	87.5%	90.9%	50.0%	90.0%	41.7%
Southwest	100.0%	—	83.3%	75.0%	81.8%	50.0%
Tidewater	88.9%	64.3%	94.7%	80.0%	53.8%	44.4%
MCO						
Aetna	100.0%	50.0%	100.0%^	0.0%^	100.0%^	57.1%^
HealthKeepers	86.4%	80.0%	90.5%	81.8%	62.5%	53.8%
Molina	100.0%	100.0%	90.9%	50.0%	66.7%	50.0%
Optima	100.0%	76.9%	81.8%^	100.0%^	76.5%	76.9%
UnitedHealthcare	100.0%	—	66.7%	50.0%	100.0%^	40.0%^
VA Premier	90.3%	80.0%	85.7%	61.5%	91.3%	62.5%
More Than One MCO	100.0%	100.0%	100.0%^	0.0%^	50.0%	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 3-12 shows that 77.9 percent of children in foster care and 60.8 percent of controls had documentation of psychosocial care as first-line treatment during MY 2022, and the difference was statistically significant (p=0.04). The rates for children in foster care were notably higher than controls for White members (by 13.1 percentage points). While there were large rate differences between children in foster care and controls for most other stratified rates, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2022 rates for both children in foster care and controls were above the MY 2022 national Medicaid 50th percentile. The rates for children in foster care and controls decreased from MY 2021 to MY 2022 by 11.3 and 7.6 percentage points, respectively. For children in foster care only, members in the Tidewater region were significantly less likely to have documentation of psychosocial care as first-line treatment during MY 2022 compared to members in other regions.

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

Table 3-13 displays the MY 2020, MY 2021, and MY 2022 *Follow-Up Care for Children Prescribed ADHD Medication* measure rates among children in foster care and controls by month of follow-up. Table 3-14 displays the MY 2020, MY 2021, and MY 2022 *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 and MY 2022, 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 3-13—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 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
One-Month	86.8%	74.8%	78.1%	66.4%	77.3%	75.0%
Two-Months	92.5%	85.4%	88.6%	81.8%	90.0%	90.1%
Three-Months	95.3%	87.8%	93.0%	90.2%	93.6%	93.4%
Six-Months	99.1%	95.9%	96.5%	96.5%	97.3%	97.4%
Nine-Month	99.1%	96.7%	98.2%	97.2%	97.3%	98.7%

Table 3-13 shows that 77.3 percent of children in foster care had a follow-up visit within one month of when their first ADHD medication was dispensed, and 97.3 percent of children in foster care had a follow-up visit within nine months. Additionally, while the rates for children in foster care were 2.3 percentage points higher than controls for a follow-up visit within one month, the gap between the rates for children in foster care and controls closed for follow-up visits for two, three, six, and nine months, with the rate for controls exceeding the rate for children in foster care for every other follow-up window besides three months. These findings indicate that children in foster care are more likely to have a follow-up visit earlier than controls; however, this gap closes over time and by nine months after the first

ADHD medication is dispensed, children in foster care are less likely to have a follow-up visit than controls. This trend contrasts with previous years, when children in foster care had higher rates across all follow-up windows compared to controls.

Table 3-14—Rates of *Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up* Among Children in Foster Care and Controls

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	86.8%+	74.8%	78.1%+	66.4%	77.3%	75.0%
Age Category						
6 to 10 Years	86.7%	79.8%	78.8%	66.7%	77.8%	77.2%
11 to 13 Years	87.1%	61.8%	75.9%	65.9%	75.9%	68.4%
Sex						
Male	83.1%	79.2%	75.6%	67.7%	73.3%	72.4%
Female	94.3%	68.6%	83.3%	64.0%	82.0%	78.5%
Race						
Black or African American	85.4%	67.5%	77.5%	62.3%	70.6%	77.0%
White	87.7%	78.0%	77.8%	68.6%	81.1%	73.3%
Other	100.0%	100.0%	100.0%^	75.0%^	50.0%^	100.0%^
Region						
Central	83.9%	75.0%	79.3%	53.6%	55.6%	78.8%
Charlottesville/Western	86.7%	81.8%	63.6%	62.1%	87.5%	84.0%
Northern & Winchester	87.5%	70.0%	80.0%	75.0%	71.4%	64.3%
Roanoke/Alleghany	84.6%	65.2%	90.9%	80.0%	87.5%	70.4%
Southwest	100.0%	78.6%	73.3%	81.3%	88.2%	76.2%
Tidewater	90.5%	76.9%	86.4%	60.6%	71.4%	71.9%
MCO						
Aetna	100.0%	100.0%	72.7%	62.5%	55.6%	87.5%
HealthKeepers	90.3%	66.7%	78.6%	57.4%	78.0%	72.5%
Molina	100.0%	66.7%	66.7%	60.0%	33.3%	80.0%
Optima	84.0%	85.2%	72.0%	72.2%	73.3%	73.5%
UnitedHealthcare	100.0%	83.3%	83.3%	83.3%	100.0%^	75.0%^
VA Premier	79.3%	74.3%	86.4%	73.0%	86.5%	75.7%
More Than One MCO	87.5%	66.7%	100.0%^	50.0%^	66.7%^	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 77.3 percent of children in foster care and 75.0 percent of controls had a follow-up care visit within 30 days of when their first ADHD medication was dispensed during MY 2022, and the difference was not statistically significant (p=0.67). Rates for children in foster care were notably higher than controls for White members (by 7.8 percentage points) and members enrolled with HealthKeepers and VA Premier (by 5.5 and 10.8 percentage points, respectively). Conversely, rates for children in foster care were notably lower than controls for Black or African American members (by 6.4 percentage points). While there were large rate differences between children in foster care and controls for members 11 to 13 years of age; members in the Other racial group; members in the Central, Roanoke/Alleghany, Northern & Winchester, and Southwest regions; and 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 2022 rates for both children in foster care and controls were above the MY 2022 national Medicaid 50th percentile. The rate for children in foster care decreased from MY 2021 to MY 2022 by 0.8 percentage points, while the rate for controls increased by 8.6 percentage points. For children in foster care only, members in the Central region were significantly less likely to have a follow-up care visit within 30 days of when the first ADHD medication was dispensed compared to members in other regions during MY 2022. There were no disparities identified for children in foster care during MY 2021.

Substance Use

Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment (IET–I)

Table 3-15 displays the MY 2020, MY 2021, and MY 2022 *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* rates among children in foster care and controls 13 years of age and older stratified by member characteristics. For MY 2021 and MY 2022, member characteristics with identified health disparities are indicated with shading. The *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* indicator measures the percentage of new SUD episodes among adolescent and adult members that result in initiation of SUD treatment within 14 days of the diagnosis.[3-7] 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.

[3-7] HSAG advises caution in interpreting rate changes over time for this indicator since CMS' measure specifications greatly changed between MY 2021 and MY 2022 (e.g., the measure changed from a percentage of members to a percentage of SUD events).

Table 3-15—Rates of *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment* Among Children in Foster Care and Controls

Category	MY 2020		MY 2021[3-8]		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	29.1%	45.8%	39.7%	50.0%	40.4%	50.0%
Age Category						
11 to 13 Years	0.0%	—	75.0%	—	66.7%	75.0%
≥ 14 Years	31.4%	45.8%	37.0%	50.0%	38.9%	47.5%
Sex						
Male	27.6%	45.5%	42.4%	63.6%	38.5%	40.9%
Female	30.8%	46.2%	36.0%	38.5%	41.9%	59.1%
Race						
Black or African American	31.6%	33.3%	52.6%	80.0%	35.7%	75.0%
White	26.5%	52.9%	31.6%	44.4%	40.5%	42.9%
Other	50.0%	0.0%	100.0%^	0.0%^	100.0%^	100.0%^
Region						
Central	40.0%	60.0%	54.5%	75.0%	44.4%	80.0%
Charlottesville/Western	36.4%	—	28.6%	60.0%	57.1%	44.4%
Northern & Winchester	11.1%	20.0%	30.8%	33.3%	33.3%	20.0%
Roanoke/Alleghany	50.0%	60.0%	55.6%	—	22.2%	77.8%
Southwest	33.3%	50.0%	12.5%	33.3%	42.9%	50.0%
Tidewater	0.0%	33.3%	50.0%	66.7%	33.3%	40.0%
MCO						
Aetna	16.7%	50.0%	14.3%	25.0%	0.0%^	50.0%^
HealthKeepers	8.3%	12.5%	38.1%	40.0%	50.0%	23.1%
Molina	20.0%	—	75.0%^	100.0%^	50.0%	66.7%
Optima	27.3%	75.0%	61.5%	66.7%	26.7%	71.4%
UnitedHealthcare	100.0%	66.7%	50.0%	50.0%	50.0%	50.0%
VA Premier	38.9%	50.0%	11.1%	33.3%	50.0%	56.3%
More Than One MCO	100.0%	100.0%	—	—	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.

[3-8] MY 2021 rates were recalculated for this year's study; therefore, these rates will not match the MY 2021 rates presented in the 2021–22 Child Welfare Focus Study.

Table 3-15 shows that 40.4 percent of new SUD episodes among children in foster care and 50.0 percent of new SUD episodes among controls resulted in initiation of treatment during MY 2022, and the difference was not statistically significant (p=0.33). Of note, children in foster care were more likely to have a qualifying denominator event for a substance other than alcohol or opioids compared to controls. While there were large rate differences between children in foster care and controls for many stratified rates, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2022 rate for children in foster care was below the MY 2022 national Medicaid 50th percentile, while the rate for controls was above the MY 2022 national Medicaid 50th percentile. The rate for children in foster care increased from MY 2021 to MY 2022 by 0.7 percentage points, while the rate for controls did not change. There were no disparities identified for children in foster care members.

Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment (IET–E)

Table 3-16 displays the MY 2020, MY 2021, and MY 2022 *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* rates among children in foster care and controls 13 years of age and older stratified by member characteristics. For MY 2021 and MY 2022, member characteristics with identified health disparities are indicated with shading. The *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* indicator measures the percentage of new SUD episodes among adolescent and adult members for which SUD treatment was initiated that also resulted in engagement in ongoing SUD treatment within 34 days of the initiation visit.[3-9] 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 3-16—Rates of *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* Among Children in Foster Care and Controls

Category	MY 2020		MY 2021[3-10]		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	14.5%	25.0%	20.7%	16.7%	10.5%	13.6%
Age Category						
11 to 13 Years	0.0%	—	0.0%^	—	33.3%	25.0%
≥ 14 Years	15.7%	25.0%	22.2%^	16.7%^	9.3%	12.5%
Sex						
Male	17.2%	27.3%	27.3%	27.3%	19.2%	13.6%
Female	11.5%	23.1%	12.0%	7.7%	3.2%	13.6%
Race						
Black or African American	15.8%	33.3%	36.8%^	0.0%^	7.1%	25.0%

3-9 HSAG advises caution in interpreting rate changes over time for this indicator since CMS' measure specifications greatly changed between MY 2021 and MY 2022 (e.g., the measure changed from a percentage of members to a percentage of SUD events).

3-10 MY 2021 rates were recalculated for this year's study; therefore, these rates will not match the MY 2021 rates presented in the 2021–22 Child Welfare Focus Study.

Category	MY 2020		MY 2021[3-10]		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
White	11.8%	23.5%	10.5%^	22.2%^	9.5%	8.6%
Other	50.0%	0.0%	100.0%^	0.0%^	100.0%^	100.0%^
Region						
Central	26.7%	20.0%	18.2%	50.0%	0.0%^	0.0%^
Charlottesville/Western	9.1%	—	0.0%^	0.0%^	7.1%	11.1%
Northern & Winchester	0.0%	20.0%	15.4%	16.7%	16.7%	10.0%
Roanoke/Alleghany	16.7%	20.0%	33.3%	—	11.1%	33.3%
Southwest	33.3%	33.3%	12.5%	16.7%	28.6%	16.7%
Tidewater	0.0%	33.3%	40.0%^	0.0%^	8.3%^	0.0%^
MCO						
Aetna	16.7%	0.0%	14.3%^	0.0%^	0.0%^	0.0%^
HealthKeepers	8.3%	12.5%	14.3%	20.0%	5.0%	15.4%
Molina	0.0%	—	50.0%	25.0%	0.0%^	0.0%^
Optima	0.0%	25.0%	30.8%^	0.0%^	6.7%	28.6%
UnitedHealthcare	0.0%	33.3%	25.0%	50.0%	50.0%^	0.0%^
VA Premier	33.3%	33.3%	11.1%	16.7%	20.0%	12.5%
More Than One MCO	0.0%	100.0%	—	—	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 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 10.5 percent of new SUD episodes among children in foster care and 13.6 percent of new SUD episodes among controls with initiation of SUD treatment resulted in engagement in ongoing SUD treatment during MY 2022, and the difference was not statistically significant (p=0.63). 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 2022 rate for children in foster care was below the MY 2022 national Medicaid 50th percentile, while the rate for controls was above the MY 2022 national Medicaid 50th percentile. The rate for both children in foster care and controls decreased from MY 2021 to MY 2022 by 10.2 and 3.1 percentage points, respectively. There were no disparities identified for children in foster care members.

Respiratory Health

Asthma Medication Ratio (AMR)

Table 3-17 displays the MY 2020, MY 2021, and MY 2022 *Asthma Medication Ratio* rates among children in foster care and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 3-17—Rates of Appropriate *Asthma Medication Ratio* Among Children in Foster Care and Controls

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	89.8%+	75.9%	85.7%	80.2%	82.5%	76.1%
Age Category						
5 to 11 Years	94.7%	70.3%	92.9%	76.3%	83.3%	85.7%
12 to 18 Years	86.7%	80.4%	81.0%	83.7%	81.8%	69.8%
Sex						
Male	85.2%	81.1%	83.3%	79.2%	84.6%	73.3%
Female	95.5%	66.7%	88.2%	81.8%	78.6%	80.8%
Race						
Black or African American	78.9%	75.0%	81.3%	74.4%	68.4%	73.7%
White	96.6%	75.6%	94.4%	85.4%	94.7%	78.8%
Other	100.0%	100.0%	0.0%^	100.0%^	100.0%^	—
Region						
Central	83.3%	66.7%	83.3%	82.4%	80.0%	77.8%
Charlottesville/Western	100.0%	73.3%	100.0%^	76.9%^	83.3%	86.7%
Northern & Winchester	83.3%	100.0%	0.0%^	75.0%^	66.7%	71.4%
Roanoke/Alleghany	100.0%	100.0%	66.7%	80.0%	83.3%	50.0%
Southwest	85.7%	76.9%	100.0%^	90.0%^	75.0%	90.9%
Tidewater	90.0%	69.2%	88.9%	78.3%	90.9%	62.5%
MCO						
Aetna	100.0%	100.0%	100.0%^	100.0%^	83.3%^	100.0%^
HealthKeepers	100.0%	70.6%	100.0%^	82.1%^	81.8%	72.2%
Molina	33.3%	66.7%	0.0%^	—	100.0%^	80.0%^
Optima	88.9%	71.4%	80.0%	69.6%	92.3%	78.9%
UnitedHealthcare	100.0%	40.0%	100.0%^	100.0%^	33.3%	66.7%
VA Premier	88.9%	91.7%	100.0%^	82.6%^	75.0%	73.7%
More Than One MCO	—	50.0%	—	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 3-17 shows that 82.5 percent of children in foster care and 76.1 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 2022, and the difference was not statistically significant (p=0.43). 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.

The rates for children in foster care and controls were above the MY 2022 national Medicaid 50th percentile for members 5 to 11 and 12 to 18 years of age. The rate for both children in foster care and controls decreased from MY 2021 to MY 2022 by 3.2 and 4.1 percentage points, respectively. There were no disparities identified for children in foster care members.

Service Utilization

Ambulatory Care Visits

Table 3-18 displays the MY 2020, MY 2021, and MY 2022 *Ambulatory Care Visits* rates among children in foster care and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 3-18—Rates of *Ambulatory Care Visits* Among Children in Foster Care and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	86.8%	88.1%
Age Category						
≤ 2 Years	—	—	92.2%	93.4%	90.3%	91.8%
3 to 5 Years	—	—	89.4%	90.1%	86.6%	89.5%
6 to 10 Years	—	—	86.5%	89.5%	85.0%	87.6%
11 to 13 Years	—	—	88.2%	89.5%	89.1%	87.9%
≥ 14 Years	—	—	88.7%	86.9%	85.0%	85.5%
Sex						
Male	—	—	88.7%	88.9%	86.9%	88.4%

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Female	—	—	89.2%	90.6%	86.8%	87.9%
Race						
Black or African American	—	—	88.4%	88.0%	85.1%	85.1%
White	—	—	89.4%	90.8%	88.0%	89.8%
Other	—	—	84.1%	84.1%	80.5%	87.8%
Region						
Central	—	—	88.2%	87.9%	83.4%	84.0%
Charlottesville/Western	—	—	90.6%	91.7%	87.8%	89.8%
Northern & Winchester	—	—	82.5%	87.6%	84.2%	89.7%
Roanoke/Alleghany	—	—	90.6%	91.3%	90.8%	91.1%
Southwest	—	—	92.1%	91.1%	92.4%	92.2%
Tidewater	—	—	89.8%	88.7%	84.3%	84.3%
MCO						
Aetna	—	—	87.5%	86.9%	83.7%	87.2%
HealthKeepers	—	—	87.7%	89.8%	87.4%	88.2%
Molina	—	—	86.7%	83.7%	79.0%	80.8%
Optima	—	—	87.8%	90.5%	87.2%	87.2%
UnitedHealthcare	—	—	91.4%	87.7%	86.8%	89.7%
VA Premier	—	—	90.9%	91.5%	88.1%	90.3%
More Than One MCO	—	—	96.4%	92.8%	97.6%	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 3-18 shows that 86.8 percent of children in foster care and 88.1 percent of controls had an ambulatory care visit during MY 2022, and the difference was not statistically significant (p=0.08). The rate differences between children in foster care and controls were consistent across the stratified rates. The rates for children in foster care were notably lower than controls for members in the Other racial group (by 7.3 percentage points) and members in the Northern & Winchester region (by 5.5 percentage points).

The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rate for both children in foster care and controls decreased from MY 2021 to MY 2022 by 2.1 and 1.6 percentage points, respectively. 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 during MY 2022, while members 14 years of age and older were significantly less likely. The disparities identified for members 2 years of age and younger also existed during MY 2021 for both children in foster care and controls, while the disparity for members 14 years of age and older did not exist for children in foster care. For both children in foster care and controls, White members were significantly more likely to have an ambulatory care visit during MY 2022 compared to members in other racial groups, while Black or African American members were significantly less likely. For both children in foster care and controls, members in the Roanoke/Alleghany region and the Southwest region were significantly more likely to have an ambulatory care visit compared to members in other regions during MY 2022, while members in the Central region and the Tidewater region were significantly less likely. The disparities identified for children in foster care in the Southwest region also existed during MY 2021; however, the remaining regional disparities were new for MY 2022. For children in foster care, members in the Northern & Winchester region were significantly less likely to have an ambulatory care visit during MY 2021; however, the rate increased in MY 2022 (by 1.7 percentage points) and the disparity was eliminated. For both children in foster care and controls, members enrolled with Molina were significantly less likely to have an ambulatory care visit compared to members enrolled with other MCOs during MY 2022. 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, while members enrolled with Aetna were significantly less likely. The disparities identified for children in foster care enrolled with More Than One MCO and controls enrolled with Molina also existed during MY 2021.

ED Visits

Table 3-19 displays the MY 2020, MY 2021, and MY 2022 *ED Visits* rates among children in foster care and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 3-19—Rates of *ED Visits* Among Children in Foster Care and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	26.9%-	35.5%
Age Category						
≤ 2 Years	—	—	26.4%	43.5%	30.6%	48.7%
3 to 5 Years	—	—	20.0%	27.2%	19.6%	37.2%
6 to 10 Years	—	—	16.0%	23.6%	19.4%	30.0%
11 to 13 Years	—	—	18.2%	26.3%	24.6%	27.6%
≥ 14 Years	—	—	37.9%	35.0%	36.6%	34.4%
Sex						
Male	—	—	22.3%	30.5%	25.3%	35.6%
Female	—	—	27.6%	32.6%	28.8%	35.4%
Race						
Black or African American	—	—	24.8%	33.8%	26.1%	38.7%

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
White	—	—	24.7%	30.5%	27.7%	34.5%
Other	—	—	26.1%	25.0%	17.1%	18.3%
Region						
Central	—	—	25.2%	34.0%	27.3%	34.3%
Charlottesville/Western	—	—	24.6%	27.8%	24.9%	32.4%
Northern & Winchester	—	—	21.3%	29.9%	26.1%	38.8%
Roanoke/Alleghany	—	—	26.9%	35.6%	29.7%	36.7%
Southwest	—	—	29.2%	36.0%	32.7%	40.8%
Tidewater	—	—	22.5%	27.3%	22.9%	32.7%
MCO						
Aetna	—	—	25.1%	32.7%	26.9%	36.9%
HealthKeepers	—	—	23.7%	32.0%	26.6%	35.5%
Molina	—	—	29.6%	40.9%	27.9%	35.2%
Optima	—	—	26.0%	29.0%	25.7%	34.1%
UnitedHealthcare	—	—	21.8%	28.0%	28.2%	43.2%
VA Premier	—	—	24.7%	31.7%	27.7%	34.0%
More Than One MCO	—	—	22.9%	26.5%	28.9%	38.6%

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 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 26.9 percent of children in foster care and 35.5 percent of controls had an ED visit during MY 2022, 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, 3 to 5 years of age, and 6 to 10 years of age (by 18.1, 17.6, and 10.6 percentage points, respectively); male members (by 10.3 percentage points); Black or African American members (by 12.6 percentage points); members in the Northern & Winchester region and the Tidewater region; and members enrolled with Aetna, HealthKeepers, UnitedHealthcare, and More Than One MCO (by 10.0, 8.9, 15.0, and 9.7 percentage points, respectively).

The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rate for children in foster care increased from MY 2021 to MY 2022 by 2.1 percentage points, while the rate for controls increased by 4.0 percentage points. For both children in foster care and controls, members 2 years of age and younger were significantly more likely to have an ED visit compared to members in other age groups during MY 2022, while members 6 to 10

years of age were significantly less likely. For children in foster care only, members 14 years of age and older were significantly more likely to have an ED visit compared to members in all other age groups, while members 3 to 5 years of age were significantly less likely. The disparity identified for members 3 to 5 years of age, 6 to 10 years of age, and 14 years of age and older also existed during MY 2021. For children in foster care only, male members were significantly less likely to have an ED visit compared to female members during MY 2021 and MY 2022. For both children in foster care and controls, members in the Other racial group were significantly less likely to have an ED visit compared to members in other racial groups during MY 2022. 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 and MY 2022. For children in foster care only, members in the Tidewater region were significantly less likely to have an ED visit during MY 2022 compared to members in all other regions.

Inpatient Visits

Table 3-20 displays the MY 2020, MY 2021, and MY 2022 *Inpatient Visits* rates among children in foster care and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 3-20—Rates of *Inpatient Visits* Among Children in Foster Care and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	5.1%	4.2%
Age Category						
≤ 2 Years	—	—	2.1%	6.0%	3.4%	7.2%
3 to 5 Years	—	—	0.8%	0.8%	1.9%	1.8%
6 to 10 Years	—	—	2.9%	2.0%	2.5%	1.7%
11 to 13 Years	—	—	8.3%	5.6%	5.4%	4.4%
≥ 14 Years	—	—	8.2%	7.1%	10.2%	5.8%
Sex						
Male	—	—	3.0%	3.5%	3.7%	3.6%
Female	—	—	6.3%	5.5%	6.7%	5.0%
Race						
Black or African American	—	—	4.7%	4.6%	5.9%	3.8%
White	—	—	4.3%	4.3%	4.6%	4.5%
Other	—	—	6.8%	3.4%	6.1%	1.2%
Region						
Central	—	—	4.8%	5.1%	6.6%	3.9%
Charlottesville/Western	—	—	5.7%	5.1%	5.8%	4.4%
Northern & Winchester	—	—	3.8%	3.2%	4.2%	6.5%
Roanoke/Alleghany	—	—	5.5%	4.0%	5.3%	3.8%
Southwest	—	—	2.6%	4.2%	3.3%	4.0%

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Tidewater	—	—	4.0%	4.4%	4.2%	3.0%
MCO						
Aetna	—	—	3.4%	4.0%	4.3%	3.8%
HealthKeepers	—	—	4.5%	4.4%	4.4%	4.2%
Molina	—	—	4.9%	5.9%	5.0%	4.1%
Optima	—	—	5.1%	4.1%	5.5%	3.2%
UnitedHealthcare	—	—	3.3%	3.3%	4.3%	2.6%
VA Premier	—	—	4.3%	4.6%	6.1%	5.2%
More Than One MCO	—	—	8.4%	6.0%	4.8%	10.8%

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 5.1 percent of children in foster care and 4.2 percent of controls had an inpatient visit during MY 2022, and the difference was not statistically significant (p=0.09). The rate differences between children in foster care and controls were varied across the stratified rates. The largest difference was for members enrolled with More Than One MCO (by 6.0 percentage points).

The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rate for children in foster care increased from MY 2021 to MY 2022 by 0.6 percentage points, while the rate for controls decreased by 0.2 percentage points. For both children in foster care and controls, members 3 to 5 and 6 to 10 years of age were significantly less likely to have an inpatient visit compared to members in other age groups during MY 2022, while members 14 years of age and older were significantly more likely. Additionally, children in foster care members 2 years of age and younger were significantly less likely to have an inpatient visit compared to members in other age groups, while control members 2 years of age and younger were significantly more likely. All the disparities identified across age groups during MY 2022 also existed during MY 2021. Additionally, for children in foster care, members 11 to 13 years of age were significantly more likely to have an inpatient visit during MY 2021 compared to members in other age groups; however, the rate for this age group decreased from MY 2021 to MY 2022 (by 2.9 percentage points) and the disparity was eliminated in MY 2022. For both children in foster care and controls, female members were significantly more likely to have an inpatient visit in MY 2021 and MY 2022 compared to male members. For children in foster care only, members in the Central region were significantly more likely to have an inpatient visit compared to members in other regions during MY 2022.

Behavioral Health Encounters—Total

Table 3-21 displays the MY 2020, MY 2021, and MY 2022 *Behavioral Health Encounters—Total* rates among children in foster care and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 3-21—Rates of *Behavioral Health Encounters—Total* Among Children in Foster Care and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	65.4%+	51.9%
Age Category						
≤ 2 Years	—	—	45.6%	33.6%	46.0%	34.6%
3 to 5 Years	—	—	62.2%	38.5%	52.0%	35.4%
6 to 10 Years	—	—	76.7%	67.5%	69.6%	53.6%
11 to 13 Years	—	—	84.8%	72.2%	79.4%	67.3%
≥ 14 Years	—	—	83.2%	70.9%	76.0%	64.7%
Sex						
Male	—	—	71.1%	57.7%	64.4%	52.1%
Female	—	—	70.9%	57.2%	66.5%	51.7%
Race						
Black or African American	—	—	70.6%	55.5%	64.3%	51.5%
White	—	—	71.4%	58.6%	66.3%	52.4%
Other	—	—	64.8%	54.5%	52.4%	45.1%
Region						
Central	—	—	71.1%	56.5%	65.0%	51.7%
Charlottesville/Western	—	—	71.3%	59.8%	63.2%	52.5%
Northern & Winchester	—	—	62.3%	46.1%	59.2%	41.7%
Roanoke/Alleghany	—	—	72.9%	62.1%	70.7%	58.2%
Southwest	—	—	76.2%	61.0%	70.4%	53.5%
Tidewater	—	—	72.7%	59.1%	64.9%	53.2%
MCO						
Aetna	—	—	69.1%	53.8%	62.8%	48.2%
HealthKeepers	—	—	70.6%	57.1%	66.4%	52.3%
Molina	—	—	68.5%	50.7%	61.6%	42.9%
Optima	—	—	69.6%	58.5%	61.9%	53.5%
UnitedHealthcare	—	—	68.3%	50.6%	66.2%	49.6%
VA Premier	—	—	73.1%	61.9%	67.0%	53.5%
More Than One MCO	—	—	86.7%	55.4%	88.0%	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 3-21 shows that 65.4 percent of children in foster care and 51.9 percent of controls had a behavioral health encounter during MY 2022, and the difference was statistically significant ($p<0.001$). Rates for children in foster care were notably higher than controls for members 3 to 5 and 6 to 10 years of age (by 16.6 and 16.0 percentage points, respectively); female members (by 14.8 percentage points); White members (by 13.9 percentage points); members in the Northern & Winchester region and the Southwest region (by 17.5 and 16.9 percentage points, respectively); and members enrolled with Aetna, HealthKeepers, Molina, UnitedHealthcare, VA Premier, and More Than One MCO (by 14.6, 14.1, 18.7, 16.6, 13.5, and 25.3 percentage points, respectively).

The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rates for children in foster care and controls both decreased from MY 2021 to MY 2022 by 5.6 percentage points. For both children in foster care 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 encounter compared to members in other age groups during MY 2021 and MY 2022, while members 2 years of age and younger and 3 to 5 years of age were significantly less likely. These identified disparities 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 significantly less likely to have a behavioral health encounter during MY 2022, while members in the Roanoke/Alleghany region were significantly more likely. For children in foster care only, members in the Southwest region were significantly more likely to have a behavioral health encounter compared to members in other regions during MY 2022. The disparity identified for members in the Northern & Winchester region also existed during MY 2021. Additionally, children in foster care members in the Other racial group were significantly less likely to have a behavioral health encounter compared to members in other racial groups during MY 2022. Lastly, for both children in foster care and controls, members enrolled with More Than One MCO were significantly more likely to have a behavioral health encounter compared to members enrolled with other MCOs during MY 2022. For children in foster care only, members enrolled with Optima were significantly less likely to have a behavioral health encounter compared to members enrolled with other MCOs.

Behavioral Health Encounters—ARTS

Table 3-22 displays the MY 2020, MY 2021, and MY 2022 *Behavioral Health Encounters—ARTS* rates among children in foster care and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 3-22—Rates of *Behavioral Health Encounters—ARTS* Among Children in Foster Care and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	2.8%+	1.5%
Age Category						
≤ 2 Years	—	—	0.0%^	0.0%^	0.0%^	0.3%^
3 to 5 Years	—	—	0.0%^	0.2%^	0.2%^	0.0%^
6 to 10 Years	—	—	0.9%	0.6%	0.8%	0.2%
11 to 13 Years	—	—	1.1%	0.6%	1.8%	1.8%
≥ 14 Years	—	—	6.0%	1.8%	8.5%	4.2%
Sex						
Male	—	—	2.4%	0.5%	2.5%	1.3%
Female	—	—	1.3%	1.0%	3.1%	1.7%
Race						
Black or African American	—	—	2.6%	0.5%	1.7%	0.6%
White	—	—	1.5%	0.8%	3.4%	2.0%
Other	—	—	3.4%	1.1%	2.4%	1.2%
Region						
Central	—	—	1.7%	1.1%	2.4%	0.9%
Charlottesville/Western	—	—	1.0%	0.1%	3.5%	1.7%
Northern & Winchester	—	—	4.0%	1.9%	3.1%	2.2%
Roanoke/Alleghany	—	—	1.3%^	0.0%^	3.8%	2.1%
Southwest	—	—	1.9%	0.9%	1.8%	1.8%
Tidewater	—	—	1.9%	0.5%	2.0%	0.6%
MCO						
Aetna	—	—	1.5%	0.9%	2.0%	0.3%
HealthKeepers	—	—	2.9%	1.1%	2.8%	1.4%
Molina	—	—	1.5%	0.5%	1.8%	1.8%
Optima	—	—	1.5%	0.3%	2.6%	1.1%
UnitedHealthcare	—	—	2.5%	1.6%	3.0%	2.6%
VA Premier	—	—	1.5%	0.3%	3.1%	2.1%
More Than One MCO	—	—	0.0%^	1.2%^	7.2%	2.4%

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 3-22 shows that 2.8 percent of children in foster care and 1.5 percent of controls had a behavioral health encounter with ARTS during MY 2022, and the difference was statistically significant (p<0.001).

The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rates for both children in foster care and controls increased from MY 2021 to MY 2022 by 0.9 and 0.8 percentage points, respectively. For both children in foster care 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 groups during MY 2021 and MY 2022. For children in foster care only, members 6 to 10 years of age were significantly less likely to have a behavioral health encounter with ARTS compared to members in other age groups during MY 2021 and MY 2022. Additionally, for both children in foster care and controls, Black or African American members were significantly less likely to have a behavioral health encounter with ARTS compared to members in other racial groups during MY 2022; however, for children in foster care during MY 2021, Black or African American members were significantly more likely to have a behavioral health encounter with ARTS compared to members in other racial groups. For children in foster care in MY 2021, White members were significantly less likely to have a behavioral health encounter with ARTS compared to members in other racial groups; however, for both children in foster care and controls during MY 2022, White members were significantly more likely to have a behavioral health encounter with ARTS compared to members in other racial groups. Lastly, children in foster care that were enrolled with More Than One MCO were significantly more likely to have a behavioral health encounter with ARTS compared to members enrolled with other MCOs during MY 2022.

Behavioral Health Encounters—CMH Services

Table 3-23 displays the MY 2020, MY 2021, and MY 2022 *Behavioral Health Encounters—CMH Services* rates among children in foster care and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 3-23—Rates of *Behavioral Health Encounters—CMH Services* Among Children in Foster Care and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	35.3%+	20.0%
Age Category						
≤ 2 Years	—	—	7.1%	3.2%	9.2%	2.9%
3 to 5 Years	—	—	33.3%	15.5%	30.0%	16.7%
6 to 10 Years	—	—	46.5%	28.8%	40.9%	24.0%
11 to 13 Years	—	—	53.0%	30.6%	47.4%	30.6%
≥ 14 Years	—	—	51.6%	28.5%	45.3%	25.0%
Sex						
Male	—	—	39.0%	23.8%	34.5%	20.7%

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Female	—	—	38.6%	19.1%	36.2%	19.2%
Race						
Black or African American	—	—	40.1%	23.8%	37.2%	19.7%
White	—	—	38.3%	21.0%	34.7%	20.4%
Other	—	—	33.0%	10.2%	23.2%	12.2%
Region						
Central	—	—	41.4%	19.8%	39.2%	17.9%
Charlottesville/Western	—	—	39.1%	21.4%	33.0%	20.3%
Northern & Winchester	—	—	29.7%	10.1%	26.1%	11.1%
Roanoke/Alleghany	—	—	43.3%	26.7%	44.2%	27.2%
Southwest	—	—	39.7%	31.3%	33.2%	29.4%
Tidewater	—	—	38.8%	22.8%	34.2%	16.6%
MCO						
Aetna	—	—	37.3%	20.2%	35.2%	16.6%
HealthKeepers	—	—	37.3%	18.6%	34.0%	15.3%
Molina	—	—	34.0%	20.7%	32.9%	12.3%
Optima	—	—	40.1%	23.5%	33.6%	22.0%
UnitedHealthcare	—	—	36.2%	15.2%	35.5%	20.1%
VA Premier	—	—	40.6%	26.4%	37.5%	27.2%
More Than One MCO	—	—	50.6%	18.1%	50.6%	19.3%

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 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 35.3 percent of children in foster care and 20.0 percent of controls had a behavioral health encounter with CMH services during MY 2022, 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 for members 6 to 10 years of age, 11 to 13 years of age, and 14 years of age and older (by 16.9, 16.8, and 20.3 percentage points respectively); female members (by 17.0 percentage points); Black or African American members (by 17.5 percentage points); members in the Central, Roanoke/Alleghany, and Tidewater regions (by 21.3, 17.0, and 17.6 percentage points, respectively); and members enrolled with Aetna, HealthKeepers, Molina, UnitedHealthcare, and More Than One MCO (by 18.6, 18.7, 20.6, 15.4, and 31.3 percentage points, respectively).

The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rates for both children in foster care and controls decreased from MY 2021 to MY 2022 by 3.5 and 1.7 percentage points, respectively. For both children in foster care and controls, members 6 to 10 years of age, 11 to 13 years of age, 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. All of these age-related disparities existed during MY 2021. For children in foster care only, members in the Other racial group were significantly less likely to have a behavioral health encounter with CMH services compared to members in other racial groups during MY 2022. 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 2022, while members in the Northern & Winchester region were significantly less likely. These regional disparities also existed during MY 2021; however, during MY 2022, there was an additional disparity identified for children in foster care in the Central region, who were significantly more likely to have a behavioral health encounter with CMH services 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 during MY 2021 and MY 2022.

Behavioral Health Encounters—RTC Services

Table 3-24 displays the MY 2020, MY 2021, and MY 2022 *Behavioral Health Encounters—RTC Services* rates among children in foster care and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 3-24—Rates of *Behavioral Health Encounters—RTC Services* Among Children in Foster Care and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	5.5%+	4.1%
Age Category						
≤ 2 Years	—	—	0.8%	0.8%	1.0%	1.9%
3 to 5 Years	—	—	1.5%	1.5%	4.9%	6.2%
6 to 10 Years	—	—	3.0%	1.1%	5.2%	2.6%
11 to 13 Years	—	—	8.8%	4.1%	5.8%	4.4%
≥ 14 Years	—	—	7.8%	5.1%	8.9%	5.2%
Sex						
Male	—	—	3.2%	1.8%	5.1%	4.1%
Female	—	—	5.7%	3.5%	5.9%	4.0%
Race						
Black or African American	—	—	4.6%	2.7%	5.5%	4.1%

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
White	—	—	4.2%	2.5%	5.4%	4.2%
Other	—	—	5.7%	2.3%	7.3%	0.0%
Region						
Central	—	—	5.1%	2.7%	5.8%	4.6%
Charlottesville/Western	—	—	5.5%	2.7%	7.0%	4.2%
Northern & Winchester	—	—	3.8%	1.7%	5.1%	4.9%
Roanoke/Alleghany	—	—	5.6%	2.3%	7.1%	4.3%
Southwest	—	—	1.4%	2.3%	2.0%	2.0%
Tidewater	—	—	3.7%	3.4%	4.7%	3.8%
MCO						
Aetna	—	—	2.4%	2.1%	5.3%	4.8%
HealthKeepers	—	—	4.7%	3.3%	5.4%	4.0%
Molina	—	—	3.9%	4.4%	4.6%	3.2%
Optima	—	—	5.0%	2.3%	4.7%	3.5%
UnitedHealthcare	—	—	3.7%	0.8%	2.6%	2.1%
VA Premier	—	—	4.2%	2.4%	7.0%	4.9%
More Than One MCO	—	—	7.2%	0.0%	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 3-24 shows that 5.5 percent of children in foster care and 4.1 percent of controls had a behavioral health encounter with RTC services during MY 2022, and the difference was statistically significant (p=0.005). The rate differences between children in foster care and controls varied across stratifications, with the greatest rate difference being for members in the Other racial group (by 7.3 percentage points).

The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rates for both children in foster care and controls increased from MY 2021 to MY 2022 by 1.1 and 1.5 percentage points, respectively. 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 RTC services compared to members in other age groups during MY 2022, while members 14 years of age and older were significantly more likely. Both age disparities identified also existed during MY 2021. For children in foster care, members 3 to 5 years of age were significantly less likely to have a behavioral health encounter with RTC services during MY 2021

compared to members in other age groups. However, this disparity was eliminated during MY 2022 since the rate for members 3 to 5 years of age increased from MY 2021 to MY 2022 (by 3.4 percentage points). For both children in foster care and controls, 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 2022. For children in foster care only, members enrolled with VA Premier were significantly more likely to have a behavioral health encounter with RTC services compared to members enrolled with other MCOs during MY 2022, while members enrolled with UnitedHealthcare were significantly less likely.

Behavioral Health Encounters—Therapeutic Services

Table 3-25 displays the MY 2020, MY 2021, and MY 2022 *Behavioral Health Encounters—Therapeutic Services* rates among children in foster care and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 3-25—Rates of *Behavioral Health Encounters—Therapeutic Services* Among Children in Foster Care and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	10.9%+	6.0%
Age Category						
≤ 2 Years	—	—	2.0%	1.8%	1.0%	1.9%
3 to 5 Years	—	—	9.2%	6.4%	8.8%	9.1%
6 to 10 Years	—	—	11.1%	8.5%	12.6%	8.3%
11 to 13 Years	—	—	12.6%	7.9%	14.1%	7.3%
≥ 14 Years	—	—	15.8%	5.4%	15.8%	4.2%
Sex						
Male	—	—	12.1%	7.1%	12.3%	7.7%
Female	—	—	8.5%	4.5%	9.3%	4.0%
Race						
Black or African American	—	—	10.5%	6.4%	10.0%	6.1%
White	—	—	10.7%	5.7%	11.5%	6.2%
Other	—	—	3.4%	5.7%	6.1%	0.0%
Region						
Central	—	—	13.4%	6.2%	10.6%	4.9%
Charlottesville/Western	—	—	9.7%	6.0%	11.9%	9.3%
Northern & Winchester	—	—	5.3%	2.7%	6.5%	3.3%
Roanoke/Alleghany	—	—	13.7%	5.1%	12.0%	5.9%
Southwest	—	—	14.7%	10.3%	16.0%	9.4%
Tidewater	—	—	6.6%	6.1%	9.2%	3.9%

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
MCO						
Aetna	—	—	9.8%	5.2%	8.5%	7.5%
HealthKeepers	—	—	8.6%	6.4%	9.7%	4.2%
Molina	—	—	10.8%	5.4%	7.8%	3.2%
Optima	—	—	10.0%	5.4%	10.4%	6.3%
UnitedHealthcare	—	—	12.8%	4.1%	10.7%	4.7%
VA Premier	—	—	12.1%	6.9%	14.1%	8.1%
More Than One MCO	—	—	13.3%	4.8%	14.5%	7.2%

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 3-25 shows that 10.9 percent of children in foster care and 6.0 percent of controls had a behavioral health visit with therapeutic services during MY 2022, and the difference was statistically significant (p<0.001). Rates for children in foster care were higher than controls for members in all regions, both gender groups, all racial groups, and members enrolled with all MCOs. The largest rate differences were for members 11 to 13 years of age and 14 years of age and older (by 6.8 and 11.6 percentage points, respectively); female members (by 5.3 percentage points); White members and members in the Other racial group (by 6.1 and 5.3 percentage points, respectively); members in the Roanoke/Alleghany, Southwest, and Tidewater regions (by 6.1, 6.6, and 5.3 percentage points, respectively); and members enrolled with HealthKeepers, UnitedHealthcare, VA Premier, and More Than One MCO (by 5.5, 6.0, 6.0, and 7.3 percentage points, respectively).

The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rates for both children in foster care and controls increased from MY 2021 to MY 2022 by 0.5 and 0.1 percentage points, respectively. 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 during MY 2021 and MY 2022. Additionally, for children in foster care, members 11 to 13 years of age and 14 years of age and older were significantly more likely to have a behavioral health encounter with therapeutic services, while for controls, members 14 years of age and older were significantly less likely. The age disparities for children in foster care identified during MY 2022 existed during MY 2021. For both children in foster care and controls, female members were significantly less likely to have a behavioral health encounter with therapeutic services compared to male members during MY 2021 and MY 2022. For children in foster care, members in the Other racial group were significantly less likely to have a behavioral health encounter with therapeutic services during MY 2021 compared to members in other racial groups; however, this disparity was

eliminated during MY 2022 due to the rate increase from MY 2021 to MY 2022 (by 2.7 percentage points). Additionally, for both children in foster care and controls, members in the Northern & Winchester region were significantly less likely to have a behavioral health encounter with therapeutic services when compared to members in other regions during MY 2022, while members in the Southwest region were significantly more likely. These disparities also existed during MY 2021. For children in foster care, members in the Tidewater region were significantly less likely to have a behavioral health encounter with therapeutic services during MY 2021 compared to members in other regions; however, this disparity was eliminated in MY 2022 due to the rate increase for this region (by 2.6 percentage points). Additionally, for children in foster care, members enrolled with HealthKeepers during MY 2021 were significantly less likely to have a behavioral health encounter with therapeutic services compared to members enrolled with other MCOs; however, this disparity was eliminated in MY 2022 due to the rate increase from MY 2021 to MY 2022 (by 1.1 percentage points).

Behavioral Health Encounters—Traditional Services

Table 3-26 displays the MY 2020, MY 2021, and MY 2022 *Behavioral Health Encounters—Traditional Services* rates among children in foster care and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 3-26—Rates of *Behavioral Health Encounters—Traditional Services* Among Children in Foster Care and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	61.2%+	47.9%
Age Category						
≤ 2 Years	—	—	42.9%	33.0%	43.3%	33.7%
3 to 5 Years	—	—	56.5%	35.3%	44.8%	30.5%
6 to 10 Years	—	—	73.7%	63.7%	64.7%	48.3%
11 to 13 Years	—	—	82.3%	68.2%	76.4%	61.1%
≥ 14 Years	—	—	80.8%	65.0%	72.9%	61.4%
Sex						
Male	—	—	67.7%	53.3%	60.0%	48.3%
Female	—	—	67.9%	54.4%	62.6%	47.4%
Race						
Black or African American	—	—	67.1%	50.8%	59.5%	47.0%
White	—	—	68.4%	55.5%	62.4%	48.6%
Other	—	—	60.2%	51.1%	51.2%	42.7%
Region						
Central	—	—	67.1%	52.9%	60.8%	48.0%
Charlottesville/Western	—	—	67.0%	57.3%	59.6%	49.4%
Northern & Winchester	—	—	59.2%	44.6%	54.6%	39.9%

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Roanoke/Alleghany	—	—	69.5%	54.6%	64.6%	49.8%
Southwest	—	—	73.8%	56.8%	68.6%	49.9%
Tidewater	—	—	71.0%	56.0%	60.8%	49.9%
MCO						
Aetna	—	—	61.8%	48.0%	57.0%	44.7%
HealthKeepers	—	—	68.4%	54.6%	63.0%	49.1%
Molina	—	—	65.0%	46.8%	56.6%	39.7%
Optima	—	—	67.1%	54.8%	58.2%	49.4%
UnitedHealthcare	—	—	63.0%	45.3%	60.3%	47.4%
VA Premier	—	—	70.2%	58.3%	62.7%	47.7%
More Than One MCO	—	—	85.5%	51.8%	88.0%	59.0%

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 61.2 percent of children in foster care and 47.9 percent of controls had a behavioral health visit with traditional services during MY 2022, and the difference was statistically significant (p<0.001). The rates for children in foster care were higher than controls across all stratified rates, with the largest differences for members 3 to 5, 6 to 10, and 11 to 13 years of age (by 14.3, 16.4, and 15.3 percentage points, respectively); female members (by 15.2 percentage points); members in the Northern & Winchester, Roanoke/Alleghany, and Southwest regions (by 14.7, 14.8, and 18.7 percentage points, respectively); and members enrolled with HealthKeepers, Molina, VA Premier, and More Than One MCO (by 13.9, 16.9, 15.0, and 29.0 percentage points, respectively).

The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rates for both children in foster care and controls decreased from MY 2021 to MY 2022 by 6.6 and 5.9 percentage points, respectively. For both children in foster care 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 encounter with traditional services compared to members in other age groups during MY 2022. For children in foster care only, members 6 to 10 years of age were significantly more likely to have a behavioral health encounter with traditional services compared to members in other age groups. Additionally, members 2 years of age and younger and 3 to 5 years of age were significantly less likely to have a behavioral health encounter with traditional services compared to members in other age groups. All identified age disparities also existed during MY 2021. For children in foster care only, White members were significantly more likely to have a behavioral health encounter with traditional services compared to members in other racial groups during MY 2022.

For both 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 compared to members in other regions during MY 2022. 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 during MY 2022. These regional disparities also existed during MY 2021. For both children in foster care and controls, 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 during MY 2022. For children in foster care only, members enrolled with Optima were significantly less likely to have a behavioral health encounter with traditional services compared to members enrolled with other MCOs during MY 2022.

Overall Service Utilization

Table 3-27 displays the MY 2020, MY 2021, and MY 2022 *Overall Service Utilization* rates among children in foster care and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 3-27—Rates of *Overall Service Utilization* Among Children in Foster Care and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	89.7%-	91.6%
Age Category						
≤ 2 Years	—	—	93.4%	95.6%	92.4%	93.8%
3 to 5 Years	—	—	90.9%	91.4%	88.5%	91.2%
6 to 10 Years	—	—	90.4%	92.9%	88.0%	90.9%
11 to 13 Years	—	—	92.3%	93.6%	91.3%	92.5%
≥ 14 Years	—	—	93.4%	91.7%	89.3%	90.6%
Sex						
Male	—	—	91.6%	92.4%	89.8%	92.0%
Female	—	—	92.8%	93.7%	89.6%	91.2%
Race						
Black or African American	—	—	91.5%	92.4%	88.3%	90.1%
White	—	—	92.6%	93.4%	90.6%	92.5%
Other	—	—	87.5%	88.6%	85.4%	89.0%
Region						
Central	—	—	92.1%	92.1%	87.0%	90.4%
Charlottesville/Western	—	—	92.9%	94.6%	91.1%	92.7%
Northern & Winchester	—	—	86.3%	90.9%	86.6%	92.0%
Roanoke/Alleghany	—	—	94.4%	94.7%	93.9%	93.2%
Southwest	—	—	95.1%	94.4%	94.0%	95.3%

Category	MY 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Tidewater	—	—	92.2%	91.3%	87.2%	87.6%
MCO						
Aetna	—	—	90.8%	89.9%	85.9%	89.7%
HealthKeepers	—	—	90.6%	93.4%	90.4%	91.5%
Molina	—	—	92.1%^	89.2%^	86.3%	86.8%
Optima	—	—	91.6%	93.1%	90.0%	92.1%
UnitedHealthcare	—	—	93.4%	90.9%	89.7%	92.7%
VA Premier	—	—	93.8%	94.6%	90.5%	92.4%
More Than One MCO	—	—	97.6%	96.4%	97.6%	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 3-27 shows that 89.7 percent of children in foster care and 91.6 percent of controls had an ambulatory care visit, ED visit, inpatient visit, or behavioral health encounter (i.e., any service) during MY 2022, and the difference was statistically significant (p=0.005). The rate differences between children in foster care and controls were similar across the stratified rates. The rate for children in foster care was notably lower than controls for members in the Northern & Winchester region (by 5.4 percentage points).

The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rates for both children in foster care and controls decreased from MY 2021 to MY 2022 by 2.4 and 1.4 percentage points, respectively. For both children in foster care and controls, members 2 years of age and younger were significantly more likely to utilize any service compared to members in other age groups during MY 2022. For both children in foster care and controls, Black or African American members were significantly less likely to utilize any service compared to members in other racial groups during MY 2022, while White members were significantly more likely. For children in foster care only, members in the Central region and the Northern & Winchester region were significantly less likely to utilize any service compared to members in other regions during MY 2022, while members in the Roanoke/Alleghany region were significantly more likely. For both children in foster care and controls, members in the Southwest region were significantly more likely to utilize any service compared to members in other regions, while members in the Tidewater region were significantly less likely. The disparities for members in the Northern & Winchester region and the Roanoke/Alleghany region existed during MY 2021. Additionally, for children in foster care only, the disparity for members in the Southwest region existed during MY 2021. For children in foster care only, members enrolled with Aetna were significantly less likely to utilize any service compared to members enrolled with other MCOs during MY 2022, while members enrolled with More Than One MCO were significantly more likely.

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 8,508 members in the children receiving adoption assistance eligible population and the 7,270 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, 2022, and receiving healthcare coverage from DMAS at any time during MY 2022. 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=8,508)†

Category	Number	Percent
Age Category		
≤ 2 years	292	3.4%
3 to 5 years	955	11.2%
6 to 10 years	2,544	29.9%
11 to 13 years	1,828	21.5%
≥ 14 years	2,889	34.0%
Sex		
Male	4,559	53.6%
Female	3,949	46.4%
Race		
Black or African American	2,537	29.8%
White	5,749	67.6%
Other	222	2.6%
Region		
Central	1,833	21.5%
Charlottesville/Western	1,351	15.9%
Northern & Winchester	1,309	15.4%
Roanoke/Alleghany	1,434	16.9%
Southwest	1,040	12.2%
Tidewater	1,532	18.0%
Latest MCO in the Measurement Year		
Aetna	727	8.5%
HealthKeepers	2,548	29.9%
Molina	371	4.4%
Optima	1,726	20.3%

Category	Number	Percent
UnitedHealthcare	646	7.6%
VA Premier	2,380	28.0%
Other	110	1.3%
Latest Medicaid Program in the Measurement Year		
CCC Plus (MLTSS)	255	3.0%
Medallion 4.0 (Acute)	8,142	95.7%
Other*	111	1.3%

† Members with Unknown Region are included in the All Eligible Members rate but are not displayed in this table.
** Includes members only enrolled in FFS.*

While children receiving adoption assistance were disproportionately male (53.6 percent) compared to the general population in Virginia, which was 49.5 percent male in 2022, children receiving adoption assistance were proportionately White (67.6 percent) compared to the general population in Virginia, which was 68.5 percent White in 2022.[4-1] Children receiving adoption assistance resided mostly in the Central (21.5 percent), Roanoke & Allegany (16.9 percent), and Tidewater (18.0 percent) regions. Children receiving adoption assistance were most likely to be enrolled with HealthKeepers (29.9 percent), VA Premier (28.0 percent), or Optima (20.3 percent). Children receiving adoption assistance were most likely to be enrolled through the Medallion 4.0 (Acute) program (95.7 percent). MCO attribution and Medicaid program attribution was Other for 1.3 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 (Acute) or CCC Plus (MLTSS) 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, 85.4 percent (n=7,270) of children met the requirements for the study population, compared to 52.7 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 adoption assistance study population mirrored the demographic characteristics of the eligible population, except that there were 1.6 percent fewer children 2 years of age and 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

4-1 United States Census Bureau. Virginia QuickFacts. Available at: https://www.census.gov/quickfacts/VA. Accessed on: Mar 20, 2024.
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: Mar 20, 2024.

(n=7,299). 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 (MLTSS) compared to the continuously enrolled controls. Furthermore, continuously enrolled children receiving adoption assistance were less likely to reside 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=7,270) 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: Characteristics of the Controls 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. The narrative focuses on differences in rates for children receiving adoption assistance and controls that were greater than 5.0 percentage points for stratified rates during MY 2022. If the difference for All Eligible Members was greater than 5.0 percentage points, the narrative for stratified rates instead focuses on differences between children receiving adoption assistance and controls that were greater than the difference for All Eligible Members or that were greater than 5.0 percentage points in the opposite direction. The narrative does not discuss differences for which the denominator for children receiving adoption assistance or the denominator for controls was less than 30, since these rates are expected to have greater variability. Additionally, the narrative compares the rates for All Eligible Members to the MY 2022 national Medicaid 50th percentile, discusses the change in the rates for All Eligible Members from MY 2021 to MY 2022, and discusses health disparities identified in MY 2022.

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, MY 2021, and MY 2022 may also be impacted by the COVID-19 pandemic; however, rate comparisons within MY 2020, MY 2021, and MY 2022 (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 2020, MY 2021, and MY 2022 *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 and MY 2022, 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. Please note that the denominators in Table 4-2 are small due to the combination of the measure specifications with the criteria for the study population. The measure specifications only include children who turned age 15 months during the measurement year, and there were few children receiving adoption assistance at this young of an age.

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 2020		MY 2021		MY 2022	
	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%	0.0%	55.3%
Sex						
Male	50.0%	62.1%	100.0%^	76.9%^	0.0%^	46.7%^
Female	—	33.3%	0.0%^	52.2%^	0.0%^	60.9%^
Race						
Black or African American	100.0%	50.0%	—	20.0%	0.0%^	50.0%^
White	0.0%	53.1%	50.0%	76.9%	0.0%^	56.7%^
Other	—	—	—	—	—	—
Region						
Central	—	63.6%	—	44.4%	—	66.7%^
Charlottesville/Western	—	25.0%	100.0%^	71.4%^	0.0%^	33.3%^

Category	MY 2020		MY 2021		MY 2022	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Northern & Winchester	—	0.0%	—	80.0%	—	83.3%^
Roanoke/Alleghany	50.0%	62.5%	100.0%^	50.0%^	0.0%^	22.2%^
Southwest	—	75.0%	—	100.0%^	—	60.0%^
Tidewater	—	44.4%	0.0%^	70.0%^	—	75.0%^
MCO						
Aetna	100.0%	100.0%	—	66.7%	—	100.0%^
HealthKeepers	—	33.3%	0.0%^	64.3%^	0.0%^	57.1%^
Molina	—	100.0%	—	40.0%	—	25.0%^
Optima	—	70.0%	100.0%^	71.4%^	—	60.0%^
UnitedHealthcare	—	25.0%	100.0%^	75.0%^	—	42.9%^
VA Premier	0.0%	50.0%	0.0%^	68.8%^	0.0%^	63.6%^
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 children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 0.0 percent of children receiving adoption assistance and 55.3 percent of controls who turned 15 months old during MY 2022 received six or more well-child visits with a PCP, and the difference was not statistically significant (p=0.11). While there were large rate differences between children receiving adoption assistance and controls for most stratified rates, these rates had very small denominators and may be less reliable.

For all eligible members, the MY 2022 rates for children receiving adoption assistance and controls were below the MY 2022 national Medicaid 50th percentile. The rate for children receiving adoption assistance and controls decreased from MY 2021 to MY 2022 by 50.0 and 10.0 percentage points, respectively. 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 2020, MY 2021, and MY 2022 *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

and MY 2022, 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 2020		MY 2021		MY 2022	
	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%	79.2%	65.7%
Sex						
Male	88.2%	71.4%	65.8%	73.1%	86.4%	66.7%
Female	70.6%	57.1%	77.4%	72.7%	73.1%	64.7%
Race						
Black or African American	94.1%	71.4%	66.7%	84.6%	91.7%	64.3%
White	72.9%	62.9%	72.2%	67.6%	74.3%	70.0%
Other	100.0%	—	—	100.0%^	100.0%^	0.0%^
Region						
Central	80.0%	42.9%	57.1%	75.0%	80.0%	58.3%
Charlottesville/Western	70.0%	87.5%	81.8%^	100.0%^	100.0%^	40.0%^
Northern & Winchester	100.0%	100.0%	75.0%^	100.0%^	60.0%	80.0%
Roanoke/Alleghany	92.3%	57.1%	61.5%	54.5%	75.0%	87.5%
Southwest	44.4%	75.0%	81.8%	44.4%	72.7%	50.0%
Tidewater	84.6%	50.0%	75.0%	85.7%	100.0%^	66.7%^
MCO						
Aetna	33.3%	66.7%	57.1%	66.7%	100.0%^	50.0%^
HealthKeepers	76.2%	77.8%	83.3%	84.6%	71.4%^	100.0%^
Molina	—	—	55.6%	71.4%	66.7%	80.0%
Optima	100.0%	44.4%	76.9%	66.7%	81.8%	37.5%
UnitedHealthcare	85.7%	80.0%	62.5%	60.0%	57.1%^	100.0%^
VA Premier	76.9%	61.5%	75.0%	72.7%	91.7%	83.3%
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 children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.

- Indicates that the rate for 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 79.2 percent of children receiving adoption assistance and 65.7 percent of controls who turned 30 months old during MY 2022 received two or more well-child visits with a PCP, and the difference was not statistically significant (p=0.17). 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 2022 rate for children receiving adoption assistance was above the MY 2022 national Medicaid 50th percentile, while controls were below the MY 2022 national Medicaid 50th percentile. The rate of well-child visits for children receiving adoption assistance increased from MY 2021 to MY 2022 by 8.2 percentage points, while the rate for controls decreased by 7.2 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 2020, MY 2021, and MY 2022 *Child and Adolescent Well-Care Visits* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 2020		MY 2021		MY 2022	
	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%	45.9%	47.3%
Age Category						
3 to 11 Years	47.1%	46.6%	50.0%	51.5%	48.8%	50.5%
12 to 17 Years	41.5%	38.2%	47.0%	48.1%	45.4%	47.5%
18 to 21 Years	27.6%	27.1%	33.6%	30.6%	34.0%	30.0%
Sex						
Male	42.6%	40.1%	47.9%	48.2%	45.6%	47.6%
Female	43.0%	41.6%	46.1%	48.3%	46.2%	47.0%
Race						
Black or African American	47.3%	41.2%	53.5%	50.2%	50.6%	48.7%
White	40.7%	40.4%	44.4%	47.3%	43.7%	46.7%
Other	40.1%	47.8%	40.3%	47.2%	48.3%	49.2%

Category	MY 2020		MY 2021		MY 2022	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Region						
Central	40.1%	38.7%	48.5%	48.5%	41.9%	47.0%
Charlottesville/Western	48.3%	39.9%	50.4%	47.9%	51.5%	46.2%
Northern & Winchester	32.5%	47.7%	31.7%	52.2%	35.8%	55.3%
Roanoke/Alleghany	45.6%	39.8%	49.5%	46.4%	48.0%	44.0%
Southwest	39.6%	33.1%	44.4%	40.2%	45.2%	39.9%
Tidewater	49.0%	44.0%	54.2%	51.8%	52.5%	50.4%
MCO						
Aetna	34.5%	36.0%	36.8%	42.4%	38.6%	48.6%
HealthKeepers	44.9%	43.9%	49.8%	53.1%	46.9%	51.5%
Molina	32.7%	26.4%	33.3%	40.6%	30.8%	36.0%
Optima	46.7%	43.5%	50.5%	51.0%	48.2%	46.6%
UnitedHealthcare	31.6%	39.0%	38.4%	43.5%	40.2%	46.7%
VA Premier	44.3%	38.8%	48.9%	44.6%	48.2%	44.6%
More Than One MCO	39.6%	50.5%	39.4%	60.0%	61.8%	52.2%

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 receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 45.9 percent of children receiving adoption assistance and 47.3 percent of controls had a well-care visit with a PCP or an OB/GYN during MY 2022, and the difference was not statistically significant (p=0.08). For children receiving adoption assistance, rates were notably higher than controls for members in the Charlottesville/Western region and the Southwest region (by 5.3 percentage points each), and for members enrolled with More Than One MCO (by 9.6 percentage points). Conversely, the rates for children receiving adoption assistance were notably lower than controls for members in the Central region and the Northern & Winchester region (by 5.1 and 19.5 percentage points, respectively), and for members enrolled with Aetna, Molina, and UnitedHealthcare (by 10.0, 5.2, and 6.5 percentage points, respectively).

Rates for children receiving adoption assistance and controls were above the MY 2022 national Medicaid 50th percentile for members 18 to 21 years of age but below the national Medicaid 50th percentile for members 3 to 11 and 12 to 17 years of age. The rates of well-care visits for both children

receiving adoption assistance and controls decreased from MY 2021 to MY 2022 by 1.2 and 0.9 percentage points, respectively. For both children receiving adoption assistance and controls, members 3 to 11 years of age were significantly more likely to have a well-care visit compared to members in other age groups during MY 2022, while members 18 to 21 years of age were significantly less likely. These disparities also existed during MY 2021. For children receiving adoption assistance, Black or African American members were significantly more likely to have a well-care visit during MY 2021 and MY 2022, while White members were significantly less likely. For both 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 and MY 2022. For children receiving adoption assistance only, members in the Charlottesville/Western region were significantly more likely to have a well-care visit compared to members in other regions during MY 2022, while members in the Central region and the Northern & Winchester region were significantly less likely. The disparities for the Charlottesville/Western region and the Northern & Winchester region also existed during MY 2021. For both children receiving adoption assistance and controls, members enrolled with Molina were significantly less likely to have a well-care visit compared to members enrolled with other MCOs during MY 2021 and MY 2022. For children receiving adoption assistance only, members enrolled with Optima, VA Premier, and More Than One MCO were significantly more likely to have a well-care visit compared to members enrolled with other MCOs during MY 2022, while members enrolled with Aetna, Molina, and UnitedHealthcare were significantly less likely. The disparities for children receiving adoption assistance enrolled with Aetna, Optima, and UnitedHealthcare also existed during MY 2021.

Oral Health

Annual Dental Visit (ADV)

Table 4-5 displays the MY 2020, MY 2021, and MY 2022 *Annual Dental Visit* rates among children receiving adoption assistance controls stratified by member characteristics. For MY 2021 and MY 2022, 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 Visit* Among Children Receiving Adoption Assistance and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	57.3%+	54.3%
Age Category						
≤ 2 Years	46.3%	34.7%	40.5%	40.2%	47.3%	35.3%
3 to 5 Years	50.8%	49.1%	52.2%	50.4%	58.0%	55.0%
6 to 10 Years	59.0%	53.2%	57.5%	55.6%	60.7%	60.5%

Category	MY 2020		MY 2021		MY 2022	
	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	56.7%	51.3%	57.2%	52.0%	61.7%	56.6%
≥ 14 Years	49.6%	47.0%	48.1%	46.6%	52.0%	48.0%
Sex						
Male	53.1%	48.0%	52.1%	49.5%	56.4%	53.4%
Female	55.1%	52.1%	54.6%	52.3%	58.4%	55.4%
Race						
Black or African American	53.4%	46.2%	53.9%	49.1%	58.6%	51.8%
White	54.3%	51.6%	53.0%	51.5%	56.7%	55.3%
Other	56.2%	51.4%	50.6%	54.7%	59.1%	55.6%
Region						
Central	55.2%	47.8%	53.7%	51.2%	59.5%	54.5%
Charlottesville/Western	57.1%	50.9%	50.8%	49.3%	59.7%	54.8%
Northern & Winchester	45.3%	57.9%	47.3%	60.0%	51.7%	65.4%
Roanoke/Alleghany	54.2%	48.4%	53.4%	46.8%	52.7%	51.2%
Southwest	62.0%	49.9%	62.9%	51.4%	67.6%	50.4%
Tidewater	52.0%	46.4%	52.8%	47.4%	54.3%	50.3%
MCO						
Aetna	47.1%	47.9%	45.8%	47.1%	48.9%	49.7%
HealthKeepers	55.2%	49.2%	55.2%	53.0%	59.2%	57.8%
Molina	38.3%	36.5%	43.1%	45.5%	43.4%	44.6%
Optima	56.5%	49.9%	54.7%	50.5%	55.6%	53.3%
UnitedHealthcare	45.0%	50.1%	51.0%	49.7%	53.8%	51.8%
VA Premier	57.3%	52.3%	53.9%	50.3%	61.7%	54.3%
More Than One MCO	54.5%	63.4%	62.1%	63.1%	64.7%	65.7%

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

- Indicates that the rate for 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 57.3 percent of children receiving adoption assistance and 54.3 percent of controls had a dental visit during MY 2022, and the difference was statistically significant ($p<0.001$). The rates for children receiving adoption assistance were notably higher than controls for members 2

years of age and younger and 11 to 13 years of age (by 12.0 and 5.1 percentage points, respectively); Black or African American members (by 6.8 percentage points); members in the Central region and Southwest region (by 5.0 and 17.2 percentage points, respectively); and members enrolled with VA Premier (by 7.4 percentage points). Conversely, the rate for children receiving adoption assistance was notably lower than controls for members in the Northern & Winchester region (by 13.7 percentage points).

Rates for children receiving adoption assistance were above the MY 2022 national Medicaid 50th percentile for members for all age groups.[4-4] For controls, the rates for the members 11 to 13 years of age and 14 years of age and older were above the national Medicaid 50th percentile, while the rates for other age categories were below the national Medicaid 50th percentile. The rates for both children receiving adoption assistance and controls increased from MY 2021 to MY 2022 by 4.1 and 3.5 percentage points, respectively. For both children receiving adoption assistance and controls, members 6 to 10 and 11 to 13 years of age were significantly more likely to have a dental visit compared to members in other age groups during MY 2022, while members 2 years of age and younger and 14 years of age and older were significantly less likely. The disparities for members 2 years of age and younger, 6 to 10 years of age, and 14 years of age and older also existed during MY 2021; however, the disparity for members 11 to 13 years of age only existed for children receiving adoption assistance during MY 2021. For both children receiving adoption assistance and controls, members in the Roanoke/Alleghany region and the Tidewater region were significantly less likely to have a dental visit compared to members in other regions during MY 2022. For children receiving adoption assistance only, members in the Central region and the Southwest region were significantly more likely to have a dental visit compared to members in other regions during MY 2022, while members in the Northern & Winchester region were significantly less likely. The disparity for members in the Northern & Winchester region also existed during MY 2021; however, the disparity for members in the Southwest region only existed for children receiving adoption assistance during MY 2021, and the disparities for members in the Roanoke/Alleghany region and the Tidewater region only existed for controls during MY 2021. For both children receiving adoption assistance and controls, members enrolled with HealthKeepers were significantly more likely to have a dental visit compared to members enrolled with other MCOs during MY 2022, while members enrolled with Aetna and Molina were significantly less likely. The same disparities existed for all three MCOs for children receiving adoption assistance during MY 2021. For children receiving adoption assistance only, members enrolled with VA Premier were significantly more likely to have a dental visit compared to members enrolled with other MCOs during MY 2022.

Preventive Dental Services (PDENT-CH)

Table 4-6 displays the MY 2020, MY 2021, and MY 2022 *Preventive Dental Services* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021 and MY 2022, 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.

[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.

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

Category	MY 2020		MY 2021		MY 2022	
	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%	53.2%+	49.5%
Age Category						
≤ 2 Years	43.5%	24.8%	37.1%	30.8%	46.2%	29.0%
3 to 5 Years	47.9%	46.4%	49.8%	47.3%	57.0%	52.3%
6 to 10 Years	55.7%	49.2%	54.7%	52.0%	58.0%	58.0%
11 to 13 Years	50.7%	44.2%	51.5%	46.4%	57.3%	51.7%
≥ 14 Years	43.3%	38.3%	41.0%	38.6%	45.7%	41.0%
Sex						
Male	49.1%	42.1%	47.4%	44.0%	52.9%	49.1%
Female	49.2%	45.1%	49.3%	46.2%	53.5%	49.9%
Race						
Black or African American	49.3%	40.1%	49.8%	43.6%	54.4%	47.3%
White	49.1%	45.0%	47.6%	45.6%	52.6%	50.4%
Other	49.0%	46.4%	45.6%	48.8%	55.8%	50.8%
Region						
Central	50.5%	41.6%	48.3%	45.0%	56.0%	50.8%
Charlottesville/Western	51.1%	42.6%	45.0%	41.6%	54.6%	49.3%
Northern & Winchester	40.4%	53.2%	42.1%	56.2%	47.6%	60.7%
Roanoke/Alleghany	49.3%	40.4%	48.3%^	41.5%^	47.5%	44.4%
Southwest	57.8%	44.1%	60.1%	45.4%	65.0%	46.2%
Tidewater	47.5%	40.9%	48.0%	42.0%	50.2%	46.0%
MCO						
Aetna	42.0%	39.8%	40.2%	42.7%	45.0%	45.0%
HealthKeepers	49.7%	43.1%	50.3%	47.2%	55.0%	53.1%
Molina	33.3%	29.2%	37.4%	40.5%	37.1%	37.5%
Optima	51.8%	43.1%	49.1%	44.7%	51.7%	48.6%
UnitedHealthcare	39.8%	44.5%	46.5%	45.8%	49.3%	47.4%
VA Premier	52.9%	46.3%	49.4%	43.9%	57.8%	49.5%
More Than One MCO	51.5%	56.4%	57.6%	53.0%	61.8%	58.8%

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 receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 53.2 percent of children receiving adoption assistance and 49.5 percent of controls had at least one preventive dental service during MY 2022, and the difference was statistically significant (p<0.001). The rates for children receiving adoption assistance were notably higher than controls for members 2 years of age and younger and 11 to 13 years of age (by 17.2 and 5.6 percentage points); Black or African American members and members in the Other racial group (by 7.1 and 5.0 percentage points, respectively); members in the Central, Charlottesville/Western, and Southwest regions (by 5.2, 5.3, and 18.8 percentage points); and members enrolled with VA Premier (by 8.3 percentage points). Conversely, the rate for children receiving adoption assistance was notably lower than controls for members in the Northern & Winchester region (by 13.1 percentage points).

MY 2022 national Medicaid benchmarks were not available for this indicator. The rates for both children receiving adoption assistance and controls increased from MY 2021 to MY 2022 by 4.9 and 4.5 percentage points, respectively. For both children receiving adoption assistance and controls, members 6 to 10 and 11 to 13 years of age were significantly more likely to have a preventive dental service compared to members in other age groups during MY 2022, while members 14 years of age and older were significantly less likely. For children receiving adoption assistance only, members 3 to 5 years of age were significantly more likely to have a preventive dental service compared to members in other age groups during MY 2022. The disparities for members 6 to 10 years of age and 14 years of age and older also existed during MY 2021; however, the disparity for members 11 to 13 years of age only existed for children receiving adoption assistance during MY 2021. The disparity for children receiving adoption assistance for members 2 years of age and younger during MY 2021 was eliminated during MY 2022, since the rate for these members increased from MY 2021 to MY 2022 (by 9.1 percentage points). For both children receiving adoption assistance and controls, members in the Roanoke/Alleghany region and the Tidewater region were significantly less likely to have a preventive dental service compared to members in other regions during MY 2022. For children receiving adoption assistance only, members in the Central region and the Southwest region were significantly more likely to have a preventive dental service compared to members in other regions during MY 2022, while members in the Northern & Winchester region were significantly less likely. The disparities for members in the Northern & Winchester region also existed during MY 2021; however, the disparity for members in the Southwest region only existed for children receiving adoption assistance during MY 2021, and the disparity for members in the Tidewater region only existed for controls during MY 2021. The disparity for children receiving adoption assistance and controls in the Charlottesville/Western region during MY 2021 was eliminated during MY 2022, since the rate for these members increased by 9.6 and 7.7 percentage points, respectively. For both children receiving adoption assistance and controls, members enrolled with HealthKeepers were significantly more likely to have a preventive dental service compared to members enrolled with other MCOs during MY 2022, while members enrolled with Aetna and Molina were significantly less likely. For children receiving adoption assistance only, members enrolled with VA Premier were significantly more likely to have a preventive dental service compared to members enrolled with other MCOs during MY 2022. The disparity for members enrolled with HealthKeepers also existed during MY 2021; however, the disparities for members enrolled with Aetna and Molina only existed for children receiving adoption assistance during MY 2021.

Oral Evaluation, Dental Services (OEV-CH)

Table 4-7 displays the MY 2020, MY 2021, and MY 2022 *Oral Evaluation, Dental Services* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 2020		MY 2021		MY 2022	
	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%	52.1%+	48.1%
Age Category						
≤ 2 Years	—	—	36.3%	30.0%	46.2%	26.9%
3 to 5 Years	—	—	49.1%	45.9%	56.4%	50.7%
6 to 10 Years	—	—	53.5%	50.5%	56.7%	56.2%
11 to 13 Years	—	—	49.6%	45.5%	56.2%	49.1%
≥ 14 Years	—	—	40.5%	38.0%	44.7%	40.8%
Sex						
Male	—	—	46.5%	43.1%	51.7%	47.7%
Female	—	—	48.0%	45.2%	52.6%	48.6%
Race						
Black or African American	—	—	49.2%	42.7%	53.9%	46.4%
White	—	—	46.3%	44.6%	51.3%	48.9%
Other	—	—	45.0%	47.5%	53.0%	48.1%
Region						
Central	—	—	47.5%	44.2%	53.8%	49.1%
Charlottesville/Western	—	—	44.1%	40.4%	54.4%	48.0%
Northern & Winchester	—	—	41.3%	55.3%	47.1%	59.3%
Roanoke/Alleghany	—	—	45.8%	39.9%	46.6%	42.6%
Southwest	—	—	58.8%	44.2%	62.3%	44.9%
Tidewater	—	—	47.8%	41.6%	50.2%	45.5%
MCO						
Aetna	—	—	38.4%	41.9%	43.2%	43.5%
HealthKeepers	—	—	49.1%	46.5%	54.4%	52.1%
Molina	—	—	36.4%	38.8%	37.5%	36.5%

Category	MY 2020		MY 2021		MY 2022	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Optima	—	—	48.1%^	44.0%^	50.9%	47.6%
UnitedHealthcare	—	—	45.3%	44.3%	48.9%	45.2%
VA Premier	—	—	48.7%	42.4%	55.9%	47.8%
More Than One MCO	—	—	56.1%	53.0%	57.4%	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 receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 52.1 percent of children receiving adoption assistance and 48.1 percent of controls received a comprehensive or periodic oral evaluation during MY 2022, and the difference was statistically significant (p<0.001). The rates for children receiving adoption assistance were notably higher than controls for members 2 years of age and younger, 3 to 5 years of age, and 11 to 13 years of age (by 19.3, 5.7, and 7.1 percentage points, respectively); Black or African American members (by 7.5 percentage points); members in the Charlottesville/Western region and the Southwest region (by 6.4 and 17.4 percentage points, respectively); and members enrolled with VA Premier (by 8.1 percentage points). Conversely, the rate for children receiving adoption assistance was notably lower than controls for members in the Northern & Winchester region (by 12.2 percentage points).

The rates for children receiving adoption assistance and controls were above the MY 2022 national Medicaid 50th percentile for members up to 21 years of age. However, members 19 to 21 years of age tend to have lower rates of comprehensive or periodic oral evaluations, so benchmarks may slightly underestimate rates for members up to age 18. The rate for children receiving adoption assistance increased from MY 2021 to MY 2022 by 4.9 percentage points, and the rate for controls increased by 4.1 percentage points. For both children receiving adoption assistance and controls, members 6 to 10 years of age were significantly more likely to have a comprehensive or periodic oral evaluation compared to members in other age groups during MY 2022, while members 14 years of age and older were significantly less likely. For children receiving adoption assistance only, members 3 to 5 and 11 to 13 years of age were significantly more likely to have a comprehensive or periodic oral evaluation compared to members in other age groups during MY 2022. The disparities for members 6 to 10 years of age, 11 to 13 years of age, and 14 years of age and older also existed during MY 2021. The MY 2021 disparity for children receiving adoption assistance 2 years of age and younger was eliminated in MY 2022, since the rate for these members increased from MY 2021 to MY 2022 (by 9.9 percentage points). 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 in

other racial groups during MY 2022, while White members were significantly less likely. These disparities also existed during MY 2021. For both children receiving adoption assistance and controls, members in the Roanoke/Alleghany region were significantly less likely to have a comprehensive or periodic oral evaluation compared to members in other regions during MY 2022. 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. The disparities for members in the Northern & Winchester region also existed during MY 2021; however, the disparity for members in the Roanoke/Alleghany region only existed for controls during MY 2021, and the disparity for members in the Southwest region only existed for children receiving adoption assistance during MY 2021. The MY 2021 disparity for members in the Charlottesville/Western region was eliminated in MY 2022, since the rate for these members increased from MY 2021 to MY 2022 (by 10.3 percentage points). 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 during MY 2022, while members enrolled with Aetna and Molina were significantly less likely. For children receiving adoption assistance only, members enrolled with VA Premier were significantly more likely to have a comprehensive or periodic oral evaluation compared to members enrolled with other MCOs during MY 2022. The disparity for members enrolled with HealthKeepers also existed during MY 2021; however, the disparities for members enrolled with Aetna and Molina only existed for children receiving adoption assistance during MY 2021.

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

Table 4-8 displays the MY 2020, MY 2021, and MY 2022 *Topical Fluoride for Children—Dental or Oral Health Services* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 2020		MY 2021		MY 2022	
	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%	23.3%+	19.5%
Age Category						
≤ 2 Years	—	—	19.0%	19.2%	18.6%	17.9%
3 to 5 Years	—	—	24.6%	20.2%	26.4%	21.7%
6 to 10 Years	—	—	29.1%	24.1%	26.8%	24.0%
11 to 13 Years	—	—	25.9%	21.0%	25.5%	20.2%

Category	MY 2020		MY 2021		MY 2022	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
≥ 14 Years	—	—	17.8%	14.7%	18.1%	14.7%
Sex						
Male	—	—	23.1%	19.8%	22.9%	19.4%
Female	—	—	24.4%	19.3%	23.7%	19.6%
Race						
Black or African American	—	—	25.2%	17.7%	23.6%	17.0%
White	—	—	23.0%	20.2%	23.1%	20.4%
Other	—	—	22.5%	26.3%	23.8%	24.9%
Region						
Central	—	—	26.9%	21.2%	24.4%	21.3%
Charlottesville/Western	—	—	23.3%	19.2%	22.4%	17.8%
Northern & Winchester	—	—	21.3%	29.8%	22.7%	29.4%
Roanoke/Alleghany	—	—	21.0%	15.8%	19.3%	14.2%
Southwest	—	—	28.2%	16.4%	30.9%	16.9%
Tidewater	—	—	21.6%	15.3%	21.3%	17.6%
MCO						
Aetna	—	—	16.2%	17.8%	16.6%	17.6%
HealthKeepers	—	—	25.5%	21.8%	24.1%	23.8%
Molina	—	—	15.2%	16.0%	16.8%	13.7%
Optima	—	—	25.0%	18.0%	22.7%	17.1%
UnitedHealthcare	—	—	21.7%	20.0%	23.7%	18.1%
VA Premier	—	—	24.6%	19.0%	25.6%	18.5%
More Than One MCO	—	—	24.2%	25.8%	20.6%	16.2%

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 receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 23.3 percent of children receiving adoption assistance and 19.5 percent of controls received at least two topical fluoride applications as dental or oral health services during MY 2022, and the difference was statistically significant ($p<0.001$). The rates for children receiving adoption assistance were notably higher than controls for members 11 to 13 years of age (by 5.3 percentage

points); Black or African American members (by 6.6 percentage points); members in the Roanoke/Alleghany region and the Southwest region (by 5.1 and 14.0 percentage points, respectively); and members enrolled with Optima, UnitedHealthcare, and VA Premier (by 5.6, 5.6, and 7.1 percentage points, respectively).

The rate for children receiving adoption assistance was above the MY 2022 national Medicaid 50th percentile for members up to 21 years of age, while the rate for controls was below the national Medicaid 50th percentile. However, members 19 to 21 years of age tend to have lower rates of topical fluoride applications, so benchmarks may slightly underestimate rates for members up to 18 years of age. The rate for both children receiving adoption assistance and controls decreased from MY 2021 to MY 2022 by 0.4 and 0.1 percentage points, respectively. 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 during MY 2022, while members 14 years of age and older were significantly less likely. For children receiving adoption assistance only, members 3 to 5 and 11 to 13 years of age were significantly more likely to have at least two topical fluoride applications compared to members in other age groups during MY 2022. The disparities for members 6 to 10 years of age, 11 to 13 years of age, and 14 years of age and older also existed during MY 2021. For both children receiving adoption assistance and controls, members in the Roanoke/Alleghany region were significantly less likely to have at least two topical fluoride applications compared to members in other regions during MY 2022, and this disparity also existed during MY 2021. 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 2022, and this disparity also existed during MY 2021. For children receiving adoption assistance in MY 2021, disparities existed for members in the Northern & Winchester region and the Tidewater region; however, these disparities were eliminated during MY 2022. For both children receiving adoption assistance and controls, members enrolled with Molina were significantly less likely to have at least two topical fluoride applications compared to members enrolled with other MCOs during MY 2022. For children receiving adoption assistance only, members enrolled with VA Premier were significantly more likely to have at least two topical fluoride applications compared to members enrolled with other MCOs during MY 2022, while members enrolled with Aetna were significantly less likely. The disparity for members enrolled with Aetna also existed during MY 2021; however, the disparity for members enrolled with Molina only existed for children receiving adoption assistance during MY 2021.

Behavioral Health

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

Table 4-9 displays the MY 2020, MY 2021, and MY 2022 *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 and MY 2022, 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 4-9—Rates of *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* Among Children Receiving Adoption Assistance and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	53.7%	59.7%
Age Category						
6 to 10 Years	80.0%	76.5%	50.0%	66.7%	75.0%	83.3%
11 to 13 Years	67.7%	69.6%	62.9%	60.0%	43.8%	65.4%
≥ 14 Years	52.2%	48.1%	60.0%	45.9%	54.3%	52.5%
Sex						
Male	63.3%	54.5%	49.2%	57.9%	60.3%	55.2%
Female	57.8%	61.0%	69.8%	48.4%	49.5%	62.8%
Race						
Black or African American	61.1%	50.0%	64.0%	47.5%	54.9%	51.9%
White	59.7%	61.3%	57.7%	54.4%	52.7%	64.4%
Other	—	100.0%	33.3%	66.7%	100.0%	—
Region						
Central	62.5%	55.6%	55.9%^	72.2%^	50.9%	63.6%
Charlottesville/Western	25.0%	68.4%	54.5%^	60.0%^	60.9%	54.5%
Northern & Winchester	50.0%	75.0%	50.0%^	30.0%^	50.0%	50.0%
Roanoke/Alleghany	71.9%	71.4%	70.0%^	60.0%^	65.4%	53.8%
Southwest	66.7%	60.0%	83.3%^	57.1%^	58.3%^	100.0%^
Tidewater	65.2%	31.3%	60.7%^	40.0%^	43.8%	61.9%
MCO						
Aetna	100.0%	22.2%	75.0%	55.6%	50.0%	66.7%
HealthKeepers	60.0%	60.0%	67.4%	55.9%	53.2%	71.4%
Molina	55.6%	0.0%	37.5%^	100.0%^	55.6%	50.0%
Optima	53.3%	42.1%	65.6%	51.7%	48.1%	61.9%
UnitedHealthcare	0.0%	0.0%	37.5%	33.3%	0.0%^	42.9%^
VA Premier	66.7%	81.6%	50.0%	47.4%	63.6%	52.6%
More Than One MCO	100.0%	100.0%	—	50.0%	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 receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.

- Indicates that the rate for 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 53.7 percent of children receiving adoption assistance and 59.7 percent of controls had a follow-up visit within seven days after discharge with a mental health provider during MY 2022, and the difference was not statistically significant (p=0.39). While there were large rate differences between children receiving adoption assistance and controls for most stratified rates, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2022 rates for both children receiving adoption assistance and controls were above the MY 2022 national Medicaid 50th percentile. The rate for children receiving adoption assistance decreased from MY 2021 to MY 2022 by 6.0 percentage points, while the rate for controls increased by 7.7 percentage points. For children receiving adoption assistance, members 6 to 10 years of age 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 age groups during MY 2022. For children receiving adoption assistance only, the disparity for male members during MY 2021 was eliminated during MY 2022, since the rate for these members increased from MY 2021 to MY 2022 (by 11.1 percentage points).

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

Table 4-10 displays the MY 2020, MY 2021, and MY 2022 *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 and MY 2022, 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 4-10—Rates of *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up* Among Children Receiving Adoption Assistance and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	84.4%	79.3%
Age Category						
3 to 5 Years	—	—	—	—	100.0%^	—
6 to 10 Years	75.0%	100.0%	100.0%^	85.7%^	100.0%^	75.0%^
11 to 13 Years	85.7%	88.2%	80.0%	53.8%	94.7%	79.2%
≥ 14 Years	76.0%	82.1%	77.5%	69.2%	71.0%	81.8%
Sex						
Male	81.1%	84.0%	65.4%	91.7%	84.8%	80.0%
Female	74.3%	89.3%	89.7%	58.8%	83.9%	78.6%

Category	MY 2020		MY 2021		MY 2022	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Race						
Black or African American	84.4%	81.8%	84.0%	73.3%	85.7%	76.9%
White	72.5%	90.0%	77.5%	65.5%	85.7%	80.0%
Other	—	100.0%	—	50.0%	0.0%^	—
Region						
Central	83.3%	85.7%	75.0%^	73.3%^	92.9%	61.5%
Charlottesville/Western	70.0%	83.3%	70.0%^	50.0%^	66.7%	85.7%
Northern & Winchester	72.2%	66.7%	90.0%^	50.0%^	88.9%	55.6%
Roanoke/Alleghany	91.7%	100.0%	70.0%^	72.7%^	91.7%	90.9%
Southwest	71.4%	100.0%	80.0%^	100.0%^	87.5%^	100.0%^
Tidewater	76.9%	84.6%	92.9%	62.5%	72.2%	91.7%
MCO						
Aetna	66.7%	100.0%	66.7%	75.0%	75.0%	66.7%
HealthKeepers	85.7%	93.3%	80.8%	50.0%	88.9%	63.6%
Molina	66.7%	100.0%	75.0%^	100.0%^	80.0%^	100.0%^
Optima	82.4%	87.5%	83.3%	83.3%	85.7%	85.7%
UnitedHealthcare	0.0%	100.0%	100.0%^	50.0%^	100.0%^	100.0%^
VA Premier	73.1%	76.9%	73.3%	70.0%	78.9%	92.3%
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 receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 84.4 percent of children receiving adoption assistance and 79.3 percent of controls had a follow-up visit for mental illness within 30 days of an ED visit during MY 2022, and the difference was not statistically significant (p=0.47). While there were large rate differences for most stratified rates, these stratified rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2022 rates for both children receiving adoption assistance and controls were above the MY 2022 national Medicaid 50th percentile. The rate for both children receiving adoption assistance and controls increased from MY 2021 to MY 2022 by 4.4 and 11.9 percentage points, respectively. For children receiving adoption assistance only, members 14 years of age and

older were significantly less likely have a follow-up visit for mental illness within 30 days of an ED visit compared to members in other age groups during MY 2022. For children receiving adoption assistance only, the disparity for male members during MY 2021 was eliminated during MY 2022, since the rate for these members increased from MY 2021 to MY 2022 (by 19.4 percentage points).

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

Table 4-11 displays the MY 2020, MY 2021, and MY 2022 *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 and MY 2022, 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 4-11—Rates of *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing* Among Children Receiving Adoption Assistance and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	37.6%	33.2%
Age Category						
≤ 2 Years	0.0%	—	—	—	—	—
3 to 5 Years	20.0%	28.6%	36.4%	16.7%	50.0%	60.0%
6 to 10 Years	26.9%	19.6%	29.1%	37.7%	36.2%	25.0%
11 to 13 Years	27.3%	41.7%	32.6%	31.8%	39.0%	26.5%
≥ 14 Years	29.0%	20.8%	38.2%	35.8%	37.1%	41.2%
Sex						
Male	26.5%	20.8%	34.0%	32.1%	36.7%	31.4%
Female	30.0%	32.3%	34.3%	39.0%	39.1%	35.8%
Race						
Black or African American	24.9%	29.8%	28.6%	30.9%	33.8%	24.4%
White	29.9%	22.7%	37.3%	36.5%	39.7%	35.5%
Other	10.0%	40.0%	0.0%^	0.0%^	25.0%	50.0%
Region						
Central	27.6%	17.1%	29.8%	29.5%	32.0%	27.0%
Charlottesville/Western	30.3%	23.8%	40.7%	15.4%	29.5%	31.3%

Category	MY 2020		MY 2021		MY 2022	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Northern & Winchester	19.1%	41.2%	13.1%	50.0%	29.3%	37.0%
Roanoke/Alleghany	33.1%	32.4%	34.8%	36.8%	43.1%	38.9%
Southwest	38.3%	26.3%	60.0%	43.8%	58.7%	41.4%
Tidewater	22.0%	19.4%	35.5%	34.6%	36.7%	26.3%
MCO						
Aetna	25.9%	40.0%	25.0%	40.0%	43.5%	25.0%
HealthKeepers	25.3%	10.2%	26.2%	34.3%	28.7%	25.0%
Molina	19.0%	100.0%	23.8%	14.3%	30.0%	20.0%
Optima	32.7%	25.7%	35.2%	32.7%	35.4%	32.6%
UnitedHealthcare	19.4%	33.3%	42.9%	15.4%	42.1%	37.5%
VA Premier	30.4%	35.6%	42.0%	41.5%	49.7%	46.3%
More Than One MCO	22.2%	0.0%	66.7%	33.3%	33.3%	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 receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 37.6 percent of children receiving adoption assistance and 33.2 percent of controls with two or more antipsychotic prescriptions received blood glucose and cholesterol testing during MY 2022, and the difference was not statistically significant (p=0.27). The rate for children receiving adoption assistance was notably higher than controls for members 6 to 10 and 11 to 13 years of age (by 11.2 and 12.5 percentage points, respectively); male members (by 5.3 percentage points); Black/African American members (by 9.4 percentage points); and members in the Central region and the Tidewater region (by 5.0 and 10.4 percentage points, respectively). While there were large rate differences between children receiving adoption assistance and controls for members 3 to 5 years of age; members of the Other racial group; members in the Northern & Winchester region and the Southwest region; and 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 2022 rates for children receiving adoption assistance were above the MY 2022 national Medicaid 50th percentile, while rates for the controls were below the national Medicaid 50th percentile. The rate for children receiving adoption assistance increased from MY 2021 to MY 2022 by 3.5 percentage points, while the rate for controls decreased from MY 2021 to MY 2022 by 1.4 percentage points. 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 and MY 2022. For children receiving adoption assistance only, the disparity for members in the Northern & Winchester region during MY 2021 was eliminated during MY 2022, since the rate for these members increased from MY 2021 to MY 2022 (by 16.2 percentage points). For both children receiving adoption assistance and controls, members enrolled with VA Premier were significantly more likely to receive blood glucose and cholesterol testing during MY 2022, and this disparity only existed for children receiving adoption assistance during MY 2021. For children receiving adoption assistance only, members enrolled with HealthKeepers were significantly less likely to receive blood glucose and cholesterol testing compared to members in enrolled with other MCOs during MY 2022, and this disparity also existed during MY 2021.

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

Table 4-12 displays the MY 2020, MY 2021, and MY 2022 *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 and MY 2022, 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 4-12—Rates of *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* Among Children Receiving Adoption Assistance and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	58.9%	53.3%
Age Category						
3 to 5 Years	33.3%	100.0%	50.0%	33.3%	50.0%	50.0%
6 to 10 Years	63.9%	66.7%	70.7%	72.7%	66.7%	30.8%
11 to 13 Years	63.2%	69.2%	48.5%	66.7%	48.6%	66.7%
≥ 14 Years	53.7%	40.0%	57.8%	62.1%	59.6%	57.1%
Sex						
Male	57.9%	50.0%	57.1%	59.1%	56.7%	35.5%
Female	61.9%	73.7%	63.0%	75.0%	62.5%	72.4%
Race						
Black or African American	70.8%	54.5%	63.8%	61.9%	57.4%	55.6%
White	53.7%	64.3%	56.6%	67.3%	59.3%	52.4%
Other	0.0%	—	—	50.0%	100.0%	—

Category	MY 2020		MY 2021		MY 2022	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Region						
Central	44.8%	58.3%	62.5%	73.3%	50.0%	58.3%
Charlottesville/Western	40.0%	60.0%	38.5%	28.6%	70.0%	66.7%
Northern & Winchester	57.1%	66.7%	50.0%	40.0%	52.9%	50.0%
Roanoke/Alleghany	80.0%	60.0%	82.1%	76.9%	67.5%	50.0%
Southwest	88.9%	75.0%	60.0%	85.7%	60.0%	50.0%
Tidewater	54.2%	60.0%	51.6%	55.6%	56.8%	44.4%
MCO						
Aetna	80.0%	0.0%	33.3%	50.0%	66.7%	50.0%
HealthKeepers	45.7%	63.2%	68.1%	63.2%	63.0%	56.3%
Molina	37.5%	—	75.0%^	100.0%^	66.7%^	100.0%^
Optima	70.6%	60.0%	53.1%	61.1%	57.9%	38.5%
UnitedHealthcare	77.8%	0.0%	50.0%	50.0%	66.7%	71.4%
VA Premier	68.8%	81.8%	48.0%	71.4%	50.0%	52.9%
More Than One MCO	100.0%	—	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 receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 58.9 percent of children receiving adoption assistance and 53.3 percent of controls with a new prescription for an antipsychotic medication had documentation of psychosocial care as first-line treatment during MY 2022, and the difference was not statistically significant (p=0.46). The rates for children receiving adoption assistance were notably higher than the rates for controls for male members (by 21.2 percentage points) and White members (by 6.9 percentage points). While there were large rate differences for members 6 to 10 and 11 to 13 years of age; female members; members in the Central, Roanoke/Alleghany, Southwest, and Tidewater regions; and members enrolled with Aetna, HealthKeepers, Molina, and Optima, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2022 rates for both children receiving adoption assistance and controls were below the MY 2022 national Medicaid 50th percentile. The rates for both children receiving adoption assistance and controls decreased from MY 2021 to MY 2022 by 0.4 and 12.0

percentage points, respectively. There were no disparities identified for children receiving adoption assistance during MY 2022.

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

Table 4-13 displays the MY 2020, MY 2021, and MY 2022 *Follow-Up Care for Children Prescribed ADHD Medication* rates among children receiving adoption assistance and controls stratified by month of follow-up. Table 4-14 displays the MY 2020, MY 2021, and MY 2022 *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 and MY 2022, 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 4-13—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 2020		MY 2021		MY 2022	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
One-Month	57.6%	54.0%	51.4%	58.1%	52.9%	62.9%
Two-Months	71.8%	76.1%	62.9%	74.3%	68.9%	80.6%
Three-Months	79.2%	85.1%	73.1%	81.0%	80.9%	87.0%
Six-Months	89.0%	94.2%	86.1%	91.5%	91.4%	94.6%
Nine-Months	91.8%	96.0%	91.0%	94.0%	94.6%	96.5%

Table 4-13 shows that 52.9 percent of children receiving adoption assistance had a follow-up visit within one month of when their first ADHD medication was dispensed, and 94.6 percent of children receiving adoption assistance had a follow-up visit within nine months. Additionally, the rates for children receiving adoption assistance were 10.0, 11.7, 6.1, 3.2, and 1.9 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.

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

Table 4-14—Rates of *Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up* Among Children Receiving Adoption Assistance and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	52.9%-	62.9%
Age Category						
6 to 10 Years	62.7%	55.7%	48.4%	56.1%	53.6%	67.3%
11 to 13 Years	47.6%	50.5%	56.7%	61.3%	51.3%	55.5%
Sex						
Male	56.8%	51.2%	48.6%	57.3%	51.3%	59.5%
Female	58.6%	58.7%	55.1%	59.6%	55.4%	69.5%
Race						
Black or African American	56.1%	48.5%	45.2%	59.6%	47.6%	58.5%
White	59.5%	57.5%	53.9%	58.4%	55.6%	65.4%
Other	16.7%	33.3%	57.1%	28.6%	50.0%	75.0%
Region						
Central	53.3%	53.8%	44.8%	55.8%	48.0%	60.8%
Charlottesville/Western	67.7%	57.1%	54.1%	65.2%	57.1%	65.9%
Northern & Winchester	48.1%	48.5%	51.5%	57.1%	40.0%	67.7%
Roanoke/Alleghany	55.6%	57.1%	53.5%	56.5%	63.0%	55.4%
Southwest	79.3%	67.9%	67.7%	62.9%	65.7%	79.4%
Tidewater	50.9%	47.0%	44.2%	54.5%	43.4%	59.7%
MCO						
Aetna	35.7%	78.6%	52.4%	47.8%	36.8%	61.1%
HealthKeepers	54.4%	54.0%	51.6%	58.0%	48.8%	56.6%
Molina	50.0%	66.7%	33.3%	54.5%	83.3%	35.7%
Optima	66.0%	46.3%	55.8%	58.6%	60.0%	64.8%
UnitedHealthcare	64.7%	35.3%	53.8%	53.3%	45.5%	69.2%
VA Premier	57.1%	58.2%	51.6%	62.1%	55.8%	73.3%
More Than One MCO	100.0%	66.7%	20.0%	50.0%	40.0%	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 children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.

- Indicates that the rate for 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 52.9 percent of children receiving adoption assistance and 62.9 percent of controls had a follow-up visit within one month after the first ADHD medication was dispensed during MY 2022, and the difference was statistically significant (p=0.02). The rates for controls were notably higher than children receiving adoption assistance for members 6 to 10 years of age (by 13.7 percentage points); female members (by 14.1 percentage points); Black or African American members (by 10.9 percentage points); members in the Central, Northern & Winchester, and Tidewater regions (by 12.8, 27.7, and 16.3 percentage points, respectively); and members enrolled with VA Premier (by 17.5 percentage points). While there were also large rate differences for members in the Other racial group and members enrolled with Aetna, Molina, and UnitedHealthcare, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2022 rates for both children receiving adoption assistance and controls and were above the MY 2022 national Medicaid 50th percentile. The rates for both children receiving adoption assistance and controls increased from MY 2021 to MY 2022 by 1.5 and 4.8 percentage points, respectively. There were no disparities identified for children receiving adoption assistance during MY 2022.

Substance Use

Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment (IET–I)

Table 4-15 displays the MY 2020, MY 2021, and MY 2022 *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* rates among children receiving adoption assistance and controls 13 years of age and older stratified by member characteristics. For MY 2021 and MY 2022, member characteristics with identified health disparities are indicated with shading. The *Initiation and Engagement of SUD Abuse or Dependence Treatment—Initiation of SUD Treatment* indicator measures the percentage of new SUD episodes among adolescent and adult members that result in initiation of SUD treatment within 14 days of the diagnosis.[4-5] 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.

[4-5] HSAG advises caution in interpreting rate changes over time for this indicator since CMS' measure specifications greatly changed between MY 2021 and MY 2022 (e.g., the measure changed from a percentage of members to a percentage of SUD events).

Table 4-15—Rates of *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* Among Children Receiving Adoption Assistance and Controls

Category	MY 2020		MY 2021[4-6]		MY 2022	
	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%	54.1%+	30.0%	42.3%	37.5%
Age Category						
11 to 13 Years	100.0%	50.0%	50.0%^	0.0%^	33.3%	50.0%
≥ 14 Years	53.8%	35.7%	54.5%^	33.3%^	43.5%	36.2%
Sex						
Male	62.5%	39.4%	47.6%	42.1%	44.0%	43.8%
Female	50.0%	32.0%	62.5%	19.0%	40.7%	31.3%
Race						
Black or African American	33.3%	41.7%	46.7%	14.3%	38.5%	61.9%
White	63.6%	33.3%	57.1%	34.4%	41.7%	27.5%
Other	—	0.0%	100.0%^	0.0%^	66.7%^	0.0%^
Region						
Central	66.7%	66.7%	54.5%	20.0%	63.6%	33.3%
Charlottesville/Western	66.7%	37.5%	83.3%	16.7%	36.4%	42.9%
Northern & Winchester	16.7%	33.3%	14.3%	27.3%	45.5%	16.7%
Roanoke/Alleghany	66.7%	38.5%	42.9%	75.0%	40.0%	41.2%
Southwest	33.3%	0.0%	66.7%	30.0%	37.5%	12.5%
Tidewater	100.0%	29.4%	100.0%^	25.0%^	16.7%	64.3%
MCO						
Aetna	33.3%	40.0%	50.0%^	0.0%^	100.0%^	25.0%^
HealthKeepers	50.0%	16.7%	61.5%	26.7%	43.5%	40.0%
Molina	25.0%	—	0.0%^	0.0%^	0.0%^	25.0%^
Optima	100.0%	35.3%	83.3%	40.0%	42.9%	47.1%
UnitedHealthcare	—	50.0%	0.0%^	20.0%^	50.0%^	0.0%^
VA Premier	54.5%	45.0%	54.5%	41.7%	40.0%	29.4%
More Than One MCO	100.0%	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).

4-6 MY 2021 rates were recalculated for this year's study; therefore, these rates will not match the MY 2021 rates presented in the 2021–22 Child Welfare Focus Study.

+ Indicates that the rate for children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 4-15 shows that 42.3 percent of SUD episodes for children receiving adoption assistance and 37.5 percent of SUD episodes for controls resulted in initiation of treatment within 14 days of the diagnosis during MY 2022, and the difference was not statistically significant (p=0.60). The rate for children receiving adoption assistance was notably higher than controls for members 14 years of age and older (by 7.3 percentage points) and White members (by 14.2 percentage points). 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 2022 rates for both children receiving adoption assistance and controls were below the MY 2022 national Medicaid 50th percentile. The rate for children receiving adoption assistance decreased from MY 2021 to MY 2022 by 11.8 percentage points, while the rate for controls increased by 7.5 percentage points. For children receiving adoption assistance only, the disparity for members in the Northern & Winchester region during MY 2021 was eliminated in MY 2022, since the rate for these members increased from MY 2021 to MY 2022 (by 31.2 percentage points). There were no disparities identified for children receiving adoption assistance during MY 2022. The rate change for children receiving adoption assistance was driven by decreases in the rates for female members, White members, members in the Charlottesville/Western region, and members enrolled with Optima and VA Premier.

Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment (IET–E)

Table 4-16 displays the MY 2020, MY 2021, and MY 2022 *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* rates among children receiving adoption assistance and controls 13 years of age and older stratified by member characteristics. For MY 2021 and MY 2022, member characteristics with identified health disparities are indicated with shading. The *Initiation and Engagement of SUD Abuse or Dependence Treatment—Engagement of SUD Treatment* indicator measures the percentage of new SUD episodes among adolescent and adult members for which SUD treatment was initiated that also resulted in engagement in ongoing SUD treatment within 34 days of the initiation visit.[4-7] 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.

[4-7] HSAG advises caution in interpreting rate changes over time for this indicator since CMS' measure specifications greatly changed between MY 2021 and MY 2022 (e.g., the measure changed from a percentage of members to a percentage of SUD events).

Table 4-16—Rates of *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* Among Children Receiving Adoption Assistance and Controls

Category	MY 2020		MY 2021[4-8]		MY 2022	
	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%	8.1%	10.0%	7.7%	6.3%
Age Category						
11 to 13 Years	50.0%	0.0%	25.0%^	0.0%^	16.7%	16.7%
≥ 14 Years	23.1%	8.9%	6.1%^	11.1%^	6.5%	5.2%
Sex						
Male	31.3%	6.1%	4.8%	15.8%	4.0%	6.3%
Female	16.7%	12.0%	12.5%	4.8%	11.1%	6.3%
Race						
Black or African American	33.3%	4.2%	6.7%^	0.0%^	7.7%	14.3%
White	22.7%	12.1%	9.5%^	12.5%^	8.3%	2.5%
Other	—	0.0%	0.0%^	0.0%^	0.0%^	0.0%^
Region						
Central	66.7%	22.2%	9.1%^	0.0%^	9.1%^	0.0%^
Charlottesville/Western	0.0%	12.5%	16.7%	16.7%	0.0%^	0.0%^
Northern & Winchester	0.0%	0.0%	0.0%^	18.2%^	18.2%^	0.0%^
Roanoke/Alleghany	0.0%	7.7%	14.3%^	0.0%^	20.0%	17.6%
Southwest	33.3%	0.0%	0.0%^	10.0%^	0.0%^	0.0%^
Tidewater	50.0%	5.9%	0.0%^	0.0%^	0.0%^	7.1%^
MCO						
Aetna	33.3%	40.0%	0.0%^	0.0%^	100.0%^	0.0%^
HealthKeepers	25.0%	0.0%	15.4%	6.7%	8.7%^	0.0%^
Molina	0.0%	—	0.0%^	0.0%^	0.0%^	0.0%^
Optima	60.0%	5.9%	0.0%^	0.0%^	0.0%^	11.8%^
UnitedHealthcare	—	0.0%	0.0%^	0.0%^	0.0%^	0.0%^
VA Premier	9.1%	10.0%	9.1%	25.0%	10.0%	5.9%
More Than One MCO	100.0%	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).

4-8 MY 2021 rates were recalculated for this year's study; therefore, these rates will not match the MY 2021 rates presented in the 2021–22 Child Welfare Focus Study.

+ Indicates that the rate for children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 7.7 percent of SUD episodes for children receiving adoption assistance and 6.3 percent of SUD episodes for controls resulted in initiation of treatment within 14 days of the diagnosis and engagement in ongoing SUD treatment within 34 days during MY 2022, and the difference was not statistically significant (p=1.00). The rate for children receiving adoption assistance was notably higher than controls for White members (by 5.8 percentage points). 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 2022 rates for both children receiving adoption assistance and controls were below the MY 2022 national Medicaid 50th percentile. The rates for both children receiving adoption assistance and controls decreased from MY 2021 to MY 2022 by 0.4 and 3.7 percentage points, respectively. There were no disparities identified for children receiving adoption assistance during MY 2022.

Respiratory Health

Asthma Medication Ratio (AMR)

Table 4-17 displays the MY 2020, MY 2021, and MY 2022 *Asthma Medication Ratio* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 4-17—Rates of Appropriate *Asthma Medication Ratio* Among Children Receiving Adoption Assistance and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	86.0%+	71.0%
Age Category						
5 to 11 Years	84.9%	85.9%	86.2%	78.9%	88.9%	77.1%
12 to 18 Years	82.4%	70.2%	86.1%	67.0%	84.2%	68.2%
Sex						
Male	81.2%	79.6%	84.3%	73.5%	84.5%	70.0%

Category	MY 2020		MY 2021		MY 2022	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Female	86.2%	70.8%	88.7%	69.0%	88.0%	72.3%
Race						
Black or African American	78.1%	77.1%	83.5%	66.0%	78.6%	68.8%
White	87.4%	74.7%	87.6%	75.0%	94.9%	72.5%
Other	100.0%	100.0%	100.0%^	50.0%^	66.7%	—
Region						
Central	81.0%	80.5%	87.5%	60.0%	87.5%	62.1%
Charlottesville/Western	84.8%	77.1%	90.9%	81.0%	82.4%	77.3%
Northern & Winchester	83.3%	77.8%	81.3%	72.2%	88.9%	77.8%
Roanoke/Alleghany	83.3%	75.0%	89.7%	72.0%	82.6%	75.0%
Southwest	86.2%	68.8%	95.5%	75.0%	100.0%^	90.5%^
Tidewater	83.0%	73.7%	75.6%	72.2%	80.0%	60.0%
MCO						
Aetna	88.2%	77.8%	80.0%	66.7%	88.9%^	100.0%^
HealthKeepers	81.8%	78.7%	83.7%	62.5%	87.1%	64.8%
Molina	100.0%	100.0%	88.9%^	100.0%^	100.0%^	100.0%^
Optima	84.8%	69.2%	88.4%	73.8%	71.4%	67.5%
UnitedHealthcare	66.7%	50.0%	100.0%^	44.4%^	100.0%^	66.7%^
VA Premier	83.3%	79.0%	85.7%	81.6%	94.4%	77.5%
More Than One MCO	71.4%	80.0%	—	—	100.0%^	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 children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.

- Indicates that the rate for 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 86.0 percent of children receiving adoption assistance and 71.0 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 2022, and the difference was statistically significant (p=0.003). The rates for children receiving adoption assistance were notably higher than controls for members 12 to 18 years of age (by 16.0 percentage points), female members (by 15.7 percentage points), White members (by 22.4 percentage points), members in the Tidewater region (by 20.0 percentage points), and members enrolled with HealthKeepers and Virginia Premier (by 22.3 and 16.9

percentage points, respectively). While there were large rate differences for members in the Central region and members enrolled with Aetna, UnitedHealthcare, and More Than One 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 2022 national Medicaid 50th percentile for members 5 to 11 years of age, while the rate for children receiving adoption assistance only was above the MY 2022 national Medicaid 50th percentile for members 12 to 18 years of age. The rates for both children receiving adoption assistance and controls decreased from MY 2021 to MY 2022 by 0.1 and 0.4 percentage points, respectively. For children receiving adoption assistance only, White members were significantly more likely to have a ratio of controller medications to total asthma medications of 0.50 or greater compared to members in other racial groups during MY 2022, while Black or African American members were significantly less likely. For children receiving adoption assistance only, the disparity for members in the Tidewater region during MY 2021 was eliminated during MY 2022, since the rate for these members increased from MY 2021 to MY 2022 (by 4.4 percentage points). For children receiving adoption assistance only, members enrolled with Optima were significantly less likely to have a ratio of controller medications to total asthma medications of 0.50 or greater compared to members enrolled with other MCOs during MY 2022.

Service Utilization

Ambulatory Care Visits

Table 4-18 displays the MY 2020, MY 2021, and MY 2022 *Ambulatory Care Visits* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 4-18—Rates of *Ambulatory Care Visits* Among Children Receiving Adoption Assistance and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	81.4%-	82.9%
Age Category						
≤ 2 Years	—	—	84.4%	93.1%	87.7%	90.8%
3 to 5 Years	—	—	83.0%	86.3%	84.1%	88.6%
6 to 10 Years	—	—	80.5%	82.8%	81.6%	84.0%
11 to 13 Years	—	—	82.4%	85.2%	81.0%	84.5%
≥ 14 Years	—	—	80.7%	81.6%	80.5%	79.0%
Sex						
Male	—	—	80.9%	83.7%	81.7%	82.9%

Category	MY 2020		MY 2021		MY 2022	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Female	—	—	81.8%	83.4%	81.2%	83.0%
Race						
Black or African American	—	—	80.7%	80.6%	81.3%	78.7%
White	—	—	81.8%	85.0%	81.6%	85.0%
Other	—	—	76.3%	80.6%	77.3%	77.9%
Region						
Central	—	—	82.0%	82.7%	80.5%	78.9%
Charlottesville/Western	—	—	84.1%	83.8%	81.6%	85.3%
Northern & Winchester	—	—	68.7%	82.4%	69.4%	81.8%
Roanoke/Alleghany	—	—	85.5%	86.7%	86.9%	87.1%
Southwest	—	—	90.5%	88.0%	91.5%	88.6%
Tidewater	—	—	78.8%	79.5%	80.0%	78.9%
MCO						
Aetna	—	—	75.5%	81.6%	77.3%	79.6%
HealthKeepers	—	—	81.7%	84.1%	82.6%	83.0%
Molina	—	—	72.4%	71.8%	68.9%	76.6%
Optima	—	—	83.1%	83.5%	81.0%	82.2%
UnitedHealthcare	—	—	74.0%	81.7%	74.5%	79.4%
VA Premier	—	—	84.4%	85.6%	84.9%	86.0%
More Than One MCO	—	—	81.8%	87.9%	91.2%	89.7%

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

- Indicates that the rate for 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 81.4 percent of children receiving adoption assistance and 82.9 percent of controls had an ambulatory care visit during MY 2022, and the difference was statistically significant (p=0.02). 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 Molina (by 7.7 percentage points).

The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rate for children receiving adoption assistance did not change from MY 2021 to MY 2022, and the rate for controls decreased by 0.7 percentage points. For both children receiving adoption assistance and controls, members in the Roanoke/Alleghany region and the Southwest region were significantly more likely to have an ambulatory care visit compared to members in other regions during MY 2021 and MY 2022. For children receiving adoption assistance only, members in the Northern & Winchester region were significantly less likely to have an ambulatory care visit compared to members in other regions during MY 2021 and MY 2022. 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 during MY 2022, while members enrolled with Aetna, Molina, and UnitedHealthcare were significantly less likely. For children receiving adoption assistance 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 during MY 2022. The disparities for members enrolled with Molina and VA Premier also existed during MY 2021; however, the disparities for members enrolled with Aetna and UnitedHealthcare only existed for children receiving adoption assistance during MY 2021.

ED Visits

Table 4-19 displays the MY 2020, MY 2021, and MY 2022 *ED Visits* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 4-19—Rates of *ED Visits* Among Children Receiving Adoption Assistance and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	17.7%-	29.3%
Age Category						
≤ 2 Years	—	—	20.6%	31.3%	30.8%	41.5%
3 to 5 Years	—	—	14.4%	23.6%	18.2%	34.9%
6 to 10 Years	—	—	12.0%	20.9%	13.6%	27.4%
11 to 13 Years	—	—	14.1%	20.0%	16.1%	27.3%
≥ 14 Years	—	—	21.0%	29.1%	21.5%	30.0%
Sex						
Male	—	—	16.1%	22.9%	17.3%	29.0%
Female	—	—	16.1%	25.4%	18.2%	29.7%
Race						
Black or African American	—	—	16.3%	26.6%	17.5%	30.7%
White	—	—	16.0%	23.0%	18.0%	29.0%
Other	—	—	14.4%	21.9%	14.4%	22.7%

Category	MY 2020		MY 2021		MY 2022	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Region						
Central	—	—	16.1%	25.0%	17.5%	30.0%
Charlottesville/Western	—	—	14.9%	21.9%	15.9%	25.8%
Northern & Winchester	—	—	13.3%	22.5%	16.1%	29.4%
Roanoke/Alleghany	—	—	16.2%	24.5%	17.6%	29.4%
Southwest	—	—	21.5%	28.5%	23.5%	34.6%
Tidewater	—	—	15.7%	22.9%	17.1%	27.7%
MCO						
Aetna	—	—	16.0%	22.9%	17.4%	29.6%
HealthKeepers	—	—	16.0%	23.8%	17.7%^	29.2%^
Molina	—	—	14.3%	20.4%	16.7%	28.8%
Optima	—	—	15.9%	22.6%	17.4%	29.3%
UnitedHealthcare	—	—	18.3%	22.7%	19.6%	31.0%
VA Premier	—	—	16.0%	26.3%	17.3%	29.0%
More Than One MCO	—	—	16.7%	37.9%	29.4%	30.9%

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 receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 17.7 percent of children receiving adoption assistance and 29.3 percent of controls had an ED visit during MY 2022, and the difference was statistically significant ($p<0.001$). The rates for children receiving adoption assistance were notably lower than controls for all stratified rates, with the largest differences for members 3 to 5 and 6 to 10 years of age (by 16.7 and 13.8 percentage points, respectively); male members (by 11.7 percentage points); Black or African American members (by 13.2 percentage points); members in the Central, Northern & Winchester, and Roanoke/Alleghany regions (by 12.5, 13.3, and 11.8 percentage points, respectively); and members enrolled with Aetna, Molina, Optima, and VA Premier (by 12.2, 12,1, 11.9, and 11.7 percentage points, respectively).

The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rates for both children receiving adoption assistance and controls increased from MY 2021 to MY 2022 by 1.6 and 5.2 percentage points, respectively. For both children receiving adoption assistance and controls, members 2 years of age and younger were

significantly more likely to have an ED visit compared to members in other age groups during MY 2022, while members 6 to 10 years of age were significantly less likely. For children receiving adoption assistance only, members 14 years of age and older were significantly more likely to have an ED visit compared to members in other age groups during MY 2022. The disparity for members 6 to 10 years of age and 14 years of age and older also existed during MY 2021; however, the disparity for members 2 years of age and younger only existed for controls during MY 2021. 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 and MY 2022. For children receiving adoption assistance only, members were significantly more likely to have an ED visit enrolled with More Than One MCO compared to members enrolled with other MCOs during MY 2022.

Inpatient Visits

Table 4-20 displays the MY 2020, MY 2021, and MY 2022 *Inpatient Visits* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 4-20—Rates of *Inpatient Visits* Among Children Receiving Adoption Assistance and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	3.3%+	2.3%
Age Category						
≤ 2 Years	—	—	3.1%	1.9%	2.3%	4.6%
3 to 5 Years	—	—	0.5%	0.6%	1.3%	1.3%
6 to 10 Years	—	—	1.4%	1.1%	1.5%	1.4%
11 to 13 Years	—	—	3.2%	2.5%	3.8%	2.5%
≥ 14 Years	—	—	4.3%	3.9%	5.1%	3.3%
Sex						
Male	—	—	2.5%	1.7%	2.6%	1.9%
Female	—	—	3.1%	3.2%	4.0%	2.9%
Race						
Black or African American	—	—	3.4%	2.7%	3.7%	2.3%
White	—	—	2.5%	2.2%	3.2%	2.4%
Other	—	—	1.9%	2.5%	1.1%	1.1%
Region						
Central	—	—	3.5%	2.1%	4.4%	1.8%
Charlottesville/Western	—	—	3.4%	2.5%	3.7%	2.4%
Northern & Winchester	—	—	1.9%	2.0%	2.4%	3.0%

Category	MY 2020		MY 2021		MY 2022	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Roanoke/Alleghany	—	—	2.4%	2.6%	2.7%	2.2%
Southwest	—	—	1.9%	1.8%	2.5%	2.4%
Tidewater	—	—	3.0%	3.0%	3.3%	2.5%
MCO						
Aetna	—	—	1.5%	2.3%	2.3%	1.5%
HealthKeepers	—	—	2.9%	2.2%	3.3%	2.4%
Molina	—	—	2.4%	1.4%	2.7%	2.0%
Optima	—	—	3.6%	2.8%	4.6%	2.8%
UnitedHealthcare	—	—	2.8%	2.4%	2.4%	2.4%
VA Premier	—	—	2.5%	2.3%	2.9%	2.2%
More Than One MCO	—	—	3.0%	4.5%	4.4%	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 children receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 3.3 percent of children receiving adoption assistance and 2.3 percent of controls had an inpatient visit during MY 2022, 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.

The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rate for children receiving adoption assistance increased from MY 2021 to MY 2022 by 0.5 percentage points, while the rate for controls decreased by 0.1 percentage point. For both children receiving adoption assistance 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 during MY 2022, while members 6 to 10 years of age were significantly less likely, and these disparities also existed during MY 2021. For children receiving adoption assistance only, members 3 to 5 years of age were significantly less likely to have an inpatient visit compared to members in other age groups during MY 2021 and MY 2022. For both children receiving adoption assistance and controls, female members were significantly more likely to have an inpatient visit during MY 2022, while male members were significantly less likely; however, this disparity only existed for controls during MY 2021. For children receiving adoption assistance only, members in the Central region were significantly more likely to have an inpatient visit compared to members in other regions during MY 2021 and MY 2022.

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 during MY 2021 and MY 2022.

Behavioral Health Encounters—Total

Table 4-21 displays the MY 2020, MY 2021, and MY 2022 *Behavioral Health Encounters—Total* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 4-21—Rates of *Behavioral Health Encounters—Total* Among Children Receiving Adoption Assistance and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	45.7%+	40.2%
Age Category						
≤ 2 Years	—	—	25.0%	25.0%	29.2%	23.8%
3 to 5 Years	—	—	31.0%	23.5%	28.5%	20.7%
6 to 10 Years	—	—	49.5%	42.5%	40.5%	35.9%
11 to 13 Years	—	—	59.5%	54.0%	51.5%	48.0%
≥ 14 Years	—	—	56.2%	48.8%	52.3%	45.5%
Sex						
Male	—	—	54.1%	47.3%	46.9%	40.2%
Female	—	—	48.7%	42.1%	44.3%	40.3%
Race						
Black or African American	—	—	54.6%	44.6%	49.4%	41.4%
White	—	—	50.7%	45.4%	44.3%	39.9%
Other	—	—	38.8%	34.4%	38.1%	34.8%
Region						
Central	—	—	51.3%	43.4%	45.3%	37.2%
Charlottesville/Western	—	—	54.1%	44.2%	46.1%	41.2%
Northern & Winchester	—	—	40.3%	37.0%	34.0%	31.6%
Roanoke/Alleghany	—	—	55.4%	48.9%	51.2%	42.9%
Southwest	—	—	49.7%	46.0%	42.7%	39.3%
Tidewater	—	—	56.6%	49.1%	52.3%	48.2%
MCO						
Aetna	—	—	45.9%	39.4%	38.4%	36.8%
HealthKeepers	—	—	53.0%	47.0%	46.9%	41.5%

Category	MY 2020		MY 2021		MY 2022	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Molina	—	—	46.6%	34.7%	39.1%	32.1%
Optima	—	—	54.6%	47.2%	50.4%	43.7%
UnitedHealthcare	—	—	42.5%	38.2%	35.4%	30.3%
VA Premier	—	—	52.4%	45.8%	46.2%	40.4%
More Than One MCO	—	—	53.0%	42.4%	55.9%	57.4%

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 receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 45.7 percent of children receiving adoption assistance and 40.2 percent of controls had a behavioral health visit during MY 2022, and the difference was statistically significant (p<0.001). There were similar rate differences between children in foster care and controls for all stratifications.

The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rates for both children in foster care and controls decreased from MY 2021 to MY 2022 by 5.9 and 4.7 percentage points, respectively. For both children in foster care 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 encounter compared to members in other age groups during MY 2022, 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, and these disparities also existed during MY 2021. For children receiving adoption assistance only, male members were significantly more likely to have a behavioral health encounter during MY 2022, while female members were significantly less likely, and this disparity also existed during MY 2021. For children receiving adoption assistance only, Black or African American members were significantly more likely to have a behavioral health encounter compared to members in other racial groups during MY 2021 and MY 2022, while White members and members in the Other racial group were significantly less likely. For both children receiving adoption assistance and controls, members were significantly more likely to have a behavioral health encounter in the Roanoke/Alleghany region and the Tidewater region compared to members in other regions during MY 2021 and MY 2022, while members in the Northern & Winchester region were significantly less likely. For both children receiving adoption assistance and controls, members enrolled with Optima were significantly more likely to have a behavioral health encounter compared to members enrolled with other MCOs during MY 2022, and members enrolled with Molina and UnitedHealthcare were significantly less likely. For children receiving adoption assistance only, members enrolled with Aetna were significantly less likely

to have a behavioral health encounter compared to members enrolled with other MCOs during MY 2022. The disparities for members enrolled with Aetna, Optima, and UnitedHealthcare also existed during MY 2021; however, the disparity for members enrolled with Molina only existed for controls during MY 2021.

Behavioral Health Encounters—ARTS

Table 4-22 displays the MY 2020, MY 2021, and MY 2022 *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 4-22—Rates of *Behavioral Health Encounters—ARTS* Among Children Receiving Adoption Assistance and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	1.0%	0.9%
Age Category						
≤ 2 Years	—	—	0.0%^	0.0%^	0.8%	0.0%
3 to 5 Years	—	—	0.0%^	0.0%^	0.0%^	0.0%^
6 to 10 Years	—	—	0.1%	0.1%	0.4%	0.1%
11 to 13 Years	—	—	0.2%	0.5%	0.7%	0.9%
≥ 14 Years	—	—	0.8%	1.1%	2.1%	1.9%
Sex						
Male	—	—	0.4%	0.5%	1.1%	0.8%
Female	—	—	0.3%	0.6%	1.0%	1.1%
Race						
Black or African American	—	—	0.5%	0.5%	1.1%	0.8%
White	—	—	0.3%	0.6%	1.0%	1.0%
Other	—	—	1.3%	0.0%	0.6%	1.1%
Region						
Central	—	—	0.4%	0.4%	1.3%	0.6%
Charlottesville/Western	—	—	0.4%	0.4%	0.8%	1.0%
Northern & Winchester	—	—	0.6%	1.1%	1.3%	0.8%
Roanoke/Alleghany	—	—	0.2%	0.6%	1.1%	1.2%
Southwest	—	—	0.3%	0.7%	1.0%	1.1%
Tidewater	—	—	0.2%	0.3%	0.8%	1.0%
MCO						
Aetna	—	—	0.2%	0.3%	1.3%	0.8%

Category	MY 2020		MY 2021		MY 2022	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
HealthKeepers	—	—	0.4%	0.5%	1.2%	0.9%
Molina	—	—	1.0%	1.0%	2.0%^	0.0%^
Optima	—	—	0.3%	0.2%	0.9%	1.0%
UnitedHealthcare	—	—	0.4%	1.0%	0.6%	0.6%
VA Premier	—	—	0.4%	0.7%	0.9%	1.1%
More Than One MCO	—	—	0.0%	1.5%	1.5%	2.9%

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 receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 1.0 percent children receiving adoption assistance and 0.9 percent of controls had a behavioral health encounter with ARTS during MY 2022, and the difference was not statistically significant (p=0.45). The rate differences between children receiving adoption assistance and controls were similar across the stratified rates.

MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator for this analysis. The rates for both children receiving adoption assistance and controls increased from MY 2021 to MY 2022 by 0.6 and 0.4 percentage points, respectively. 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 groups during MY 2022, while members 6 to 10 years of age were significantly less likely, and these disparities also existed during MY 2021.

Behavioral Health Encounters—CMH Services

Table 4-23 displays the MY 2020, MY 2021, and MY 2022 *Behavioral Health Encounters—CMH Services* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 4-23—Rates of *Behavioral Health Encounters—CMH Services* Among Children Receiving Adoption Assistance and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	13.1%	13.4%
Age Category						
≤ 2 Years	—	—	2.5%	2.5%	3.1%	2.3%
3 to 5 Years	—	—	9.4%	8.6%	8.2%	9.0%
6 to 10 Years	—	—	13.8%	16.1%	13.0%	14.8%
11 to 13 Years	—	—	15.6%	15.2%	14.3%	14.5%
≥ 14 Years	—	—	15.3%	14.5%	14.5%	13.5%
Sex						
Male	—	—	16.2%	16.3%	15.0%	14.6%
Female	—	—	11.5%	11.7%	11.0%	12.0%
Race						
Black or African American	—	—	15.3%	15.6%	14.9%	15.4%
White	—	—	13.7%	13.8%	12.6%	12.7%
Other	—	—	6.9%	8.1%	6.6%	10.5%
Region						
Central	—	—	12.1%	12.3%	11.3%	10.6%
Charlottesville/Western	—	—	13.6%	13.3%	13.1%	13.0%
Northern & Winchester	—	—	9.5%	6.8%	8.7%	6.2%
Roanoke/Alleghany	—	—	17.7%	20.5%	14.9%	18.6%
Southwest	—	—	18.7%	21.6%	17.5%	19.2%
Tidewater	—	—	13.9%	12.6%	14.2%	14.2%
MCO						
Aetna	—	—	12.4%	12.9%	9.4%	9.9%
HealthKeepers	—	—	13.2%	11.3%	12.6%	11.8%
Molina	—	—	11.2%	9.5%	8.7%	13.0%
Optima	—	—	15.1%	14.4%	15.1%	13.7%
UnitedHealthcare	—	—	13.5%	13.3%	11.2%	11.4%
VA Premier	—	—	15.1%	18.2%	14.5%	16.3%
More Than One MCO	—	—	13.6%	16.7%	14.7%	19.1%

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 receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 13.1 percent of children receiving adoption assistance and 13.4 percent of controls had a behavioral health encounter with CMH services during MY 2022, and the difference was not statistically significant (p=0.61). The rate differences between children receiving adoption assistance and controls were similar across stratified rates.

The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rates for both children receiving adoption assistance and controls decreased from MY 2021 to MY 2022 by 0.9 and 0.8 percentage points, respectively. For both children receiving adoption assistance and controls, members 2 years of age and younger and 3 to 5 years of age were significantly less likely to have a behavioral health encounter with CMH services compared to members in other age groups during MY 2022, and these disparities also existed during MY 2021. For children receiving adoption assistance only, members 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 during MY 2022, and this disparity also existed during MY 2021. For both children receiving adoption assistance and controls, male members were significantly more likely to have a behavioral health encounter with CMH services during MY 2021 and MY 2022, while female members were significantly less likely. 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 members in other racial groups during MY 2021 and MY 2022. For children receiving adoption assistance only, members in the Other racial group were significantly less likely to have a behavioral health encounter with CMH services compared to members in other racial groups during MY 2021 and MY 2022. For both children receiving adoption assistance and controls, members in the Roanoke/Alleghany region and the Southwest region were significantly more likely to have a behavioral health encounter with CMH services compared to members in other regions during MY 2021 and MY 2022, while members in the Central region and 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 a behavioral health encounter with CMH services compared to members enrolled with other MCOs during MY 2022, while members enrolled with Aetna were significantly less likely. The disparity for members enrolled with VA Premier only existed for controls during MY 2021. For children receiving adoption assistance only, members enrolled with Optima were significantly more likely to have a behavioral health encounter with CMH services compared to members enrolled with other MCOs during MY 2022, while members enrolled with Molina were significantly less likely.

Behavioral Health Encounters—RTC Services

Table 4-24 displays the MY 2020, MY 2021, and MY 2022 *Behavioral Health Encounters—RTC Services* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 4-24—Rates of *Behavioral Health Encounters—RTC Services* Among Children Receiving Adoption Assistance and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	4.3%+	2.6%
Age Category						
≤ 2 Years	—	—	0.0%	1.9%	1.5%	1.5%
3 to 5 Years	—	—	1.7%	1.5%	4.6%	3.3%
6 to 10 Years	—	—	2.1%	0.7%	4.1%	2.1%
11 to 13 Years	—	—	2.5%	2.0%	4.4%	2.9%
≥ 14 Years	—	—	3.9%	2.8%	4.5%	2.5%
Sex						
Male	—	—	2.7%	1.6%	4.6%	2.8%
Female	—	—	2.7%	2.1%	4.0%	2.3%
Race						
Black or African American	—	—	3.3%	2.1%	5.0%	3.1%
White	—	—	2.4%	1.7%	4.0%	2.4%
Other	—	—	3.1%	1.9%	2.2%	1.7%
Region						
Central	—	—	4.0%	1.7%	5.9%	2.8%
Charlottesville/Western	—	—	2.8%	1.4%	3.6%	2.5%
Northern & Winchester	—	—	2.2%	1.9%	3.6%	2.3%
Roanoke/Alleghany	—	—	2.8%	2.5%	4.4%	2.8%
Southwest	—	—	1.0%	1.2%	3.0%	1.0%
Tidewater	—	—	2.5%	2.2%	4.2%	3.4%
MCO						
Aetna	—	—	1.7%	2.0%	3.5%	1.8%
HealthKeepers	—	—	3.4%	2.1%	5.2%	3.0%
Molina	—	—	2.0%	0.7%	3.7%	1.3%
Optima	—	—	3.0%	2.1%	5.3%	2.7%
UnitedHealthcare	—	—	2.8%	1.2%	3.7%	3.1%
VA Premier	—	—	2.1%	1.7%	3.0%	2.1%
More Than One MCO	—	—	1.5%	3.0%	5.9%	4.4%

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 receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 4.3 percent of children receiving adoption assistance and 2.6 percent of controls had a behavioral health encounter with RTC services during MY 2022, and the difference was statistically significant ($p<0.001$). The rate differences between children receiving adoption assistance and controls were similar across stratified rates.

The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rates for both children receiving adoption assistance and controls increased from MY 2021 to MY 2022 by 1.6 and 0.7 percentage points, respectively. 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 during MY 2022, and this disparity also existed during MY 2021. For both children receiving adoption assistance and controls, 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 2022. This disparity only existed for children receiving adoption assistance during MY 2021. 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 2022, and this disparity also existed during MY 2021. For children receiving adoption assistance only, members enrolled with HealthKeepers and Optima were significantly more likely to have a behavioral health encounter with RTC services compared to members enrolled with other MCOs during MY 2022, while members enrolled with VA Premier were significantly less likely. The disparity for members enrolled with HealthKeepers also existed during MY 2021.

Behavioral Health Encounters—Therapeutic Services

Table 4-25 displays the MY 2020, MY 2021, and MY 2022 *Behavioral Health Encounters—Therapeutic Services* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 4-25—Rates of *Behavioral Health Encounters—Therapeutic Services* Among Children Receiving Adoption Assistance and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	5.3%+	4.2%
Age Category						
≤ 2 Years	—	—	2.5%	2.5%	2.3%	1.5%

Category	MY 2020		MY 2021		MY 2022	
	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	—	—	6.5%	5.2%	5.6%	5.4%
6 to 10 Years	—	—	5.8%	5.7%	6.9%	6.2%
11 to 13 Years	—	—	4.2%	3.9%	4.9%	3.7%
≥ 14 Years	—	—	4.6%	3.0%	4.4%	2.6%
Sex						
Male	—	—	6.4%	5.6%	6.8%	5.5%
Female	—	—	3.4%	2.7%	3.6%	2.7%
Race						
Black or African American	—	—	4.9%	4.4%	5.8%	4.5%
White	—	—	5.1%	4.2%	5.2%	4.1%
Other	—	—	2.5%	3.8%	4.4%	3.3%
Region						
Central	—	—	5.4%	4.4%	4.8%	4.0%
Charlottesville/Western	—	—	4.8%	4.1%	5.4%	4.4%
Northern & Winchester	—	—	3.5%	1.8%	3.6%	2.0%
Roanoke/Alleghany	—	—	6.3%	5.0%	5.7%	4.4%
Southwest	—	—	6.5%	8.2%	7.8%	6.7%
Tidewater	—	—	4.0%	3.0%	5.2%	4.2%
MCO						
Aetna	—	—	3.8%	3.5%	4.1%	3.3%
HealthKeepers	—	—	5.4%	3.9%	5.8%	4.1%
Molina	—	—	3.7%	2.4%	3.7%	3.7%
Optima	—	—	4.5%	4.0%	5.2%	3.8%
UnitedHealthcare	—	—	5.6%	5.2%	5.7%	4.9%
VA Premier	—	—	5.4%	5.0%	5.5%	4.6%
More Than One MCO	—	—	3.0%	4.5%	2.9%	7.4%

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 receiving adoption assistance was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 5.3 percent of children receiving adoption assistance and 4.2 percent of controls had a behavioral health visit with therapeutic services during MY 2022, 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.

The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rate for children receiving adoption assistance increased from MY 2021 to MY 2022 by 0.3 percentage points, while the rate for controls decreased by 0.1 percentage point. 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 during MY 2022, while members 14 years of age and older were significantly less likely. The disparity for members 6 to 10 years of age also existed during MY 2021; however, the disparity for members 14 years of age and older only existed for controls during MY 2021. For both children receiving adoption assistance and controls, male members were significantly more likely to have a behavioral health encounter with therapeutic services during MY 2022, while female members were significantly less likely, and these disparities also existed during MY 2021. 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 and MY 2022, while members in the Northern & Winchester region were significantly less likely.

Behavioral Health Encounters—Traditional Services

Table 4-26 displays the MY 2020, MY 2021, and MY 2022 *Behavioral Health Encounters—Traditional Services* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 4-26—Rates of *Behavioral Health Encounters—Traditional Services* Among Children Receiving Adoption Assistance and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	43.2%+	37.2%
Age Category						
≤ 2 Years	—	—	25.0%	25.0%	26.9%	23.1%
3 to 5 Years	—	—	29.7%	21.8%	25.4%	17.4%
6 to 10 Years	—	—	47.8%	39.5%	37.5%	31.9%
11 to 13 Years	—	—	58.4%	51.9%	49.6%	45.4%
≥ 14 Years	—	—	55.0%	46.1%	50.0%	42.9%
Sex						
Male	—	—	52.7%	44.3%	43.7%	36.7%

Category	MY 2020		MY 2021		MY 2022	
	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%	42.6%	37.7%
Race						
Black or African American	—	—	53.6%	41.1%	47.1%	37.5%
White	—	—	49.2%	43.4%	41.7%	37.2%
Other	—	—	38.1%	32.5%	35.9%	30.9%
Region						
Central	—	—	49.9%	41.2%	42.8%	34.2%
Charlottesville/Western	—	—	53.5%	42.6%	43.3%	38.9%
Northern & Winchester	—	—	39.0%	35.9%	32.2%	29.9%
Roanoke/Alleghany	—	—	53.6%	44.1%	48.2%	37.7%
Southwest	—	—	47.4%	44.2%	39.3%	36.8%
Tidewater	—	—	55.9%	46.2%	50.5%	44.9%
MCO						
Aetna	—	—	43.6%	36.9%	36.8%	34.1%
HealthKeepers	—	—	52.3%	45.1%	44.7%	38.6%
Molina	—	—	43.9%	33.3%	36.8%	28.8%
Optima	—	—	53.8%	44.9%	48.3%	40.8%
UnitedHealthcare	—	—	39.8%	36.0%	31.4%	28.3%
VA Premier	—	—	51.0%	42.4%	43.1%	36.7%
More Than One MCO	—	—	53.0%	39.4%	54.4%	52.9%

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

- Indicates that the rate for 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 43.2 percent of children receiving adoption assistance and 37.2 percent of controls had a behavioral health visit with traditional services during MY 2022, and the difference was statistically significant ($p<0.001$). The rate differences for children receiving adoption assistance were notably higher than controls for members 3 to 5 years of age and 14 years of age and older (by 8.0 and 7.1 percentage points, respectively); male members (by 7.0 percentage points); Black or African American members (by 9.6 percentage points); members in the Central region and the Roanoke/Alleghany region (by 8.6 and 10.5 percentage points, respectively); and members enrolled

with HealthKeepers, Molina, Optima, and VA Premier (by 6.1, 8.0, 7.5, and 6.4 percentage points, respectively).

The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rates for both children receiving adoption assistance and controls decreased from MY 2021 to MY 2022 by 7.1 and 5.2 percentage points, respectively. 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 encounter with traditional services compared to members in other age groups during MY 2022, 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. These disparities also existed during MY 2021. For children receiving adoption assistance only, 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 White members and members in the Other racial group were significantly less likely. These disparities also existed during MY 2021. 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 2022, while members in the Northern & Winchester region were significantly less likely, and these disparities also existed during MY 2021. For children receiving adoption assistance only, members in the Roanoke/Alleghany region were significantly more likely to have a behavioral health encounter with traditional services compared to members in other regions during MY 2022, while members in the Southwest region were significantly less likely. The disparity for members in the Roanoke/Alleghany region also existed during MY 2021. For both children receiving adoption assistance and controls, members enrolled with Optima were significantly more likely to have a behavioral health encounter with traditional services compared to members enrolled with other MCOs during MY 2021 and MY 2022, while members enrolled with Molina and UnitedHealthcare were significantly less likely. For children receiving adoption assistance only, members enrolled with Aetna were significantly less likely to have a behavioral health encounter with traditional services compared to members enrolled with other MCOs during MY 2021 and MY 2022.

Overall Service Utilization

Table 4-27 displays the MY 2020, MY 2021, and MY 2022 *Overall Service Utilization* rates among children receiving adoption assistance and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 4-27—Rates of *Overall Service Utilization* Among Children Receiving Adoption Assistance and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	84.0%-	86.9%
Age Category						

Category	MY 2020		MY 2021		MY 2022	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
≤ 2 Years	—	—	86.3%	93.8%	92.3%	91.5%
3 to 5 Years	—	—	83.9%	87.8%	85.4%	90.1%
6 to 10 Years	—	—	83.3%	85.7%	83.5%	87.7%
11 to 13 Years	—	—	84.6%	87.9%	83.9%	88.1%
≥ 14 Years	—	—	84.2%	86.1%	83.7%	84.2%
Sex						
Male	—	—	83.8%	87.0%	84.1%	86.9%
Female	—	—	84.4%	86.4%	83.9%	86.9%
Race						
Black or African American	—	—	83.9%	85.1%	83.7%	84.6%
White	—	—	84.2%	87.6%	84.3%	88.1%
Other	—	—	82.5%	83.8%	80.7%	81.2%
Region						
Central	—	—	84.8%	86.0%	83.4%	84.0%
Charlottesville/Western	—	—	86.3%	87.0%	84.5%	87.9%
Northern & Winchester	—	—	72.2%	84.6%	72.9%	85.6%
Roanoke/Alleghany	—	—	87.5%	90.0%	88.8%	90.1%
Southwest	—	—	92.4%	91.2%	92.8%	91.3%
Tidewater	—	—	82.2%	83.3%	82.8%	84.4%
MCO						
Aetna	—	—	78.8%	84.8%	79.8%	84.9%
HealthKeepers	—	—	84.4%	87.2%	85.0%	87.3%
Molina	—	—	75.2%	74.8%	71.2%	81.3%
Optima	—	—	85.8%	86.6%	84.0%	86.3%
UnitedHealthcare	—	—	78.5%	84.7%	78.8%	83.9%
VA Premier	—	—	86.4%	88.9%	87.0%	88.7%
More Than One MCO	—	—	86.4%	92.4%	95.6%	95.6%

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

- Indicates that the rate for 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 84.0 percent of children receiving adoption assistance and 86.9 percent of controls had an ambulatory care visit, ED visit, inpatient visit, or behavioral health encounter (i.e., any service) during MY 2022, 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 12.7 percentage points) and members enrolled with Aetna, Molina, and UnitedHealthcare (by 5.1, 10.1, and 5.1 percentage points, respectively).

The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rate for children receiving adoption assistance decreased during MY 2021 to MY 2022 by 0.1 percentage point, while the rate for controls increased by 0.2 percentage points. For children receiving adoption assistance only, members 2 years of age and younger were significantly more likely to utilize any service compared to members in other age groups during MY 2022. For both children receiving adoption assistance and controls, members in the Roanoke/Alleghany region and the Southwest region were significantly more likely to utilize any service compared to members in other regions during MY 2022, and these disparities also existed during MY 2021. For children receiving adoption assistance only, members in the Northern & Winchester region were significantly less likely to utilize any service compared to members in other regions during MY 2021 and MY 2022. For both children receiving adoption assistance and controls, members enrolled with VA Premier and More Than One MCO were significantly more likely to utilize any service compared to members enrolled with other MCOs during MY 2022, while members enrolled with Molina and UnitedHealthcare were significantly less likely. The disparities for members enrolled with VA Premier and Molina also existed during MY 2021; however, the disparity for members enrolled with UnitedHealthcare only existed for children receiving adoption assistance during MY 2021 and the disparity for members enrolled in More Than One MCO was new for MY 2022. For children receiving adoption assistance only, members enrolled with Aetna were significantly less likely to utilize any service compared to members enrolled with other MCOs during MY 2021 and MY 2022.

5. Healthcare Utilization: Former Foster Care Members Findings

Characteristics of the Former Foster Care Members Eligible Population and Study Population

This section provides findings describing the demographic characteristics of the 2,145 members in the former foster care eligible population and the 1,779 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, 2022, and receiving healthcare coverage from DMAS at any time during MY 2022. 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=2,145)†

Category	Number	Percent
Age Category		
19 to 22 years	1,303	60.7%
23 to 26 years	842	39.3%
Sex		
Male	1,090	50.8%
Female	1,055	49.2%
Race		
Black or African American	780	36.4%
White	1,280	59.7%
Other	85	4.0%
Region		
Central	547	25.5%
Charlottesville/Western	351	16.4%
Northern & Winchester	242	11.3%
Roanoke/Alleghany	306	14.3%
Southwest	234	10.9%
Tidewater	462	21.5%
Latest MCO in the Measurement Year		
Aetna	184	8.6%
HealthKeepers	598	27.9%
Molina	149	6.9%
Optima	492	22.9%
UnitedHealthcare	153	7.1%
VA Premier	545	25.4%
Other	24	1.1%
Latest Medicaid Program in the Measurement Year		
CCC Plus (MLTSS)	94	4.4%

Category	Number	Percent
Medallion 4.0 (Acute)	2,026	94.5%
Other*	25	1.2%

† Members with Unknown Region are included in the All Eligible Members rate but are not displayed in this table.
** Includes members only enrolled in FFS.*

Members in the former foster care population were disproportionately Black or African American (36.4 percent) compared to the general population in Virginia, which was 20.0 percent Black or African American in 2022.[5-1] Former foster care members were mostly from the Central (25.5 percent), Tidewater (21.5 percent), or Charlottesville/Western (16.4 percent) regions. Former foster care members were most likely to be enrolled with HealthKeepers (27.9 percent), VA Premier (25.4 percent), or Optima (22.9 percent). Former foster care members were most likely to be enrolled through the Medallion 4.0 (Acute) program (94.5 percent). MCO attribution and Medicaid program attribution was Other for 1.1 and 1.2 percent of former foster care members, respectively, who were only enrolled in FFS during the measurement year.[5-2]

The study population consisted of members in the former foster care eligible population who were continuously enrolled in either the Medallion 4.0 (Acute) or CCC Plus (MLTSS) 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, 82.9 percent (n=1,779) 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 2.1 percent more members enrolled through Medallion 4.0 (Acute).

Table B-3 and Table B-6 present the demographic and health characteristics of continuously enrolled former foster care members (n=1,780) and the continuously enrolled comparison group (n=198,618) 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 Optima, and less likely to be enrolled through CCC Plus (MLTSS) compared to the continuously enrolled comparison group. Furthermore, continuously enrolled former foster care members were less likely to live in the Tidewater 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.

HSAG was able to match 99.9 percent (n=1,779) 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.

5-1 United States Census Bureau. Virginia QuickFacts. Available at: https://www.census.gov/quickfacts/VA. Accessed on: Mar 20, 2024.

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.

Appendix B: Characteristics of the Controls 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. The narrative focuses on differences in rates for former foster care members and controls that were greater than 5.0 percentage points for stratified rates during MY 2022. If the difference for All Eligible Members was greater than 5.0 percentage points, the narrative for stratified rates instead focuses on differences between former foster care members and controls that were greater than the difference for All Eligible Members or that were greater than 5.0 percentage points in the opposite direction. The narrative does not discuss differences for which the former foster care members denominator or the controls denominator was less than 30, since these rates are expected to have greater variability. Additionally, the narrative compares the rates for All Eligible Members to the MY 2022 national Medicaid 50th percentile, discusses the change in the rates for All Eligible Members from MY 2021 to MY 2022, and discusses health disparities identified in MY 2022.

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, MY 2021, and MY 2022 may also be impacted by the COVID-19 pandemic; however, rate comparisons within MY 2020, MY 2021, and MY 2022 (i.e., to controls) are still reliable.

Primary Care

Child and Adolescent Well-Care Visits (WCV)

Table 5-2 displays the MY 2020, MY 2021, and MY 2022 *Child and Adolescent Well-Care Visits* rates among former foster care members and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 2020		MY 2021		MY 2022	
	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%	17.8%	16.6%
Sex						
Male	9.3%	7.4%	11.0%	9.8%	7.8%	9.1%
Female	21.8%	24.0%	28.3%	26.0%	28.6%	25.3%
Race						
Black or African American	17.4%	15.3%	20.2%	17.0%	19.0%	15.4%
White	14.2%	14.4%	18.4%	17.6%	17.1%	17.5%
Other	10.0%	10.0%	35.7%	19.0%	17.6%	11.8%
Region						
Central	20.5%	14.2%	22.5%	22.3%	20.8%	15.6%
Charlottesville/Western	15.6%	11.0%	20.3%	12.4%	23.1%	15.8%
Northern & Winchester	14.0%	20.0%	22.2%	25.8%	15.6%	22.5%
Roanoke/Alleghany	6.1%	17.5%	17.1%	12.8%	18.3%	17.2%
Southwest	14.0%	5.2%	16.7%	9.1%	11.8%	9.1%
Tidewater	16.0%	19.0%	17.8%	19.4%	14.3%	18.2%
MCO						
Aetna	3.2%	18.8%	18.4%	19.5%	26.5%	9.5%
HealthKeepers	19.3%	15.5%	20.3%	22.0%	17.7%	18.8%
Molina	3.2%	8.8%	0.0%^	18.2%^	11.1%	10.0%
Optima	17.3%	16.4%	22.7%	17.5%	14.3%	13.3%
UnitedHealthcare	10.5%	12.8%	12.9%	21.9%	13.3%	26.5%
VA Premier	15.7%	13.2%	21.7%	11.3%	20.2%	18.3%
More Than One MCO	50.0%	33.3%	0.0%	50.0%	50.0%	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 former foster care members was significantly higher than the rate for the control group of all eligible members.

- Indicates that the rate for 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 17.8 percent of former foster care members and 16.6 percent of controls had a well-care visit with a PCP or an OB/GYN during MY 2022, and the difference was not statistically significant (p=0.60). The rates for former foster care members were notably higher than controls for members in the Central region and the Charlottesville/Western region (by 5.2 and 7.3 percentage points, respectively), and members enrolled with Aetna (by 17.0 percentage points). Conversely, the rate for former foster care members enrolled with UnitedHealthcare (by 13.2 percentage points) and members in the Northern & Winchester region (by 6.9 percentage points) were lower than the rates for controls. While there were large rate differences for members in the Other racial group and members enrolled with More Than One MCO, these rates had small denominators, so rates may be less reliable.

For all eligible members, the MY 2022 rates for both former foster care members and controls were below the MY 2022 national Medicaid 50th percentile for 18 to 21 years of age. However, the rates for former foster care members and controls are limited to members 19 years of age and older as of the beginning of the measurement year, and older members tend to have lower rates of well-care visits. The rate of well-care visits for former foster care members decreased by 1.8 percentage points from MY 2021 to MY 2022, while the rate for controls increased by 0.8 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 during MY 2022, and this disparity also existed during MY 2021.

Oral Health

Annual Dental Visit (ADV)

Table 5-3 displays the MY 2020, MY 2021, and MY 2022 *Annual Dental Visit* rates among former foster care members and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 Visit* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	29.1%	28.0%
Sex						
Male	23.1%	19.8%	25.0%	20.1%	21.4%	25.3%
Female	29.9%	32.7%	39.8%	35.1%	36.2%	31.3%
Race						
Black or African American	28.0%	17.6%	37.1%	25.6%	25.7%	27.0%
White	26.0%	27.7%	28.9%	29.1%	31.4%	27.2%

Category	MY 2020		MY 2021		MY 2022	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Other	20.0%	50.0%	37.5%	16.7%	25.0%	62.5%
Region						
Central	37.5%	20.9%	45.1%	29.9%	34.3%	27.4%
Charlottesville/Western	33.3%	31.4%	35.7%	25.4%	46.2%	35.6%
Northern & Winchester	21.4%	21.4%	38.9%	22.9%	37.5%	46.2%
Roanoke/Alleghany	15.6%	26.1%	26.3%	28.6%	17.2%	27.1%
Southwest	13.0%	28.6%	40.0%	28.6%	28.6%	15.6%
Tidewater	23.5%	22.2%	17.9%	27.0%	14.6%	20.8%
MCO						
Aetna	26.7%	12.5%	23.5%	36.4%	31.6%	30.8%
HealthKeepers	31.7%	31.5%	37.2%	23.0%	36.4%	32.0%
Molina	22.2%	28.6%	23.1%	50.0%	15.4%	25.0%
Optima	28.0%	20.3%	21.8%	25.9%	27.1%	27.1%
UnitedHealthcare	15.4%	15.0%	23.1%	6.3%	20.0%	11.1%
VA Premier	21.7%	26.4%	40.0%	30.8%	28.0%	28.4%
More Than One MCO	100.0%	—	—	100.0%	33.3%	20.0%

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 former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 29.1 percent of former foster care members and 28.0 percent of controls had a dental visit during MY 2022, and the difference was not statistically significant (p=0.80). The rates for former foster care members were notably higher than controls for members in the Central region (by 6.9 percentage points). Conversely, the rates for former foster care members were notably lower than controls in the Tidewater region (by 6.2 percentage points). While there were large rate differences for members in the Other racial group; members in the Charlottesville/Western, Northern & Winchester, Roanoke/Alleghany, and Southwest regions; and members enrolled in Molina, UnitedHealthcare, and More Than One MCO, these rates had small denominators, so the rates may be less reliable.

The rates for the former foster care members and controls were similar to the MY 2022 national Medicaid 50th percentile for members 19 to 20 years of age. The rate of dental visits for former foster

care members decreased by 3.0 percentage points from MY 2021 to MY 2022, while the rate for controls increased by 0.8 percentage points. For former foster care members only, female members were significantly more likely to have a dental visit compared to male members during MY 2022, and this disparity also existed during MY 2021. For former foster care members only, members in the Charlottesville/Western 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. The disparity for the Tidewater region also existed during MY 2021.

Preventive Dental Services (PDENT-CH)

Table 5-4 displays the MY 2020, MY 2021, and MY 2022 *Preventive Dental Services* rates among former foster care members and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 2020		MY 2021		MY 2022	
	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%	21.7%	21.7%
Sex						
Male	18.3%	12.6%	17.7%	14.0%	12.2%	18.8%
Female	22.2%	21.5%	27.7%	26.7%	30.5%	25.0%
Race						
Black or African American	24.0%	15.4%	28.1%	19.0%	17.6%	20.7%
White	18.9%	15.3%	19.1%	21.5%	24.0%	21.0%
Other	0.0%	50.0%	25.0%	8.3%	25.0%	50.0%
Region						
Central	34.4%	16.4%	34.6%	20.8%	27.1%	19.2%
Charlottesville/Western	26.7%	19.6%	18.6%	23.1%	30.8%	31.1%
Northern & Winchester	14.3%	17.9%	27.8%	22.9%	31.3%	43.6%
Roanoke/Alleghany	3.1%	13.0%	23.1%	17.9%	10.3%	20.8%
Southwest	8.3%	14.3%	23.3%	17.1%	23.8%	6.3%
Tidewater	17.6%	14.8%	13.4%	17.6%	9.8%	14.3%
MCO						
Aetna	20.0%	12.5%	16.7%	27.3%	31.6%	23.1%
HealthKeepers	20.6%	23.3%	23.1%	17.0%	27.3%	26.8%

Category	MY 2020		MY 2021		MY 2022	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Molina	11.1%	14.3%	23.1%	40.0%	0.0%^	12.5%^
Optima	24.0%	12.5%	17.9%	20.0%	16.7%	20.0%
UnitedHealthcare	15.4%	15.0%	7.7%	6.3%	13.3%	11.1%
VA Premier	18.0%	13.8%	29.6%	21.7%	26.0%	21.1%
More Than One MCO	100.0%	—	—	0.0%	0.0%^	20.0%^

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 former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 21.7 percent of former foster care members and 21.7 percent of controls had a preventive dental service during MY 2021, and the difference was not statistically significant (p=1.00). The rates for former foster care members were notably higher than controls for female members (by 5.5 percentage points) and members in the Central region (by 7.9 percentage points). Conversely, the rates for former foster care members were notably lower than controls for male members (by 6.6 percentage points). While there were large rate differences for members in the Other racial group; members in the Southwest, Roanoke/Alleghany, and Northern & Winchester regions; and members enrolled with Aetna and Molina, these rates had small denominators, so the rates may be less reliable.

MY 2022 national Medicaid benchmarks were not available for this indicator. The rate of preventive dental services for former foster care members decreased by 0.8 percentage points from MY 2021 to MY 2022, while the rate for controls increased by 1.6 percentage points. For former foster care members only, female members were significantly more likely to have a preventive dental service compared to male members. Additionally, members in the Tidewater region were significantly less likely to have a preventive dental service compared to members in other regions during MY 2022.

Oral Evaluation, Dental Services (OEV-CH)

Table 5-5 displays the MY 2020, MY 2021, and MY 2022 *Oral Evaluation, Dental Services* rates among former foster care members and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 2020		MY 2021		MY 2022	
	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%	22.2%	22.0%
Sex						
Male	—	—	19.2%	15.2%	14.3%	20.0%
Female	—	—	29.4%	26.7%	29.5%	24.3%
Race						
Black or African American	—	—	31.5%	18.2%	18.9%	20.7%
White	—	—	19.7%	23.2%	24.0%	21.5%
Other	—	—	25.0%	8.3%	25.0%	50.0%
Region						
Central	—	—	38.5%	20.8%	27.1%	20.5%
Charlottesville/Western	—	—	27.9%	21.5%	34.6%	31.1%
Northern & Winchester	—	—	22.2%	22.9%	31.3%	46.2%
Roanoke/Alleghany	—	—	20.5%	25.0%	10.3%	18.8%
Southwest	—	—	23.3%	17.1%	23.8%	6.3%
Tidewater	—	—	13.4%	18.9%	9.8%	14.3%
MCO						
Aetna	—	—	22.2%	27.3%	31.6%	15.4%
HealthKeepers	—	—	26.9%	17.0%	25.5%	27.8%
Molina	—	—	15.4%	40.0%	0.0%^	12.5%^
Optima	—	—	19.6%	20.0%	16.7%	20.0%
UnitedHealthcare	—	—	7.7%	6.3%	20.0%	11.1%
VA Premier	—	—	29.6%	22.8%	26.0%	22.1%
More Than One MCO	—	—	—	100.0%	33.3%	20.0%

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 former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 22.2 percent of former foster care members and 22.0 percent of controls had a comprehensive or periodic oral evaluation during MY 2022, and the difference was not statistically significant (p=0.96). The rates for former foster care members were notably higher than controls for female members (by 5.2 percentage points) and members in the Central region (by 6.6 percentage points). Conversely, the rates for former foster care members were notably lower than controls for male members (by 5.7 percentage points). While there were large rate differences for members in the Other racial group; members in the Northern & Winchester, Roanoke/Alleghany, and Southwest regions; and members enrolled with Aetna, Molina, UnitedHealthcare, and More Than One MCO, these rates had small denominators, so the rates may be less reliable.

Comparable MY 2022 national Medicaid benchmarks were not available for this indicator for this age group. The rate of comprehensive or periodic oral evaluations for former foster care members decreased by 1.9 percentage points from MY 2021 to MY 2022, while the rate for controls increased by 1.3 percentage points. For former foster care members only, female members were significantly more likely to have a comprehensive or periodic oral evaluation compared to male members. Additionally, for former foster care members only, members in the Tidewater region were significantly less likely to have a comprehensive or periodic oral evaluation, and this disparity also existed during MY 2021.

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

Table 5-6 displays the MY 2020, MY 2021, and MY 2022 *Topical Fluoride for Children—Dental or Oral Health Services* rates among former foster care members and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 *Topical Fluoride for Children—Dental or Oral Health Services* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	4.9%	3.5%
Sex						
Male	—	—	4.7%	1.8%	2.0%	2.4%
Female	—	—	4.2%	6.8%	7.6%	4.9%
Race						
Black or African American	—	—	7.9%	0.8%	5.4%	3.6%

Category	MY 2020		MY 2021		MY 2022	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
White	—	—	1.3%	6.7%	4.1%	3.6%
Other	—	—	25.0%^	0.0%^	12.5%^	0.0%^
Region						
Central	—	—	7.8%	5.2%	11.4%	4.1%
Charlottesville/Western	—	—	4.8%	4.8%	3.8%	4.4%
Northern & Winchester	—	—	0.0%^	5.7%^	6.3%	7.7%
Roanoke/Alleghany	—	—	7.9%	3.6%	0.0%^	0.0%^
Southwest	—	—	3.3%	2.9%	0.0%^	3.1%^
Tidewater	—	—	1.5%	2.7%	0.0%^	2.6%^
MCO						
Aetna	—	—	5.9%	4.5%	5.3%^	0.0%^
HealthKeepers	—	—	3.8%	2.3%	7.3%	4.1%
Molina	—	—	15.4%^	0.0%^	0.0%^	12.5%^
Optima	—	—	0.0%^	4.7%^	4.2%	1.4%
UnitedHealthcare	—	—	7.7%	6.3%	6.7%^	0.0%^
VA Premier	—	—	5.7%	5.5%	4.0%	4.2%
More Than One MCO	—	—	—	0.0%	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 former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 4.9 percent of former foster care members and 3.5 percent of controls received at least two topical fluoride applications as dental or oral health services during MY 2022, and the difference was not statistically significant (p=0.42). 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.[5-3] Additionally, ADA has less strict clinical recommendations for people 6 years of age and older (e.g., people 6 years of age and older can use home-use fluoride

[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: Mar 20, 2024.

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 members in the Central region (by 7.3 percentage points). While there were large rate differences for members in the Other racial group and members enrolled with Aetna, Molina, and UnitedHealthcare, these rates had small denominators, so the rates may be less reliable.

Comparable MY 2022 national Medicaid benchmarks were not available for this indicator for this age group. The rate of topical fluoride applications for former foster care members increased by 0.4 percentage points from MY 2021 to MY 2022, while the rate for controls decreased by 0.7 percentage points. For former foster care members only, members in the Central region were significantly more likely to have topical fluoride applications compared to members in other regions during MY 2022. The disparity for White members during MY 2021 was eliminated in MY 2022, since the rate for White members increased from MY 2021 to MY 2022 (by 2.8 percentage points).

Behavioral Health

Antidepressant Medication Management—Effective Acute Phase Treatment (AMM–A)

Table 5-7 displays the MY 2020, MY 2021, and MY 2022 *Antidepressant Medication Management—Effective Acute Phase Treatment* rates among former foster care and controls stratified by member characteristics. For MY 2021 and MY 2022, 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.

Table 5-7—Rates of *Antidepressant Medication Management—Effective Acute Phase Treatment* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	27.8%	36.2%
Age Category						
19–22 years	—	—	33.3%	35.9%	26.2%	38.1%
23–26 Years	—	—	33.3%	54.8%	31.3%	33.3%
Sex						
Male	—	—	25.0%	42.9%	13.5%	32.4%

5-4 Ibid.

Category	MY 2020		MY 2021		MY 2022	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Female	—	—	36.7%	41.8%	36.7%	38.2%
Race						
Black or African American	—	—	19.6%	36.7%	30.8%	24.0%
White	—	—	42.9%	45.3%	26.5%	39.0%
Other	—	—	50.0%^	0.0%^	33.3%	66.7%
Region						
Central	—	—	30.0%	50.0%	19.2%	22.2%
Charlottesville/Western	—	—	47.4%	50.0%	29.4%	33.3%
Northern & Winchester	—	—	38.5%	25.0%	16.7%	53.8%
Roanoke/Alleghany	—	—	22.2%	33.3%	33.3%	40.0%
Southwest	—	—	42.9%	36.4%	29.4%	50.0%
Tidewater	—	—	23.5%	38.5%	38.5%	28.6%
MCO						
Aetna	—	—	40.0%	45.5%	36.4%	25.0%
HealthKeepers	—	—	25.0%	39.1%	26.1%	26.7%
Molina	—	—	30.0%	33.3%	50.0%	12.5%
Optima	—	—	26.1%	28.6%	28.6%	40.0%
UnitedHealthcare	—	—	62.5%	66.7%	14.3%	40.0%
VA Premier	—	—	39.4%	51.6%	25.7%	50.0%
More Than One MCO	—	—	0.0%^	—	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 former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 27.8 percent of former foster care members and 36.2 percent of controls who had a diagnosis of major depression and who were treated with an antidepressant medication remained on antidepressant medication for at least 12 weeks during MY 2022, and the difference was not statistically significant (p=0.20). The rates for former foster care members were notably lower than controls for members 19 to 22 years of age (by 11.9 percentage points), male members (by 18.9 percentage points), White members (by 12.5 percentage points), and members enrolled with VA Premier (by 24.3 percentage points). While there were large rate differences for members in the Other racial group; members in the Northern & Winchester region and the Southwest region; and members

enrolled with 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 2022 rates for both former foster care members and controls were below the MY 2022 national Medicaid 50th percentile. The rate of antidepressant medication adherence for former foster care members decreased by 5.5 percentage points from MY 2021 to MY 2022, while the rate for controls decreased by 5.9 percentage points. For former foster care members only, male members were significantly less likely to remain on an antidepressant medication for at least 12 weeks compared to female members during MY 2022.

Antidepressant Medication Management—Effective Continuation Phase Treatment (AMM–C)

Table 5-8 displays the MY 2020, MY 2021, and MY 2022 *Antidepressant Medication Management—Effective Continuation Phase Treatment* rates among former foster care and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 5-8—Rates of *Antidepressant Medication Management—Effective Continuation Phase Treatment* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	12.4%	16.2%
Age Category						
19–22 years	—	—	13.6%	18.8%	9.2%	14.3%
23–26 Years	—	—	13.3%	22.6%	18.8%	19.0%
Sex						
Male	—	—	6.3%	17.9%	2.7%	21.6%
Female	—	—	16.5%	20.9%	18.3%	13.2%
Race						
Black or African American	—	—	10.9%	16.7%	11.5%	4.0%
White	—	—	15.9%	21.9%	11.8%	18.2%
Other	—	—	0.0%^	0.0%^	33.3%	66.7%
Region						
Central	—	—	16.7%	23.3%	7.7%	5.6%

Category	MY 2020		MY 2021		MY 2022	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Charlottesville/Western	—	—	5.3%	22.2%	17.6%	19.0%
Northern & Winchester	—	—	15.4%	12.5%	0.0%^	30.8%^
Roanoke/Alleghany	—	—	11.1%^	0.0%^	16.7%	20.0%
Southwest	—	—	21.4%	36.4%	5.9%	16.7%
Tidewater	—	—	11.8%	23.1%	23.1%	9.5%
MCO						
Aetna	—	—	20.0%	18.2%	9.1%	12.5%
HealthKeepers	—	—	8.3%	21.7%	13.0%	13.3%
Molina	—	—	10.0%^	0.0%^	16.7%^	0.0%^
Optima	—	—	8.7%	14.3%	28.6%	10.0%
UnitedHealthcare	—	—	25.0%	66.7%	0.0%^	20.0%^
VA Premier	—	—	18.2%	22.6%	8.6%	28.1%
More Than One MCO	—	—	0.0%^	—	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 former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 12.4 percent of former foster care members and 16.2 percent of controls who had a diagnosis of major depression and who were treated with an antidepressant medication remained on antidepressant medication for at least six months during MY 2022, and the difference was not statistically significant (p=0.44). The rates for former foster care members were notably lower than controls for members 19 to 22 years of age (by 5.1 percentage points), male members (by 18.9 percentage points), and members enrolled with VA Premier (by 19.5 percentage points). Conversely, the rates for former foster care members were notably higher than controls for female members (by 5.1 percentage points). While there were large rate differences for Black or African American members and members in the Other racial group; members in the Northern & Winchester, Tidewater, and Southwest regions; and members enrolled with Molina, Optima, and UnitedHealthcare, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2022 rates for both former foster care members and controls were below the MY 2022 national Medicaid 50th percentile. The rate of antidepressant medication adherence for at least six months for former foster care members decreased by 1.1 percentage points from MY

2021 to MY 2022, while the rate for controls decreased by 3.8 percentage points. There were no disparities identified for former foster care members during MY 2022.

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

Table 5-9 displays the MY 2020, MY 2021, and MY 2022 *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 and MY 2022, 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 5-9—Rates of *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	14.9%	32.1%
Age Category						
19–22 years	24.5%	9.1%	22.9%	35.0%	20.0%	35.3%
23–26 Years	15.4%	22.2%	36.8%	30.8%	4.5%	27.3%
Sex						
Male	14.3%	7.1%	18.8%	36.8%	12.0%	25.0%
Female	29.4%	17.6%	34.3%	28.6%	16.7%	41.7%
Race						
Black or African American	27.3%	0.0%	22.2%	31.3%	21.4%	26.7%
White	21.1%	18.2%	27.3%	37.5%	8.1%	41.7%
Other	0.0%	—	40.0%^	0.0%^	50.0%^	0.0%^
Region						
Central	21.1%	0.0%	21.1%	45.5%	26.1%	33.3%
Charlottesville/Western	26.7%	11.1%	22.2%	50.0%	12.5%	20.0%
Northern & Winchester	20.0%	100.0%	37.5%^	0.0%^	33.3%	33.3%
Roanoke/Alleghany	0.0%	33.3%	14.3%^	100.0%^	9.1%	50.0%
Southwest	33.3%	25.0%	36.4%	20.0%	0.0%^	0.0%^
Tidewater	16.7%	0.0%	30.8%	12.5%	7.1%	25.0%
MCO						
Aetna	0.0%	0.0%	44.4%	66.7%	50.0%^	0.0%^

Category	MY 2020		MY 2021		MY 2022	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
HealthKeepers	26.3%	0.0%	27.8%	25.0%	10.5%	50.0%
Molina	50.0%	—	0.0%^	100.0%^	0.0%^	20.0%^
Optima	25.0%	0.0%	33.3%	36.4%	11.1%	40.0%
UnitedHealthcare	0.0%	25.0%	50.0%^	0.0%^	0.0%^	50.0%^
VA Premier	23.1%	25.0%	15.0%	23.1%	22.2%	25.0%
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 former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 14.9 percent of former foster care members and 32.1 percent of controls had a follow-up visit within seven days after discharge during MY 2022, and the difference was not statistically significant (p=0.06). 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 2022 rate for the former foster care members was below the MY 2022 national Medicaid 50th percentile for members 18 to 64 years of age, while the rate for controls was above the national Medicaid 50th percentile. The rate for former foster care members decreased from MY 2021 to MY 2022 by 12.0 percentage points, while the rate for controls decreased by 1.2 percentage points. The rate change for former foster care members was driven by decreases in the rates for members 23 to 26 years of age, female members, and White members. There were no disparities identified for former foster care members during MY 2022.

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

Table 5-10 displays the MY 2020, MY 2021, and MY 2022 *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 and MY 2022, 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 5-10—Rates of *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	36.4%	43.8%
Age Category						
19–22 years	32.1%	54.5%	38.1%	20.0%	53.8%	50.0%
23–26 Years	50.0%	50.0%	64.3%	40.0%	11.1%	33.3%
Sex						
Male	33.3%	28.6%	47.1%^	0.0%^	40.9%	37.5%
Female	38.9%	66.7%	50.0%^	50.0%^	31.8%	50.0%
Race						
Black or African American	40.0%	57.1%	55.6%	66.7%	45.8%	20.0%
White	35.0%	50.0%	45.8%	16.7%	26.3%	55.6%
Other	0.0%	—	50.0%	—	0.0%^	50.0%^
Region						
Central	55.6%	0.0%	40.0%	50.0%	42.9%	42.9%
Charlottesville/Western	50.0%	83.3%	85.7%^	100.0%^	40.0%	33.3%
Northern & Winchester	0.0%	100.0%	0.0%^	0.0%^	0.0%^	—
Roanoke/Alleghany	28.6%	40.0%	50.0%	14.3%	14.3%	33.3%
Southwest	25.0%	50.0%	20.0%^	0.0%^	50.0%^	100.0%^
Tidewater	33.3%	25.0%	57.1%^	0.0%^	45.5%	50.0%
MCO						
Aetna	50.0%	50.0%	80.0%	33.3%	40.0%	50.0%
HealthKeepers	30.0%	25.0%	33.3%^	100.0%^	33.3%	25.0%
Molina	0.0%	0.0%	66.7%^	0.0%^	50.0%^	0.0%^
Optima	50.0%	50.0%	50.0%	50.0%	42.9%^	100.0%^
UnitedHealthcare	0.0%	0.0%	66.7%^	0.0%^	0.0%^	0.0%^
VA Premier	44.4%	85.7%	37.5%	14.3%	33.3%	40.0%
More Than One MCO	—	—	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 former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 36.4 percent of former foster care members and 43.8 percent of controls had a follow-up visit within 30 days after an ED visit during MY 2022, and the difference was not statistically significant (p=0.60). 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 2022 rates for both former foster care members and controls were lower than the MY 2022 national Medicaid 50th percentile for members 18 to 64 years of age. The rate of follow-up visits within 30 days of an ED visit for mental illness for former foster care members decreased by 12.2 percentage points from MY 2021 to MY 2022, returning to a rate similar to the MY 2020 rate, while the rate for controls increased by 17.1 percentage points. The decrease in the rate for former foster care members was driven by decreases in the rates for members 23 to 26 years of age and White members. Members 19 to 22 years of age were significantly more likely to have a follow-up visit within 30 days after an ED visit compared to members 23 to 26 years of age.

Substance Use

Follow-Up after Emergency Department Visit for Substance Use—30-Day Follow-Up (FUA)

Table 5-11 displays the MY 2020, MY 2021, and MY 2022 *Follow-Up After ED Visit for Substance Use—30-Day Follow-Up* rates among former foster care members and controls stratified by member characteristics. For MY 2021 and MY 2022, member characteristics with identified health disparities are indicated with shading. The *Follow-Up After ED Visit for SUD 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 SUD abuse or dependence for which the member had a follow-up visit for SUD. Since the former foster care population includes members 19 to 26 years of age, this indicator has been modified to include the corresponding ages. Please note, due to substantial changes to the measure specifications for this indicator, there is a break in trending between MY 2021 and MY 2022.

Table 5-11—Rates of *Follow-Up after Emergency Department Visit for Substance Use—30-Day Follow-Up* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	18.4%	13.3%
Age Category						
19–22 years	0.0%	40.0%	6.7%^	18.2%^	20.8%^	0.0%^

Category	MY 2020		MY 2021		MY 2022	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
23–26 Years	14.3%	50.0%	0.0%^	0.0%^	14.3%^	25.0%^
Sex						
Male	11.1%	75.0%	0.0%^	22.2%^	15.0%^	33.3%^
Female	0.0%	20.0%	9.1%^	0.0%^	22.2%^	0.0%^
Race						
Black or African American	0.0%	50.0%	0.0%^	33.3%^	11.1%^	0.0%^
White	9.1%	42.9%	9.1%^	9.1%^	20.7%	11.1%
Other	0.0%	—	—	—	—	25.0%
Region						
Central	0.0%	100.0%	0.0%^	0.0%^	0.0%^	—
Charlottesville/Western	0.0%	50.0%	0.0%^	0.0%^	0.0%^	0.0%^
Northern & Winchester	20.0%	50.0%	0.0%^	100.0%^	50.0%^	0.0%^
Roanoke/Alleghany	0.0%	33.3%	0.0%^	20.0%^	33.3%^	25.0%^
Southwest	0.0%	—	25.0%^	—	20.0%	—
Tidewater	0.0%	0.0%	0.0%^	0.0%^	0.0%^	0.0%^
MCO						
Aetna	0.0%	0.0%	0.0%^	33.3%^	25.0%^	0.0%^
HealthKeepers	0.0%	50.0%	0.0%^	100.0%^	15.4%^	0.0%^
Molina	0.0%	50.0%	0.0%^	—	0.0%^	0.0%^
Optima	0.0%	50.0%	33.3%^	0.0%^	0.0%^	0.0%^
UnitedHealthcare	50.0%	—	—	—	40.0%	—
VA Premier	0.0%	50.0%	0.0%^	0.0%^	28.6%	16.7%
More Than One MCO	—	—	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 former foster care members was significantly higher than the rate for the control group of all eligible members.

- Indicates that the rate for 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 18.4 percent of former foster care members and 13.3 percent of controls had a follow-up visit within 30 days after an ED visit for substance use during MY 2022, and the difference was not statistically significant (p=1.00). 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 2022 rates for both former foster care members and controls were below the MY 2022 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 SUD for former foster care members increased by 13.4 percentage points from MY 2021 to MY 2022, while the rate for controls decreased by 1.0 percentage points. However, the national benchmark for this indicator also increased by 15.0 percentage points from MY 2021 to MY 2022 due to changes to the measure specifications. Furthermore, the denominators for the All Eligible Members group are small; therefore, a few members may drive large fluctuations in the rates. There were no disparities identified for former foster care members during MY 2022.

Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment (IET–I)

Table 5-12 displays the MY 2020, MY 2021, and MY 2022 *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* rates among former foster care members and controls stratified by member characteristics. For MY 2021 and MY 2022, member characteristics with identified health disparities are indicated with shading. The *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* indicator measures the percentage of new SUD episodes among adolescent and adult members that result in initiation of SUD treatment within 14 days of the diagnosis.[5-5] 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 *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021[5-6]		MY 2022	
	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%	47.0%	45.8%	44.0%	43.3%
Age Category						
19–22 years	45.1%	50.0%	46.8%	38.6%	44.9%	40.4%
23–26 Years	37.9%	43.3%	47.5%	57.1%	43.0%	47.4%
Sex						
Male	49.0%	50.0%	46.6%	45.0%	47.9%	35.4%
Female	36.7%	43.8%	47.5%	46.9%	41.1%	52.4%
Race						
Black or African American	48.0%	55.6%	30.6%	39.3%	40.9%	57.1%
White	40.3%	44.4%	52.6%	50.0%	44.5%	42.2%

5-5 HSAG advises caution in interpreting rate changes over time for this indicator since CMS' measure specifications greatly changed between MY 2021 and MY 2022 (e.g., the measure changed from a percentage of members to a percentage of SUD events).

5-6 MY 2021 rates were recalculated for this year's study; therefore, these rates will not match the MY 2021 rates presented in the 2021–22 Child Welfare Focus Study.

Category	MY 2020		MY 2021[5-6]		MY 2022	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Other	66.7%	50.0%	80.0%	—	60.0%^	0.0%^
Region						
Central	41.2%	83.3%	36.8%	35.0%	54.1%	65.0%
Charlottesville/Western	42.9%	27.3%	52.6%	58.3%	42.9%	58.8%
Northern & Winchester	40.0%	40.0%	47.1%	50.0%	31.6%	50.0%
Roanoke/Alleghany	40.9%	35.7%	54.5%	44.4%	52.9%	36.8%
Southwest	38.9%	41.7%	40.0%	70.0%	37.5%	22.2%
Tidewater	58.3%	53.3%	50.0%	30.8%	34.6%	17.6%
MCO						
Aetna	54.5%	44.4%	38.5%	44.4%	33.3%	20.0%
HealthKeepers	31.8%	69.2%	48.3%	52.9%	45.8%	45.2%
Molina	50.0%	40.0%	60.0%	50.0%	36.4%	57.1%
Optima	45.0%	25.0%	57.1%	44.4%	32.1%	30.8%
UnitedHealthcare	42.9%	36.4%	61.5%	50.0%	47.1%	71.4%
VA Premier	41.9%	57.9%	35.3%	38.9%	52.3%	38.5%
More Than One MCO	100.0%	—	50.0%	—	60.0%^	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 former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 44.0 percent of former foster care members and 43.3 percent of controls with a new episode of SUD initiated treatment during MY 2022, and the difference was not statistically significant (p=0.91). The rates for former foster care members were notably lower than controls for female members (by 11.3 percentage points). Conversely, the rate for former foster care members was notably higher than controls for male members (by 12.5 percentage points). While there were large rate differences for Black or African American members and members in the Other racial group; members in all regions; and members enrolled with Aetna, Molina, UnitedHealthcare, VA Premier, and More Than One MCO, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2022 rates for both former foster care members and controls were similar to the MY 2022 national Medicaid 50th percentile for the 18 years of age and older age group.

The rate of treatment initiation for former foster care members decreased by 3.0 percentage points from MY 2021 to MY 2022, while the rate for controls decreased by 2.5 percentage points. There were no disparities identified for former foster care members during MY 2022.

Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment (IET–E)

Table 5-13 displays the MY 2020, MY 2021, and MY 2022 *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* rates among former foster care members and controls stratified by member characteristics. For MY 2021 and MY 2022, member characteristics with identified health disparities are indicated with shading. The *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* indicator measures the percentage of new SUD episodes among adolescent and adult members for which SUD treatment was initiated that also resulted in engagement in ongoing SUD treatment within 34 days of the initiation visit.[5-7] 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 SUD Treatment—Engagement of SUD Treatment* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021[5-8]		MY 2022	
	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%	12.0%	13.9%	13.7%	12.2%
Age Category						
19–22 years	14.1%	18.2%	9.1%	11.4%	11.2%	11.5%
23–26 Years	10.3%	30.0%	17.5%	17.9%	16.5%	13.2%
Sex						
Male	17.6%	21.4%	13.8%	15.0%	12.3%	10.4%
Female	8.2%	25.0%	10.2%	12.5%	14.7%	14.3%
Race						
Black or African American	12.0%	27.8%	11.1%	7.1%	6.8%	14.3%
White	13.9%	20.4%	10.5%	18.2%	16.0%	12.5%
Other	0.0%	50.0%	40.0%	—	20.0%^	0.0%^
Region						
Central	23.5%	33.3%	0.0%^	10.0%^	18.9%	15.0%
Charlottesville/Western	9.5%	18.2%	15.8%^	0.0%^	14.3%	17.6%

5-7 HSAG advises caution in interpreting rate changes over time for this indicator since CMS' measure specifications greatly changed between MY 2021 and MY 2022 (e.g., the measure changed from a percentage of members to a percentage of SUD events).

5-8 MY 2021 rates were recalculated for this year's study; therefore, these rates will not match the MY 2021 rates presented in the 2021–22 Child Welfare Focus Study.

Category	MY 2020		MY 2021[5-8]		MY 2022	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Northern & Winchester	10.0%	30.0%	11.8%	12.5%	10.5%^	0.0%^
Roanoke/Alleghany	13.6%	21.4%	9.1%	22.2%	14.7%	15.8%
Southwest	16.7%	25.0%	15.0%	30.0%	16.7%	11.1%
Tidewater	0.0%	13.3%	20.0%	15.4%	3.8%	5.9%
MCO						
Aetna	27.3%	22.2%	7.7%	22.2%	20.0%^	0.0%^
HealthKeepers	0.0%	38.5%	17.2%	23.5%	10.4%	6.5%
Molina	0.0%	20.0%	0.0%^	0.0%^	9.1%	14.3%
Optima	5.0%	8.3%	19.0%	11.1%	3.6%	23.1%
UnitedHealthcare	14.3%	9.1%	15.4%	12.5%	17.6%	14.3%
VA Premier	25.8%	31.6%	5.9%	5.6%	18.2%	15.4%
More Than One MCO	0.0%	—	0.0%^	—	40.0%^	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 former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 13.7 percent of former foster care members and 12.2 percent of controls with a new episode of SUD initiated treatment and engaged in treatment during MY 2022, and the difference was statistically significant (p=0.72). While there were large rate differences for Black or African American members and members in the Other racial group; members in the Northern & Winchester and Southwest regions; and members enrolled in Aetna, Molina, Optima, and More Than Once MCO, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2022 rate for former foster care members was similar to the MY 2022 national Medicaid 50th percentile for members 18 years of age and older, while the rate for controls was lower than the national Medicaid 50th percentile. The rate of engaging in SUD treatment for former foster care members increased by 1.7 percentage points from MY 2020 to MY 2021, while the rate for controls decreased by 1.7 percentage points. There were no disparities identified for former foster care members during MY 2022.

Respiratory Health

Asthma Medication Ratio (AMR)

Table 5-14 displays the MY 2020, MY 2021, and MY 2022 *Asthma Medication Ratio* rates among former foster care members and controls stratified by member characteristics. For MY 2021 and MY 2022, member characteristics with identified health disparities are indicated with shading. The *Asthma Medication Ratio* indicator measures the percentage of members 19 to 64 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. Since the former foster care population includes members 19 to 26 years of age, this indicator has been modified to include the corresponding ages. Please note that the denominators in Table 5-14 are small due to the combination of the measure specifications with the criteria for the study population. The measure specifications only include members who were identified as having persistent asthma through an emergency department or inpatient visit, at least four outpatient visits, or at least four medication events, and there were few former foster care members ages 19 to 26 who met these criteria.

Table 5-14—Rates of Appropriate *Asthma Medication Ratio* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	22.2%	60.0%
Sex						
Male	50.0%	66.7%	50.0%^	100.0%^	0.0%^	58.8%^
Female	57.1%	25.0%	72.7%^	44.4%^	28.6%^	61.5%^
Race						
Black or African American	50.0%	33.3%	40.0%	83.3%	25.0%	42.9%
White	57.1%	33.3%	87.5%	55.6%	20.0%	80.0%
Other	—	—	—	—	—	0.0%^
Region						
Central	—	0.0%	0.0%^	66.7%^	0.0%^	50.0%^
Charlottesville/Western	100.0%	33.3%	100.0%^	33.3%^	66.7%^	33.3%^
Northern & Winchester	0.0%	50.0%	100.0%^	100.0%^	0.0%^	75.0%^
Roanoke/Alleghany	100.0%	0.0%	100.0%^	50.0%^	0.0%^	80.0%^
Southwest	0.0%	0.0%	100.0%^	100.0%^	—	100.0%^
Tidewater	50.0%	75.0%	60.0%	75.0%	0.0%^	60.0%^
MCO						
Aetna	0.0%	0.0%	—	100.0%^	—	100.0%^
HealthKeepers	0.0%	40.0%	66.7%	33.3%	0.0%^	44.4%^

Category	MY 2020		MY 2021		MY 2022	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Molina	—	0.0%	—	—	—	0.0%^
Optima	75.0%	0.0%	62.5%^	100.0%^	66.7%^	55.6%^
UnitedHealthcare	—	—	—	—	0.0%^	100.0%^
VA Premier	100.0%	50.0%	100.0%^	75.0%^	0.0%^	71.4%^
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 former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 22.2 percent of former foster care members and 60.0 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 2022, and the difference was not statistically significant (p=0.06). While there were large rate differences for nearly all stratified rates, these rates had very small denominators, so the rates may be less reliable.

For all eligible members, the MY 2022 rate for former foster care members was below the MY 2022 national Medicaid 50th percentile for members 19 to 50 years of age, while the MY 2022 rate for controls was above the benchmark. The rate for former foster care members and controls decreased by 47.0 percentage points and 6.7 percentage points, respectively, from MY 2021 to MY 2022. There were no disparities identified for former foster care members during MY 2022.

Service Utilization

Ambulatory Care Visits

Table 5-15 displays the MY 2020, MY 2021, and MY 2022 *Ambulatory Care Visits* rates among former foster care members and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 5-15—Rates of *Ambulatory Care Visits* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	60.5%-	66.6%
Age Category						
19–22 years	—	—	63.3%	68.8%	61.3%	66.9%
23–26 Years	—	—	60.4%	63.3%	59.4%	66.1%
Sex						
Male	—	—	48.4%	54.9%	47.9%	55.6%
Female	—	—	76.5%	79.4%	74.0%	78.0%
Race						
Black or African American	—	—	59.0%	63.9%	57.2%	63.1%
White	—	—	64.2%	68.9%	62.6%	69.1%
Other	—	—	65.0%	63.3%	59.7%	58.2%
Region						
Central	—	—	62.2%	66.9%	63.2%	64.5%
Charlottesville/Western	—	—	63.7%	70.9%	63.5%	68.9%
Northern & Winchester	—	—	61.7%	62.8%	56.9%	63.6%
Roanoke/Alleghany	—	—	60.0%	70.6%	62.1%	70.5%
Southwest	—	—	66.1%	68.9%	62.1%	68.4%
Tidewater	—	—	61.4%	61.9%	55.1%	65.1%
MCO						
Aetna	—	—	61.0%	75.9%	62.6%	67.7%
HealthKeepers	—	—	63.6%	65.0%	63.4%	68.9%
Molina	—	—	45.0%	49.5%	46.5%	55.9%
Optima	—	—	62.4%	71.7%	59.5%	69.7%
UnitedHealthcare	—	—	58.0%	52.1%	54.6%	59.2%
VA Premier	—	—	66.2%	69.2%	62.7%	65.6%
More Than One MCO	—	—	82.4%	94.1%	84.6%	76.9%

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 former foster care members was significantly higher than the rate for the control group of all eligible members.

- Indicates that the rate for 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 60.5 percent of former foster care members and 66.6 percent of controls had an ambulatory care visit during MY 2022, and the difference was statistically significant ($p<0.001$). The rates for former foster care members were notably lower than controls for members 23 to 26 years of age (by 6.5 percentage points); male members (by 7.7 percentage points); White members (by 6.5 percentage points); members in the Northern & Winchester, Roanoke/Alleghany, Southwest, and Tidewater regions (by 6.7, 8.4, 6.3, and 10.0 percentage points, respectively); and members enrolled with Molina and Optima (by 9.4 and 10.2 percentage points). While there was a large positive rate difference for members enrolled with More Than One MCO, these rates had small denominators, so the rates may be less reliable.

MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rate for former foster care members and controls decreased by 1.8 percentage points and 0.3 percentage points, respectively, from MY 2021 to MY 2022. For both former foster care members and controls, female members were significantly more likely to have an ambulatory care visit compared to male members during MY 2022, and these disparities also existed during MY 2021. White members were also significantly more likely to have an ambulatory care visit compared to members in other racial groups, while Black or African American members were significantly less likely. For former foster care members only, the disparity for Black or African American members also existed during MY 2021.

ED Visits

Table 5-16 displays the MY 2020, MY 2021, and MY 2022 *ED Visits* rates among former foster care members and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 5-16—Rates of *ED Visits* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	45.4%+	39.1%
Age Category						
19–22 years	—	—	45.9%	38.3%	47.9%	39.4%
23–26 Years	—	—	41.2%	38.9%	41.6%	38.5%
Sex						
Male	—	—	39.5%	31.0%	39.1%	30.8%
Female	—	—	49.1%	46.2%	52.1%	47.7%
Race						
Black or African American	—	—	45.4%	47.1%	46.1%	43.1%
White	—	—	44.9%	34.9%	46.2%	37.8%
Other	—	—	21.7%	11.7%	25.4%	20.9%

Category	MY 2020		MY 2021		MY 2022	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Region						
Central	—	—	43.8%	47.9%	47.7%	39.9%
Charlottesville/Western	—	—	40.8%	31.5%	43.0%	35.8%
Northern & Winchester	—	—	43.3%	26.7%	45.1%	30.8%
Roanoke/Alleghany	—	—	51.0%	35.9%	49.4%	42.9%
Southwest	—	—	44.6%	44.1%	46.3%	42.6%
Tidewater	—	—	43.2%	38.9%	41.5%	40.4%
MCO						
Aetna	—	—	49.6%	42.6%	47.1%	43.9%
HealthKeepers	—	—	45.0%	36.4%	47.9%	39.3%
Molina	—	—	38.7%	38.7%	38.6%	33.9%
Optima	—	—	42.0%	41.2%	41.5%	42.2%
UnitedHealthcare	—	—	43.7%	35.3%	46.9%	31.5%
VA Premier	—	—	45.3%	38.4%	46.5%	36.8%
More Than One MCO	—	—	41.2%	23.5%	69.2%	76.9%

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 former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 45.4 percent of former foster care members and 39.1 percent of controls had an ED visit during MY 2022, and the difference was statistically significant (p<0.001). The rates for former foster care members were particularly higher than controls for members 19 to 22 years of age (by 8.5 percentage points); male members (by 8.4 percentage points); White members (by 8.4 percentage points); members in the Central, Charlottesville/Western, Northern & Winchester, and Roanoke/Alleghany regions (by 7.8, 7.2, 14.3, and 6.5 percentage points, respectively); and members enrolled with HealthKeepers, UnitedHealthcare, and VA Premier (by 8.6, 15.4, and 9.7 percentage points, respectively). While there was a large negative rate difference for members enrolled with More Than One MCO, these rates had small denominators, so the rates may be less reliable.

MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rate for former foster care members and controls increased

by 1.1 percentage points and 0.6 percentage points, respectively, from MY 2021 to MY 2022. Among former foster care members only, members 19 to 22 years of age were significantly more likely to have an ED visit compared to members 23 to 26 years of age during MY 2022. For both former foster care members and controls, female members were significantly more likely to have an ED visit compared to male members during MY 2022, and this disparity also existed during 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 during MY 2022, and this disparity also existed during MY 2021.

Inpatient Visits

Table 5-17 displays the MY 2020, MY 2021, and MY 2022 *Inpatient Visits* rates among former foster care members and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 5-17—Rates of *Inpatient Visits* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	9.9%	9.9%
Age Category						
19–22 years	—	—	11.0%	8.8%	10.4%	9.2%
23–26 Years	—	—	9.2%	11.3%	9.3%	11.1%
Sex						
Male	—	—	6.7%	4.6%	6.7%	5.1%
Female	—	—	14.1%	14.9%	13.4%	15.1%
Race						
Black or African American	—	—	10.3%	11.7%	10.2%	10.6%
White	—	—	10.5%	8.8%	9.7%	9.7%
Other	—	—	10.0%	3.3%	11.9%	9.0%
Region						
Central	—	—	9.9%	10.2%	10.9%	10.9%
Charlottesville/Western	—	—	9.0%	11.8%	8.2%	10.9%
Northern & Winchester	—	—	10.0%	5.6%	9.7%	6.7%
Roanoke/Alleghany	—	—	10.2%	8.6%	12.3%	11.1%
Southwest	—	—	12.4%	13.6%	8.4%	7.4%
Tidewater	—	—	11.4%	8.2%	9.4%	10.2%
MCO						
Aetna	—	—	12.8%	12.1%	9.7%	9.0%

Category	MY 2020		MY 2021		MY 2022	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
HealthKeepers	—	—	10.2%	6.8%	10.3%	9.3%
Molina	—	—	7.2%	9.0%	7.1%	13.4%
Optima	—	—	9.9%	10.4%	10.4%	8.3%
UnitedHealthcare	—	—	9.2%	9.2%	8.5%	2.3%
VA Premier	—	—	11.3%	11.0%	10.1%	12.7%
More Than One MCO	—	—	11.8%	17.6%	23.1%	46.2%

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 former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 9.9 percent of former foster care members and 9.9 percent of controls had an inpatient visit during MY 2022, and the difference was not statistically significant (p=1.00). The rates for former foster care members were notably higher than controls for members enrolled with UnitedHealthcare (by 6.2 percentage points), while the rates for former foster care members were notably lower than controls for members enrolled with Molina (by 6.3 percentage points). While there was a large negative rate difference for members enrolled with More Than One MCO, these rates had small denominators, so the rates may be less reliable.

MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rate for former foster care members decreased by 0.5 percentage points and the rate for controls increased by 0.3 percentage points from MY 2021 to MY 2022. For both former foster care members and controls, female members were significantly more likely to have an inpatient visit compared to male members during MY 2022, and this disparity also existed during MY 2021.

Behavioral Health Encounters—Total

Table 5-18 displays the MY 2020, MY 2021, and MY 2022 *Behavioral Health Encounters—Total* rates among former foster care members and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 5-18—Rates of *Behavioral Health Encounters—Total* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	33.6%+	28.3%
Age Category						
19–22 years	—	—	36.4%	32.3%	35.7%	28.4%
23–26 Years	—	—	34.3%	31.1%	30.4%	28.1%
Sex						
Male	—	—	28.4%	26.0%	25.9%	21.0%
Female	—	—	43.0%	38.1%	41.7%	35.9%
Race						
Black or African American	—	—	34.0%	28.7%	33.9%	24.4%
White	—	—	36.9%	34.6%	33.5%	30.8%
Other	—	—	31.7%	20.0%	31.3%	23.9%
Region						
Central	—	—	38.5%	33.6%	39.4%	29.4%
Charlottesville/Western	—	—	37.0%	36.3%	34.8%	29.7%
Northern & Winchester	—	—	32.8%	27.2%	26.7%	23.6%
Roanoke/Alleghany	—	—	38.4%	34.7%	35.6%	33.3%
Southwest	—	—	33.3%	35.6%	31.1%	26.3%
Tidewater	—	—	32.1%	25.0%	28.9%	25.7%
MCO						
Aetna	—	—	37.6%	38.3%	40.0%	25.8%
HealthKeepers	—	—	35.5%	32.7%	32.5%	29.8%
Molina	—	—	27.9%	19.8%	24.4%	22.0%
Optima	—	—	35.4%	30.8%	33.0%	28.2%
UnitedHealthcare	—	—	34.5%	29.4%	33.8%	26.9%
VA Premier	—	—	37.0%	33.8%	34.4%	28.5%
More Than One MCO	—	—	52.9%	29.4%	69.2%	69.2%

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 former foster care members was significantly higher than the rate for the control group of all eligible members.

- Indicates that the rate for 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 33.6 percent of former foster care members and 28.3 percent of controls had a behavioral health encounter during MY 2022, 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 7.3 percentage points); female members (by 5.8 percentage points); Black or African American members and members in the Other racial group (by 9.5 and 7.4 percentage points, respectively); members in the Central region (by 10.0 percentage points); and members enrolled with Aetna, UnitedHealthcare, and VA Premier (by 14.2, 6.9, and 5.9 percentage points, respectively).

MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rate for former foster care members decreased by 2.0 percentage points and the rate for controls decreased by 3.6 percentage points from MY 2021 to MY 2022. For former foster care members only, members 19 to 22 years of age were significantly more likely to have a behavioral health encounter during MY 2022. For both former foster care members and controls, female members were significantly more likely to have a behavioral health encounter compared to male members during MY 2022, and this disparity also existed during MY 2021. Former foster care members in the Central region were significantly more likely to have a behavioral health encounter compared to members in other regions, while members in the Northern & Winchester region and the Tidewater region were less likely. Additionally, former foster care members and controls enrolled with More Than One MCO were significantly more likely to have a behavioral health encounter, while former foster care members enrolled with Molina were less likely.

Behavioral Health Encounters—ARTS

Table 5-19 displays the MY 2020, MY 2021, and MY 2022 *Behavioral Health Encounters—ARTS* rates among former foster care members and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 5-19—Rates of *Behavioral Health Encounters—ARTS* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	7.3%+	5.5%
Age Category						
19–22 years	—	—	5.4%	4.0%	7.0%	4.5%
23–26 Years	—	—	6.7%	5.5%	7.7%	6.9%
Sex						
Male	—	—	5.5%	5.5%	5.4%	5.1%
Female	—	—	6.2%	3.4%	9.4%	5.9%
Race						
Black or African American	—	—	4.6%	2.7%	6.3%	3.6%

Category	MY 2020		MY 2021		MY 2022	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
White	—	—	6.7%	5.8%	8.2%	6.7%
Other	—	—	5.0%^	0.0%^	3.0%	3.0%
Region						
Central	—	—	5.2%	3.9%	7.4%	4.6%
Charlottesville/Western	—	—	3.8%	5.5%	5.8%	5.8%
Northern & Winchester	—	—	5.6%	3.9%	7.2%	4.6%
Roanoke/Alleghany	—	—	6.5%	3.3%	10.7%	9.2%
Southwest	—	—	10.7%	10.7%	11.1%	7.4%
Tidewater	—	—	5.4%	2.3%	4.2%	3.1%
MCO						
Aetna	—	—	7.1%	5.7%	7.7%	3.9%
HealthKeepers	—	—	7.3%	4.8%	7.6%	4.3%
Molina	—	—	2.7%	2.7%	3.9%	5.5%
Optima	—	—	4.1%	3.6%	6.1%	5.3%
UnitedHealthcare	—	—	7.6%	7.6%	10.0%	6.2%
VA Premier	—	—	5.3%	4.4%	7.5%	6.8%
More Than One MCO	—	—	17.6%	0.0%	30.8%	15.4%

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 former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 7.3 percent of former foster care members and 5.5 percent of controls had a behavioral health encounter with ARTS during MY 2022, and the difference was statistically significant (p=0.02). While there was a large rate difference for members enrolled with More Than One MCO, these rates had small denominators, so the rates may be less reliable.

MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rate for former foster care members increased by 1.5 percentage points and the rate for controls increased by 1.0 percentage point from MY 2021 to MY 2022. For former foster care members only, female members were significantly more likely to have a behavioral health encounter with ARTS compared to male members during MY 2022. Additionally, former foster care members in the Roanoke/Alleghany region and both former foster care members and

controls in the Southwest region were significantly more likely to have a behavioral health encounter with ARTS compared to members in other regions, while former foster care members and controls in the Tidewater region were significantly less likely. The disparity for the Southwest region also existed during MY 2021.

Behavioral Health Encounters—CMH Services

Table 5-20 displays the MY 2020, MY 2021, and MY 2022 *Behavioral Health Encounters—CMH Services* rates among former foster care members and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 5-20—Rates of *Behavioral Health Encounters—CMH Services* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	9.8%+	5.1%
Age Category						
19–22 years	—	—	10.1%	6.1%	11.0%	5.6%
23–26 Years	—	—	10.1%	6.5%	8.0%	4.4%
Sex						
Male	—	—	8.9%	5.3%	8.6%	3.9%
Female	—	—	11.3%	7.3%	11.0%	6.4%
Race						
Black or African American	—	—	12.2%	7.9%	13.7%	7.1%
White	—	—	8.7%	5.5%	7.8%	4.2%
Other	—	—	11.7%	1.7%	4.5%	1.5%
Region						
Central	—	—	15.6%	9.6%	17.4%	9.8%
Charlottesville/Western	—	—	9.7%	6.6%	7.8%	4.8%
Northern & Winchester	—	—	5.6%	3.9%	3.6%	0.5%
Roanoke/Alleghany	—	—	10.2%	8.2%	9.6%	5.4%
Southwest	—	—	9.6%	6.2%	8.9%	4.2%
Tidewater	—	—	6.8%	2.3%	5.8%	2.4%
MCO						
Aetna	—	—	14.2%	7.1%	15.5%	3.2%
HealthKeepers	—	—	9.8%	6.1%	9.3%	4.1%
Molina	—	—	8.1%	3.6%	7.9%	3.1%

Category	MY 2020		MY 2021		MY 2022	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Optima	—	—	9.6%	4.9%	9.7%	6.1%
UnitedHealthcare	—	—	7.6%	5.9%	5.4%	4.6%
VA Premier	—	—	9.4%	8.0%	9.6%	6.1%
More Than One MCO	—	—	41.2%	5.9%	30.8%	23.1%

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 former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 9.8 percent of former foster care members and 5.1 percent of controls had a behavioral health encounter with CMH services during MY 2022, 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 5.4 percentage points), Black or African American members (by 6.6 percentage points), members in the Central region (by 7.6 percentage points), and members enrolled with Aetna and HealthKeepers (by 12.3 and 5.2 percentage points, respectively). While there was a large rate difference for members enrolled with More Than One MCO, these rates had small denominators, so the rates may be less reliable.

MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rate for former foster care members decreased by 0.3 percentage points and the rate for controls decreased by 1.2 percentage points from MY 2021 to MY 2022. For former foster care members only, members 19 to 22 years of age were significantly more likely to have a behavioral health encounter with CMH services compared to members 23 to 26 years of age during MY 2022. For both former foster care members and controls, Black or African American members were significantly more likely to have a behavioral health encounter with CMH services compared to members in other racial groups, while White members were significantly less likely. The disparities for former foster care members also existed during MY 2021. Former foster care members and controls in the Central region were significantly more likely to have a behavioral health encounter with CMH services compared to members in other regions, while former foster care members and controls in the Northern & Winchester region and the Tidewater region were less likely. These disparities also existed during MY 2021, except for controls in the Northern & Winchester region. Former foster care members enrolled with Aetna and both former foster care members and controls enrolled with More Than One MCO were significantly more likely to have a behavioral health encounter

with CMH services. For former foster care members only, the disparity for members enrolled with More Than One MCO also existed in MY 2021.

Behavioral Health Encounters—RTC Services

Table 5-21 displays the MY 2020, MY 2021, and MY 2022 *Behavioral Health Encounters—RTC Services* rates among former foster care members and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 5-21—Rates of *Behavioral Health Encounters—RTC Services* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	5.1%+	2.7%
Age Category						
19–22 years	—	—	5.4%	2.2%	5.5%	2.7%
23–26 Years	—	—	4.4%	3.0%	4.4%	2.7%
Sex						
Male	—	—	4.9%	3.0%	4.4%	3.1%
Female	—	—	5.2%	1.9%	5.8%	2.3%
Race						
Black or African American	—	—	4.9%	2.5%	5.5%	3.0%
White	—	—	5.1%	2.5%	4.9%	2.5%
Other	—	—	5.0%	1.7%	3.0%	3.0%
Region						
Central	—	—	5.2%	2.6%	6.1%	3.1%
Charlottesville/Western	—	—	3.8%	4.2%	3.8%	3.8%
Northern & Winchester	—	—	5.0%	1.1%	4.1%	2.6%
Roanoke/Alleghany	—	—	4.1%	1.2%	6.5%	3.4%
Southwest	—	—	7.3%	3.4%	4.7%	1.6%
Tidewater	—	—	5.4%	2.0%	4.5%	1.6%
MCO						
Aetna	—	—	4.3%	2.1%	5.2%	1.3%
HealthKeepers	—	—	5.7%	1.8%	5.1%	2.3%
Molina	—	—	3.6%	1.8%	3.1%	4.7%
Optima	—	—	4.9%	3.3%	5.3%	2.4%
UnitedHealthcare	—	—	3.4%	1.7%	3.8%	2.3%

Category	MY 2020		MY 2021		MY 2022	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
VA Premier	—	—	5.7%	3.0%	5.5%	3.1%
More Than One MCO	—	—	0.0%	0.0%	7.7%	15.4%

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 former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 5.1 percent of former foster care members and 2.7 percent of controls had a behavioral health encounter with RTC services during MY 2022, 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, except for members enrolled with More Than One MCO for which the denominators were too small to ensure reliable rates.

MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rate for former foster care members increased by 0.1 percentage point and the rate for controls increased by 0.2 percentage points from MY 2021 to MY 2022. There were no disparities identified for former foster care members.

Behavioral Health Encounters—Therapeutic Services

Table 5-22 displays the MY 2020, MY 2021, and MY 2022 *Behavioral Health Encounters—Therapeutic Services* rates among former foster care members and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 5-22—Rates of *Behavioral Health Encounters—Therapeutic Services* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	2.0%+	0.6%
Age Category						
19–22 years	—	—	4.0%	2.9%	1.7%	0.9%
23–26 Years	—	—	4.4%	2.8%	2.4%	0.1%
Sex						
Male	—	—	3.3%	2.6%	1.6%	0.2%
Female	—	—	5.0%	3.1%	2.3%	1.0%
Race						
Black or African American	—	—	5.6%	4.6%	3.5%	0.8%
White	—	—	3.1%	2.1%	1.2%	0.6%
Other	—	—	6.7%^	0.0%^	0.0%^	0.0%^
Region						
Central	—	—	10.2%	6.8%	3.9%	0.7%
Charlottesville/Western	—	—	2.4%	1.4%	0.7%	0.3%
Northern & Winchester	—	—	0.0%^	0.6%^	0.5%^	0.0%^
Roanoke/Alleghany	—	—	2.9%	3.7%	2.7%	0.8%
Southwest	—	—	1.1%	2.3%	1.1%	0.5%
Tidewater	—	—	3.4%	0.9%	1.3%	1.0%
MCO						
Aetna	—	—	5.0%	1.4%	5.8%^	0.0%^
HealthKeepers	—	—	4.3%	3.2%	2.1%	0.6%
Molina	—	—	1.8%	0.9%	0.0%^	0.8%^
Optima	—	—	4.1%	2.7%	1.2%	1.0%
UnitedHealthcare	—	—	3.4%	2.5%	2.3%	0.8%
VA Premier	—	—	3.4%	3.7%	1.3%	0.4%
More Than One MCO	—	—	29.4%	5.9%	15.4%^	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 former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 2.0 percent of former foster care members and 0.6 percent of controls had a behavioral health encounter with therapeutic services during MY 2022, and the difference was statistically significant ($p<0.001$). The rates for former foster care members were notably higher than controls for members enrolled with Aetna (by 5.8 percentage points). While there was a large rate difference for members enrolled with More Than One MCO, the denominators for these rates were small, so rates may be less reliable.

MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rate for former foster care members decreased by 2.1 percentage points and the rate for controls decreased by 2.3 percentage points from MY 2021 to MY 2022. For former foster care members only, Black or African American members were significantly more likely to have a behavioral health encounter with therapeutic services compared to members in other racial groups, while White members were significantly less likely during MY 2022. This disparity also existed in MY 2021 for both former foster care members and controls. For former foster care members only, members in the Central region were significantly more likely to have a behavioral health encounter with therapeutic services compared to members in other regions. This disparity also existed in MY 2021 for both former foster care members and controls.

Behavioral Health Encounters—Traditional Services

Table 5-23 displays the MY 2020, MY 2021, and MY 2022 *Behavioral Health Encounters—Traditional Services* rates among former foster care members and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 5-23—Rates of *Behavioral Health Encounters—Traditional Services* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	32.2%+	27.0%
Age Category						
19–22 years	—	—	34.8%	31.3%	33.9%	27.2%
23–26 Years	—	—	33.0%	30.0%	29.5%	26.7%
Sex						
Male	—	—	26.7%	24.9%	24.7%	20.2%
Female	—	—	41.8%	37.1%	40.0%	34.0%
Race						
Black or African American	—	—	32.1%	26.5%	32.4%	22.2%
White	—	—	35.6%	34.2%	32.0%	30.0%
Other	—	—	31.7%	20.0%	31.3%	23.9%

Category	MY 2020		MY 2021		MY 2022	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Region						
Central	—	—	35.7%	30.7%	37.7%	25.9%
Charlottesville/Western	—	—	36.0%	35.6%	33.8%	29.0%
Northern & Winchester	—	—	32.8%	26.7%	25.6%	23.6%
Roanoke/Alleghany	—	—	35.1%	33.9%	33.3%	32.6%
Southwest	—	—	32.8%	35.6%	30.5%	25.3%
Tidewater	—	—	31.8%	24.7%	27.6%	25.5%
MCO						
Aetna	—	—	36.9%	36.9%	38.7%	24.5%
HealthKeepers	—	—	34.5%	31.4%	31.5%	28.8%
Molina	—	—	25.2%	19.8%	24.4%	21.3%
Optima	—	—	34.1%	29.9%	30.8%	26.5%
UnitedHealthcare	—	—	33.6%	29.4%	31.5%	26.9%
VA Premier	—	—	34.9%	32.4%	33.1%	26.8%
More Than One MCO	—	—	47.1%	29.4%	69.2%	69.2%

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 former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 32.2 percent of former foster care members and 27.0 percent of controls had a behavioral health encounter with traditional services during MY 2022, 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 6.7 percentage points), female members (by 6.0 percentage points), Black or African American members and members in the Other racial group (by 10.2 and 7.4 percentage points, respectively), members in the Central region and the Southwest region (by 11.8 and 5.2 percentage points, respectively), and members enrolled with Aetna and VA Premier (by 14.2 and 6.3 percentage points, respectively).

MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rate for former foster care members decreased by 2.0 percentage points and the rate for controls decreased by 3.9 percentage points from MY 2021 to MY

2022. 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 during MY 2022, and this disparity also existed during MY 2021. For former foster care members only, members in the Central region were significantly more likely to have a behavioral health encounter with traditional services compared to members in other regions, and members in the Northern & Winchester region and the Tidewater region were less likely. Additionally, former foster care members and controls enrolled with More Than One MCO were significantly more likely to have a behavioral health encounter with traditional services.

Overall Service Utilization

Table 5-24 displays the MY 2020, MY 2021, and MY 2022 *Overall Service Utilization* rates among former foster care members care and controls stratified by member characteristics. For MY 2021 and MY 2022, 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 5-24—Rates of *Overall Service Utilization* Among Former Foster Care Members and Controls

Category	MY 2020		MY 2021		MY 2022	
	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%	73.7%	75.0%
Age Category						
19–22 years	—	—	76.3%	75.7%	75.7%	75.3%
23–26 Years	—	—	71.6%	74.7%	70.7%	74.5%
Sex						
Male	—	—	65.7%	64.5%	64.4%	65.2%
Female	—	—	83.8%	86.7%	83.6%	85.2%
Race						
Black or African American	—	—	73.8%	75.3%	72.8%	75.7%
White	—	—	75.8%	75.9%	74.7%	75.5%
Other	—	—	65.0%	66.7%	65.7%	59.7%
Region						
Central	—	—	75.0%	78.1%	75.8%	74.9%
Charlottesville/Western	—	—	75.1%	75.8%	77.1%	75.1%
Northern & Winchester	—	—	72.8%	70.6%	70.8%	71.3%
Roanoke/Alleghany	—	—	77.1%	76.7%	76.2%	76.6%
Southwest	—	—	75.1%	78.0%	74.7%	77.4%
Tidewater	—	—	73.0%	72.2%	67.7%	74.5%

Category	MY 2020		MY 2021		MY 2022	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
MCO						
Aetna	—	—	74.5%	84.4%	73.5%	76.1%
HealthKeepers	—	—	74.8%	74.1%	75.9%	76.5%
Molina	—	—	60.4%	64.9%	62.2%	63.0%
Optima	—	—	74.5%	76.9%	71.6%	79.9%
UnitedHealthcare	—	—	73.9%	63.0%	68.5%	64.6%
VA Premier	—	—	77.9%	77.7%	77.2%	74.3%
More Than One MCO	—	—	94.1%	94.1%	100.0%	92.3%

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 former foster care members was significantly higher than the rate for the control group of all eligible members.
- Indicates that the rate for 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 73.7 percent of former foster care members and 75.0 percent of controls had an ambulatory care visit, ED visit, inpatient visit, or behavioral health encounter (i.e., any service) during MY 2022, and the difference was not statistically significant (p=0.38). The rates for former foster care members were notably higher than controls for members in the Other racial group (by 6.0 percentage points). Conversely, the rates for former foster care members were notably lower than controls for members in the Tidewater region (by 6.8 percentage points) and members enrolled with Optima (by 8.3 percentage points). While there was a large rate difference for members enrolled with More Than One MCO, the denominators for these rates were small, so rates may be less reliable.

MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. The rate for former foster care members decreased by 1.0 percentage points and the rate for controls decreased by 0.4 percentage points from MY 2021 to MY 2022. 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 during MY 2022, and this disparity also existed during 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. These disparities also existed during MY 2021. Additionally, former foster care members in the Tidewater region were significantly less likely to utilize any service compared to members in other regions, and members enrolled with VA Premier were significantly more 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 2022. 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 and MY 2022 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 Care 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 for New Foster Care Members*

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
All Eligible Members*	1,699	1,464	86.2%	1,778	1,544	86.8%
Age Category						
≤ 2 Years	580	534	92.1%	547	505	92.3%
3 to 5 Years	207	183	88.4%	252	223	88.5%
6 to 10 Years	301	246	81.7%	338	308	91.1%
11 to 13 Years	228	193	84.6%	246	211	85.8%
≥ 14 Years	383	308	80.4%	395	297	75.2%
Sex						
Male	877	751	85.6%	903	758	83.9%
Female	822	713	86.7%	875	786	89.8%
Race						
Black or African American	515	435	84.5%	580	508	87.6%
White	1,150	1,000	87.0%	1,148	995	86.7%
Other	34	29	85.3%	50	41	82.0%
Region						
Central	287	244	85.0%	326	277	85.0%
Charlottesville/Western	285	253	88.8%	287	256	89.2%
Northern & Winchester	243	193	79.4%	240	194	80.8%
Roanoke/Alleghany	358	317	88.5%	362	328	90.6%
Southwest	231	209	90.5%	254	221	87.0%
Tidewater	288	243	84.4%	301	260	86.4%
MCO						

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
Aetna	225	187	83.1%	197	173	87.8%
HealthKeepers	409	347	84.8%	434	374	86.2%
Molina	129	114	88.4%	137	110	80.3%
Optima	333	289	86.8%	352	311	88.4%
UnitedHealthcare	174	154	88.5%	170	146	85.9%
VA Premier	419	363	86.6%	485	427	88.0%

** 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 6-1 shows that 86.8 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 during MY 2022, and this rate increased by 0.6 percentage points from MY 2021. MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. Members 2 years of age and younger and members 6 to 10 years of age were significantly more likely to have a PCP visit compared to members in other age groups. Members 14 years of age and older were less likely to have a PCP visit compared to members in other age groups. The disparities for members 2 years of age and younger and members 14 years of age and older also existed during MY 2021; however, members 6 to 10 years of age were significantly less likely to have at least one visit with a PCP within 30 days during MY 2021. Additionally, members in the Roanoke/Alleghany 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. The disparity for the Northern & Winchester region also existed during MY 2021. Finally, members enrolled with Molina were significantly less likely to have a PCP visit.

Timely Access to Dental Care

Table 6-2 displays the MY 2021 and MY 2022 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 Care 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 for New Foster Care Members*

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
All Eligible Members*	1,699	747	44.0%	1,778	840	47.2%
Age Category						
≤ 2 Years	580	114	19.7%	547	124	22.7%
3 to 5 Years	207	120	58.0%	252	158	62.7%

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
6 to 10 Years	301	178	59.1%	338	216	63.9%
11 to 13 Years	228	141	61.8%	246	153	62.2%
≥ 14 Years	383	194	50.7%	395	189	47.8%
Sex						
Male	877	347	39.6%	903	421	46.6%
Female	822	400	48.7%	875	419	47.9%
Race						
Black or African American	515	210	40.8%	580	293	50.5%
White	1,150	518	45.0%	1,148	529	46.1%
Other	34	19	55.9%	50	18	36.0%
Region						
Central	287	121	42.2%	326	158	48.5%
Charlottesville/Western	285	124	43.5%	287	123	42.9%
Northern & Winchester	243	107	44.0%	240	131	54.6%
Roanoke/Alleghany	358	148	41.3%	362	120	33.1%
Southwest	231	125	54.1%	254	140	55.1%
Tidewater	288	119	41.3%	301	164	54.5%
MCO						
Aetna	225	101	44.9%	197	82	41.6%
HealthKeepers	409	193	47.2%	434	225	51.8%
Molina	129	51	39.5%	137	58	42.3%
Optima	333	119	35.7%	352	167	47.4%
UnitedHealthcare	174	84	48.3%	170	78	45.9%
VA Premier	419	196	46.8%	485	228	47.0%

** 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 47.2 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 during MY 2022, and this rate increased by 3.2 percentage points from MY 2021. MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed 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 groups, while members in all other age groups except 14 years of age and older were more likely to have visit with a dental provider. These disparities also existed during MY 2021. Additionally, members in the Northern & Winchester, Southwest, and Tidewater regions were significantly more likely to have a visit with a dental provider compared to members in other regions, while members in the Roanoke/Alleghany region were significantly less likely to have a visit with a dental provider. The

disparity for the Southwest region also existed during MY 2021. Members enrolled with HealthKeepers were more 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 and MY 2022 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 Care 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 for New Foster Care Members*

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
All Eligible Members*	1,699	1,534	90.3%	1,778	1,621	91.2%
Age Category						
≤ 2 Years	580	535	92.2%	547	507	92.7%
3 to 5 Years	207	192	92.8%	252	235	93.3%
6 to 10 Years	301	262	87.0%	338	326	96.4%
11 to 13 Years	228	209	91.7%	246	225	91.5%
≥ 14 Years	383	336	87.7%	395	328	83.0%
Sex						
Male	877	790	90.1%	903	806	89.3%
Female	822	744	90.5%	875	815	93.1%
Race						
Black or African American	515	456	88.5%	580	535	92.2%
White	1,150	1,046	91.0%	1,148	1,042	90.8%
Other	34	32	94.1%	50	44	88.0%
Region						
Central	287	262	91.3%	326	295	90.5%
Charlottesville/Western	285	266	93.3%	287	267	93.0%
Northern & Winchester	243	205	84.4%	240	209	87.1%
Roanoke/Alleghany	358	326	91.1%	362	335	92.5%
Southwest	231	217	93.9%	254	236	92.9%
Tidewater	288	253	87.8%	301	271	90.0%
MCO						
Aetna	225	202	89.8%	197	183	92.9%
HealthKeepers	409	364	89.0%	434	394	90.8%
Molina	129	116	89.9%	137	119	86.9%
Optima	333	303	91.0%	352	322	91.5%
UnitedHealthcare	174	159	91.4%	170	153	90.0%

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
VA Premier	419	380	90.7%	485	447	92.2%

** 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 91.2 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 during MY 2022, and this rate increased by 0.9 percentage points from MY 2021. MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. Members 6 to 10 years of age were significantly more likely to have a PCP or dental provider visit compared to members in other age groups, and members 14 years of age and older were significantly less likely during MY 2022. The rate for members 6 to 10 years of age greatly increased (by 9.4 percentage points) from MY 2021 to MY 2022, eliminating the negative disparity seen for MY 2021. Female members were significantly more likely than male members to have a PCP or dental provider visit. Additionally, members in the Northern & Winchester region were less likely to have a PCP or dental provider visit compared to members in other regions, and this disparity also existed during MY 2021.

Timely Access to Primary Care and Dental Care

Table 6-4 displays the MY 2021 and MY 2022 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 Care 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 for New Foster Care Members*

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
All Eligible Members*	1,699	677	39.8%	1,778	763	42.9%
Age Category						
≤ 2 Years	580	113	19.5%	547	122	22.3%
3 to 5 Years	207	111	53.6%	252	146	57.9%
6 to 10 Years	301	162	53.8%	338	198	58.6%
11 to 13 Years	228	125	54.8%	246	139	56.5%
≥ 14 Years	383	166	43.3%	395	158	40.0%
Sex						
Male	877	308	35.1%	903	373	41.3%

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
Female	822	369	44.9%	875	390	44.6%
Race						
Black or African American	515	189	36.7%	580	266	45.9%
White	1,150	472	41.0%	1,148	482	42.0%
Other	34	16	47.1%	50	15	30.0%
Region						
Central	287	103	35.9%	326	140	42.9%
Charlottesville/Western	285	111	38.9%	287	112	39.0%
Northern & Winchester	243	95	39.1%	240	116	48.3%
Roanoke/Alleghany	358	139	38.8%	362	113	31.2%
Southwest	231	117	50.6%	254	125	49.2%
Tidewater	288	109	37.8%	301	153	50.8%
MCO						
Aetna	225	86	38.2%	197	72	36.5%
HealthKeepers	409	176	43.0%	434	205	47.2%
Molina	129	49	38.0%	137	49	35.8%
Optima	333	105	31.5%	352	156	44.3%
UnitedHealthcare	174	79	45.4%	170	71	41.8%
VA Premier	419	179	42.7%	485	208	42.9%

** 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 42.9 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 during MY 2022, and this rate increased by 3.1 percentage points since MY 2021. MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed 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 groups, 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 groups. These disparities also existed during MY 2021. Additionally, members in the Southwest region and the Tidewater region were more likely to have a PCP visit and a dental provider visit compared to members in other regions, while members in the Roanoke/Alleghany region were less likely to have a PCP visit and a dental provider visit. The disparity for the Southwest region also existed during MY 2021. Members enrolled with HealthKeepers 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 Within 60 Days for New Foster Care Members

Timely Access to Behavioral Health Care Within 60 Days

Table 6-5 displays the MY 2021 and MY 2022 rates for the *Timely Access to Behavioral Health Care Within 60 Days for New Foster Care 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 Behavioral Health Care Within 60 Days for New Foster Care Members* indicator measures the percentage of members newly enrolled in the foster care program who had at least one visit with a mental health provider (MHP) within 60 days of the first foster care enrollment date.

Table 6-5—Rates of *Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members*

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
All Eligible Members*	—	—	—	1,601	809	50.5%
Age Category						
≤ 2 Years	—	—	—	484	101	20.9%
3 to 5 Years	—	—	—	232	106	45.7%
6 to 10 Years	—	—	—	304	210	69.1%
11 to 13 Years	—	—	—	222	161	72.5%
≥ 14 Years	—	—	—	359	231	64.3%
Sex						
Male	—	—	—	812	380	46.8%
Female	—	—	—	789	429	54.4%
Race						
Black or African American	—	—	—	516	264	51.2%
White	—	—	—	1,038	520	50.1%
Other	—	—	—	47	25	53.2%
Region						
Central	—	—	—	293	138	47.1%
Charlottesville/Western	—	—	—	257	117	45.5%
Northern & Winchester	—	—	—	212	64	30.2%
Roanoke/Alleghany	—	—	—	334	214	64.1%
Southwest	—	—	—	228	133	58.3%
Tidewater	—	—	—	270	143	53.0%
MCO						
Aetna	—	—	—	178	83	46.6%
HealthKeepers	—	—	—	374	186	49.7%
Molina	—	—	—	123	58	47.2%
Optima	—	—	—	312	149	47.8%

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
UnitedHealthcare	—	—	—	152	65	42.8%
VA Premier	—	—	—	426	252	59.2%
More Than One MCO	—	—	—	36	16	44.4%

** Members with Unknown Region 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.
— Indicates that a rate was not presented because it was not calculated for the measurement year.

Table 6-5 shows that 50.5 percent of newly enrolled members in the foster care program had at least one visit with an MHP within 60 days after the first foster care enrollment date during MY 2022. MY 2022 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. Members 2 years of age and younger were significantly less likely to have an MHP visit compared to members in other age groups, while members 6 to 10 years of age, 11 to 13 years of age, and 14 years of age and older were more likely to have an MHP visit compared to members in other age groups. Female members were more likely to have an MHP visit compared to male members. Additionally, members in the Southwest region and the Roanoke/Alleghany region were more likely to have an MHP visit compared to members in other regions, while members in the Northern & Winchester region were less likely to have an MHP visit. Members enrolled with VA Premier were more likely to have an MHP visit compared to members enrolled with other MCOs, while members enrolled with UnitedHealthcare were less likely.

Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members With a Behavioral Health Diagnosis

Table 6-6 displays the MY 2021 and MY 2022 rates for the *Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members 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 Within 60 Days for New Foster Care Members With a Behavioral Health Diagnosis* indicator measures the percentage of members newly enrolled in the foster care program with a diagnosis of mental illness who had at least one visit with an MHP within 60 days of the first foster care enrollment date.

Table 6-6—Rates of *Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members With a Behavioral Health Diagnosis*

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
All Eligible Members*	—	—	—	643	508	79.0%
Age Category						
≤ 2 Years	—	—	—	S	S	S
3 to 5 Years	—	—	—	S	S	S
6 to 10 Years	—	—	—	179	155	86.6%

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
11 to 13 Years	—	—	—	144	116	80.6%
≥ 14 Years	—	—	—	266	200	75.2%
Sex						
Male	—	—	—	303	228	75.2%
Female	—	—	—	340	280	82.4%
Race						
Black or African American	—	—	—	219	164	74.9%
White	—	—	—	405	328	81.0%
Other	—	—	—	19	16	84.2%
Region						
Central	—	—	—	126	95	75.4%
Charlottesville/Western	—	—	—	105	77	73.3%
Northern & Winchester	—	—	—	57	41	71.9%
Roanoke/Alleghany	—	—	—	136	123	90.4%
Southwest	—	—	—	115	96	83.5%
Tidewater	—	—	—	104	76	73.1%
MCO						
Aetna	—	—	—	59	44	74.6%
HealthKeepers	—	—	—	144	114	79.2%
Molina	—	—	—	37	28	75.7%
Optima	—	—	—	134	104	77.6%
UnitedHealthcare	—	—	—	51	39	76.5%
VA Premier	—	—	—	211	172	81.5%

** Members with Unknown Region and More Than One MCO 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). In instances where only one stratification was suppressed, the value for a secondary population was also suppressed.
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 a rate was not presented because it was not calculated for the measurement year.

Table 6-6 shows that 79.0 percent of newly enrolled members in the foster care program with a diagnosis of mental illness had at least one visit with an MHP within 60 days after the first foster care enrollment date during MY 2022. MY 2022 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. Members 14 years of age and older were significantly less likely to have an MHP visit compared to members in other age groups, while members 6 to 10 years of age were more likely to have an MHP visit compared to members in other age groups. Female members were more likely to have an MHP visit compared to male members. Additionally, members in the Roanoke/Alleghany region were more likely to have an MHP visit compared to members in other regions.

Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members

Timely Access to Behavioral Health Care Within 1 Year

Table 6-7 displays the MY 2021 and MY 2022 rates for the *Timely Access to Behavioral Health Care Within 1 Year for New Foster Care 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 Behavioral Health Care Within 1 Year for New Foster Care Members* indicator measures the percentage of members newly enrolled in the foster care program who had at least one visit with an MHP within one year of the first foster care enrollment date.

Table 6-7—Rates of *Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members*

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
All Eligible Members*	—	—	—	1,368	918	67.1%
Age Category						
≤ 2 Years	—	—	—	419	134	32.0%
3 to 5 Years	—	—	—	207	133	64.3%
6 to 10 Years	—	—	—	252	226	89.7%
11 to 13 Years	—	—	—	138	127	92.0%
≥ 14 Years	—	—	—	352	298	84.7%
Sex						
Male	—	—	—	706	464	65.7%
Female	—	—	—	662	454	68.6%
Race						
Black or African American	—	—	—	414	271	65.5%
White	—	—	—	926	629	67.9%
Other	—	—	—	28	18	64.3%
Region						
Central	—	—	—	223	156	70.0%
Charlottesville/Western	—	—	—	242	156	64.5%
Northern & Winchester	—	—	—	198	103	52.0%
Roanoke/Alleghany	—	—	—	285	193	67.7%
Southwest	—	—	—	188	146	77.7%
Tidewater	—	—	—	226	160	70.8%
MCO						
Aetna	—	—	—	175	125	71.4%
HealthKeepers	—	—	—	344	225	65.4%
Molina	—	—	—	88	54	61.4%
Optima	—	—	—	262	163	62.2%

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
UnitedHealthcare	—	—	—	119	81	68.1%
VA Premier	—	—	—	309	218	70.6%
More Than One MCO	—	—	—	71	52	73.2%

** Members with Unknown Region 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.
— Indicates that a rate was not presented because it was not calculated for the measurement year.

Table 6-7 shows that 67.1 percent of newly enrolled members in the foster care program had at least one visit with an MHP within one year of the first foster care enrollment date during MY 2022. MY 2022 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. Members 2 years of age and younger were significantly less likely to have an MHP visit compared to members in other age groups, while members 6 to 10 years of age, 11 to 13 years of age, and 14 years of age and older were more likely to have an MHP visit compared to members in other age groups. Additionally, members in the Northern & Winchester region were significantly less likely to have an MHP visit compared to members in other regions, while members in the Southwest region were significantly more likely.

Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members With a Behavioral Health Diagnosis

Table 6-8 displays the MY 2021 and MY 2022 rates for the *Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members 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 Within 1 Year for New Foster Care Members With a Behavioral Health Diagnosis* indicator measures the percentage of members who newly enrolled in the foster care program with a diagnosis of mental illness who had at least one visit with an MHP within one year of the first foster care enrollment date.

Table 6-8—Rates of *Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members With a Behavioral Health Diagnosis*

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
All Eligible Members*	—	—	—	520	484	93.1%
Age Category						
≤ 2 Years	—	—	—	—	—	—
3 to 5 Years	—	—	—	33	30	90.9%
6 to 10 Years	—	—	—	137	134	97.8%
11 to 13 Years	—	—	—	96	91	94.8%
≥ 14 Years	—	—	—	254	229	90.2%
Sex						

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
Male	—	—	—	245	225	91.8%
Female	—	—	—	275	259	94.2%
Race						
Black or African American	—	—	—	158	142	89.9%
White	—	—	—	354	335	94.6%
Region						
Central	—	—	—	96	92	95.8%
Charlottesville/Western	—	—	—	96	87	90.6%
Northern & Winchester	—	—	—	45	40	88.9%
Roanoke/Alleghany	—	—	—	133	123	92.5%
Southwest	—	—	—	81	76	93.8%
Tidewater	—	—	—	66	63	95.5%
MCO						
Aetna	—	—	—	63	57	90.5%
HealthKeepers	—	—	—	128	121	94.5%
Molina	—	—	—	19	19	100.0%^
Optima	—	—	—	111	101	91.0%
UnitedHealthcare	—	—	—	35	31	88.6%
VA Premier	—	—	—	141	133	94.3%
More Than One MCO	—	—	—	23	22	95.7%

** Members with Other Race and Unknown Region 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.
^ 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 a rate was not presented because it was not calculated for the measurement year.

Table 6-8 shows that 93.1 percent of newly enrolled members in the foster care program with a behavioral health diagnosis had at least one visit with an MHP within one year of the first foster care enrollment date during MY 2022. MY 2022 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. Members 14 years of age and older were significantly less likely to have an MHP visit compared to members in other age groups, while members 6 to 10 years of age were more likely to have an MHP visit compared to members in other age groups. Additionally, White members were significantly more likely than members in other racial groups to have an MHP visit.

Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members

Timely Access to Behavioral Health Care Within 1 Year

Table 6-9 displays the MY 2021 and MY 2022 rates for the *Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance 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 Behavioral Health Care Within 1 Year for New Adoption Assistance Members* indicator measures the percentage of members newly enrolled in the adoption assistance program who had at least one visit with an MHP within one year of the first adoption assistance enrollment date.

Table 6-9—Rates of *Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members*

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
All Eligible Members*	—	—	—	812	360	44.3%
Age Category						
≤ 2 Years	—	—	—	90	24	26.7%
3 to 5 Years	—	—	—	187	48	25.7%
6 to 10 Years	—	—	—	262	136	51.9%
11 to 13 Years	—	—	—	130	62	47.7%
≥ 14 Years	—	—	—	143	90	62.9%
Sex						
Male	—	—	—	437	191	43.7%
Female	—	—	—	375	169	45.1%
Race						
Black or African American	—	—	—	230	90	39.1%
White	—	—	—	559	256	45.8%
Other	—	—	—	23	14	60.9%
Region						
Central	—	—	—	168	71	42.3%
Charlottesville/Western	—	—	—	113	47	41.6%
Northern & Winchester	—	—	—	134	37	27.6%
Roanoke/Alleghany	—	—	—	135	84	62.2%
Southwest	—	—	—	113	52	46.0%
Tidewater	—	—	—	148	69	46.6%
MCO						
Aetna	—	—	—	69	23	33.3%
HealthKeepers	—	—	—	234	99	42.3%
Molina	—	—	—	44	13	29.5%
Optima	—	—	—	174	77	44.3%

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
UnitedHealthcare	—	—	—	69	32	46.4%
VA Premier	—	—	—	184	98	53.3%
More Than One MCO	—	—	—	38	18	47.4%

** Members with Unknown Region 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.
— Indicates that a rate was not presented because it was not calculated for the measurement year.

Table 6-9 shows that 44.3 percent of newly enrolled members in the adoption assistance program had at least one visit with an MHP within one year of the first adoption assistance enrollment date during MY 2022. MY 2022 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. Members 2 years of age and younger and 3 to 5 years of age were significantly less likely to have an MHP visit compared to members in other age groups, while members 6 to 10 years of age and 14 years of age and older were more likely to have an MHP visit compared to members in other age groups. Additionally, members in the Northern & Winchester region were significantly less likely to have an MHP visit compared to members in other regions, while members in the Roanoke/Alleghany region were significantly more likely. Members enrolled with Molina were significantly less likely to have an MHP visit compared to members enrolled with other MCOs, while members enrolled with VA Premier were significantly more likely.

Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members With a Behavioral Health Diagnosis

Table 6-10 displays the MY 2021 and MY 2022 rates for the *Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members 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 Within 1 Year for New Adoption Assistance Members With a Behavioral Health Diagnosis* indicator measures the percentage of members newly enrolled in the adoption assistance program with a diagnosis of mental illness who had at least one visit with an MHP within one year of the first adoption assistance enrollment date.

Table 6-10—Rates of *Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members With a Behavioral Health Diagnosis*

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
All Eligible Members*	—	—	—	356	243	68.3%
Age Category						
≤ 2 Years	—	—	—	S	S	S
3 to 5 Years	—	—	—	38	25	65.8%
6 to 10 Years	—	—	—	149	101	67.8%

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
11 to 13 Years	—	—	—	S	S	S
≥ 14 Years	—	—	—	91	68	74.7%
Sex						
Male	—	—	—	200	135	67.5%
Female	—	—	—	156	108	69.2%
Race						
Black or African American	—	—	—	94	61	64.9%
White	—	—	—	252	173	68.7%
Region						
Central	—	—	—	72	44	61.1%
Charlottesville/Western	—	—	—	49	31	63.3%
Northern & Winchester	—	—	—	41	26	63.4%
Roanoke/Alleghany	—	—	—	76	61	80.3%
Southwest	—	—	—	61	40	65.6%
Tidewater	—	—	—	57	41	71.9%
MCO						
Aetna	—	—	—	22	12	54.5%
HealthKeepers	—	—	—	116	76	65.5%
Molina	—	—	—	S	S	S
Optima	—	—	—	77	47	61.0%
UnitedHealthcare	—	—	—	19	15	78.9%
VA Premier	—	—	—	106	80	75.5%

** Members with Other Race, Unknown Region and More Than One MCO 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). In instances where only one stratification was suppressed, the value for a secondary population was also suppressed.
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 a rate was not presented because it was not calculated for the measurement year.

Table 6-10 shows that 68.3 percent of newly enrolled members in the adoption assistance program with a behavioral health diagnosis had at least one visit with an MHP within one year of the first adoption assistance enrollment date during MY 2022. MY 2022 is the first year this measure was calculated, so this year's rates cannot be compared to rates for this measure historically. MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator for this analysis. Members in the Roanoke/Alleghany region were significantly more likely to have an MHP visit compared to members in other regions.

Timely Access to Care for Members Who Aged Out of Foster Care

Timely Access to Primary Care

Table 6-11 displays the MY 2021 and MY 2022 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 percentage 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 6-11—Rates of *Timely Access to Primary Care Among Members Who Aged Out of Foster Care*

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
All Eligible Members*	179	125	69.8%	152	103	67.8%
Sex						
Male	97	59	60.8%	75	35	46.7%
Female	82	66	80.5%	77	68	88.3%
Race						
Black or African American	65	45	69.2%	51	30	58.8%
White	109	78	71.6%	95	68	71.6%
Region						
Central	43	30	69.8%	55	35	63.6%
Charlottesville/Western	34	25	73.5%	S	S	S
Northern & Winchester	S	S	S	S	S	S
Roanoke/Alleghany	28	20	71.4%	26	18	69.2%
Southwest	25	20	80.0%	20	15	75.0%
Tidewater	S	S	S	19	14	73.7%
MCO						
Aetna	S	S	S	S	S	S
HealthKeepers	58	42	72.4%	42	27	64.3%
Molina	S	S	S	S	S	S
Optima	38	25	65.8%	27	19	70.4%
UnitedHealthcare	S	S	S	S	S	S
VA Premier	51	41	80.4%	41	30	73.2%

** Members with Other Race and More Than One MCO 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). In instances where only one stratification was suppressed, the value for a secondary population was also suppressed.
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 6-11 shows that 67.8 percent of members who aged out of foster care had at least one visit with a PCP during MY 2022, and this rate decreased by 2.0 percentage points from MY 2021. The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. Female members who aged out of foster care were significantly more likely to have a PCP visit compared to male members during MY 2022. This disparity has worsened since MY 2021 due to the rate for male members decreasing (by 14.1 percentage points) and the rate for female members increasing (by 7.8 percentage points).

Timely Access to Dental Care

Table 6-12 displays the MY 2021 and MY 2022 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 percentage 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 6-12—Rates of *Timely Access to Dental Care for Members Who Aged Out of Foster Care*

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
All Eligible Members*	179	62	34.6%	152	45	29.6%
Sex						
Male	97	27	27.8%	75	15	20.0%
Female	82	35	42.7%	77	30	39.0%
Race						
Black or African American	65	26	40.0%	51	12	23.5%
White	109	34	31.2%	95	31	32.6%
Region						
Central	43	21	48.8%	55	20	36.4%
Charlottesville/Western	S	S	S	S	S	S
Northern & Winchester	S	S	S	S	S	S
Roanoke/Alleghany	S	S	S	S	S	S
Southwest	25	11	44.0%	S	S	S
Tidewater	S	S	S	S	S	S
MCO						
Aetna	S	S	S	S	S	S
HealthKeepers	58	21	36.2%	42	14	33.3%
Molina	S	S	S	S	S	S
Optima	S	S	S	S	S	S
UnitedHealthcare	S	S	S	S	S	S
VA Premier	51	25	49.0%	41	11	26.8%

** Members with Other Race and More Than One MCO 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). In instances where only one stratification was suppressed, the value for a secondary population was also suppressed.

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 6-12 shows that 29.6 percent of members who aged out of foster care had at least one visit with a dental provider during MY 2022, and this rate decreased by 5.0 percentage points from MY 2021. This rate change was primarily driven by the rate for Black or African American members decreasing (by 16.5 percentage points). The MY 2022 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, and this disparity also existed during MY 2021. However, the rates for male members had small denominators, so rates may be less reliable.

Timely Access to Primary Care or Dental Care

Table 6-13 displays the MY 2021 and MY 2022 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 percentage 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 6-13—Rates of *Timely Access to Primary Care or Dental Care for Members Who Aged Out of Foster Care*

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
All Eligible Members*	179	133	74.3%	152	109	71.7%
Sex						
Male	97	63	64.9%	75	39	52.0%
Female	82	70	85.4%	77	70	90.9%
Race						
Black or African American	65	48	73.8%	51	31	60.8%
White	109	83	76.1%	95	73	76.8%
Region						
Central	43	32	74.4%	55	38	69.1%
Charlottesville/Western	34	25	73.5%	21	14	66.7%
Northern & Winchester	15	12	80.0%	S	S	S
Roanoke/Alleghany	28	22	78.6%	S	S	S
Southwest	25	22	88.0%	20	16	80.0%
Tidewater	34	20	58.8%	19	14	73.7%
MCO						
Aetna	S	S	S	14	11	78.6%
HealthKeepers	58	43	74.1%	42	28	66.7%
Molina	S	S	S	S	S	S

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
Optima	38	25	65.8%	27	21	77.8%
UnitedHealthcare	S	S	S	S	S	S
VA Premier	51	45	88.2%	41	31	75.6%

** Members with Other Race and More Than One MCO 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). In instances where only one stratification was suppressed, the value for a secondary population was also suppressed.
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 6-13 shows that 71.7 percent of members who aged out of foster care had at least one visit with a PCP or dental care provider during MY 2022, and this rate decreased by 2.6 percentage points from MY 2021. The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed 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, and this disparity also existed during MY 2021. Additionally, Black or African American members were significantly less likely to have a visit with a PCP or dental care provider compared to members in other racial groups. The negative disparity for members in the Tidewater region during MY 2021 no longer existed during MY 2022 due to an increase in the rate for members in the Tidewater region (by 14.9 percentage points).

Timely Access to Primary Care and Dental Care

Table 6-14 displays the MY 2021 and MY 2022 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 percentage 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 6-14—Rates of *Timely Access to Primary Care and Dental Care for Members Who Aged Out of Foster Care*

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
All Eligible Members*	179	54	30.2%	152	39	25.7%
Sex						
Male	97	23	23.7%	75	11	14.7%
Female	82	31	37.8%	77	28	36.4%
Race						
Black or African American	65	23	35.4%	51	11	21.6%
White	109	29	26.6%	95	26	27.4%

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
Region						
Central	43	19	44.2%	55	17	30.9%
Charlottesville/Western	S	S	S	S	S	S
Northern & Winchester	S	S	S	S	S	S
Roanoke/Alleghany	S	S	S	S	S	S
Southwest	S	S	S	S	S	S
Tidewater	S	S	S	S	S	S
MCO						
Aetna	S	S	S	S	S	S
HealthKeepers	58	20	34.5%	42	13	31.0%
Molina	S	S	S	S	S	S
Optima	S	S	S	S	S	S
UnitedHealthcare	S	S	S	S	S	S
VA Premier	51	21	41.2%	S	S	S

** Members with Other Race and More Than One MCO 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). In instances where only one stratification was suppressed, the value for a secondary population was also suppressed.
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 6-14 shows that 25.7 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 2022, and this rate decreased by 4.5 percentage points from MY 2021. Given that the statewide rates for the *Timely Access to Dental Care for Members Who Aged Out of Foster Care* indicator were 38.2 percentage points lower than the rates for the *Timely Access to Primary 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 2022 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, and this disparity also existed during MY 2021.

Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care

Timely Access to Behavioral Health Care

Table 6-15 displays the MY 2021 and MY 2022 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 percentage 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 6-15—Rates of *Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care*

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
All Eligible Members*	179	58	32.4%	152	59	38.8%
Sex						
Male	97	27	27.8%	75	20	26.7%
Female	82	31	37.8%	77	39	50.6%
Race						
Black or African American	65	22	33.8%	51	19	37.3%
White	109	34	31.2%	95	37	38.9%
Region						
Central	43	15	34.9%	55	26	47.3%
Charlottesville/Western	S	S	S	S	S	S
Northern & Winchester	S	S	S	S	S	S
Roanoke/Alleghany	S	S	S	S	S	S
Southwest	S	S	S	S	S	S
Tidewater	S	S	S	S	S	S
MCO						
Aetna	S	S	S	S	S	S
HealthKeepers	58	17	29.3%	42	16	38.1%
Molina	S	S	S	S	S	S
Optima	S	S	S	S	S	S
UnitedHealthcare	S	S	S	S	S	S
VA Premier	51	23	45.1%	41	15	36.6%

** Members with Other Race and More Than One MCO 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). In instances where only one stratification was suppressed, the value for a secondary population was also suppressed.
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 6-15 shows that 38.8 percent of members who aged out of the foster care program had at least one visit with an MHP during MY 2022, and this rate increased by 6.4 percentage points from MY 2021. This rate change was driven by an increase in the rate for female members (by 12.8 percentage points). The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. Female members were significantly more likely to have a visit with an MHP compared to male members.

Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care With a Behavioral Health Diagnosis

Table 6-16 displays the MY 2021 and MY 2022 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 percentage 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 6-16—Rates of *Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care With a Behavioral Health Diagnosis*

Category	MY 2021			MY 2022		
	Denom	Num	Rate	Denom	Num	Rate
All Eligible Members*	142	56	39.4%	120	55	45.8%
Sex						
Male	76	27	35.5%	56	19	33.9%
Female	66	29	43.9%	64	36	56.3%
Race						
Black or African American	55	22	40.0%	43	18	41.9%
White	84	33	39.3%	73	35	47.9%
Region						
Central	33	14	42.4%	46	24	52.2%
Charlottesville/Western	S	S	S	S	S	S
Northern & Winchester	S	S	S	S	S	S
Roanoke/Alleghany	S	S	S	S	S	S
Southwest	S	S	S	S	S	S
Tidewater	S	S	S	S	S	S
MCO						
Aetna	S	S	S	S	S	S
HealthKeepers	43	16	37.2%	34	15	44.1%
Molina	S	S	S	S	S	S
Optima	S	S	S	S	S	S
UnitedHealthcare	S	S	S	S	S	S
VA Premier	44	23	52.3%	29	14	48.3%

** Members with Other Race and More Than One MCO 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). In instances where only one stratification was suppressed, the value for a secondary population was also suppressed.
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 6-16 shows that 45.8 percent of members who had aged out of foster care and who have a behavioral health diagnosis had at least one visit with an MHP during MY 2022, and this rate increased by 6.4 percentage points from MY 2021. This rate change was driven by an increase in the rate for female members (by 12.4 percentage points). The MY 2022 national Medicaid benchmarks were not applicable to this indicator since it is a custom indicator developed for this analysis. Female members were significantly more likely to have a visit with an MHP compared to male members.

7. Conclusions and Recommendations

SFY 2022–23 is the eighth year of the Child Welfare Focus Study and the fifth 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. Additionally, the study included 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 2022–23 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.

- The administrative claims and encounter data do not include denied pharmacy encounters. Therefore, study indicators for which the specifications include denied claims may underestimate pharmaceutical events (e.g., identification of members on antipsychotics for the denominator of the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* indicator). However, this limitation applies to all reported measurement years and populations, so trending and comparisons between populations are not affected.
- 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, MY 2021, and MY 2022 findings may be impacted by the onset of the COVID-19 PHE. Therefore, HSAG recommends exercising caution when interpreting these findings, where applicable.

Conclusions and Recommendations

The 2022–23 Child Welfare Focus Study highlights identified priorities for the Virginia Medicaid program related to improving and monitoring healthcare utilization and timely access to care for members in child welfare programs and identifying health disparities. DMAS continues to work with HSAG and the MCOs to address areas of opportunity to provide high quality care to Virginians. This section includes the conclusions from this year's study, recommendations for DMAS' consideration, and DMAS' follow-up on prior year focus study recommendations. As context for the conclusions and recommendations, DMAS has implemented policy changes and supported initiatives during the study period to improve utilization of and timely access to care among members in child welfare programs, including the following:

- As part of the SFY 2022–23 Medallion 4.0 Managed Care Services Agreement, effective July 1, 2022:
  - DMAS added language to improve continuity of and timely access to care for former foster care members, including ensuring MCOs provide members who are aging out of foster care with a "health summary" consolidating key medical information, ensuring MCOs coordinate with the local departments of social services (LDSS) during the transition period, ensuring case management continues during the transition period, and ensuring MCOs document transition needs for children in foster care who will age out of foster care in their individualized care plan, if applicable.
  - DMAS added language requiring MCOs to participate in child welfare stakeholder collaboration work groups, when requested.
- On April 1, 2022, Governor Glenn Youngkin launched the Safe and Sound Task Force, which aims to work collaboratively across state and local agencies to address barriers related to safe and appropriate placements for children in foster care. DMAS participates in the Task Force and

supports efforts to improve timely access to and utilization of medical and behavioral healthcare services for children in foster care.

- DMAS and the Department of Behavioral Health and Developmental Services collaborated to launch Project BRAVO (Behavioral Health Redesign for Access, Value and Outcomes), a multi-phase initiative to enhance behavioral health services in Virginia. Under this initiative, Virginia Medicaid began covering additional behavioral health services such as mental health intensive outpatient services, effective July 1, 2021, and multisystemic therapy, effective December 1, 2021.

Please see the DMAS' Input on Prior Year Focus Study Recommendations section for more details regarding additional DMAS initiatives related to members in child welfare programs.

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 had higher rates of appropriate healthcare utilization than comparable controls for the majority of study indicators in MY 2022, MY 2021, and MY 2020. Among study indicators where children in foster care had higher rates, MY 2022 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 14.9, 15.6, 15.6, and 9.8 percentage points, respectively), the *Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics* indicator (by 17.1 percentage points), and the *Behavioral Health Encounters—CMH Services*, *Behavioral Health Encounters—Traditional Services,* and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* indicators (by 15.3, 13.3, and 13.3 percentage points, respectively). Rate differences between children in foster care and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2022, children in foster care had lower rates compared to controls for nine study indicators, of which three were statistically significant: *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*, *ED Visits*, and *Overall Service Utilization.* For *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*, the rate for children in foster care was 22.0 percentage points lower than the rate for controls in MY 2022, although children in foster care had a higher rate than controls during MY 2020 and MY 2021. For the *ED Visits* study indicator, the rate for children in foster care was 8.6 percentage points lower than the rate for controls, which could reflect better management of health conditions for children in foster care. For the *Overall Service Utilization* indicators, the rate difference between children in foster care and controls was less than 2 percentage points, and the rates for children in foster care were very high. Additionally, while the rate difference was not statistically significant due to small denominators, the rate for children in foster for the *Initiation and Engagement of*

7-1 Virginia Department of Social Services. Foster Care (FC). Available at: https://www.dss.virginia.gov/family/fc/index.cgi#manuals. Accessed on: Mar 20, 2024.

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: Mar 20, 2024.

SUD Treatment—Initiation of SUD Treatment was 9.6 percentage points lower than rate for controls, and there were similar findings in MY 2020 and MY 2021.

Among children in foster care, eight study indicator rates increased, while 18 study indicator rates decreased from MY 2021 to MY 2022, and from MY 2020 to MY 2022, two study indicator rates increased, while 13 study indicator rates decreased. The largest declines from MY 2021 to MY 2022 were for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* indicator (by 28.6 percentage points), the *Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics* indicator (by 11.0 percentage points), and the *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* indicator (by 10.2 percentage points). However, eight of the MY 2021 to MY 2022 rate declines for children in foster care were by less than 3 percentage points. Among controls for children in foster care, 12 study indicator rates increased, while 16 study indicator rates decreased from MY 2021 to MY 2022, and from MY 2020 to MY 2022, 12 study indicator rates increased, while five study indicator rates decreased.

Among children in foster care, 15 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, children in foster care who were 14 years of age and older also had significantly lower rates for the *Preventive Dental Services; Oral Evaluation, Dental Services;* and *Topical Fluoride for Children—Dental or Oral Health Services* indicators despite Virginia State guidelines that children in foster care should have dental examinations every six months while in foster care.[7-3] Additionally, for the *ED Visits* and *Inpatient Visits* indicators, the rates for children in foster care 14 years of age and older were higher than the rates for controls as well as all other age categories. Five study indicators demonstrated disparities between males and females—female members had significantly higher rates for the *Inpatient Visits* indicator, while male members had significantly higher rates for 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* and *Behavioral Health Encounters—Therapeutic Services* indicators. Seven study indicators demonstrated disparities between racial groups—Black or African American members had significantly lower rates for the *Ambulatory Care Visits, Behavioral Health Encounters—ARTS*, and *Overall Service Utilization* indicators compared to other racial groups, while White members had significantly higher rates for the *Ambulatory Care Visits*, *Behavioral Health Encounters—ARTS, Behavioral Health Encounters—Traditional Services*, and *Overall Service Utilization* indicators. Finally, members in the Other racial group had significantly lower rates for the *ED Visits*, *Behavioral Health Encounters—CMH Services*, *Behavioral Health Encounters—Total* indicators. These disparities typically existed among controls as well.

Among children in foster care, 15 study indicators had disparities across regions. Of note, members in the Roanoke/Alleghany region consistently had significantly lower rates for Oral Health domain study indicators, while members in the Southwest region had significantly better rates for several of the Oral Health domain and *Behavioral Health Encounters* indicators compared to members in other regions. Findings also showed 15 study indicators with disparities between MCOs. Of note, members enrolled

[7-3] 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: Mar 20, 2024.

with Molina had lower rates for three of the four Oral Health domain study indicators as well as the *Ambulatory Care Visits* indicator compared to members enrolled with other MCOs.

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

- Findings show that the rates for children in foster care for the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* indicator were lower than controls for MY 2020, MY 2021, and MY 2022. Additionally, the rates for the *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* indicator were lower than controls for MY 2020 and MY 2022. For both indicators, MY 2022 rates were below the national Medicaid 50th percentiles. Additionally, children in foster care had a significantly lower rate than controls for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* indicator. However, children in foster care had a similar rate as controls when looking at follow-up visits within 30 days, suggesting that timeliness of care is a key factor. Therefore, HSAG recommends that DMAS consider focusing quality improvement efforts toward improving utilization of these services for children in foster care. For example, the MCOs could work with case managers, service workers, and foster parents to identify barriers to SUD treatment and mental health treatment (e.g., the foster child's consent for SUD treatment, timeliness of review for ARTS coverage, and timely access to mental health providers) and test strategies to address those specific barriers.
- The COVID-19 PHE impacted healthcare utilization nationally and ended in May 2023. All study indicator findings in this report may be affected by the COVID-19 PHE. DMAS may consider continuing to monitor these study indicators to ensure that these rates stabilize over MY 2023 and MY 2024 and establish a new baseline post-pandemic.
- SFY 2022–23 is the second year to include a health disparities analysis in this study. While a greater percentage of indicators demonstrated racial disparities during MY 2022 compared to MY 2021, a lower percentage of indicators had disparities by age, sex, region, and MCO in MY 2022. The analysis identified few disparities of concern among children in foster care. DMAS may consider focusing quality improvement efforts to reduce health disparities toward improving the rate of dental services, preventing ED visits, where appropriate, and understanding the main drivers of inpatient visits among older children in foster care and improving the rates of dental services among children in foster care in the Roanoke/Alleghany region. DMAS and the MCOs may consider conducting focus groups with key parties (i.e., case managers, service workers, and foster parents) for these subpopulations (i.e., older children and members in the Roanoke/Alleghany region) to understand challenges associated with utilization of these services and implement targeted interventions for the greatest impact.
- While the current study design provides insight into utilization of healthcare services, it does not assess the comprehensiveness 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 psychotic disorders are receiving and adhering to appropriate medications and managing their condition in the appropriate settings.

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.[7-4] 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.[7-5] This study demonstrated that children receiving adoption assistance have higher rates of appropriate healthcare utilization than comparable controls for approximately half of the study indicators in MY 2022, MY 2021, and MY 2020. Study findings show that children receiving adoption assistance had higher rates than controls for all four Oral Health domain study indicators, *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, Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up*, *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing*, *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*, both *Initiation and Engagement of SUD Treatment* indicators, *Asthma Medication Ratio, Inpatient Visits*, and five 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 2022, children receiving adoption assistance had lower rates compared to controls 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*, *Child and Adolescent Well-Care Visits, Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up,* all *Follow-Up Care for Children Prescribed ADHD Medication* study indicators, *Ambulatory Care Visits*, *ED Visits*, *Behavioral Health Encounters—CMH Services,* and *Overall Service Utilization*, of which six differences were statistically significant. 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 55.3 percentage points) and the *Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up* study indicator (by 11.7 percentage points). However, the denominator 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 was very small, so the rate is expected to fluctuate more. For five 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 11.6 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, 16 study indicator rates increased, while 12 study indicator rates decreased from MY 2021 to MY 2022, and from MY 2020 to MY 2022, nine study indicator rates increased, while six study indicator rates decreased. The largest declines from MY 2021 to MY 2022 were for the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment*

[7-4] 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: Mar 20, 2024.

[7-5] 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: Mar 20, 2024.

study indicator (by 11.8 percentage points) and *the Behavioral Health Encounters—Traditional* study indicator (by 7.1 percentage points). 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 also decreased (by 50.0 percentage points); however, the denominator is very small for this study indicator, so rate changes across time are expected to be larger. Additionally, six of the rate declines among children in adoption assistance from MY 2021 to MY 2022 were by less than 3 percentage points. Among controls for children receiving adoption assistance, 15 study indicator rates increased, while 14 study indicator rates decreased from MY 2021 to MY 2022, and from MY 2020 to MY 2022, 13 study indicator rates increased, while four study indicator rates decreased.

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, 15 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 all indicators in the Oral Health domain, older children receiving adoption assistance had significantly lower rates compared to younger children. Four study indicators demonstrated disparities between males and females—female members had significantly higher rates for the *Inpatient Visits* indicator, while male members had significantly higher rates for the *Behavioral Health Encounters—Total, Behavioral Health Encounters—CMH Services,* and *Behavioral Health Encounters—Therapeutic Services* indicators. Seven study indicators demonstrated disparities between racial groups—Black or African American members had significantly higher rates for the *Child and Adolescent Well-Care Visits*, *Oral Evaluation, Dental Services*, *Behavioral Health Encounters—CMH Services, Behavioral Health Encounters—RTC Services,* and *Behavioral Health Encounters—Traditional* Services indicators and a significantly lower rate for the *Ambulatory Care Visits* indicator compared to other racial groups, while White members had a significantly higher rate for the *Ambulatory Care Visits* indicator and significantly lower rates for the *Child and Adolescent Well-Care Visits, Oral Evaluation, Dental Services,* and *Behavioral Health Encounters—Traditional Services* indicators. Additionally, children receiving adoption assistance in the Other racial group had a significantly lower rate for the *Behavioral Health Encounters—Traditional Services* indicator. Some of these disparities were also seen among controls.

There were also some disparities identified across regions and MCOs. For example, members in the Northern & Winchester region had significantly lower rates for well-child visits, three of the four indicators in the Oral Health domain, and three types of behavioral health encounters compared to members in other regions. Additionally, members enrolled with Aetna and Molina had significantly lower rates for well-child visits, all indicators in the Oral Health domain, and two types of behavioral health encounters compared to members enrolled with other MCOs.

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

- The SFY 2022–23 study found that children receiving adoption assistance had lower rates than controls 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*, *Child and Adolescent Well-Care Visits*, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up,* and all *Follow-Up Care for Children Prescribed ADHD Medication* study indicators. However, many children receiving adoption assistance have special medical conditions that may preclude doctor visits from being billed as a well-child visit. Therefore, HSAG recommends that DMAS consider focusing quality improvement

efforts toward improving utilization of behavioral health services, where appropriate, for children receiving adoption assistance. For example, MCOs could work with care coordinators and adoptive parents to identify barriers to behavioral health follow-up visits (e.g., availability of behavioral health providers and transportation challenges for adoption parents) and test strategies to address those specific barriers.

- The COVID-19 PHE impacted healthcare utilization nationally and ended in May 2023. All study indicator findings in this report may be affected by the COVID-19 PHE. DMAS may consider continuing to monitor these study indicators to ensure that these rates stabilize over MY 2023 and MY 2024 and establish a new baseline post-pandemic.
- SFY 2022–23 is the second year to include a health disparities analysis in this study. While a greater percentage of indicators demonstrated disparities by age during MY 2022 compared to MY 2021, a lower percentage of indicators had disparities by sex, race, region, and MCO in MY 2022. Rates tended to be lower for older members, as well as for members in the Northern & Winchester region and members enrolled with Aetna and Molina. DMAS and the MCOs may consider conducting focus groups with key parties (i.e., care coordinators and adoptive parents) for these subpopulations to understand challenges associated with utilization of these services and implement targeted interventions for the greatest impact.
- While the current study design provides insight into utilization of healthcare services, it does not assess the comprehensiveness 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.[7-6] This study demonstrated that former foster care members have higher rates of appropriate healthcare utilization than comparable controls for approximately half of study indicators in MY 2022, MY 2021, and MY 2020. Study findings show that former foster care members had higher rates than controls for *Child and Adolescent Well-Care Visits*, *Annual Dental Visit*, *Oral Evaluations, Dental Services*, *Topical Fluoride for Children—Dental or Oral Health Services, Follow-Up After ED Visit for Substance Use—30-Day Follow-Up*, both *Initiation and Engagement of SUD Treatment* indicators*, ED Visits,* and all *Behavioral Health Encounters* study

[7-6] 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_2022/Section_13_achieving_permanency_for_older_youth.pdf. Accessed on: Mar 20, 2024.

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 2022, former foster care members had lower rates compared to controls for all Behavioral Health domain study indicators*, Asthma Medication Ratio, Ambulatory Care Visits*, and *Overall Service Utilization*. The largest differences were for the *Asthma Medication Ratio* study indicator (by 37.8 percentage points), the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* study indicator (by 17.2 percentage points), the *Antidepressant Medication Management—Effective Acute Phase Treatment* study indicator (by 8.4 percentage points), and the *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* study indicator (by 7.4 percentage points).

Among former foster care members, all study indicator rates except the *Topical Fluoride for Children—Dental or Oral Health Services, Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment, ED Visits, Behavioral Health Encounters—ARTS,* and the *Behavioral Health Encounters—RTC Services* study indicators decreased from MY 2021 to MY 2022. The largest declines from MY 2021 to MY 2022 were for the *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* indicator (by 12.2 percentage points) and the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* indicator (by 12.0 percentage points). The *Asthma Medication Ratio* indicator also decreased substantially (by 47.0 percentage points); however, the denominator is small, so rate changes across time are expected to be larger. Among controls for former foster care members, all study indicator rates decreased from MY 2021 to MY 2022 except for the *Annual Dental Visit, Preventive Dental Services, Topical Fluoride for Children—Dental or Oral Health Services, Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up, Inpatient Visits, ED Visits, Behavioral Health Encounters—ARTS,* and *Behavioral Health Encounters—RTC Services* study indicators.

Among former foster care members, five study indicators demonstrated disparities across age categories. Members 23 to 26 years of age were less likely to have an ED visit, behavioral health encounter with CMH services or any service, a follow-up visit after an ED visit for mental illness, or any service utilization type compared to members 19 to 22 years of age. Twelve indicators demonstrated disparities by sex, where male members consistently had lower rates of healthcare utilization compared to female members. Male members had significantly lower rates for the *Child and Adolescent Well-Care Visits, Annual Dental Visit, Preventive Dental Services, Oral Evaluation, Dental Services, Ambulatory Care Visits, ED Visits, Inpatient Visits, Behavioral Health Encounters—Total, Behavioral Health Encounters—ARTS, Behavioral Health Encounters—Traditional Services,* and *Overall Service Utilization* indicators. Four study indicators demonstrated disparities by race/ethnicity. Of note, White members had significantly higher rates for the *Ambulatory Care Visits* indicator, while Black or African American members had significantly lower rates; however, Black or African American members had significantly higher rates for the *Behavioral Health Encounters—CMH Services* and *Behavioral Health Encounters—Therapeutic Services* indicators, while White members had significantly lower rates. Eleven study indicators demonstrated disparities by region. Of note, members in the Tidewater region had significantly lower rates for the *Ambulatory Care Visits, Annual Dental Visit, Preventive Dental Services, Oral Evaluation, Dental Services, Behavioral Health Encounters—ARTS, Behavioral Health Encounters—CMH Services, Behavioral Health Encounters—Traditional Services, Behavioral Health Encounters—Total,* and *Overall Service Utilization* indicators. Six study indicators demonstrated disparities by MCO; however, there were no overarching trends.

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

- The SFY 2022–23 study found that former foster care members had lower rates than controls for all Behavioral Health domain study indicators. HSAG recommends that DMAS consider focusing quality improvement efforts toward improving utilization of these services, where appropriate, for former foster care members. MCOs could work with case managers and service workers who maintain contact with former foster care members to identify challenges with utilizing these behavioral health services to inform quality improvement efforts.
  - In July 2022, DMAS began requiring MCOs to provide members aging out of foster care with a "health summary" consolidating key medical information (e.g., providers, appointments, prescriptions). It will be important to monitor whether these additional resources impact utilization of behavioral health services for members who aged out of foster care in CY 2023.
- The COVID-19 PHE impacted healthcare utilization nationally and ended in May 2023. All study indicator findings in this report may be affected by the COVID-19 PHE. DMAS may consider continuing to monitor these study indicators to ensure that these rates stabilize over MY 2023 and MY 2024 and establish a new baseline post-pandemic.
- SFY 2022–23 is the second year to include a health disparities analysis in this study. The analysis identified disparities in healthcare utilization across age, sex, race, and region among former foster care members. Disparities were particularly consistent for male members, who had significantly lower utilization of services for 11 study indicators, and for members in the Tidewater region, who had significantly lower utilization of services for nine study indicators. DMAS may consider focusing quality improvement efforts among former foster care members toward these subpopulations. DMAS and the MCOs may consider conducting focus groups with members from these subpopulations (i.e., male members and members in the Tidewater region) to understand challenges associated with utilization of these services and implement targeted interventions for the greatest impacts.

Timely Access to Care

SFY 2022–23 is the second year to include analyses for timely access to care in this study. Virginia State guidelines require that children in foster care receive a medical examination no later than 30 days after initial placement in foster care.[7-7] Virginia State guidelines also require that the child have a visit with a mental health professional within 60 days of initial placement in foster care if a trauma, mental health, or substance use condition is identified during the medical examination.[7-8] 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.[7-9] DMAS is working with VDSS and the MCOs to meet a goal of statewide improvement in timely initial medical exams. The SFY 2022–23 study found that 86.8 percent of new foster care members had a visit with a PCP within 30 days after or 90 days prior to entering foster care during MY 2022, an increase of 0.6 percentage points from the year prior. Therefore, most children in foster care are receiving timely access to primary

7-7 Virginia Department of Social Services. Child and Family Services Manual: Identifying Services to Be Provided. Available at: https://www.dss.virginia.gov/files/division/dfs/fc/intro_page/guidance_manuals/fc/07_2022/section_12_identifying_services_to_be_provided.pdf. Accessed on: Mar 20, 2024.

7-8 Ibid.

7-9 Commonwealth of Virginia DMAS. Medallion 4.0 Managed Care Services Agreement. Available at: https://www.dmas.virginia.gov/media/4981/medallion-40-sfy23.pdf. Accessed on: Mar 20, 2024.

care; however, there may still be some room for improvement in meeting State guidelines. Additionally, 47.2 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 during MY 2022. This rate improved by 3.2 percentage points from MY 2021. Study indicators also assessed timely access to primary and dental care for members who aged out of foster care. Findings demonstrate that 67.8 percent of members who aged out of foster care in the year prior to the MY had a visit with a PCP during MY 2022, and this rate decreased by 2.0 percentage points from MY 2021. Similar to new foster care members, only 29.6 percent of members who aged out of foster care had a visit with a dental practitioner during MY 2022, and most of these members also had a visit with a PCP. This rate decreased by 5.0 percentage points from MY 2021.

Several study indicators assessed timely access to behavioral healthcare, including several new study indicators introduced in the SFY 2022–23 study assessing timely access to behavioral healthcare for new foster care members and new adoption assistance members. The SFY 2022–23 study found that 50.5 percent of new foster care members and 79.0 percent of new foster care members with a diagnosed behavioral health condition had at least one visit with an MHP within 60 days of enrollment in the foster care program. Additionally, 67.1 percent of new foster care members and 93.1 percent of new foster care members with a behavioral health diagnosis had a visit with an MHP within a year after enrollment in the foster care program. For newly enrolled members in the adoption assistance program, 44.3 percent of all members and 68.3 percent of members with a behavioral health diagnosis had a visit with an MHP. Lastly, 78.9 percent of members who aged out of foster care had a behavioral health diagnosis, and 45.8 percent of these members with a behavioral health diagnosis had a visit with an MHP during MY 2022; this rate improved by 6.4 percentage points from MY 2021.

Similar to the healthcare utilization analysis, HSAG conducted a health disparities analysis for the timely access to care study indicators. Among new foster care members, older members were less likely to have a visit with a PCP and more likely to have a visit with a dental practitioner. Additionally, for new foster care members, older members were more likely to have an MHP visit among all members but less likely among members with a behavioral health diagnosis for both the 60-day and one-year time frames. Female members who aged out of foster care were more likely to have a visit with a dental practitioner 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 PCP. The rate difference was particularly large for members who aged out of foster care and had PCP visits, where the rate for male members was 41.6 percentage points lower than the rate for female members. Members newly enrolled in foster care in the Northern & Winchester region were significantly less likely to have a PCP or MHP visit compared to members in other regions, and members newly enrolled in the adoption assistance program in Northern & Winchester were significantly less likely to have an MHP visit. There were no notable trends across indicators by race/ethnicity or MCO.

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, particularly in dental care for new foster care members and both primary care and dental care for members who aged out of foster care. The MCOs may consider working with case managers for both new foster care members and members who age out of foster care, service workers and foster parents for new foster care members, and service workers who maintain contact with members who aged out of foster care to identify challenges (e.g., healthcare navigation, dental provider availability, and transiency) to inform quality improvement efforts.

  - In July 2022, DMAS began requiring MCOs to provide members aging out of foster care with a "health summary" consolidating key medical information (e.g., providers, appointments, prescriptions). It will be important to monitor whether these additional resources impact timely access to care for members who aged out of foster care in CY 2023.
  - During SFY 2022–23, the Foster Care Affinity Group, which is co-led by DMAS and VDSS, piloted strategies to improve timely access to initial comprehensive medical examinations for new foster care members and will continue to adapt and scale up strategies to improve timely access to care.
- The health disparities analysis identified disparities in timely access to care across age, sex, and region. The greatest disparity was between female and male members who aged out of foster care, where male members were much less likely to have a PCP visit. This disparity persisted over both MY 2021 and MY 2022. DMAS may consider focusing quality improvement efforts for timely access to care toward male members who aged out of foster care.
- SFY 2022–23 is the second year to include analyses for timely access to care, and both MY 2021 and MY 2022 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 2021–22 Child Welfare Focus Study.

Data Recommendations

SFY 2021–22 was the first year to introduce new analyses related to health disparities and timely access to care for children in foster care, children receiving adoption assistance, and former foster care members. 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 such as age, sex, race, region, and MCO. DMAS has requested that the 2022–23 study, as well as all future studies, continue to include these additional analyses to verify appropriate baseline rates, identify areas for improvement, and monitor impacts of program changes.

SFY 2021–22 is the second year to include analyses for children receiving adoption assistance and former foster care members. However, considering the impact of the COVID-19 pandemic on healthcare utilization during MY 2020 and MY 2021, children receiving adoption assistance and former foster care members' rates during MY 2020 and MY 2021 may not be representative of their historical rates. Therefore, DMAS has requested that the 2022–23 study 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 and reduce health disparities among members involved in the child welfare system, to determine areas of focus and improvement.

Safe and Sound Task Force

Under the leadership of Virginia's Governor, the Safe and Sound Task Force has continued through SFY 2022–23. The objective of the task force is to work collaboratively across state and local agencies to address the barriers related to safe and appropriate placements (including access to medical and behavioral health services) for children in foster care.

Two core priorities identified by the Task Force during SFY 2022–23 include addressing gaps in children's community-based behavioral health services and increasing access to evidence-based services, as well as improving residential treatment services for children. DMAS will continue to analyze data and utilize recommendations posed by HSAG around behavioral health encounters measures (including timely access to care) to determine areas of focus and improvement for all three child welfare member populations included in this study.

The Task Force will continue under the current administration to focus on increasing the provision of services to children, families, and those in the community who provide for their well-being. Representatives from DMAS' Health Care Services and Behavioral Health divisions will continue to participate in the Core Team of the Task Force to work toward the goal of improving medical and behavioral healthcare services as well as timely access to and utilization of services for child welfare members.

Community Partnerships

During SFY 2022–23, DMAS continued hosting virtual statewide Foster Care Partnership meetings with child welfare stakeholders from across the state. These stakeholders included those from the VDSS, the Virginia Commission on Youth, LDSS, Licensed Child Placing Agencies (LCPAs), MCOs, and the Virginia Office of Children's Services, among others.

The purpose of the Foster Care Partnership is to improve collaboration among all individuals involved in the treatment and care of youth in foster care in Virginia, as well as to focus on actionable goals related to improving services for youth in foster care. The areas of focus, or "action groups" for this year were created based on cross-sector discussions around current needs of youth in foster care, factoring in results and recommendations of the 2021–22 Child Welfare Focus Study.

One action group planned and implemented four webinar trainings for local and state DSS workers and foster parents related to various topics of interest and importance, including:

- Medicaid services and benefits available, care coordination, and MCOs' role in assisting DSS in meeting the spectrum of healthcare needs of youth in foster care
- Residential treatment services for youth
- Dental benefit for youth in foster care
- Trauma-informed MCO care coordination

The second action group of the Foster Care Partnership this year focused on continuing the Foster Care Affinity Group project, with a specific focus on timely access to initial well-child visits upon entering foster care, which will be discussed in the Foster Care Affinity Group section below.

DMAS plans to continue facilitating the Foster Care Partnership and related sub-groups, with a continued focus on interagency collaboration for improved outcomes and service utilization for children in foster care, children receiving adoption assistance, and former foster care members in Virginia. DMAS will continue to use HSAG study recommendations for these member populations to inform the quality improvement focus areas for the group.

Right Help Right Now

The Governor's Right Help Right Now plan aims to achieve the goal that all Virginians will, 1) be able to access behavioral healthcare when they need it; 2) have prevention and management services personalized to their needs, particularly for children, youth, and families; 3) know who to call, who will help, and where to go when in crisis; and 4) have paths to re-entry and stabilization when transitioning from a crisis. DMAS is an integral partner and stakeholder within this plan. This year, in support of the Governor's Right Help Right Now Behavioral Health Transformation Plan, DMAS in collaboration with other state agencies and stakeholders has been working on the following initiatives:

- Identifying service innovations and best practices in behavioral health services, which include a specific focus on developing a new school-based behavioral health service for youth and researching best practice models for youth mental health residential treatment services
- Identifying and researching evidence-based programs specific to youth
- Assessment of health plan behavioral health network adequacy.

DMAS' goal, in partnership with this plan, is to increase efficacy, access, and utilization of effective and appropriate behavioral health services for Medicaid members in Virginia. Considering the importance of behavioral health services to the child welfare member population, DMAS will continue to work collaboratively with its partners to move Right Help Right Now forward, enhance current services, identify innovations in service delivery, and close capacity gaps in these services.

Foster Care Affinity Group

During CY 2023, 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 work together toward the goals of the project. 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 SFY 2022–23 continuing to gather and analyze data related to the process and outcome measures identified in the project, which include: the timely transfer of information about new foster care members from the LDSS agencies to the MCOs, timely initial MCO outreach to foster care members to begin care coordination and service initiation efforts, and timely initial comprehensive medical examinations. According to the data collected for this project, most children entering foster care in Virginia are already enrolled in a Medicaid MCO. However, upon entering DSS custody there is still a statewide delay of 63 days on average for the data system to update the enrollment information for the MCO to be notified that their member has entered foster care. This means that Medicaid and MCOs are

not often able to intervene or assist with care coordination for members in foster care in the first 30 days of their placement into custody.

The most successful pilot to date has been a warm handoff with Bedford County DSS, where the Foster Care Supervisor sends a secure email to DMAS on the date of custody for all new foster care admissions in Bedford. DMAS is then able to inform the child's assigned MCO that their member has entered foster care and needs outreach and assistance in setting up initial services, which includes a comprehensive medical exam within the first 30 days of placement. Through this warm handoff, the MCO notification time in Bedford during SFY 2022–23 improved from an average of 39 days to one (1) day from the date of custody. Additionally, successful outreach by the MCO to the member or legal guardian improved in Bedford County from an average of 52 days to an average of four days. Finally, the rate of initial medical exams occurring within 30 days of custody has improved in Bedford from an average of 69 percent to 73 percent since starting the warm handoff pilot.

The Affinity Group will continue to meet as a quality improvement-focused action group of the Foster Care Partnership. This group will continue working to adapt and scale up the current Affinity Group project aim and will also develop collaborative quality improvement projects in different areas of service utilization for youth in foster care taking into account the recommendations of the HSAG Child Welfare Focus Study.

Member Outreach

During SFY 2022–23, DMAS launched a quarterly Foster Care Newsletter to keep partners and stakeholders up to date about resources, events and trainings, and any changes or news related to Medicaid that may impact youth in the child welfare system. These newsletters have included information from all recent Foster Care Partnership trainings, as well as upcoming events and trainings, and member "success stories" related to MCOs addressing barriers to necessary services and improving access to care.

Additionally, during SFY 2022–23, a flyer created by the Foster Care Partnership continued to be distributed electronically on a regular basis to LDSS foster care staff and other stakeholders. 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 for all MCOs and DMAS, 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 at the annual Children's Services Act Conference, DMAS' BabySteps Bimonthly meeting, Safe & Sound Task Force, and the Central Region Independent Living Advocates for Youth, among others. 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 children in foster care, children receiving adoption assistance, 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 2023, DMAS compiled a 2021–22 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 2021–22. 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 (Acute) Program Oversight Efforts

On October 1, 2023, DMAS began rolling out a unified health program called Cardinal Care. Cardinal Care is a single brand encompassing all health coverage programs for Virginia's 2 million Medicaid members. Cardinal Care includes Medallion 4.0 (Acute), CCC Plus (MLTSS), 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 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, including DMAS, has continued to work together on this initiative 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.

Psychiatric Residential Treatment Facility (PRTF) Workgroup

At the direction of the Secretary of Health and Human Resources, DMAS convened a workgroup consisting of program experts, representatives of stakeholder organizations, and other local and state agencies to assess the impacts of including coverage for Residential Treatment Services for youth with a primary mental health diagnosis provided by a PRTF in the Medicaid Managed Care contract. (Members are currently excluded from managed care for all services for the duration of their time in a PRTF.) This workgroup met three times for two-hour sessions each to discuss the impact, structure, and costs of including this service in managed care. The work group recommended that DMAS be directed to implement a managed care carve-out for PRTF, such that members would remain with their MCO for coverage of all non-PRTF services, and that the benefits and services that make up PRTF are carved out and managed via FFS.

Current Procurement for Cardinal Care Managed Care Contracts and a Single Foster Care Specialty Plan

The current procurement underway reflects DMAS' goals to improve MCO accountability in service delivery and member access with particular focus on behavioral health, and maternal and child health. Cardinal Care will emphasize enhanced expectations for performance and quality improvement, member engagement, use of new technology, and new payment models.

The current procurement includes a provision for one MCO to administer a single specialty plan for the child welfare member populations. Through the Foster Care Specialty Plan, DMAS will select one MCO that will operate statewide and work collaboratively with DMAS, the Department of Social Services (DSS), and the Office of Childrens' Services.

DMAS plans to enroll all children and youth in foster care in the Foster Care Specialty Plan. It is anticipated that youth in adoption assistance and former foster care members will be auto-assigned to the Foster Care Specialty Plan but may elect to enroll in another health plan.

Appendix A: Study Indicators

For reference, Appendix A provides the technical specifications set, description, denominator, and numerator(s) for each of the 48 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 2023 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 2023 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 2023 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 2023 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

Behavioral Health

Antidepressant Medication Management (AMM)

- *Specifications Set*: FFY 2023 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*:
  - *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 2023 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 2023 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 Value Set) 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 2023 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 2023 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 2023 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 Substance Use—30-Day Follow-Up (FUA)

- *Specifications Set:* FFY 2023 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 SUD or any diagnosis of drug overdose who had a follow-up visit for SUD 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 and older as of the date of the ED visit with an ED visit (ED Value Set) with a principal diagnosis of SUD (AOD Abuse and Dependence Value Set) or any diagnosis of drug overdose (Unintentional Drug Overdose Value Set)
- *Numerator:* A follow-up visit or pharmacotherapy dispensing event within 30 days after the ED visit, including visits that occur on the date of the ED visit

Initiation and Engagement of SUD Treatment (IET)

- *Specifications Set:* FFY 2023 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 SUD use or dependence for all eligible children
- *Description:* Percentage of new episodes of SUD that result in SUD treatment initiation and engagement
- *Denominator:* New episodes of SUD during the intake period (Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set) for members in the study population who are at least 13 years old as of the SUD episode date
- *Numerator:*
  - *Initiation of SUD Treatment:* An initiation visit, defined as an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, non-residential substance abuse treatment facility visit, community mental health center visit, telehealth visit, substance use disorder service, observation visit, telephone visit, e-visit or virtual check-in, weekly or monthly opioid treatment service, or medication treatment within 14 days of diagnosis
  - *Engagement of SUD Treatment:* An initiation visit AND two or more additional SUD services or medication treatment within 34 days of the initiation visit

Respiratory Health

Asthma Medication Ratio (AMR)

- *Specifications Set:* FFY 2023 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 2023 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 2023 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 2023 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*:
  - *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.

- *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 any 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.

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 *2022–23 Task I2 Child Welfare Focus Study Methodology* document.

[A-1] Please note, acute inpatient psychiatric hospital stays, identified by revenue code 0204, are included as RTC services.

- *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 [Acute] or CCC Plus [MLTSS]) 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 Behavioral Health Care Within 60 Days for New Foster Care Members

- *Specifications Set:* None. Defined by HSAG and DMAS. Full specifications are available in the *2022–23 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 behavioral healthcare within 60 days of enrollment.
- *Denominator*:
  - *Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members:* 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 November 1 of the measurement year. Members must be continuously enrolled in a single Medicaid managed care program (i.e., Medallion 4.0 [Acute] or CCC Plus [MLTSS]) with aid category "076" with any MCO or combination of MCOs for the 61-day period that includes the first foster care program enrollment date through 60 days after the first foster care program enrollment date.

  - *Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members With a Behavioral Health Diagnosis*: Among the members identified in the denominator for the *Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members* 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 first foster care enrollment date.
- *Numerator*: Members in the denominator who had at least one visit with an MHP during the 61-day period that includes the first foster care enrollment date through 60 days after the first foster care enrollment date.

Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members

- *Specifications Set:* None. Defined by HSAG and DMAS. Full specifications are available in the *2022–23 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 behavioral healthcare within one year of enrollment.
- *Denominator*:
  - *Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members:* Members in the study population who were under 18 years of age as of January 1 of the year prior to the measurement year and who were newly enrolled in the foster care program during the year prior to the measurement year. Members must be continuously enrolled in a single Medicaid managed care program (i.e., Medallion 4.0 [Acute] or CCC Plus [MLTSS]) with aid category "076" with any MCO or combination of MCOs for one year starting on their first foster care enrollment date.
  - *Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members With a Behavioral Health Diagnosis*: Among the members identified in the denominator for the *Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members* 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 first foster care enrollment date.
- *Numerator*: Members in the denominator who had at least one visit with an MHP during the one-year period that begins on the first foster care enrollment date.

Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members

- *Specifications Set:* None. Defined by HSAG and DMAS. Full specifications are available in the *2022–23 Task I2 Child Welfare Focus Study Methodology* document.
- *Description:* Percentage of members who were newly enrolled in the adoption assistance program who received timely access to behavioral healthcare within one year of enrollment.
- *Denominator*:
  - *Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members:* Members in the study population who were under 18 years of age as of January 1 of the year prior to the measurement year and who were newly enrolled in the adoption assistance program

during the year prior to the measurement year. Members must be continuously enrolled in a single Medicaid managed care program (i.e., Medallion 4.0 [Acute] or CCC Plus [MLTSS]) with aid category "072" with any MCO or combination of MCOs for one year starting on their first adoption assistance enrollment date.
  - *Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members With a Behavioral Health Diagnosis*: Among the members identified in the denominator for the *Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members* 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 first adoption assistance enrollment date.
- *Numerator*: Members in the denominator who had at least one visit with an MHP during the one-year period that begins on the first adoption assistance 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 *2022–23 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 [Acute] or CCC Plus [MLTSS]) 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 *2022–23 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 [Acute] or CCC Plus [MLTSS]) 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=3,873) and Controls (n=665,087) 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	704	18.2%	117,915	17.7%
3 to 5 years	666	17.2%	116,200	17.5%
6 to 10 years	921	23.8%	185,793	27.9%
11 to 13 years	522	13.5%	109,788	16.5%
≥ 14 years	1,060	27.4%	135,391	20.4%
Sex				
Male	2,072	53.5%	339,842	51.1%

Category	Number of Children in Foster Care	Percent of Children in Foster Care	Number of Controls	Percent of Controls
Female	1,801	46.5%	325,245	48.9%
Race				
Black or African American	1,302	33.6%	241,849	36.4%
White	2,476	63.9%	360,614	54.2%
Other	95	2.5%	62,624	9.4%
Region				
Central	769	19.9%	168,357	25.3%
Charlottesville/Western	728	18.8%	75,433	11.3%
Northern & Winchester	568	14.7%	173,165	26.0%
Roanoke/Alleghany	647	16.7%	61,552	9.3%
Southwest	S	S	S	S
Tidewater	685	17.7%	150,637	22.6%
Unknown	S	S	S	S
Continuously Enrolled MCO				
Aetna	418	10.8%	69,187	10.4%
HealthKeepers	1,096	28.3%	222,546	33.5%
Molina	233	6.0%	31,771	4.8%
Optima	833	21.5%	134,589	20.2%
UnitedHealthcare	254	6.6%	63,823	9.6%
VA Premier	929	24.0%	137,648	20.7%
More Than One MCO	110	2.8%	5,523	0.8%
Medicaid Program				
CCC Plus (MLTSS)	28	0.7%	23,896	3.6%
Medallion 4.0 (Acute)	3,845	99.3%	641,191	96.4%

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 value for a secondary population was also suppressed.

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=7,299) and Controls (n=665,087) 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	130	1.8%	117,915	17.7%

Category	Number of Children Receiving Adoption Assistance	Percent of Children Receiving Adoption Assistance	Number of Controls	Percent of Controls
3 to 5 years	749	10.3%	116,200	17.5%
6 to 10 years	2,212	30.3%	185,793	27.9%
11 to 13 years	1,631	22.3%	109,788	16.5%
≥ 14 years	2,577	35.3%	135,391	20.4%
Sex				
Male	3,924	53.8%	339,842	51.1%
Female	3,375	46.2%	325,245	48.9%
Race				
Black or African American	2,197	30.1%	241,849	36.4%
White	4,913	67.3%	360,614	54.2%
Other	189	2.6%	62,624	9.4%
Region				
Central	1,587	21.7%	168,357	25.3%
Charlottesville/Western	1,130	15.5%	75,433	11.3%
Northern & Winchester	1,077	14.8%	173,165	26.0%
Roanoke/Alleghany	1,244	17.0%	61,552	9.3%
Southwest	S	S	S	S
Tidewater	1,328	18.2%	150,637	22.6%
Unknown	S	S	S	S
Continuously Enrolled MCO				
Aetna	608	8.3%	69,187	10.4%
HealthKeepers	2,216	30.4%	222,546	33.5%
Molina	301	4.1%	31,771	4.8%
Optima	1,518	20.8%	134,589	20.2%
UnitedHealthcare	515	7.1%	63,823	9.6%
VA Premier	2,072	28.4%	137,648	20.7%
More Than One MCO	69	0.9%	5,523	0.8%
Medicaid Program				
CCC Plus (MLTSS)	214	2.9%	23,896	3.6%
Medallion 4.0 (Acute)	7,085	97.1%	641,191	96.4%

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 value for a secondary population was also suppressed.

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=1,780) and Controls (n=198,618) 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	1,069	60.1%	110,003	55.4%
23 to 26 years	711	39.9%	88,615	44.6%
Sex				
Male	916	51.5%	81,419	41.0%
Female	864	48.5%	117,199	59.0%
Race				
Black or African American	635	35.7%	75,063	37.8%
White	1,078	60.6%	98,563	49.6%
Other	67	3.8%	24,992	12.6%
Region				
Central	459	25.8%	51,964	26.2%
Charlottesville/Western	293	16.5%	23,393	11.8%
Northern & Winchester	195	11.0%	42,565	21.4%
Roanoke/Alleghany	261	14.7%	19,894	10.0%
Southwest	S	S	S	S
Tidewater	381	21.4%	48,084	24.2%
Unknown	S	S	S	S
Continuously Enrolled MCO				
Aetna	155	8.7%	28,744	14.5%
HealthKeepers	486	27.3%	55,368	27.9%
Molina	127	7.1%	15,868	8.0%
Optima	412	23.1%	39,465	19.9%
UnitedHealthcare	130	7.3%	20,781	10.5%
VA Premier	457	25.7%	36,980	18.6%
More Than One MCO	13	0.7%	1,412	0.7%
Medicaid Program				
CCC Plus (MLTSS)	61	3.4%	19,662	9.9%
Medallion 4.0 (Acute)	1,719	96.6%	178,956	90.1%

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 value for a secondary population was also suppressed.

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, 2022, the claims assessment period was January 1, 2021, through December 31, 2021. For children two years of age or younger as of January 1, 2022, the claims assessment period was January 1, 2022, through December 31, 2022, 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, 2021, through December 31, 2021) 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]

These diagnoses were grouped into 14 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 were introduced to the Child Welfare Focus Study for MY 2021 or later (e.g., maltreatment/abuse), HSAG used the version 2023 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]

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 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, 2022 through December 31, 2022) 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: Mar 20, 2024.

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: Mar 20, 2024.

- **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:
  - 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]

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.

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, maltreatment/abuse 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.

  - 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]

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 2023 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 2023 CMS Core Set Inpatient Stay Value Set
  - The claim's revenue code and type of bill code is not included in the FFY 2023 CMS Core Set Nonacute Inpatient Stay Value Set
  - The claim's primary diagnosis is included in the FFY 2023 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=3,873) and Controls (n=665,087) 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	1,208	31.2%	17,274	2.6%
ADHD	1,226	31.7%	44,421	6.7%
Anxiety Disorder	914	23.6%	19,782	3.0%
Congenital Anomaly	203	5.2%	18,797	2.8%
Developmental Disorder	967	25.0%	52,889	8.0%
Intentional Self-Harm	143	3.7%	3,144	0.5%
Maltreatment/Abuse	110	2.8%	1,406	0.2%
Mood Disorder	811	20.9%	19,604	2.9%
Obesity and Metabolic Syndrome	710	18.3%	45,581	6.9%
Other Mental Health Disorder	306	7.9%	3,021	0.5%
Substance Use Disorder	133	3.4%	1,210	0.2%
ED Visit for Mental Health	68	1.8%	1,337	0.2%
Acute Inpatient Visit for Mental Health	148	3.8%	2,525	0.4%

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=7,299) and Controls (n=665,087) 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	694	9.5%	17,274	2.6%
ADHD	2,289	31.4%	44,421	6.7%
Anxiety Disorder	843	11.5%	19,782	3.0%
Congenital Anomaly	289	4.0%	18,797	2.8%
Developmental Disorder	1,280	17.5%	52,889	8.0%
Mood Disorder	780	10.7%	19,604	2.9%
Neurological Disorder	197	2.7%	7,927	1.2%
Substance Use Disorder	48	0.7%	1,210	0.2%
ED Visit for Mental Health	31	0.4%	1,337	0.2%

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=1,780) and Controls (n=198,618) 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	64	3.6%	3,936	2.0%
ADHD	127	7.1%	5,569	2.8%
Anxiety Disorder	243	13.7%	17,001	8.6%
Mood Disorder	380	21.3%	19,839	10.0%
Psychotic Disorder	57	3.2%	2,835	1.4%
Rheumatologic Condition	164	9.2%	13,688	6.9%
Substance Use Disorder	134	7.5%	6,380	3.2%

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=3,695) and Controls (n=3,695) 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	682	18.5%	682	18.5%	1.00	0.000
3 to 5 years	627	17.0%	627	17.0%		0.000
6 to 10 years	868	23.5%	868	23.5%		0.000
11 to 13 years	504	13.6%	504	13.6%		0.000
≥ 14 years	1,014	27.4%	1,014	27.4%		0.000
Sex						
Male	1,972	53.4%	2,019	54.6%	0.27	-0.026
Female	1,723	46.6%	1,676	45.4%		0.026
Race						
Black or African American	1,231	33.3%	1,231	33.3%	1.00	0.000
White	2,382	64.5%	2,382	64.5%		0.000
Other	82	2.2%	82	2.2%		0.000
Region						
Central	737	19.9%	737	19.9%	1.00	0.000
Charlottesville/Western	688	18.6%	688	18.6%		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*
Northern & Winchester	551	14.9%	551	14.9%		0.000
Roanoke/Alleghany	607	16.4%	607	16.4%		0.000
Southwest	449	12.2%	449	12.2%		0.000
Tidewater	663	17.9%	663	17.9%		0.000
Continuously Enrolled MCO						
Aetna	398	10.8%	398	10.8%	1.00	0.000
HealthKeepers	1,050	28.4%	1,050	28.4%		0.000
Molina	219	5.9%	219	5.9%		0.000
Optima	806	21.8%	806	21.8%		0.000
UnitedHealthcare	234	6.3%	234	6.3%		0.000
VA Premier	905	24.5%	905	24.5%		0.000
More Than One MCO	83	2.2%	83	2.2%		0.000
Medicaid Program						
CCC Plus (MLTSS)	27	0.7%	84	2.3%	<0.001*	-0.127*
Medallion 4.0 (Acute)	3,668	99.3%	3,611	97.7%		0.127*

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. Both the Chi-square test and the standardized differences assessment identified imbalance in the Medicaid Program category. However, during the matching process, the difference in the distribution of Medicaid Program between children in foster care and the controls improved by 1.3 percentage points.

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= 7,270) and Controls (n= 7,270) 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	130	1.8%	130	1.8%	1.00	0.000
3 to 5 years	747	10.3%	747	10.3%		0.000
6 to 10 years	2,203	30.3%	2,203	30.3%		0.000
11 to 13 years	1,622	22.3%	1,622	22.3%		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*
≥ 14 years	2,568	35.3%	2,568	35.3%		0.000
Sex						
Male	1,972	53.4%	2,019	54.6%	0.26	-0.019
Female	1,723	46.6%	1,676	45.4%		0.019
Race						
Black or African American	2,182	30.0%	2,182	30.0%	1.00	0.000
White	4,907	67.5%	4,907	67.5%		0.000
Other	181	2.5%	181	2.5%		0.000
Region						
Central	1,580	21.7%	1,580	21.7%	1.00	0.000
Charlottesville/Western	1,126	15.5%	1,126	15.5%		0.000
Northern & Winchester	1,075	14.8%	1,075	14.8%		0.000
Roanoke/Alleghany	1,236	17.0%	1,236	17.0%		0.000
Southwest	929	12.8%	929	12.8%		0.000
Tidewater	1,324	18.2%	1,324	18.2%		0.000
Continuously Enrolled MCO						
Aetna	604	8.3%	604	8.3%	1.00	0.000
HealthKeepers	2,211	30.4%	2,211	30.4%		0.000
Molina	299	4.1%	299	4.1%		0.000
Optima	1,514	20.8%	1,514	20.8%		0.000
UnitedHealthcare	509	7.0%	509	7.0%		0.000
VA Premier	2,065	28.4%	2,065	28.4%		0.000
More Than One MCO	68	0.9%	68	0.9%		0.000
Medicaid Program						
CCC Plus (MLTSS)	214	2.9%	251	3.5%	0.08	-0.029
Medallion 4.0 (Acute)	7,056	97.1%	7,019	96.5%		0.029

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=1,779) and Controls (n=1,779) 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	1,068	60.0%	1,068	60.0%	1.00	0.000
23 to 26 years	711	40.0%	711	40.0%		0.000
Sex						
Male	915	51.4%	909	51.1%	0.84	0.007
Female	864	48.6%	870	48.9%		-0.007
Race						
Black or African American	635	35.7%	635	35.7%	1.00	0.000
White	1,077	60.5%	1,077	60.5%		0.000
Other	67	3.8%	67	3.8%		0.000
Region						
Central	459	25.8%	459	25.8%	1.00	0.000
Charlottesville/Western	293	16.5%	293	16.5%		0.000
Northern & Winchester	195	11.0%	195	11.0%		0.000
Roanoke/Alleghany	261	14.7%	261	14.7%		0.000
Southwest	190	10.7%	190	10.7%		0.000
Tidewater	381	21.4%	381	21.4%		0.000
Continuously Enrolled MCO						
Aetna	155	8.7%	155	8.7%	1.00	0.000
HealthKeepers	486	27.3%	486	27.3%		0.000
Molina	127	7.1%	127	7.1%		0.000
Optima	412	23.2%	412	23.2%		0.000
UnitedHealthcare	130	7.3%	130	7.3%		0.000
VA Premier	456	25.6%	456	25.6%		0.000
More Than One MCO	13	0.7%	13	0.7%		0.000
Medicaid Program						
CCC Plus (MLTSS)	61	3.4%	61	3.4%	1.00	0.000
Medallion 4.0 (Acute)	1,718	96.6%	1,718	96.6%		0.000

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=3,695) and Controls (n=3,695) 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	1,069	28.9%	1,089	29.5%	0.61	-0.012
ADHD	1,118	30.3%	1,131	30.6%	0.50	-0.008
Anxiety Disorder	810	21.9%	786	21.3%	0.74	0.016
Congenital Anomaly	185	5.0%	204	5.5%	0.32	-0.023
Developmental Disorder	856	23.2%	823	22.3%	0.36	0.021
Intentional Self-Harm	127	3.4%	97	2.6%	0.04*	0.047
Maltreatment/Abuse	81	2.2%	78	2.1%	0.36	0.006
Mood Disorder	734	19.9%	703	19.0%	0.81	0.021
Obesity and Metabolic Syndrome	654	17.7%	713	19.3%	0.08	-0.041
Other Mental Health Disorder	242	6.5%	183	5.0%	0.003*	0.069
Substance Use Disorder	103	2.8%	73	2.0%	0.02*	0.053
ED Visit for Mental Health	59	1.6%	40	1.1%	0.05	0.045
Acute Inpatient Visit for Mental Health	130	3.5%	86	2.3%	0.002*	0.071

** 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, Other Mental Health Disorder, Substance Use 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 1.6 percentage points for Obesity and Metabolic Syndrome, and this difference was a substantial improvement from the 11.4 percentage point difference between children in foster care 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=7,270) and Controls (n=7,270) 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	676	9.3%	662	9.1%	0.69	0.007
ADHD	2,261	31.1%	2,287	31.5%	0.64	-0.008
Anxiety Disorder	823	11.3%	806	11.1%	0.65	0.007
Congenital Anomaly	286	3.9%	265	3.6%	0.36	0.015
Developmental Disorder	1,258	17.3%	1,190	16.4%	0.13	0.025
Mood Disorder	762	10.5%	782	10.8%	0.59	-0.009
Neurological Disorder	193	2.7%	158	2.2%	0.06	0.031
Substance Use Disorder	47	0.6%	34	0.5%	0.15	0.024
ED Visit for Mental Health	31	0.4%	35	0.5%	0.62	-0.008

The health characteristics distributions for the children receiving adoption assistance study population and the controls were balanced by matching. The Chi-square tests found no imbalances in the health characteristics, the omnibus test (p=0.05) indicated overall balance, and the standardized differences assessment found no imbalances in the health characteristics.

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=1,779) and Controls (n=1,779) 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	64	3.6%	52	2.9%	0.26	0.038
ADHD	126	7.1%	127	7.1%	0.95	-0.002
Anxiety Disorder	242	13.6%	237	13.3%	0.81	0.008
Mood Disorder	379	21.3%	372	20.9%	0.77	0.010
Psychotic Disorder	57	3.2%	34	1.9%	0.01*	0.082
Rheumatologic Condition	164	9.2%	172	9.7%	0.65	-0.015
Substance Use Disorder	134	7.5%	130	7.3%	0.80	0.009

** Indicates that the covariate balance test found imbalance between the children in foster care and controls.*

The health characteristics distributions for the former foster care members study population and the controls were balanced by matching. The Chi-square tests indicated imbalance for one health characteristic (i.e., Psychotic Disorder), but the standardized differences assessment did not identify

any imbalances in the health characteristics. The omnibus test also did not identify any imbalance (p=0.56). 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.